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Cross-Cultural Issues in Clinical Psychology Training Programmes

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In line with wide-spread demands by Maori people for a culturally-sensitive health care system, and concerns regarding the appropriateness of cross-cultural therapy, recent years have witnessed an increasing need for Maori clinical psychologists. A survey of New Zealand university clinical psychology training programmes indicated that almost all clinical staff are Paheka and only half of the programmes have any Maori trainees. Despite some efforts to encourage more Maori applicants and attempts to include a bi-cultural focus in training, in both content and process, the emphasis on western psychological theories and treatments remains predominant. Potential difficulties for Maori students as they apply for and train in clinical diploma programmes are examined, and the ability of existing training programmes to adequately prepare students for work with Maori clients is discussed.

Despite a variety of legislative changes aimed at honouring the Treaty of Waitangi by restoring Maori resources, and an increasing awareness of New Zealand as a bicultural nation, progress towards complete cultural equity has been painfully slow. After more than a century of assimilation into the Pakeha way of life, Maori are acutely aware of the erosion of their cultural perspective and are demanding the urgent recognition and implementation of promises inherent in the Treaty (Walker, 1990). Issues of land ownership (Walker, 1990), unequal educational opportunities (McKenzie, 1985), unemployment (Easton, 1990; Puao Te-Ata-Tu, 1986), and health care (Standing Committee on Maori Health, 1987) are repeatedly raised in an effort to have imbalances in these areas redressed. Evidence of cultural insensitivity in the implementation of mental health care is frequently cited as an example of Pakeha disregard for the welfare of Maori, and counselling practices have been harshly criticised (e.g., Drewery, 1990; Awatere, 1981). This paper looks briefly at issues in cross-cultural therapy, examines the extent to which university clinical psychology programmes have met the demand for more Maori clinical psychologists, describes the procedures for entry and training (with particular emphasis on potential difficulties for Maori trainees), and comments on the ability of existing training programmes to prepare students for work with Maori clients.

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Over recent years, discontent has increased at the inability of the mental health system to address the specific needs of Maori people (Murchie, 1984; Ratana, 1989; Standing Committee on Maori Health, 1986). A major concern has been the disproportionate number of Maori in psychiatric or criminal institutions (Jackson, 1988), many in the care of professionals largely ignorant of Maori mental health perspectives (Abbott & Durie, 1987). Maori reluctance to seek treatment for mental disturbances has been viewed as indicative of a lack of confidence in the ability of health professionals to understand Maori culture and provide appropriate treatments (Durie, 1985). Sachdev (1990) has suggested that the failure of some Maori clients to benefit from psychiatric treatments may be attributable to misdiagnosis by professionals ignorant of Maori culture. He adds that the mental health of these patients may in fact deteriorate as a result of misinterpretation of patient behaviours and consequent inappropriate treatments. If this is so, then the implications for Maori in need of psychological or psychiatric treatments are grave.

Clinical psychologists regularly working with Maori clients (e.g., Justice system, hospitals and the Department of Social Welfare) are almost all Pakeha and concerns regarding culturally-appropriate therapy are similar to those raised regarding psychiatric treatments; namely that Maori clients may not only not gain from but be negatively affected by cross-cultural therapy (Abbott & Durie, 1987; Sachdev, 1990; Sue & Zane, 1987). In addressing these

problems, some writers have argued that bi-cultural education for practising clinicians should be energetically pursued (Abbott & Durie, 1987; Murchie, 1984; Sawrey, 1990), but a somewhat uneven response from the psychological community has been noted. A survey conducted by Sawrey (1990) found that clinical psychologists were divided on the issue of how much Maori content should be compulsory during training. Meanwhile, the question of the effectiveness of cross-cultural therapy continues to provoke debate (Abbott & Durie, 1987; Awatere, 1981; Sue, 1988).

The issues are clouded and available data have not helped to clarify matters. Sue and Zane (1987), for example, have commented that conceptual and methodological shortcomings in published research on cross-cultural counselling make it hard to obtain evidence of systematic negative effects due entirely to ethnic differences between therapist and client. These authors noted that a significant proportion (approximately 50%) of ethnic-minority clients do not return for a second treatment session with white therapists, compared to a 30% drop-out rate by whites. Many reasons are identified: non-bilingual therapists, discrimination, and stereotypes which therapists have of culturally different clients (Abbott & Durie, 1987; Awatere, 1981; Sue & Zane 1987). Sue and Zane (1987) suggest that the most important factor may be the inability of the therapist to provide "culturally responsive forms of treatment" (p.37). This is strengthened by Sue's (1988) observation that, irrespective of client/therapist match or mismatch, twenty years of research in the area of cross-cultural therapy has failed to "systematically reveal outcome difference" (p.307) in terms of client well-being. Furthermore, he observed, ethnic match had not uniformly resulted in more efficacious outcomes. Thus, the critical factor in therapeutic failures, in terms of these findings, would seem to be cultural ignorance (resulting in an inability to provide appropriate therapy) rather than ethnicity per se. If one accepts this, then the apparent reluctance of so many New Zealand psychologists to agree that taha Maori should be a compulsory component during training (Sawrey, 1990) does not augur well for cross-cultural therapy, especially in view of Awatere's (1981) comment that the imposition of Western definitions of normality is a deliberate extension of colonization. Clearly, any reluctance to include taha Maori in training programmes could easily be construed as further evidence of indifference to Maori clients' welfare.

Some agencies (e.g., Department of Social Welfare and the Justice Department) provide, cross-cultural education for their clinicians and, undoubtedly, many private clinicians have sought to extend their own knowledge. Unfortunately, there are no published data to show whether an increase in knowledge of taha Maori consistently results in either appropriate behaviour change on the part of the therapist or beneficial effects on Maori clients' well-being during or following therapy. Therefore, although the emphasis on cultural awareness education in some health service areas is promising, we cannot afford to be complacent. Maori psychologists are still urgently needed and requests for their services are expanding (J. Ogden, personal communcation, 1992). How to increase the number of qualified Maori clinicians is an issue of much debate among clinical trainers (Brady, 1990).

Survey of Clinical Training Programmes

University-based clinical psychology diploma programmes provide one recognised route to achieving a clinical qualification. Obviously, clinicians cannot be produced overnight, so how are these training programmes addressing this need? To explore this question, a telephone survey was conducted of key personnel in each of the six university clinical psychology programmes. The following questions were asked: Was there a Maori member of staff in the programme? How many Maori trainees graduated over the last three years? Were applications received from Maori students? How many Maori students were currently in the programme? Was there a culturally relevant selection interview protocol for Maori applicants? Did the programme make Maori culture or language courses a prerequisite for entry? Were such courses recommended to aspiring applicants? It was not the writer's intention to compare individual programme's rate of progress. The focus was on identifying the extent to which programmes overall were responding to the demands for Maori psychologists. Respondents were co-operative and forthcoming on the issues put before them.

Results showed that there were no Maori clinical staff in any of the programmes. One programme was advertising for a Maori staff member, and two others could call upon Maori staff in their department for contributions to clinical courses. However, this call on non-clinical Maori staff adds considerably to their workload (Nikora, 1991). One programme relied upon students being placed with a Maori external supervisor for some period during field training. All respondents perceived that the lack of Maori clinical teaching staff was due to no applications being

received from Maori; a not unexpected finding since there are so few Maori clinical psychologists.

Over the past six years three Maori clinical students have graduated (all three in the past three years). Only three programmes reported receiving applications from Maori students, but all six asserted that applications would be welcome. Some respondents saw the lack of student applications as a function of a skewed Maori population distribution. Certainly, more Maori live in the North Island, but clinical applicants typically apply to programmes throughout the country and expect to move if necessary.

One programme had a formal interview format which was culturally appropriate for Maori clinical applicants, but all stated that they would welcome whanau (family) being present if an applicant expressed such a desire. Three programmes recommended cultural courses to intending applicants (one included a Maori culture course in their graduate programme), and all but one said that they had a commitment to kaupapa Maori. Overall, it seems that Maori students would be welcomed into clinical programmes but the best method of encouraging them has not yet been found.

It may be that they are discouraged by the lack of role models or so few Maori peers to provide support within a Pakeha dominated system. Maori students who apply, and are selected, may encounter special difficulties with the structure, content and training processes which reflect only the perspective of the dominant culture.

Applying for a Position In a Clinical Training Programme

Respondents in the telephone survey reported that there were five or six applicants for every available place (average six-eight places per programme), and that students were usually selected for interview on the basis of their previous academic performance. Only one programme reported interviewing all applicants. Generally, an undergraduate degree with a psychology major is essential, and students are expected to have course prerequisites or their equivalent. It has been found that Maori students often feel alienated and fail to achieve academically relatively early during their schooling (McKenzie, 1985). This being so, the first obstacle a Maori applicant may encounter is having to compete with students who have better undergraduate grades.

The Selection Interview

The next potential hurdle for a Maori clinical applicant is the selection interview. As only one programme reported having a culturally-relevant protocol for interviewing Maori applicants, a Maori student would have to request a whanau interview (interview which includes applicants family members). Not so difficult for eager applicants perhaps, but potentially anxiety-inducing for one who has felt alienated in educational establishments.

Although two programmes reported including a Maori representative, the composition of the selection panel typically comprises Pakeha academics and clinicians and this can pose special difficulties for Maori candidates. Metge and Kinloch (1978) have vividly described the body language which differentiates Maori from Pakeha across situations. For example, when being interviewed for clinical training, students are encouraged to present as confident, assured, eager and competitive (attributes lauded in western culture), but Maori run the risk of whakama (shame) should they boast their own qualities and convictions regarding their performance (Sachdev, 1990). Typically, interviewees answer questions aimed at clarifying their reasons for choosing clinical psychology as a career, areas of interest, previous experience and commitment to clinical psychology. The focus is on the individual, individual work, individual responsibility. Maori students may, however, be applying as the spearhead of family or tribal community, all of whom will have a vested interest in the student's success — or failure (Lawson, 1991), and all of whom will feel involved and responsible for the work undertaken (Nikora, 1991).

In addition to the close connection to whanau, Maori feel spiritually linked to their ancestors whom, they believe, provide them with strength, courage and advice as they face their daily tasks, and with whom they have ongoing communication (Sachdev, 1990). This spiritual link is a powerful bond for Maori people and pervades all activities, allowing strength from the forebears to flow to the individual, and sometimes the wrath of those deceased when cultural mores are infringed (Sachdev, 1990). From this standpoint, the interview is most definitely not an *individual* interview, but at the very least, an extended family interview. It is the student's whanau who speak, promoting the student's valuable characteristics, and contracting to support the student throughout training. Without whanau present, a Maori student might be unable to present favourably or appear confident. Unless Pakeha are aware of

these differences Maori applicants may fail to be selected simply because panellists are not familiar with Maori culture.

The Clinical Training Programme: Process and Content

If they are selected, Maori students still face obstacles at many points during the three-year training period that are additional to those encountered by their Paheka counterparts. There are minor variations between programmes but generally a three-year clinical diploma programme and Master's degree in psychology run concurrently. During the first year of training the emphasis is on academic work: papers, reviews, assignments, seminars and tests. In keeping with western tradition, the written word is the key method for the transmission and testing of essential knowledge during this period. Published material is subject to peer review and academic arguments rest upon being able to cite the appropriate literature. Students are expected to reference material from the literature of the discipline. For Maori, however, important knowledge has traditionally been transmitted orally (King, 1990) and efforts to adapt may generate conflict with their cultural norms (Lawson 1991). McKenzie (1985) has viewed this enforced move from a wholly oral to a literate culture as a prime example of European assumptions about the comprehension, status, and the binding power of the written word. This view is echoed by Pomare and Cowan (1987) who, discussing the transfer of knowledge, have emphasized that oral transmission is no less valid than the classical European literature. They conclude that knowledge, so carefully passed on by word of mouth, as Maori traditionally do, is literature in the fullest sense. Our western emphasis on the written word may be denying Maori the freedom to demonstrate their knowledge in a culturally appropriate form.

For a Maori student, the training programme content may be as problematic as the Pakeha methods of learning. Across all of the training programmes, the academic content comprises subjects generally accepted to represent the predominant areas of human cognitive, affective and behavioural development and disturbance. Such areas are defined broadly as thoughts, emotions, and behaviour (Rosenhan & Seligman, 1989). Relevant literature supports a variety of aetiological explanations and therapies relating to dysfunction in any of these areas. Typically, these theories are well covered in prescribed texts, none of which are Maori in origin, and most not even New Zealand texts. Maori students are forced to consider human dysfunction in terms which do not reflect Maori beliefs or value systems, and which omit the very essence of Maori cultural existence: spirituality (Sachdev, 1990).

Clinicians are urged to practice from a scientist-practitioner model (Barlow, Hayes & Nelson, 1984), and are ethically, as well as academically, required to demonstrate that their work reflects empirically tested theories. A student who included spirituality as a theoretical clinical psychology perspective in written work, without referring to empirical data to adequately support this, or considered questions only in this light when addressing clinical problems, would be considered unsatisfactory. Continuance in a training programme requires an ongoing satisfactory performance, so Maori students are effectively required to adhere to western literature and practices to avoid failing.

One major difficulty, not noticeable at the outset, is that of time management. Maori typically resolve issues over the period of time necessary to achieve a resolution, rather than *within* a period of time (Ratana, 1989). With a heavy academic workload during the first year, and little room for extended debate (Brady, 1990) unless specifically included, Maori students may not have their cultural perspective addressed in any depth (if at all) during the first phase of training.

Any desire to move from a mono-cultural approach is unlikely to be achieved at second year either. At this level, in the majority of programmes, students move from wholly academic to practical training in a variety of settings for relatively short periods. As they observe their external supervisors, learn how particular institutions work, practise test administration, interviewing, and report writing, it is incumbent upon trainees to adopt the practices of the organization within which they train. It would be difficult (and unethical) for students to arbitrarily introduce a therapeutic perspective not already covered in course work or on placement. Equally, busy placement supervisors cannot reasonably be asked to adopt and promote a perspective in which they themselves may not be trained and may be unable to adequately evaluate. Consequently, during their second year, Maori students may not have an opportunity to develop a treatment approach consistent with their cultural perspective without the risk of jeopardizing their success on placement.

A similar situation occurs during the third year of training, in which students are placed in one or two external settings. Obtaining an internship can depend on a number of factors: student mobility, occasionally a need to balance the sex ratio in a setting, sometimes the availability of funding and,

of course, the availability of internships. The number of suitable settings varies from year to year and, for numerous reasons, shortages are not infrequent. Consequently, external supervisors can choose from among the available students. Since supervisors have observed how a number of students have performed during second year, they have presumably decided what kind of student will best suit their organization. Aware of the pressure for placements, students who want internships are unlikely to indicate that they wish to work in a way which is very different from the methods of the setting. For Maori students this can mean passing through their last year of training without experiencing a Maori approach to therapeutic interventions.

The Final Examination

Clinical students approach the final examination with clearly defined tasks to complete. Their chief task is to demonstrate a good grounding in psychological theory and the ability to apply therapeutic interventions in a competent, ethical and sensitive manner. Throughout three years of training, criteria for the final examination have been gradually and methodically instilled. If a Maori mental health perspective has not been part of the curriculum or practical training, Maori students may have by now put it to one side and adopted Pakeha models of abnormality and therapy — which, incidentally, are purportedly failing to help a high proportion of our clients (Standing Committee on Maori Health, 1986). Alternatively, by challenging the system, these students may have risked being viewed as 'unsuitable'. So, as they present for their final examination, Maori students face a panel of judges who reflect the dominant culture's training practices, and who are expecting to see a student trained in a similar manner.

What issues this may raise for 'whanau supported' students can be only surmised, but one might expect a measure of cognitive dissonance to be present if they had aspirations of utilizing their skills in their whanau, hapu and iwi. The potential for conflict as they try to absorb and practise western psychology while they risk being rejected by their whanau as a 'Pakeha' psychologist (Nikora, 1991), is an issue not formally addressed when Maori students first apply for positions in training programmes, or considered as they approach graduation.

The Implications For Training Programmes

It seems that while issues surrounding the effectiveness of cross-cultural therapy and counselling are not yet resolved (Abbott & Durie, 1987; Sue & Zane, 1987) and Maori psychologists number so few, it is vital to include taha Maori in clinical training if Pakeha psychologists are to provide at least a culturally sensitive service for Maori clients (Ratana, 1989). Eliminating barriers for Maori students coming in to training may encourage more applicants, but to significantly increase the number of Maori clinicians will take some years yet. Thus, we may have to accept that with existing staff and the present structures all we can ensure is coverage of taha Maori. We are not equipped to train Maori students in a Maori approach to psychology. This raises the question of whether we should restructure our programmes to include a Maori perspective (accepting that we may have to employ non-psychologists from the Maori community) or provide resources so that Maori can train their own people. Arguments can be mounted for and against either approach. Clearly, including a taha Maori component during training would aid all our students as they work with Maori clients, but to train students in a Maori approach to psychology entails a major revamping of already tightly-packed programmes. We would need to broaden aspects of our code of ethics (e.g., appropriate touching, client confidentiality) and assessment methods. Changing our structure would mean reviewing university rules and regulations, course formats, texts and psychometric tests employed in training. The alternative, separate Maori training programmes, could provide Maori clients with a culturally relevant service, but might leave Maori graduates restricted to working with Maori clients only (and while they may wish to do so, surely the choice should remain theirs). Such an approach would surely enshrine a policy of separatism.

Clearly, despite the efforts of some clinical programmes, there is much to do before clinical psychology can claim that we are serving our bi-cultural population fairly. There are no quick remedies. The hope here is to promote discussion rather than urge a particular course of action, but there is an urgent need to be more accountable to our Maori clients and students. Irrespective of the programme in which they train, Maori and Pakeha clinicians can expect to find themselves working with Maori clients. Agencies such as the Justice Department and the Department of Social Welfare are actively seeking, and supporting the training of, more Maori students (Ogden, 1992) so programmes will be pressured to address the collective shortcomings that exist in terms of providing clinical training that reflects both Pakeha and Maori reality. If we cannot do this our

trained clinicians, whether Maori or Pakeha, will continue to work from the dominant culture's perspective, and our Maori clients will remain ill-served. Therefore, no programme can afford to overlook taha Maori as an essential component of training. Tardiness on our part to bring about changes in training may galvanise Maori to look to their own people for a formal training system not linked with the existing tertiary institution programmes. Unless we are in favour of separate systems, we must be willing to invest more energy and display an even greater willingness to effect real changes in the present system. Maybe the iconoclastic nature of such fundamental dismantling of the existing structures is too daunting and is responsible for our slowness to change. If so, we must be courageous and face this fact.

We could begin by identifying and addressing concerns Pakeha staff may have regarding incorporating a Maori health perspective, by ensuring that Maori are represented on selection panels and by making it a requirement for all clinical applicants to have taha Maori in their undergraduate degree. Iwi-approved Maori trainers might work alongside Pakeha staff and Maori writers could be asked to write texts reflecting their cultural approaches to psychology. It would be essential to request the New Zealand Psychological Society and the New Zealand College of Clinical Psychologists to review the code of ethics and make alterations to encourage an acceptance within the psychological community of Maori psychological approaches, and to develop examination procedures which adequately test this knowledge. Consideration could also be given to utilising Maori-controlled settings as training placements.

There is an urgent need to recognize that, as the indigenous people of New Zealand, Maori people have the right to be culturally different from the majority. While they are striving for cultural parity generally, within clinical psychology their need for a health perspective which reflects their culture and values is long overdue. It is time now to accept the dual perspectives and look realistically at our training programmes processes and structures, and *together with Maori* refashion these programmes to meet the needs of all our students for the benefit of all our prospective clients.

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