Steering by Matariki and the Southern Cross: Plotting clinical psychology's course in New Zealand

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Matariki (the Māori name for the star cluster also known as Pleiades) and the constellation called the Southern Cross have both served as important navigational aids in Māori and Pākehā (New Zealand European) voyaging traditions. Using this symbolism, I plot some recent developments in clinical psychology in Aotearoa New Zealand, in which the bi-cultural imperative afforded by te Tiriti o Waitangi (the Treaty of Waitangi) has the potential to allow exploration of many challenging issues facing the profession. I consider contemporary standards of clinical practice, drawing on my own research as well as that of my students. As the Southern Cross appears on the national flags of both Australia and New Zealand, I endeavour to show the value of these concepts for the emergence of a unique and less imitative professional identity for clinical psychology in all of Australasia.

Introduction

In 2004 I was honoured to receive the New Zealand Psychological Society's Hunter Award, which by tradition involves presenting an address to the Society the following year. In discussing this obligation with me, Professor Bob Knight from the University of Otago suggested that it would be interesting to offer a critical overview of the state of clinical psychology in New Zealand, since I had recently stepped down as director of the clinical programme at the University of Waikato. It was then suggested that if the Hunter address were delayed one year, it could be presented at the annual conference to be held in Auckland in 2006, which was to be a joint meeting of the Australian and the New Zealand Psychological Societies. This duly occurred and the present paper is based on that talk.

Sir Thomas Hunter, after whom the award was named, pioneered academic psychology in New Zealand, started a clinic, and founded the first psychology laboratory in all of Australasia. He was interested in the breadth of psychology as a discipline, in ethno-psychology, and in the intrinsic value of people over privilege: *"all human institutions must be judged not by their respectable ancestry but by the effects they actually produce in the life of the people of the day"* (Hunter, 1924, quoted by Taylor, 2002). Is not improving lives what clinical psychology is all about? After all, despite great material and natural wealth, we do have some serious social problems in this country, very similar in frequency to those in Australia—the two countries have almost identical negative indicators such as suicide rates, incidence of domestic violence, life expectancy, income inequality, and educational failure (drop-out) (Ministry of Social Development, 2006).

There are thus two overall themes of this paper. One is that of culture, based on increased scholarly awareness of the indigenous perspectives from both Māori and Aboriginal cultures and how they co-exist with the majority cultures of New Zealand and Australia, both of which, however--in the context of *clinical* psychology--are in turn dominated by two other academic and professional cultures, British and American. The second theme is whether we in Australasia would benefit from developing a more home-grown clinical psychology, and, of equal gravity, whether attention to our own indigenous cultures would strengthen such a development in unique and important ways. Here then are the questions: Can we develop a clinical psychology that is specific to New Zealand and Australia? And why should we bother?

Our marvellous new *Code of Ethics for Psychologists: Working in Aotearoa/New Zealand* (New Zealand Psychological Society, 2002), begins with the following preamble:

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

Each of the four key principles also specifies the centrality of te Tiriti (the Treaty) regarding respect, responsible caring, integrity in relationships, and social justice. But how thoroughly have we discussed the implication of this declaration for clinical psychology in this country? What does it actually mean for daily professional practice? In considering this question I am using stellar navigation as symbols of different sources of knowledge, but it must be made clear that I am not presuming to

represent Māori ideas about the meaning of this declaration. What I will do is suggest, from *my* perspective only, the potential advantages of steering a new course according to respect for some different traditions of exploration and discovery.

A Sample Study

Let me start off by describing an experiment. Since attitude measurement is so susceptible to social desirability influences, and since verbal report of feelings is so confounded by cognition rather than emotion, clinicians need ways of measuring defensiveness and unexpressed affect. One such way is to ask the person to make emotive judgments. I can demonstrate this by asking the reader to evaluate the two people who wrote the following essays about the Treaty of Waitangi. These were both written by international students from an Asian country, attending high school in New Zealand. Think about whether you would like to get to know these individuals, would enjoy them as a friend, or support their families' application for permanent residency:

> **Essay A**. *"When looking at how the Treaty has affected the lives of those it was imposed on, it is easy to see that Maori, the co-partners of the Crown, were treated unfairly and unjustly. The Maori suffered mass land confiscation, neglect of Treaty rights and obligations, as well as lack of recognition of cultural beliefs and protocols. Differences in the texts between the Maori and non-Maori versions resulted in cultural misunderstanding, poverty, and heart break."*

> **Essay B**. *"Many New Zealanders are of the opinion that they are all one people. What is good for one should be good for another. New Zealanders are very self-reliant and productive people. Maori should not be given special treatment because of the Treaty. In a recent speech, the leader of the National party voiced his opinion about Maori and the advantages they receive. Mr Brash has a very good point. Why should Maori receive special treatment when there are other people who are in the same position, yet receive no such treatment at all?"*

Now you may well not like either student, or you may think both have a point, so rather than simply looking at how you would rate each one, we could examine the *difference* between your two rating scores: regardless of the absolute level of your feelings, positive or negative, towards these two individuals, a large difference indicates that you are defensive about other people's honouring the Treaty. And since you did not know that that is what I was going to be measuring, this is an implicit, or unconscious attitude measure. These essays are, of course, entirely fictional—but hopefully they represent a plausible rating task that provides a reasonable index of defensiveness.

Clinical Master's student Hemi Heta and I reasoned that being defensive about the Treaty is not some sort of fixed or permanent feature of emotional attitude (Heta, 2006). Instead, we thought, that when secure in one's cultural identity, low anxiety and positive affect would lead to less defensiveness, as found in terror management theory research (Rosenblatt et al., 1989). To test this experimentally, and in consultation with a respected kaumatua, we used an emotive prime designed to raise or lower cultural confidence. An emotive prime is a stimulus event that activates affect-laden cognitive schema. The participants were high school students attending kaupapa Māori boarding schools. We had a balanced 2 by 2 design with four types of primes, which were either Māori focused or culturally neutral, and either positive or negative. Here are shortened examples of the primes written by Heta from his own experiences:

> **Positive Māori:** *Imagine you are participating in your annual hapu festival. Once the sporting events and kai are finished, everyone forms into their kapa haka groups to compete for the ultimate prize, Te Wairua o te Hapu kapa haka trophy. Your group comes first in the waiata section. Everyone cheers in delight while you receive your trophy. (In the balanced non-Māori-relevant version the scene is getting a salary bonus because your work is so good)*

> **Negative non-Māori:** *Imagine you see your baby sister Kelly, and her friend biking on the other side of the road. Just as they get near to where you are, a car backs out of a driveway and knocks your sister off her bike. She seems to be OK but then the driver starts to yell at her, telling her she should look where she is going. (In the Māori-relevant version it is clear that the sister is Māori and the driver of the car uses racist slurs.)*

Using the Positive and Negative Affect Scale (PANAS), we ascertained that the negative primes did induce a negative affective state, and the positive primes enhanced participants' positive mood. So we hypothesised that negative emotive primes would make one insecure and thus defensive, particularly if they were Māori-related. Conversely, positive emotive primes would make one less defensive, particularly if they reflected Māoritanga. In fact we found the exact opposite: a positive Māori prime generated greater defensiveness in these teenagers (negative judgment of Essay B relative to judgment of Essay A).

This study needs to be replicated with the addition of non-Māori participants and the elimination of a few confounds, such as the element of competitiveness in the kapa haka contest. However it is just this sort of design that can bring robust methodologies and methods of measurement to bear on important and controversial issues relating to cultural identity. In this case, for example, one clear implication is that those popular intervention programmes designed to reduce aggression simply by strengthening cultural identity could have the opposite effect.

Overseas Influences on the Profession

Why is there a dearth in New Zealand of this kind of research on important psychological processes and mechanisms? There are many reasons, but let us consider one: we are all highly influenced by research traditions from America and Britain. A class activity I often set is a scavenger hunt, one item being "find a psychology text written by someone other than a

person of European origin." It is not an easy task—at Massey, for instance, our undergraduates learn their clinical psychology entirely from a text by American authors Davison and Neale. In my postgraduate course on professional practice, all of the teams produce Durie's (2001) recent work, *Mauri Ora*. "Oh no" say I, "no points for that—first it is not really a psychology text and secondly Professor Durie is a psychiatrist, not a psychologist!" I am vigorously shouted down by the class members and in the end I invariably concede defeat. But in reflecting on their selection it does reveal that within Durie's Māori metaphors, rigid disciplinary barriers between what is psychology and what is psychiatry, education, and social policy are much less differentiated, since his focus is on meaningful and acceptable influences on people's lives.

Where there is—as for Māori and Aboriginal peoples—a small population with a shortage of professionally qualified academics and practitioners, and where there is a strong utilitarian focus on bettering the lot, lives, and quality of life of a people, and where there might be a cultural expectation around scholarly developments being for the benefit of the people rather than the individual career of the scholar, it is possible that strict inter-disciplinary boundaries are not particularly functional. I think in New Zealand we tend to accept fully the validity of that conclusion for Māori, but is it not equally true that all of those same conditions apply to the country as a whole—small numbers, limited professional capacity, a desire to benefit society, and an aversion to tall poppies? And if that is true, could it not follow that rigid disciplinary boundaries may not be very functional for New Zealand psychology as a whole?

It may be too late to start such a contentious discussion, as in this country we are now in the throes of new definitions, alignments, specialised competencies, and scopes of practice in accordance with our new registration act, the Health Practitioners Competence Assurance Act of 2003. The great turf divide really started with the formation of the New Zealand College of Clinical Psychologists as a break-away group from the Society. Emerging boundaries will tend to be restrictive and I can predict that they will quickly mirror the professional identities that have evolved in British and American psychology—clinical, educational, I/O, counselling, and so on. As we move towards Board accreditation of training programmes, so the assumed curricular necessities for each category will be specified and thus rigidly adhered to by the academic programmes for their own survival. I am not totally opposed to categorisation of our professional activities, if that encourages people to do what they have been trained to do, but it can be limiting in various ways. Boundaries stifle, for example, the emergence of new types of professional, as well as innovation and creativity, without any direct evidence that they protect the public or assure competence.

Evaluating Our Training Programmes

We face another challenge in New Zealand. Our training courses, especially those in clinical, have traditionally been designed as "General Practice" programmes, from which the graduates are supposed to have acquired a good set of foundation skills and a smattering of more specific knowledge about some special areas—disability, neuropsychology, family systems, the elderly, criminal behaviour, adolescents, drug and alcohol abuse, on top of the standard child and adult community mental health work. I think our clinical graduates do amazingly well in these areas and can turn their hand to solving a wide range of problems—they read and respect the empirical literature, they learn fast, they are curious and have healthy scepticism. Yet the effectiveness with which clinical graduates are able to function in areas they have had little direct training in must depend to a very large extent on their acquisition of a foundation of more basic skills. These include (a) the ability to establish meaningful rapport with a range of clients; (b) the ability to use actuarial measurement and clinical judgment to formulate the nature of a problem; (c) sufficient understanding of mechanisms of change and social influence to allow an intervention to be devised; and (d) knowledge of research methods and common threats to validity in order to allow for objective evaluation of the outcomes. To these four quintessential clinical abilities we would need to add cultural competence.

It is, unfortunately, anybody's guess as to how well we are doing in the New Zealand academic clinical programmes in teaching those five critical generic competencies, as we have no evaluations of any of the training programmes. Therefore, on the grounds that my guess is no worse than anyone else's, I will venture to provide my own critique, based on having taught in one of the country's clinical programmes and examined in all of the remaining five.

An area I think we do very well in is teaching good formulations. Psychological case conceptualisation requires a complex understanding of personality dynamics, by which I mean a sense of how emotional, cognitive, and behavioural elements of individual repertoires are organised and interrelate. It means some knowledge of psychiatric syndromes, combined with a good sense of how these labels can distort judgment and have a pejorative influence on clients. Thinking that assessment equals diagnosis is happily not a common failing of New Zealand clinical psychologists. Generally I think our graduates have a good appreciation of the importance of understanding the *function* of behaviours that are judged to be pathological. As Mahalia Paewai and I have argued (Evans & Paewai, 1999), functional analysis is useful for allowing close rapprochement with a Māori perspective on psychopathology, which very briefly, has the following characteristics: (a) holistic, interested in the total person; (b) emphasises social causes, both distal, such as the effects of colonisation, and proximal, such as the effects of ongoing discrimination; and (c) spiritual, meaning that distress is related to disruption of beliefs, or identity, of connectedness with meaningful values.

The second area in which we do quite well, I believe, is in understanding the principles of change, recognising multiple sources of influence, and having a general model of behaviour. One reason this is strong is that New Zealand clinical psychology has always tended to endorse a broad sort of social learning theory model, or social behaviourism. Today this is represented

by the dominance of cognitive behaviour therapy (CBT) in the various training programmes. The only risk here is that as the cognitive components of CBT grow in influence, and as formal protocols and manuals rise in popularity, understanding an integrative model of change may decline. Cognitive therapy is not derived from social learning theory, and valuable as they may be for changing adult depression cognitive principles cannot provide a foundation for working with young children, or people with significant developmental disabilities, or with habit disorders such as binge drinking, or violent behaviour. With many clients we do not want to change only what they are thinking about—or worse, only change their telling us what they are thinking about—we want to change what they are doing. Behavioural or social learning principles allow for the implementation of change through a diversity of environmental, social, and interpersonal influences, all of which are equally relevant to Māori clients.

A generic skill area I feel that our clinical graduates are less strong in is that of outcome evaluation. Here the problem is not one of lack of knowledge, as we do a fairly good job of teaching general research methodology, within both the quantitative and qualitative traditions. The problem is that we have not figured out—and thus cannot teach to students—the trick of implementing research skills within the major agencies employing clinical psychologists, such as the District Health Boards, Child Youth and Family services, and to a lesser extent, Psychological Service in the Department of Corrections. We have not yet convinced the most senior managers of these agencies that outcome evaluation is a major part of what we do as a profession. It is a real challenge for a well-trained clinical graduate in New Zealand to take up a position in any of our public mental health agencies and implement even single-case designs, conduct a clinical trial of a particular procedure, or evaluate the effectiveness of an ingrained practice in that centre. Meanwhile our government ministries, senior policy analysts, and politicians love to import programmes from overseas, no matter how cockamamie they may be. A current untested favourite is “Roots to Empathy”-- bringing babies into primary school classrooms to reduce bullying. Clinical psychologists get very low marks for our influence on public policy.

Clinical Research in New Zealand: A Sample Study

As a result of all this, the clinical research being conducted in this country is limited to a handful of academics, a smaller group of research scientists operating out of funded research centres, and a disorganised collection of doctoral theses. Individually, however, many of these are very good, and I will illustrate some further points by means of a clinical thesis project carried out by Sandra Heriot, a doctoral student of mine at the time and now Director of Allied Health and Clinical Research based at the John Hunter Hospital in New South Wales. Heriot’s study (Heriot, Evans, & Foster 2001) was successfully conducted on site at the Child Development Centre of Waikato Hospital where she was employed as a clinical psychologist. We were interested in the effectiveness of an acceptance-based parent training programme for very young children (five years of age or under) who were diagnosed with ADHD. The age criterion made this a relatively innovative study and it had an implicit political agenda derived from the fact that in the Waikato at the time, “treatment as usual”, even for these very young children, was inevitably Ritalin.

The children were randomly assigned to one of four treatment groups, involving receiving either Ritalin or a placebo (supplied by the drug company and dispensed by the hospital pharmacist); and receiving either Behavioural Parent Training or a placebo. Although blind to the drug condition, we could not be blind to the psychological condition, which was either active behaviour management with an emphasis on developmental and relationship principles, or an opportunity to sit and talk about their children (placebo). The first hurdle was that of the 93 children referred by either their GP or their paediatrician as having ADHD only 16 actually met the DSM criteria when carefully assessed.

You will see immediately that with only a few children in each cell, we were going to have a hard time demonstrating statistical significance with weak measures. So our strategy was to go for hard, criterion-referenced measures—meaningful effects rather than meaningful effect sizes. Thus, Heriot took as the critical outcome whether the children, following the treatment procedure, still met criteria for ADHD.

One of the biggest challenges facing clinical psychologists in New Zealand is how to manage the obvious interface between the experience of debilitating emotional distress and dysfunction that defines our distinctive client group and the broad social, economic, and educational issues affecting the population —what Dr Cindy Kiro, our Children’s Commissioner in New Zealand, has described as “the invisible hand that rocks the cradle in New Zealand”. To take a simple example, just under 30% of all New Zealand households with dependent children are single parent families, and a quarter of all New Zealand children live below the poverty line. Depressing though they are, these facts are too remote for me: the psychological issues are the circumstances of the parental partners’ dissolution, the availability of suitable adult role models, the daily economic hardships encountered by the solo parent, the ability of the caregiving adult to provide nurturing, authoritative, securely attached parenting, and the support from extended family.

The daily parenting realities for the mothers who participated in Heriot’s study were engagement in power struggles and competition with their children, harshness in their interactions, and having little to say that was positive about their offspring. The children were almost certainly responding to environmental conditions, marital separation and/or ongoing conflict, history of abuse by father, poor living conditions, and maternal depression. We can add to this mix one additional factor, which was the great reluctance by the parents to recognise or change the contribution of these family circumstances, as opposed to automatically attributing the difficulty to a problem residing within the child.

By carefully observing the individual cases, and assessing the study outcomes, it became clear what needed

to be targeted for change. Consider the following facts.

- According to our strict criterion-based outcome measurement (no longer being able to be defined as having ADHD), combined active treatments (medication plus a genuine parenting programme) did have the best results.
- But some children in all four groups improved significantly, even when receiving combined placebo interventions.
- Most parents in the programme did not carry out most of the procedures.

What hypothesis can we generate that accounts for all of these primary facts? It would not be "validation" of one treatment--that one method "works" and another does not. Instead, our conclusions were as follows. Children's behaviour is judged by adults, both the professional clinician and the parent. When the parent judges the child's behaviour in a more positive direction, good things happen. This altered judgment can be achieved in different ways, such as a direct or expected alteration in behaviour as a result of medication, whether active or placebo. Or it can be achieved by redefining parental attributions for the child's problems. A small positive change in the parent's judgment of the child alters the climate or the emotional relationship between parent and child, which in turn results in small but true improvements in the child's behaviour. Interactions between parent and child become rewarding for both, and interacting with one another becomes a happy experience. This results in inevitable positive change even though neither the parent nor the child behaviours could be considered ideal or consistently good. Thus, the clinical question becomes: given the current circumstances of the client family, what will it take to achieve this shift towards a mutually rewarding relationship? I propose a simple conclusion: effective treatment is always going to have to be individualised, but driven by powerful generalisations regarding what is needed (not a protocol but a principle), influenced by circumstantial systemic family factors related to abuse, poverty, knowledge of development, attributions, emotional dysfunction, conflict, and lack of social support.

Beyond No. 8 Wire: Another Sample Study

Culture is embedded in the mundane routines of daily life, and to illustrate this, consider a completely different example, this time from Māori research, to see if we reach similar conclusions. Here I would like to draw on Averil Herbert's (2001) doctoral research which was a Māori-centred approach to child rearing, called *whānau whakapakari*—strengthening families. For this study the criterion resulting in referral was not the behaviour of the child, although it could have been. Instead it was the high level of risk to healthy development presented by a group of parents, mostly, again, mothers, whose family circumstances placed them at substantial risk of child maltreatment. These risk factors, by no means unique to Māori, were economic deprivation, partner abuse, previous involvement with CYFS and the uplifting of other children, drug use, fathers of the children in prison. These are the invisible hands rocking the cradle so hard that it tips over.

Herbert's work was marae-based, carefully integrated into a whole set of skill-developing experiences for disadvantaged women, including cooking, healthy lifestyle, budgeting, and first aid. The programme was conducted on the marae one day a week by the Māori Women's Welfare League. How would you explain in a scientific paper the fact that compliance was achieved by a no-nonsense kuia who picked up any non-attenders in the marae minivan?

Herbert compared three programmes. One, the Matua-tanga Relationships model, emphasised the importance of child, parent, and whānau relationships and interactions, and could be said to parallel the conclusions drawn by Heriot. A second, the Matua-tanga Values Model, emphasised Māori values derived from qualitative data obtained from talking to kaumatua and focus groups about Māori ideas on child rearing, and the central importance of whanaungatanga (family connections), whakapapa (genealogy), and awhinatanga (support). The third was standard positive behavioural parent training.

All three programmes produced positive results. But it was clear from the follow-up that those mothers who continued to attend more than one programme did best, and that a *combination* of skills from standard parent training and values from Māori tradition had the greatest impact on parent effectiveness.

Clinical Research Methods

Herbert made the point that to be acceptable as a doctoral thesis in New Zealand her conclusions had to be derived from conventional outcome methodology. This might have satisfied the overseas examiners but did not impress people like the marae kuia, who just *knew* that what Averil Herbert was doing was great. If a desirable goal is to be less imitative and to generate New Zealand or Australasian knowledge and standards of practice, does this mean that we need to question the standard methods of discovery that characterise clinical psychology in Europe and America? This is a difficult question, one which almost immediately divides us into two cultures—not inevitably Māori and Pākehā, but divided views about the nature of science and scientific discovery. There have been some rather passionate debates about indigenous knowledge, indigenous ways of knowing, and indigenous methods of discovery (science), which are often treated as though they were one, but I agree with Armon Tamatea (2006) that these are three very different things. For the sake of both clinical trainees and future clinical effectiveness, these methodological arguments need to be openly and critically discussed. One common assumption favours a more qualitative, postmodernist, and anti-positivist approach to discovery. An emotive driving force behind many of these arguments is that in the past Māori have been disadvantaged by being the objects of study. To quote Russell Bishop (2003):

> *"The researcher has been the story teller, the narrator, and the person who decides what constitutes the narrative. Researchers in the past have taken the stories of research participants*

and have submerged them within their own stories, and re-told these reconstituted stories in a language and culture determined by the researcher" (p. 229).

If you substitute the word clinician for researcher here, you can see how the self-same argument describes the way some clinical assessments were conducted in New Zealand, as opposed to now, with most clinicians seeing themselves in alliance with clients. Bishop emphasised that the central issue is one of unequal power, not of method. So replacing quantitative methods with qualitative will not address *"Māori cultural aspirations for power and control over the issues of initiation, benefits, representation, legitimacy and accountability"* (p. 221).

Now that there is a substantial number of Māori clinical researchers conducting research with Māori participants, the ethnic confound between powerful researcher and powerless participants begins to unravel. In Herbert's marae-based study of parent effectiveness training, she centred the work strongly in Māori perspectives and traditions, but for her participants she was clearly an extremely influential figure, educated, sophisticated, world-travelled, stylishly dressed. Yet as I watched her teach simple weaving skills to these disadvantaged young Māori mothers, it struck me quite forcefully that she also had a role that was completely compatible with Māori traditions—that of respected grandmother and teacher, not Herbert, university senior lecturer, registered clinical psychologist, holder of two Master's degrees, doctoral candidate. So too in clinical practice, credibility with most clients comes not from the letters after your name but from the depth of your commitment. Commitment alone is never enough, however, you have to have something valuable to offer—Herbert could teach weaving *and* a sophisticated perspective on the nature of parenting, drawn from many years of international research as well as generations of Māori whānau tradition.

Contexts and Culture

Families or whānau are sometimes the problem, not always the solution. Social contexts are incredibly complicated. Perhaps clinical psychologists know this better than anyone. My PhD student Narelle Dawson (2006), now in Australia, interviewed 200 young adults who had received the Independent Youth Benefit (IYB) between the ages of 16 and 18, which allowed them to leave their highly dysfunctional home environments. Far from becoming welfare dependents, these young people were generally doing well, despite having many risk factors at the time of the original assessment. Their success was related strongly to their perception of the IYB as an opportunity to make something of themselves. How do such challenged young people develop self confidence? One member of my research group, Ailaoa Aoina (2006), studied Pacific nation girls' own perceptions of their confidence. In Rotorua, where there is a very small Pasifika community, teenage girls stated that they felt more confident in the community and church groups than they did among family members. The cohort from Auckland, living in a community that was predominantly Pasifika, felt the exact opposite. Different settings afford different levels of critical feedback and different densities (richness) of positive reinforcement. Aoina concluded:

> *Confidence is enhanced when participants receive encouragement, they enjoy what they are doing, and they develop their knowledge and skills, they set achievable goals for themselves and gain strength through spiritual and cultural identities.*

Recently my colleague at UCLA, Professor Ron Gallimore, and I (Evans, 2005) have been developing the argument that it is in the mundane and familiar routines of everyday life that it is possible to see the workings of culture as well as ecology and human agency. Church, family, urban life and school define routines for the Pasifika teens in Aoina's study. These routines and the activities embedded in them are a compromise between what is culturally desirable and what is practical, given the surrounding ecology. Cultural models are mental schema by which we code and interpret the environment and events, know and decide what is valued and ideal, and what activities should be enacted and avoided. Some features of routines may be idiosyncratic, but many are shared (making them cultural), as well as influenced by environmental or contextual constraints.

A further possible example of the centrality of context can be seen in school experiences. I have already mentioned Russell Bishop's views of Māori-focused research. He has obtained some interesting insights into how Māori high school pupils interpret their experiences and threats to a positive self identity. Consider the following comment:

> *"Yeah…when the reliever comes and they call the roll, and they come to me and they say "Henare" and I go 'yeah' and they say 'oh, so you're the kid that the teacher doesn't like'…"*

Unfairness themes were commonly reported:

> "They mentioned one fellow and said *'everyone picks on him.'*
>
> *'Cause he's got a big mouth.'*
>
> *'And he's smart.'*
>
> *'But he's a Māori too.'*
>
> *'But when he settles down, everyone still gets on to him. I feel sorry for him. If someone is making a noise the teacher turns straight to him, even though he's quiet."*

I wonder if day to day unfair treatment and humiliations affect mood state more than historical injustices? I hope so, because these are things we can do something about, unlike past history. Day to day unfairness is undoubtedly harmful: I have been working on the possible relationship between experiences of unfairness and the development of hostility towards authority figures (e.g., Evans, Galyer, & Smith, 2001), which our work suggests is mediated by an attitudinal construct called cynical distrust. The items on our 9-item Cynical Distrust scale include:

- *No-one cares much about what happens to you.*
- *I think most people would lie to get ahead.*
- *I usually wonder what hidden reasons another person may have for doing something nice to me*

So it is not surprising that scores on this instrument correlate highly

with scores on the Beck Depression Inventory. Brian Wilson's Master's research (2006), conducted with youth in Christchurch, replicated John Fitzgerald's (2002) original data from Taranaki, namely that the correlations between cynical distrust and depression are in the nature of $r = .6$

Bishop asked his 14- and 15-year-old Māori student participants about the characteristics of an effective teacher. One replied:

> *"Have a smile on your face. Look pleased to see us. Treat us respectfully. Look like you want to be here. Say 'hi' to us as we come in. Don't bawl us out. If you don't like something we're doing, tell us quietly. If we muck up, then warn us and if we are too thick to listen, then move us…"*

These students seemed to be Skinnerian reinforcement theorists:

> *'Maybe we are too old, but at least when the teacher goes to the trouble of putting a sticker in your book you know they appreciate your hard work. It's good to show Mum. She knows then that you are working okay…When they just tick a page you know they probably haven't read it. They've just gone tick, tick, tick. The teacher would look pretty stupid if they put a sticker on saying "ka pai" and it was [actually] all shit!*

From a more clinical rather than educational perspective Shane Harvey and I have some very comparable data (Harvey & Evans, 2003). Our starting point was the difficulty that a psychological consultant dealing with children's behaviour in the school will have in obtaining any degree of teacher compliance with recommended procedures. It is just like Supernanny's families on TV: the moment the psychologist leaves the classroom the teachers slip back into their old practices. For some teachers however, the emphasis on positive practices comes so naturally that it is barely necessary to introduce formal intervention protocols at all. Such teachers are able to create a positive emotional climate in their classroom, which appears to drastically reduce the occurrence of disruptive behaviour.

For the first study, Harvey (2003) asked both teachers and pupils about positive emotional management and we obtained some fascinating insights. I will mention one feature as an example. The central component of our model is the emotional relationship between teacher and child, as illustrated in the following quote from a teacher:

> *"It comes from knowing them, from taking time to get to know them and being interested. I think also allowing them to know you as well, because the connection isn't just from us to them, it has to come back the other way. And so to do that you've got to share part of who you are…"*

How does this relate to challenging behaviour? Let us consider the same dimension of the emotional relationship from the child's perspective:

> *"And like I care what my current teacher thinks of me. Like I wouldn't be naughty because I care what she thinks of me; but if it was last year's teacher, I don't like him, so I didn't behave for him 'cause I don't care what he thinks of me."*

Affective regulation skills can be achieved by emotion coaching, which is defined as being aware of the child's emotions, seeing them as an opportunity for intimacy, helping the child label emotions, and validating feelings to allow the child to problem solve. How did we see this in operation? Let me quote another student:

> *"I like a teacher that doesn't stress out and like when you got a problem in the class or in the playground, our teacher helps us through it and she like talks to us and brings us together so we can sort out what our problems are and all that. And after that it is pretty much clearer. So that we're not so down and we actually feel a lot better."*

Meaningful Change

Positive, constructive classroom behaviour, academic achievement, and justified self confidence in Pākehā, Māori, and Pasifika young people, therefore, all seem to emerge from roughly the same social context, one in which the influential adults in their lives value them and communicate this positive regard. However that alone seems insufficient because meaningful emotional relationships are transactional, exactly as we saw from Heriot's study with the children diagnosed as ADHD. Herbert's very challenged mothers felt secure, supported, confident, and at home in the marae setting, even though at first they had none of the practical skills of cooking, weaving, and participating in a group. In other words, background variables form a critical context for planful intervention.

Natasha Moltzen, Averil Herbert, and myself, have applied the same sort of logic to community services for people with the most severe psychiatric histories (Evans & Moltzen, 2000). Here I would venture to state that New Zealand clinical psychologists have largely failed to assert their intellectual muscle—we do not do much on the acute in-patient psychiatric wards or with respect to community care for people with severe and persistent mental health needs. Some promising intervention work has taken place in New Zealand (e.g., Gillingham, Dulin, & Evans, 2005). However an intensive CBT programme that is not backed by a sense of people's daily lives and social and emotional needs might result in impressive statistics for someone seeking the kudos of an empirically validated treatment, but does not meet the needs of clients. Jenny McCleery, in her Master's thesis at the University of Waikato (McCleery & Evans, 2001), found this out, and ended up describing CBT for these clients as "attacking psychosis with a wet noodle." True, we obtained significant symptom reduction, but we did not get improvements in quality of life or a reduction in the clients' primary complaint of loneliness, although most clients stated that the benefit of the therapy was the interest shown them. They had been in mental health services most of their adult life and what was most salient to them was that someone had listened to them.

Where could we get some leverage with these lonely marginalised people? Obviously in the supported living services that developed all over the country with the ending of institutional care. Non-professional psychiatric

support staff are a mixed lot in New Zealand—some have certificates and qualifications, some have degrees but not in service provision, some have little or no background in mental health. What they have in common is a caring spirit and a commitment to emotionally taxing work for little pay. But if they are stressed, threatened, fearful, or unsure of the nature of their authority, they deal with clients' challenging behaviours and emotional difficulties in ineffectual ways, using controlling tactics, or avoidance, or compassion without direction. They also use medical analogies and think of their clients as either "well" or "unwell." We could train these support staff in CBT methods, or we could as consultants devise behaviour management programmes for them to implement. Either way there is little chance that they could really do so successfully, particularly as the language of contingency management and other sound psychological principles is foreign to most. In particular, contingency management does not sound like a Kiwi sort of thing, far less a Māori thing.

So we need to create for care staff non-specific skill sets that fit the cultural ethos and that have the same ability to regulate emotion and serve a meaningful function as does the set of positive emotional skills for teachers. The community residential support programmes, in other words, need a positive emotional climate, focused on the likely specific needs of these individuals. In the course of our research programme Moltzen, Herbert and Evans identified six behavioural principles that define, we believe, effective community support and care. These domains are characteristics of the social environment of the service. (a) First, acceptance—non-judgemental validation of the client's feelings. (b) The second is positive atmosphere, which includes staff warmth, flexibility, fairness and tolerance for eccentric behaviour. (c) Third is that support staff need to have an expectation that change is possible. This expectation of change is achieved by encouraging clients to engage in novel experiences, sharing their own skills, and discussing opportunities. (d) Next is that staff need to be psychologically responsive, which in this context means making attributions about client behaviours that emphasise their function and their origin in the client's learning history, rather than attributing them either to intentional behaviours within the client's control, or to illness totally outside the client's control. (e) Fifth is the importance of normalisation, which encourages client empowerment and ensures that staff facilitate the development of social relationships outside the care facility. (f) Finally, it is incumbent on care facilities to provide an educative climate. In such a climate symptoms are not seen as inappropriate behaviours that must be controlled and eliminated, but clues to the client's needs, indicating areas in which the client either lacks skills or cannot access them for some reason.

Culture and the Medical Model

Those familiar with Māori-centred models of mental health services will hopefully agree that the domains described above, coming from a pure social behavioural model, could be considered quite compatible with Māori practices, and probably much more so than highly specific, protocol-driven behavioural and cognitive-behavioural treatment paradigms.

A major communication difficulty in the past is that much of our current debate actually takes place within the limitations of the medical or psychiatric model, with its concept of disease–like syndromes and where assuming relatively unitary causal factors is the norm. Modern clinical psychologists do not think and function this way. Let me offer two examples of the difficulty arising from the medical model dominance. First, consider cultural identity as one example. Loss of cultural identity cannot *literally* be the cause of psychiatric symptoms, as some claim. As shown by John Pahina in my lab (Pahina, 2006), even when a group of high-achieving Māori university students with strong cultural support are assessed on cultural identity, there is considerable individual difference—although they are still all on the high end. But the relationship between measured cultural identity and depression was mediated by other variables, such as how much stress these students were under, and how they coped with it. Since they all reported very high levels of social support, it was those who coped by seeking social support who were in the best emotional shape.

My second example comes from the recently published New Zealand Mental Health Survey—*Te Rau Hinengaro* (2006). This is a meticulous survey of 13,000 New Zealanders, with participants reporting Māori and Pacific ethnicity being oversampled. Interviews were face to face by trained interviewers, using the Composite International Diagnostic Interview (CIDI 3.0) based on Robins et al. 1981 Diagnostic Interview Schedule, which allows DSM-IV diagnoses. Four groups of mental disorders were assessed: anxiety disorders, mood disorders, substance use disorders, and eating disorders. Also assessed were suicidal behaviour, disability, and general health. The survey excluded people in inpatient psychiatric services or prison. There's good news and there's bad news. The good news is we will never run out of potential clients. The bad news is that many of those in need do not seek treatment, and of those that do, many do not return after the first appointment (Fortune, Seymour, & Lambie, 2005).

Conclusions

I will now try to twist together the threads of this discussion to draw some general conclusions. Firstly, I have frequently heard criticisms, mostly from Māori, of conventional clinical psychology practices in this country. There have been suggestions that CBT doesn't really work for Māori, challenges to the value of psychometric testing, and claims that Māori are misdiagnosed when spiritual and cultural beliefs are misinterpreted as symptoms. I think all of these arguments are dubious, but they do deserve critical and open examination. Not to do so places Māori trainees and recent graduates of clinical programmes in the unfortunate position of having to acquire principles and conform to practices that are viewed negatively by some of the professional leadership in their own cultural group.

Furthermore, I think that Pākehā clinical psychologists have an obligation to openly scrutinise these issues because our Code of Ethics places the bi-cultural imperative firmly in the centre

of principled professional practice. It is not always comfortable to examine some of these matters, because the risk of offending someone's sensibilities is quite considerable.

Third, I have started with the premise that some sort of rapprochement between Māaori and Pākehā professional views (if not world views) would be of value to us all. But here I need to emphasise that flowing together or mingling of the elements is not quite the same as a synthesis that diminishes the elements in favour of a new compound. As I understand one of my obligations under Article 2 of the Treaty (protection), it would be important not to swamp Māori knowledge. Indeed we have an obligation to respect it and encourage its survival. Although there may not be the same constitutional requirement, I would think that simple professionalism would obligate Australian psychologists to have the same duty of respect towards Aboriginal knowledge and traditions.

Here, however, we face a dilemma. I feel that mainstream clinical psychology in New Zealand and in Australia is itself already swamped by overseas practices and values. I am not xenophobic or anti--American or anti intellectual: why would anyone reject a good idea just because it came from somewhere else? The issue is in the degree of literalness with which we adopt ideas. When we adopt or imitate something too literally, it may be seen as somehow contrary to Māori ideas or values. We have to recognise that these same things might be just as contrary to mainstream New Zealand and Australian ideas and values.

Psychology is a broad and multifaceted discipline, and it invites an assortment of perspectives. If we concentrate on its principles rather than its products, we might be better able to use psychological knowledge to forge practices more suited to all our local needs. In trying to show how this might be done I have particularly emphasised the gains to be made from thinking of the individual client in social contexts. This is not advocating a shift towards community psychology, although there is a certain sympathy with that perspective. But for me, community psychology draws on generalisations and universal influences that are far too broad. No, I am still talking about clinical psychology with its emphasis on the individual and the complex interaction between the individual and the social environment. For every generalisation such as "cultural identity improves mental health," or "family should be the focus of intervention," I can find individual clients for whom these things are not true. Therefore useful generalisations need to be accompanied by an understanding of the mechanisms or processes that fill the space between these very broad variables.

A good mix of qualitative analysis, which gives us the richness of the individual and idiosyncratic perspective (that, after all, *is* the clinical method), together with experimental and correlational techniques that reveal what is shared within a culture, can provide us with those analytic tools. The two are fully compatible.

But Māori researchers, with their sensitivity to the exploitative and power differential between researcher and participant to be found in many traditional studies, have taught a valuable lesson in establishing the researcher within the community of the participant. This makes the applied research exercise much more of a partnership; again an idea that is in no way foreign to clinical practice. Behaviour therapy, for example, led the way in seeing the clinician and the client collaborating in problem solving, as opposed to intrapsychical therapies, including cognitive therapies, in which the client is more putty than partner. Both Bishop's and Herbert's work are excellent exemplars of the researcher centred in the Māori community, and from that we can all learn.

It is, however, much more complicated if immersion in Māori knowledge means a rejection of the methods of psychological science. One can see the arguments: mainstream science is sometimes tainted with colonisation. And one can agree that scientific thinking tends to mandate a linear, logical, and causal view of the world that may seem rather different to that of indigenous peoples. But you only have to teach what the politicians like to refer to as "ordinary New Zealanders" to discover that the formal rules of scientific logic do not come that easily to non-indigenous people either. Durie (2001) has proposed that we can and should do our research at the interface. This safeguards professional respect for both sources and discourages clinical researchers from extolling their method by denigrating the other. Matauranga Māori, Durie emphasises, is not the same as tradition, for it advances and develops like any other process of discovery. All good science is always a harsh task-master—insights and understandings either withstand objective scrutiny or they do not and are discarded. That is not true of government policies, or well-meaning intentions.

Clinical psychology research and evidence-based practice at this same interface, could, I think, develop over time into a uniquely Australasian activity and not a pallid imitation of British and American ideas. This could change practices in interesting ways, allowing clinical psychologists to use sound but complex principles to develop programmes and methods that suit local conditions. That does not mean going it alone or rejecting overseas research, but it does mean that we should try to adopt the core of any good idea and be careful that we are not accepting the superficial trappings along with it. None of these things will come easily, but hopefully if we can come to agreement on where we are going then we can use our combined and uniquely Southern Hemisphere navigational aids to good effect.

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