

# Taha Maori and Aotearoa/New Zealand Clinical Psychology: Developments at the University of Canterbury

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Maori continue to be over-represented in many negative social statistics, but are less likely to voluntarily access mainstream mental health services than non-Maori (Ministry of Health, 2002). Reviews of Aotearoa/New Zealand Clinical Psychology training programmes (Abbot & Durie, 1987; Brady, 1992) identified a lack of Maori trainees and culturally specific clinical skills as key concerns. The writers review progress in these areas, with reference to the requirements of the *Code of Ethics for Psychologists Working in Aotearoa/New Zealand (2002)* and the overall aims of the Maori mental health strategy, *Te Puawaitanga* (Ministry of Health, 2002). New Zealand clinical psychology programmes are extending the years of study and content areas for students to mirror the doctoral format of the USA and UK. However, this has generally not been matched by efforts to extend cross-cultural clinical practice skills for clinical psychology trainees. Recent initiatives to integrate taha Maori into the post-graduate diploma in clinical psychology programme at the University of Canterbury are outlined. It is suggested that the short-term goal of educating non-Maori to work with Maori is attendant upon the long-term goal of creating an environment that is more attractive to Maori students, thereby lessening the barriers to Maori participation in clinical psychology (Levy, 2002). Cultural training for clinical psychologists must be integrated into the overall course programme. Recommendations are made to achieve that aim.

Maori and other New Zealanders is a fundamental goal of the new Labour government" (Te Puni Kokiri, 1999, p.1). Mental health policy has focused on providing more choices for tangata whaiora through there being a greater number of trained mental health staff. An example is the Ministry of Health's Maori mental health policy (2002) which aimed to increase the numbers of trained Maori mental health workers by 50% over 1998 baselines. Similarly, it was proposed that 50% of tangata whaiora should have the choice of a mainstream or kaupapa maori mental health provider. Te Rau Matatini (2002), a workforce development initiative aims "to ensure that Maori mental health consumers...have access to a well-prepared and well-qualified Maori mental health workforce".

These strategies are based on the principle that Maori clients will often have a preference for working with Maori mental health workers. However, Maori may still opt to work with non-Maori, as occurs with the Department of Corrections Bicultural Therapy Model (McFarlane-Nathan, 1994). This combined with the still low numbers of Maori in key areas such as clinical psychology (Levy, 2002) suggests that non-Maori mental health workers need to be competent to work with Maori. These have been some of the factors in the authors' attempts to better develop the bicultural component of the University of Canterbury post-graduate clinical psychology programme.

**M**aori comprise approximately 15% of the New Zealand population. Maori continue to be vastly over-represented at the negative end of a wide range of social statistics, particularly for health, income, employment and offending. For example, Maori on average have a shorter life expectancy than Pakeha, even when living in more favourable socio-economic circumstances (Te Puni Kokiri, 2000). There is limited data on mental health service utilisation. However, the trends are for Maori to be over-represented in non-voluntary (hospital committal) or legislative

pathways (forensic services) to receiving assistance, and to be under-represented in utilisation of general medical practitioners and mental health outpatient services (Ministry of Health, 2002)

There have been several proposed strategies for addressing the disadvantage of Maori. The New Zealand Labour government attempted to implement a "closing the gaps" policy instructing all departments to develop plans and strategies for addressing the needs of Maori. According to Prime Minister Helen Clark, "closing the gaps between

## Clinical Psychology in Aotearoa

Clinical Psychology has a brief history in Aotearoa. The first post-graduate programme commenced at the University of Canterbury in 1960 with the Post-Graduate Diploma in Clinical Psychology available from 1962. Clinical psychology training currently occurs at six universities throughout Aotearoa<sup>1</sup>. The programmes differ in content and theoretical approach. For example, the University of Waikato has a strong background in community psychology and Victoria University has a strong criminal justice focus. Nonetheless, all programmes have a strong emphasis on North American, and to a lesser extent, British/European models of mental health, illness and treatment. This is evident in the reliance on the DSM-IV and ICD-10 diagnostic systems as the basis for assessing mental health disorders.

Abbot and Durie (1987) sought information from course directors regarding inclusion of taha Maori in clinical psychology programmes. They identified a dearth of Maori students and staff, and little or no course content devoted to clinical psychology practice with Maori, as key concerns. Brady (1992) identified several potential barriers to Maori entering and completing Aotearoa clinical psychology training. These included Maori applicants "having to compete with students who have better undergraduate grades" (p.58), and Maori students on clinical programmes being "forced to consider human dysfunction in terms which do not reflect Maori beliefs or value systems" (p.59). More recently, Levy (2002) reported "the number of Maori psychologists continues to remain low, raising serious questions about the ability of the profession to effectively meet the needs of its clientele" (p.1). A psychology workforce survey indicated that 42 (4.7%) of 889 active psychologists were Maori (New Zealand Psychologists Board, 2004).

The University of Waikato has traditionally had a much higher proportion of Maori clinical psychology trainees than other universities (Herbert, 2002), though currently there are only 23 Maori clinical psychologists in the

whole of Aotearoa. This suggests the majority of Maori clients who present for treatment will be seen by non-Maori.

Non-Maori who work with Maori need to overcome several potential barriers. First, there are overt or subtle attitudes that downplay the role of culture in wellness and psychopathology. Johnstone and Read (2000) found a significant proportion of psychiatrists and psychologists regarded knowledge of taha Maori as unimportant to their clinical practice. Second, practitioners need to understand how cultural difference may directly influence the relationship of client and therapist. Thus, minority-culture clients may feel ill at ease in both their own, and the dominant culture (Sue & Sue, 1990). Third, the clinical psychology research literature has failed to incorporate cultural factors. Iwamassa, Sorrocco and Koonce (2002) reviewed several North American psychology journals and found that few research studies included participants of ethnic minorities or attempted to include culturally-based hypotheses within the research. They contrasted the increasingly diverse ethnicity of clinical psychology clients for American clinical psychologists, with the paucity of evidence-based research to guide practitioners.

Aotearoa psychologists are expected to have the skills to work with clients from different cultural backgrounds, especially with tangata whenua. The Code of Ethics for Psychologists working in Aotearoa/New Zealand (2002) requires psychologists to only practice within their areas of competency, highlights "sensitivity to diversity" as a key principle, and expects that "psychologists seek to be responsive to cultural and social diversity..." (1.4.1, p.3). The New Zealand Corrections Department Psychological Service developed a set of cultural competencies<sup>2</sup> in addition to other core competencies for their psychologists. The Health Practitioner's Competence Assurance Act (HPCA, 2003) sets forth 'scopes of practice' for psychologists, and the required cultural competencies of psychologists are currently being developed. These developments all have implications for the training of clinical psychology

students, given that the majority will work in the health and justice sectors (New Zealand Psychologist Board, 2004).

## The University of Canterbury Clinical Psychology Programme

### Course content & geographical location

Canterbury University's Post-Graduate Diploma in Clinical Psychology has a strong emphasis on standard clinical psychology topics (e.g., assessment, formulation and treatment within a cognitive-behavioural and scientist-practitioner paradigm). Students learn about prevailing classification systems for psychological and psychiatric disorders, particularly the American Psychiatric Association DSM-IV. The Canterbury district is located in the South Island of Aotearoa/New Zealand. The main tribal or iwi groupings in the South Island are Ngai Tahu/Kai Tahu, and Kati Mamoe. Proportionately fewer Maori live in the South Island than the North Island. For example, 9 out of 20 residents on the East Coast of the North Island are Maori, whereas five to ten percent of South Island residents identify as Maori, depending on the region. Until 2001 the Canterbury programme did not have any specific training for clinical psychology students about working with Maori. Prior to that, the first author had participated in selection panels for course applicants. It was evident that students often lacked specific ideas about things Maori, and how this might be applicable to clinical psychology. The first two authors were invited to develop the bicultural component of the programme, in conjunction with the third author.

### Outline of the programme bicultural components

Since 2001, students have been encouraged to attend a te reo Maori course prior to undertaking the programme. In addition, students are expected to attend a Treaty of Waitangi workshop in year one of the programme. Feedback from the Treaty of Waitangi workshops highlighted student interest in linking their general awareness of the importance of Maori within Aotearoa with actual clinical practice

situations. Another initiative was for the second author (Ngati Porou and identifiably Maori) to role-play a client for the first year clinical psychology students undertaking evaluation of their interview skills. For many, this was their first formal interaction with a Maori tangata whaiora.

There have also been direct efforts to introduce taha Maori and tikanga Maori into the second and third year curriculum for students. In year two (beginning in 2004) this comprised a two-day hui at a local Ngai Tahu marae attended by students and clinical staff. Students had immediate contact with many aspects of taha Maori and experienced first-hand tikanga such as manakitanga. It also provided a safe environment for those Maori who presented to students on topics such as being a tangata whaiora; provision of mental health services as a pukenga atawhai; and funding and delivery of health services to Maori within the Ngai Tahu rohe. Student feedback on the hui was positive with students identifying the most helpful components being: the first hand experience of tikanga Maori; learning about Te Whare Tapa Wha (Durie, 1994) which represents Maori health as four interdependent domains: taha wairua (spirituality), taha hinengaro (the mind), taha tinana (the body), and taha whanau (family); and developing an awareness of, and connections with, Maori mental health service providers. Interestingly, almost all the students commented that the experience had the added benefits of increased group cohesiveness and enhanced staff-student relationships.

For final (third) year students, the first two authors developed and delivered a series of four three hour seminars. The seminars, which have occurred annually since 2002, were based around some of the requirements of New Zealand Code of Ethics for Psychologists working in Aotearoa (discussed earlier), with attention to specific cultural competencies. Seminars were conducted within the normal class time, and at psychology lecture facilities. Attendance was consistently high, with most seminars being fully attended by the 10 students. The seminars were given priority by the authors, given that those students

were usually about to embark upon their clinical practice.

#### *Seminar aims*

1. To generate interest among students in tikanga Maori; and motivate them to learn and develop further skills post-seminars.
2. To heighten their awareness of areas of knowledge regarding Maori culture and tangata whaiora, but also to increase awareness of personal, attitudinal and professional deficits.
3. To begin to understand possible links between the seminar material, and actual work situations; and where relevant, to better understand employers' expectations regarding cultural competency.
4. To meet the dual aims of providing culturally safe, and culturally competent clinical practice (Durie, 2001).

It was emphasised that the programme was not an introduction to Maori culture and language. The seminars were presented as being an introduction to some of the background, contextual factors affecting Maori; and an introduction to requisite skills relevant to clinical psychology practice with Maori clients.

#### *Te ahua o te matauranga/ Teaching Process*

The facilitators took the stance that the seminars were essentially not a wero but a koha to the students. A wero can be threatening and punishing but a koha is more likely to be accepted as a peaceful gesture. Koha infers reciprocity. The facilitators' expectations were that students would attend and participate in all aspects of the teaching (e.g., role play); would provide accurate feedback about their views of the material and would treat the material in a respectful manner. Nonetheless, humour and a relaxed atmosphere were seen as culturally appropriate and useful for undermining residual resistance to the experience. Students were encouraged to participate by the explicit expectation that contradiction and honest mistakes were necessary to learn. Teaching strategies used included modeling clinical practice scenarios by the authors, role-play, paper-case, narrative and clinical anecdote, practice of skills

(during and between seminars), reading and critique of articles.

#### *Content*

The authors shared their whakapapa and professional history with the students. Children of the facilitators and students were sometimes present, and this was used as a basis for discussing topics such as whakawhanaungatanga. As part of the introductions it was made clear that the facilitators were not experts in te reo Maori or tikanga Maori but were experienced clinical psychologists with life experience of being Maori.

The sessions were based around themes of identity, history (past and recent), understanding disparities, and working with Maori (health providers and clients). The aim was to provide students with a broad contextual understanding about Maori clients, to extend their focus beyond typical clinical issues and questions. For example, students were expected to begin gaining an understanding of some of the traditional Maori reference points for identity (e.g., rohe, waka, iwi, tupuna, whanau); but were also encouraged to gain some understanding of the many "diverse realities" (Durie, 1994) that contribute to a Maori sense of identity.

The facilitators developed and refined a model of clinical practice with Maori over the course of the three years of seminars. In brief, the phases of practice were:

- 1) preparation and knowledge required prior to meeting the client;
- 2) developing meeting and greeting skills, aimed to improve student and client comfort;
- 3) developing engagement and rapport with tangata whaiora and whanau. This included assessing cultural identity; and
- 4) assessment, using a Maori world-view and health model.

The emphasis of the seminars was on developing assessment rather than treatment skills. The facilitators attempted throughout to link traditional Maori concepts (e.g., whanaungatanga) with Maori health models (e.g., Te Whare Tapa Wha) and actual clinical vignettes. In the final session, students debated the merits of acknowledging

taha Maori in their practice, traversing issues raised by Johnstone and Read (2000). The content of the sessions, and learning achieved, was then informally compared with a set of cultural competencies that could guide the students' future learning goals.

### Evaluation

Students were informed that the seminars were a new initiative. Evaluation consisted of students' verbal and written feedback, the facilitators' observations of student progress during the seminars, and student responses to a case study<sup>3</sup> presented at the outset of session one (time-one). The case study had several possible cultural questions regarding identity (a child and grandmother who had a mix of Maori and Pakeha names), presenting concerns (some straightforward clinical, but hints of a cultural basis to some of the problems or desired treatment); possible options regarding who should be regarded as the client (the child, the grandmother, other whanau members); and options about where the client/s should be seen (at a clinic, at their home, back at their turangawaewae or home rohe/area).

Students were given their first set of case-study responses (usually completed on the front of the sheet outlining the case) at the completion of the seminars (time-two), and were invited to add or alter any comments. The facilitators did not attempt to group or count resultant themes, though students usually provided many more responses at the end of the seminars and elaborated more fully on possible cultural features. Time-one responses stressed probable clinical issues, for example that the client may be depressed. References to culture were not well-defined, e.g., suggestions there may be (non-specified) "cultural" and "family" issues. When revising and adding comments at time-two, students showed more willingness to use Maori terms (e.g., use of "whanau") and identified more areas warranting further investigation, such as "possibility of whakama (and) loss of wairua". Student responses at time-two indicated a preparedness to liaise with "a Maori health worker", to assess using a Maori health model (Te Whare

Tapa Wha), and to consider seeing the client and whanau at culture-friendly settings such as their marae or own home. Therefore, the seminars had met the aim of teaching students to think and use (here verbally rather than in actual practice) knowledge of taha Maori when responding to a case scenario. Their responses also demonstrated adherence to the clinical practice framework outlined earlier.

The written evaluation form feedback (identifying strengths and weaknesses of the seminars, comments regarding facilitation style, overall self-evaluation of the seminars) was almost uniformly positive. Students were keen to extend the time spent learning about bicultural issues and clinical practice, and asked that this course component be dealt with in more depth earlier in their training. Of interest, there were some negative comments about the "history" section of the seminars, with comments suggesting that this material had already been covered elsewhere (e.g., legislation restricting and subverting Maori land rights) and/or questioning the relevance of historical events to tangata whaiora today. An additional request of the first group of students completing the seminars in 2002 was for more practical exercises to be incorporated into the training. The facilitators' stance is that history is a powerful contextual factor for understanding Maori, and a stronger rationale was provided for inclusion of historical analyses when the seminars were repeated. Consequently, there were fewer critical comments regarding this aspect of the seminars. From 2003 practical exercises were included earlier in the seminars (i.e. during the first seminar, including the use of an evolving case-study strategy, in which the same two client profiles were gradually elaborated throughout all sessions). Students reacted well to the expectation that they would be actively involved in low-key role-play to implement some of what was taught.

Students also commented about the style of teaching. Several stated that they enjoyed doing role-plays, and "seeing it actually done" (i.e. facilitators role-playing preferred and non-preferred approaches to meeting and greeting clients, and beginning the

interview). The intention to provide a safe learning environment was achieved as shown by comments, such as, "very relaxed...excellent learning opportunity – best Maori training I've been to, user-friendly". Another commented that they "felt very safe to participate and discuss areas of uncertainty".

Finally, the facilitators observed that students were gradually more capable and prepared to take small risks within the class, as had been the initial intention. This perhaps was the only wero aspect of the seminars, to challenge students to start acting on their learning. Thus, the facilitators were often greeted in Maori with "kia ora" or "tena koe" prior to and after sessions, and students were prepared to show their aptitude at waiata for visiting kaikorero. Students openly admitted to knowledge deficits in earlier sessions, for example, being uncertain about more than one or two iwi groupings within Aotearoa when initially discussing the bases for identity.

### Discussion

Clinical psychology programmes in New Zealand mirror the strengths and weaknesses of the field internationally. Extending programmes into doctoral formats is consistent with overseas (e.g., UK and Australian) trends in clinical training. However, clinical psychology students and practitioners in Aotearoa risk "cultural malpractice" (Dana, 2000) if cultural factors are ignored when assessing and treating tangata whaiora. Working cross-culturally is not regarded as a core skill compared with, for example, skills in delivering cognitive-behaviour therapies for common psychological disorders. This may reflect a bias towards the view that psychiatric and psychological conditions and their treatment are essentially culture-free (see Thakker & Ward, 1998), despite the lack of research evidence to support this assumption (Iwamassa et al., 2002). Assumptions underlying the development of culture-specific mental health treatment services need to be tested. For example, is matched ethnicity as important for therapy outcome as other factors such as

shared worldview? (Knipscheer & Kleber, 2004). These questions are highly relevant to those currently working as clinical psychologists with Maori, and for those involved in the professional training of clinical psychology students.

With regard to cross-cultural (here, bicultural) training for clinical psychology students, the authors support the view of Glover and Robertson (1997) that this not be an "add-on", but should be an integrated part of any training programme. For this to occur, the cultural component should be incorporated throughout the programme rather than being restricted to a few days or included in only one year of the course. There needs to be a developmental perspective, that is, a curriculum, with increasingly complex and challenging learning and practical tasks for post-graduate clinical students. Written information (e.g., academic papers and other written commentary) as well as oral information is provided. This fits with university culture, and stresses the importance of the topic. Students need exposure to a wide-range of cultural presenters, Maori with experience in te ao hurihuri and te ao tawhito. At the University of Canterbury, students have met with Pukenga Atawhai (Maori mental health workers) with varying strengths regarding professional background, immersion in te reo Maori and tikanga Maori; with Maori tangata whaiora, and with professionally-trained Maori clinicians. Finally, course-evaluation requirements for cultural training need to be similar to other course components. The authors recommend, for example, that clinical-psychology exams formally include examination of cultural factors related to client presentations.

Maori practitioners including clinical psychologists have challenges when being asked to contribute to teaching in this area. For instance, the authors involved in providing the training feel obligated to our whanau whanui and iwi, to increase the likelihood Maori who encounter psychologists receive a high quality service. Training needs should not outweigh cultural needs. That is, students warrant exposure to what is

important and treasured about Maori culture, with the proviso that this doesn't signal handing over knowledge that is deemed tapu or intensely personal. As clinical psychologists, the first two authors believe they have some skill in assessing overt and underlying racist attitudes that could negatively impact upon their practice with tangata whaiora. When observed, this should form part of the feedback process to course staff just as further training needs are identified within supervisory arrangements.

### Summary

Maori remain disadvantaged in many areas compared to non-Maori in Aotearoa. This disadvantage is both exacerbated by, and extends to, receiving appropriate services for psychological and psychiatric problems. Efforts to integrate cultural knowledge and skills training for clinical psychology students have been sporadic, with notable exceptions such as what occurs at Waikato University (Herbert, 2002). The University of Canterbury now has some of the features of an integrated approach to cultural skills training. This approach has the dual advantages of enhancing bicultural skills of non-Maori psychologists, and providing a stronger basis for attracting and retaining Maori clinical psychology students. The next challenge for students who have participated in some of the cultural initiatives described in this paper, is to implement the knowledge and skills into their clinical practice, upon completion of training. The overall aim of providing best possible service to Maori tangata whaiora should be more achievable, with the combined efforts of policy makers (e.g., the Ministry of Health), workforce developers (Te Rau Matatini) and those providing professional oversight for the practice of psychologists (Code of Ethics for Psychologists working in Aotearoa/New Zealand 2002; HPCA Act 2003).

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**Notes**

- 1 Massey (Palmerston North) also has clinical psychology programmes at its Auckland & Wellington campuses.
- 2 Philip Skogstad was chairperson of the working party that developed the Corrections Psychological Service cultural competencies (1997).
- 3 A copy of the case-study is available upon request from the first author.

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