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***Te Ara Whakamana: Mana Enhancement Framework in the mahi (work) of New Zealand  
Psychologists'***

A thesis presented in partial fulfilment of the requirements for the degree of

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in

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## GLOSSARY

- Aotearoa** New Zealand (land of long white cloud)
- Atua** Supernatural being
- Awa** River
- Hapū** Subtribe, to be pregnant, conceived in the womb
- Hauora** Health, fit
- Hinengaro** Mind, thought, intellect, consciousness, awareness
- Iwi** Extended kinship group, tribe, nation, people, bone
- Kaitakawaenga** Working in special education
- Karakia** Prayer, chant
- Kaumātua** Elder(s)
- Kaupapa** Topic, policy, matter for discussion
- Kaupapa Māori** An approach that privileges the perspectives and protocol of Māori
- Kohanga reo** Māori language immersion for preschool children. Concerned primarily with the survival of te reo Māori
- Mahi** Work or activity
- Mana** A supernatural force in a person, place or object; prestige, authority, control, power, influence, status, spiritual power, charisma; mana goes hand in hand with tapu, one affecting the other
- Māori** Indigenous New Zealander, natural
- Māoritanga (Māoridom)** Māori culture, practices and beliefs
- Marae** The complex where whānau and hapū collectives or groups meet, and discuss political and social matters, and host tangi and important events; where Maori lived pre-colonisation
- Mātauranga Māori** Māori epistemology, traditional and contemporary Māori knowledge brought to Aotearoa by Polynesian ancestors of present day Māori
- Mauri Life** principle, vitality, special nature, material symbol of a life principle, source of emotions
- Mana whenua** Māori who have customary authority over a particular land area
- Oranga** Wellbeing
- Pākehā** New Zealander of European descent
- Papakāinga** Original home, home base, village, communal Māori land, ancestral land
- Papatūānuku** (Papa) Earth/ mother of the earth, wife of Ranginui
- Pepeha** A recitation of whakapapa and geographical areas of significance
- Rangiātea** Ancient name strongly associated with Hawaiki, both a physical place and a spiritual realm, literally a clear sky, clear spiritual realm, state of enlightenment, the upmost heaven
- Ranginui (Rangi)** Atua of the sky, husband of Papatūānuku
- Ruāmoko** Atua of earthquakes and volcanoes
- Tānemahuta** Atua of the trees and birdlife also known as Tane-te-toko-o-te-rangi due to his ability to push his father Ranginui into the sky
- Tangaroa** Atua of fish and reptiles
- Tāngata** People, persons, human beings (tangata singular)
- Tāngata whenua** Local people, hosts, Indigenous people of the land- people born of the whenua (of the placenta and the land)
- Tāwhirimātea** Atua of the wind

**Te ao Māori** The Māori world  
**Te ao Pākehā** The western world  
**Te ao wairua** The spiritual realm  
**Te Whare Tapa Wha** The four walls of a house, a Māori model of health care  
**Te Wheke** The octopus, a Māori model of health care  
**Tikanga** the customary system of values and practices that have developed over time and are deeply embedded in the social context  
**Tinana** Physical body  
**Tīpuna/ tūpuna** Ancestors, grandparents (tipuna/tupuna singular)  
**Tūmataunga** Atua of war  
**Wāhine** Woman, (wahine singular)  
**Wairua** Spirit, soul  
**Wairuatanga** Spirituality  
**Whakamana** To give authority to, give effect to, give prestige to, confirm, enable, authorise, legitimise, empower, validate, enact, grant.  
**Whakapapa** Genealogy, lineage, descent, to layer  
**Whakawhānaungatanga** Process of establishing and maintaining links and relationships with others, relating well to others  
**Whānau** Family and extended family, to be born, to give birth  
**Whānaungatanga** Relationship, kinship, sense of family connection  
**Whare** House

## **Abstract**

This study explores Te Ara Whakamana: Mana Enhancement framework, an emotional regulation and behavioural modification tool, which is centred in te ao Māori (the Māori world). This research looks at the experiences of the psychologists who use the model in various work contexts with both Māori and non-Māori clients. This was done by recounting the experiences of psychologists who participated in training for the model and are utilising the framework in practice with clients, have done so in the past, or are planning to do so in the future. Interviews allowed participants to explore how they are using the model, and what are its strengths and potential barriers. Further, this study aims at describing the key ideas that emerged while practitioners were engaging Te Ara Whakamana: Mana Enhancement. A qualitative approach was selected as the research method for this study, utilising eleven semi-structured interviews. The research findings indicate that psychologists value learning about Māori mental health models and are looking for frameworks that can enrich their cultural competence. Psychologists who are using the model found it to be helpful in their practise and those who were unable to use it expressed an interest in returning to the model or using it when their circumstance allow. Structural issues within organisations were identified as some of the possible barriers to the model.

*'Cultural competence requires more than becoming culturally aware or practising tolerance. Rather, it is the ability to identify and challenge one's own cultural assumptions, values, and beliefs, and to make a commitment to communicating at the cultural interface' (SNAICC, 2012)*

## **Chapter One**

### **Introduction**

The aim of this research is to explore New Zealand psychologists' experiences using Te Ara Whakamana: Mana Enhancement, an emotional regulation and behavioural modification tool, which is centred in mātauranga Māori/Māori epistemology. The focus of this thesis is how this framework impacts psychologists' practice with their clients, what are the framework's strengths and what are the possible barriers and limitations. This chapter will demonstrate the rationale for choosing this research topic; it will also provide an overview of the following chapters by briefly outlining the content of each one.

#### **1.0 Rationale for undertaking the research project**

#### **1.2 Mental health and suicide rates in New Zealand**

Mental health and suicide rates in New Zealand have been strongly criticised by leading global health and human rights organisations such as UNICEF and the World Health Organisation, indicating that current approaches to the issue are failing (Illmer, 2017). Looking at the current statistics and the numbers of referrals from general practitioners to mental health professionals emphasizes the paramount importance of tackling the issue. Obtaining a referral to secondary mental health services is challenging, as it can be hard to meet referral criteria, furthermore, many people refuse to be referred as there is a lack of trust in health services (Dowell, Garrett, Collings, 2009; MaGPIe Research Group, 2009). According to the latest UNICEF report New Zealand has the highest rates of youth suicide in developed countries compared to 41 (OECD) countries and 28 European Union (UE) countries; rates are the highest for New Zealand youth aged between 15 to 16. New Zealand youth are the most likely to experience anxiety or depressive disorders and have the highest rates for suicide compared to other (OECD) nations. Furthermore, it's estimated that 15.6 out of 10,000 people in New Zealand will become a victim of suicide (Ministry of Health, 2018); which is five times higher than in the UK. Nevertheless, demands for mental health services in New Zealand have increased by up to 70% over the past 20 years. Currently public services such as helplines or youth lines are incapable of meeting the needs of young people seeking support due to high demands and severity of issues (Illmer, 2017).

### 1.3 Mental health and suicide rates for Māori population

Māori, the indigenous people of Aotearoa New Zealand comprise 15% of the country's population and their population grows annually at present by 1.4% (Statistics New Zealand, 2018). However, Māori occupy a vulnerable and disadvantaged position in Aotearoa/New Zealand society with a high level of unmet needs. Especially important in this context is the concept of trauma and the very fact that Māori experience trauma in a distinct way which is related to the process of colonisation, discrimination, and racism as well as ongoing negative stereotyping which further results in unequal rates of poverty, poor health, and violence (Pihama, 2017). Māori are continuously overrepresented in physical and mental health as well as criminal statistics (Department of Corrections, 2018; Ministry of Health, 2018; Oakley-Browne, Wells & Scott, 2006). Statistics indicate poorer health outcomes for Māori than non-Māori. Furthermore, the disparities in Māori mental wellbeing are present across the spectrum of mental disorders (Oakley-Browne, Wells & Scott, 2006).

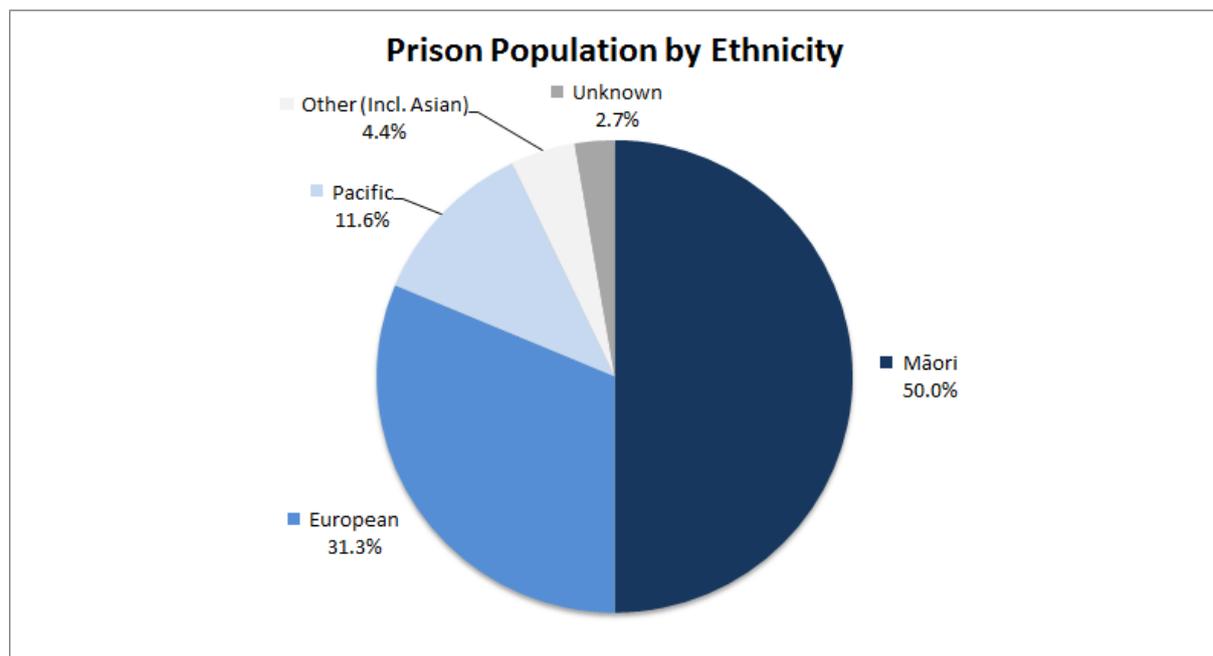


Figure 1. Prison population by ethnicity (Department of Corrections, 2018)

**Psychological distress among adults 15 years and over**

Ethnicity	Percentage of people	Estimated number of people
Maori	9.6%	17900.0
Pacific Islander	8.9%	43300.0
European/Other	5.9%	160300.0
Asian	4.9%	19600.0
Total number of people living with psychological distress		218400.0

(Average across all ethnic groups: 6.1%)

Source: New Zealand Health Survey, conducted by Ministry of Health

Image 1. (Ministry of Health, 2018).

For Māori and non-Māori New Zealanders, stigma associated with mental health diagnosis is one of the biggest barriers preventing people from seeking professional help when faced with psychological distress (Chandra & Minkovitz, 2006). Mental health problems and suicide rates are growing rapidly and especially affect young Māori males. As shown by the Ministry of Health statistics there were 31.7 suicides per 100,000 Māori males in 2016 which is 6.1 percent higher than in 2015. This number was the highest in a decade (Ministry of Health, 2018). There is an existing culture of silent suffering in New Zealand, admitting to having psychological distress is often perceived as a weakness in society and as a result, young people are encouraged to ‘harden up’, ‘deal with an issue on their own’, and to ‘grin and bear it’ (Illmer, 2017; White, 2013). Many people do not seek professional help because their concerns are approached using the Western, biomedical model of health that is individualistic and reductionist (Stephens, 2008). This limiting and narrow approach to health issues does not consider factors such as spirituality, cultural identity, historical trauma, or the importance of whānau (family) that is a critical element of wellbeing for many cultures residing in New Zealand (Barnett & Barnes, 2010). The alienation and burden of being diagnosed with mental health issues and being ‘labelled’ without approaching case holistically further leads to many social issues, such as increased crime, addictions, problems at schools and home (Boulton, Tamehana, & Brannelly, 2013).

High rates of psychological distress among Māori are often measured at the individual and not collective level, without much regard to the concept of whānau (family), inherent to Māori wellbeing (Te Oranga Hinengaro-Māori Mental Wellbeing, 2018). Māori represent a collectivist culture; thus, emphasis is placed on the individual’s identification with the group. Being a part of the group is the ultimate source of understanding the individual. It creates expectations from the individual to obey and conform to the values and norms of the group (Benet-Martínez & Oishi, 2008). Western models

of health offer limited space to include the concept of collectivism that includes family (Royal, 2003). The concept of whānau is a fundamental part of Māori society, it is a key element of connectedness and the source of wellbeing (Boulton, Tamehana, & Brannelly, 2013; King, Young, Li, Rua, & Nikora, 2012).

The process of colonisation changed the concept of whānau and therefore limited the way wellbeing can be practised. Māori ancient connectedness to their land was severed due to land confiscation by the Crown and New Zealand Government (Durie, 2003). Being connected to the land and belonging to the distinct territory is a key feature of Māori identity, as well as many other indigenous cultures across the globe. The shared worldview of Māori for whom their land is the source of wellbeing and connectedness to others emphasises that humans are inherently linked to the natural world (Royal, 2003). As pointed out by Ring and Brown, (2003) and Durie, (2003) indigenous people across the globe, who were disconnected from their land as a result of colonisation, experience disparities in their health status as compared to a non-indigenous people in developed countries.

### **1.3 Tāngata whenua/people of the land**

Tāngata whenua (people of the land) is the term used by Māori to distinguish their perception of the world from the British or the French, the two main nations that began colonising New Zealand in early 1800s (Orange, 1987). Together with the settlers arrived patriarchal dogmatism that largely differed from a Māori worldview and lifestyle (Mikaere, 1999). In the process of colonisation, Māori land was confiscated, rich in natural resources, followed by their identity, culture, and language also being taken by colonisation (Jackson, 1992). The concept of *Mana* was compromised. Mana is understood as a status, when a person has mana, they are present (Marsden, 1992). Mana can be inherited but also lost or acquired through a person's actions. In the context of mental health, mana influences the behaviours of individuals and groups. Mana is defended and sought through achievements and successes (Marsden, 1992). It is vital that mana is considered when working with Māori and this means using a mental health framework that will recognise and acknowledge the principals of Māori worldview. Recognising the vital role of mana in the mental health context requires utilising an approach that reaches beyond the Western paradigm and incorporates the unique indigenous perspectives (Mahuika, 2008). Culturally centred approaches can enhance the quality of life for Māori and other indigenous groups by honouring and recognising issues specific to these people and their culture, such as frameworks derived from cultural knowledge systems (Barnes, 2000).

When considering Māori wellbeing, we must recognise the holistic makeup of Māori both as individuals and collective members of the community in which aspects of self are intertwined (King et al., 2012). Recreating and rediscovering cultural identity relates to being around whānau/family which helps the person in the processes of defining self and self-construal. 'All iwi ... can recount from their own histories, stories of parents, children or siblings searching for each other and within these stories are located our histories, values and beliefs of what it is to be who we are, Māori.' (Edwards, 1999 p. 20).

#### **1.4 Historical trauma and Te Tiriti o Waitangi/ The Treaty of Waitangi**

Western models of mental health and healing are targeting wellbeing mostly at an individual level (Stephens, 2008). It is often assumed that for most clients, trauma is a result of a deeply distressing and disturbing experience at the individual level. From this standpoint the assessment and further diagnosis and interventions take place (Wirihana & Smith, 2014). However, there is a lack of recognition of historical trauma, which is cross-generational, inter-generational, and multi-layered. Such trauma is due to exposure to a chronic, complex, and a long-term collective trauma (Pokhrel & Herzog, 2014; Whitbeck, Adams, Hoyt, & Chen, 2004). Historical trauma is a cumulative psychological and emotional suffering that takes place over lifespans and throughout generations and results in many mental health issues such as depression, anxiety, self-destructive behaviour, anger, or low self-esteem. Historical trauma underlies trauma at an individual level and is a part of social context (Wirihana & Smith, 2014). Assessment, diagnosis, and intervention are all social activities embedded in a social context (Murray, 2014; Lyons & Chamberlain, 2006). Therefore, when a client and their whānau (family) are treated with an approach based on an individualistic view of health, it is not in agreement with social equality and achieving health for all (Prilleltensky & Prilleltensky, 2003). For Māori, individualistic approaches do not adequately address the needs of whānau and collective needs, historical and intergenerational trauma, and does not include Māori models of wellbeing as per te Tiriti o Waitangi/the Treaty of Waitangi:

The practice of psychology in Aotearoa /New Zealand reflects paradigms and worldviews of both partners to te Tiriti o Waitangi /the Treaty of Waitangi. Cultural competence requires an awareness of cultural diversity and the ability to function effectively and respectfully when working with people of different cultural backgrounds.

(New Zealand Psychologist Board, 2011, p. 7).

## 1.5 Te Ara Whakamana: The Mana Enhancement Framework Overview

Te Ara Whakamana: Mana Enhancement model will be explored as a response to the issues just discussed. This model is a culturally centred framework that uses the process of co-construction in identifying and responding to adverse life circumstances. Marshall and Ngawati Osborne (2018) the authors of the framework, point out the process of co-construction enables for strength-based conversations at the individual and whānau level. The mana of the individual and their whānau is the focus point when approaching a case.

Te Ara Whakamana: Mana Enhancement is a circular framework that allows clients to use colour, imagery, narrative, and cultural metaphors. These elements are used to help people connect to their mana, their sources of strength, their world and their cultural identity. It is a tool that develops rapport, a fundamental requirement for positive communication:

Te Ara Whakamana: Mana Enhancement moves us back to the richness and power of imagery, stories of our origins, of archetypes and superheroes, of amazing adventures, actions and deeds, of individuals overcoming great adversity. Stories passed down to us by our mothers and fathers, our aunts and uncles, our grandparents and from our revered ancestors. Myths and legends, fables and parables, sayings and proverbs have been used through the ages in this way to illustrate instructive lessons or principles for living well on this earth

(AKO Solutionz, 2019, p. 7)

Each segment of the model uses an inquiry-based approach that promotes self-knowledge and emotional literacy which in turn provides the opportunity for an early intervention and prevention. The segments of the model are designed to develop a plan that can be shared with the whānau, community support workers, and other social services. The model is designed to serve as a reference point that will help client and clinician to set future goals, support self-monitoring, check for progress, and collect and analyse data. The goal is to create a triangular source of data that is in depth and measures outcomes holistically. This dynamic data includes key participants, individuals, whānau, health practitioners, and others with the potential to identify important themes for wellbeing plans, development of strategies, or regulate emotions. The process of collecting data is an

intervention in itself, as dynamic interaction occurs which means people share their experiences, discuss their responses, and explore mana enhancing strategies to problems (AKO Solutionz, 2019).

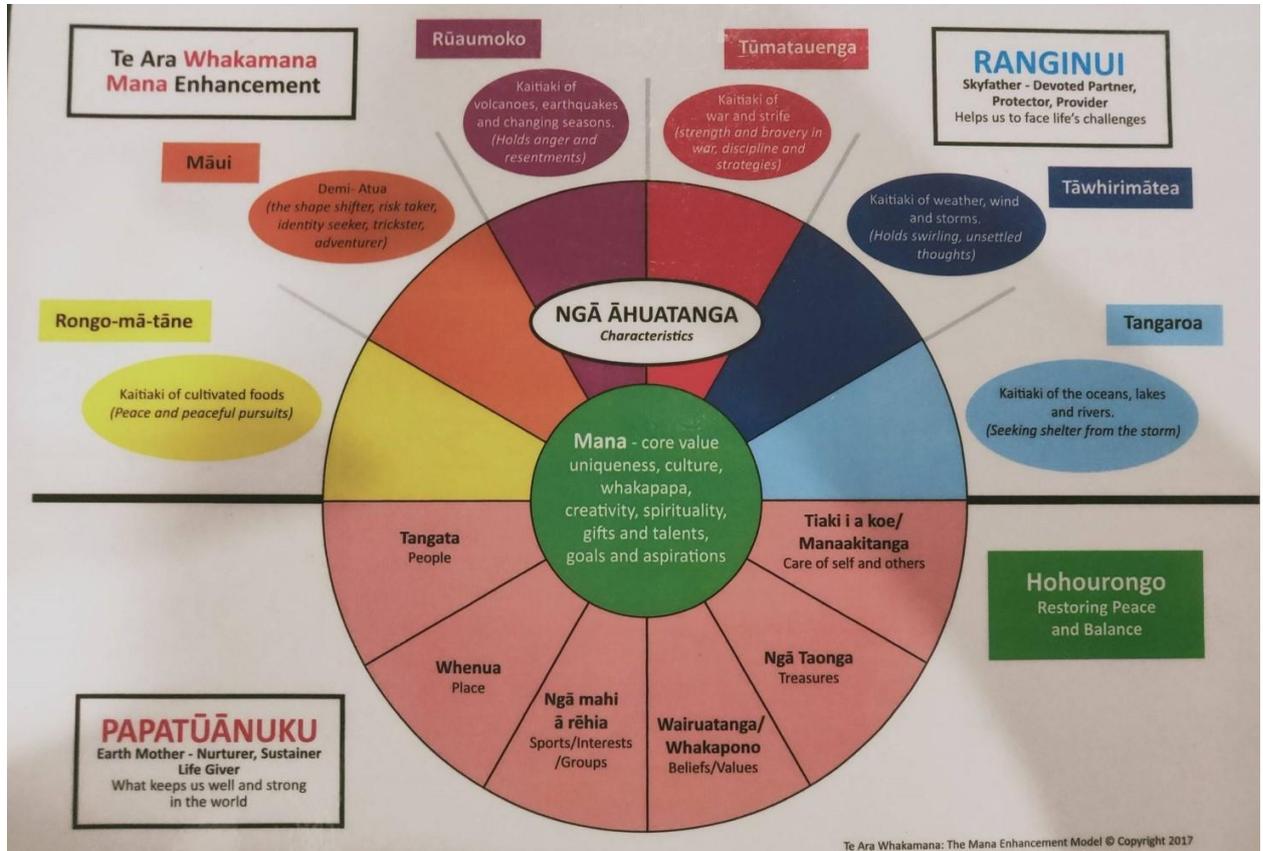


Image 2. (AKO Solutionz, 2019)

## **Chapter Two**

### **Literature Review**

#### **2.1 Introduction**

The aim of this chapter is to review available literature that contributed to this research study. It will examine the importance of cultural competence, while working in Aotearoa New Zealand. Many limitations still exist for psychologists who aspire to obtain training that will adequately prepare them to work with Māori. Literature canvassing research projects involving existing culturally centred frameworks will be presented. Finally, this chapter will explore culturally adapted Cognitive Behavioural Therapy (CBT) as an example of a culturally centred framework that can effectively meet the needs of Māori. This indicates that Te Ara Whakamana: Mana Enhancement could also be incorporated into empirically validated CBT.

#### **2.2 Cultural competence in Aotearoa New Zealand**

When it comes to cultural competence there are standards and principals to be adhered to by psychologists working in Aotearoa New Zealand and registered under the Health Practitioners Competence Assurance Act (2003). Cultural competence is defined as:

Having the awareness, knowledge, and skills, necessary to perform a myriad of psychological tasks that recognises the diverse worldviews and practices of oneself and of clients from different ethnic/cultural backgrounds. Competence is focused on the understanding of self as a culture bearer; the historical, social and political influences on health, in particular psychological health and wellbeing whether pertaining to individuals, peoples, organizations or communities and the development of relationships that engender trust and respect. Cultural competence includes an informed appreciation of the cultural basis of psychological theories, models and practices and a commitment to modify practice accordingly.

(New Zealand Psychologist Board, 2011, p. 4).

Although, these guidelines are explicit and psychologists are obliged to act accordingly to ensure that they are culturally competent, inequalities, high dropout rates from treatments, inaccurate diagnosis, and delayed response in Māori mental health are continuously highlighted in the literature (Baxter, Durie, & McGee, 2006; McLeod, King, Stanley, Lacey, & Cunningham, 2017; Kingi, Tapsell, Newton-Howes, Lacey, & Banks, 2014;). Despite high mental health statistics for

Aotearoa New Zealand, Māori still make fewer visits to mental health services, as there is an ongoing issue with an access and a lack of culturally appropriate service provision (Baxter, Kokaua, Wells, McGee, & Oakley Browne, 2006). The New Zealand Mental Health Survey (NZMHS), the first New Zealand survey measuring the prevalence of mental disorders in Māori, Pasifika and other ethnic groups of adults, showed Māori had the highest mental health rate followed by Pasifika (Baxter et al., 2006). Baxter et al. (2006) used the standardised diagnostic measures for different ethnic groups to highlight differences, and the researchers ensured sufficient number of Māori and Pasifika participants took part in order to obtain precise estimates.

Literature points out Western diagnostic standards lack capacity to meaningfully measure mental disorders in different cultural groups (Karlson, Nazroo, McKenzie, Bhui, & Weich, 2005). McLeod, King, Stanley, Lacey, and Cunningham, (2017) showed Māori had a 39% higher rate of seclusion in inpatient psychiatric units than non-Māori. Rates of seclusion for Māori remained 33% greater even after demographic variables such as age, gender, and admission factors were adjusted. This suggests mental health services are not responding appropriately to Māori needs on multiple levels. Across the globe ethnic minorities exhibit underuse of mental health services and a dropout from psychological treatments (Casar, Vasques, & Ruiz de Esparzo, 2002). In Aotearoa New Zealand, especially rural areas, there is reduced access to mental health services for Māori, Pasifika, and other ethnic groups with serious psychological illnesses, and a lack of practitioners which further impacts communities (Baxter et al. 2006). The current state of affairs raises questions about the high disparities among ethnic groups in terms of seclusion, prevalence, and severity, as well as access to mental health services.

Despite the evidence of inequalities in Māori mental health, educational providers still offer limited and varying ways in which psychologists can prepare themselves to work with Māori clients and their whānau. In this context, it is challenging to ensure clinicians are adequately trained and have the ability to reduce the inequality in mental health for Māori and other ethnic groups in New Zealand (Pitama et al., 2017). Johnstone and Read (2000) showed that this is also an issue for psychiatrists, as out of 247 psychiatrists (75 %responding), only 40% believed their training had adequately prepared them to work efficiently with Māori clients. The Code of Ethics for Psychologists Working in Aotearoa New Zealand also encourages psychologists to apply the principles of te Tiriti o Waitangi/the Treaty of Waitangi by seeking advice and further training. This is to ensure mental health practitioners are able to effectively respond to Māori needs and help support Māori to maintain their dignity as documented in the Treaty (New Zealand Psychological Society, 2002). Pitama et al. (2017) point out that in spite of the Health Practitioners Competence Assurance Act (2003) emphasising cultural

competencies is critically important when working with Māori and other ethnic minorities, and current reviews of psychology trainings still show that less time is assigned to teaching about Māori mental health.

A growing number of studies confirm the critical importance of recognising and honouring a client's culture, cultural background, and experiences as these impact client-psychologist relationships, therapeutic alliance, treatment selection, and therapy outcomes (Casas, Suzuki, Alexander, & Jackson, 2016; La Roche, 2012; Yeh, Parham, Gallardo, & Trimble, 2011; Vasquez 2007). Therefore, investing in psychologist's cultural competence is vital with research increasingly reflecting growing awareness of these factors (Tao, Owen, Pace, & Imel, 2011). The use of culturally adapted mental health treatments and frameworks has proved to be an effective way of ensuring cultural competence (Soto, Smith, Griner, Rodriques, & Bernal, 2018). Culturally adapted models and frameworks suggest that therapeutic healing is grounded in cultural context which in turn provides a frame of reference for understanding how people make sense out of their experiences. In other words, human ways, emotions, behaviours, and thoughts are embedded in cultural context (Kleinman, Eisenberg, & Good, 2006; Murray, 2014; Lyons & Chamberlain, 2006, Wampold, 2007). Therefore, culturally adapted interventions can ensure a meaningful alignment with a client's culture. Moreover, literature shows culturally adaptive interventions are more effective than interventions that are developed by Western Academic Scientific Psychology (WASP) and Western Educated Industrialised Rich Democratic (WEIRD) which are applied to other cultures and cultural groups (Bernal, Saez-Santiago, 2006; La Roche & Lasting, 2013). Still, limited studies evaluating interventions that use culturally adapted models are available.

### **2.3 Māori health models- culturally centred approaches to mental health**

As pointed out previously, Māori delay contacting mental health services as a response to a lack of culturally inclusive services, and research suggests this may result in poor provision of appropriate care. The consequence of the above-mentioned issue is that many Māori are seeking help only when the illness has turned into an acute state and the symptoms become severe (Eade, 2014; Ministry of Health, 2006). It is well documented that treating a severe onset of a mental health illness is very difficult. Often the risk of remission is so high, that targeting the control of the optimal symptoms becomes a more realistic goal of the therapy (Rush, Aaronson, & Demyttenaiere, 2018). Therefore, mental health assessment with Māori clients should be comprehensive and consider the specific cultural context in order to avoid inaccurate diagnosis which results in misunderstanding, misdiagnosis, and mistreatment (Pitama et al., 2007). Cultural competence is not always ensured

when it comes to Māori admitted as inpatients who are referred by the health services to see any available psychologist in the area. Often it results in ending up being seen by someone who is not adequately prepared to meet Māori needs and therefore not being able to see the holistic make up of Māori wellbeing (Adamson, Sellman, Deering, Robertson, & de Zwart 2006; Pitama et al., 2017; Wheeler, Robinson & Robinson 2005).

Accurate identification of needs at the right time can positively impact therapy outcomes and the literature shows inclusion of Māori mental health models can advance the quality of clinical care and increase the use of mental health services (Ihimaera, 2004; Wratten-Stone, 2017). Numbers of Māori health models are now available, however the literature evaluating these frameworks and research on clinical interventions applying them, remains limited, especially regarding models specific to mental health. When reviewing the studies evaluating Māori models of mental health the message is that there is a need to recognize these models as having the capacity of improving mental health services for indigenous populations and ethnic minorities. Some of the models that can be found in the literature include; Te Whare Tapa Whā (Durie, 1984); Raranga, Te Whare Pora (Fletcher, Green, MacDonald & Hoskyns, 2014); Te Wheke (Pere, 1991); Pōwhiri Poutama (Watene & Mataira, 1991); Te Ao Tūtahi Ngā Pou Mana and The (Ihimaera, 2004); and The Meihana Model (Pitama, Huria, & Lacey, 2014).

Reviewing all of them is beyond the scope of this thesis. However, the most frequently reviewed Māori model of health, Durie's (1994) Te Whare Tapa Whā will be discussed to highlight that there is a need for more models of health for Māori especially Māori mental health. Te Whare Tapa Whā compares wellbeing to the four walls of a whare/house, in which all must be in balance in order to achieve good health. These components are taha tinana (physical health), taha wairua (spiritual health), taha hinengaro (thoughts and feelings/mental health) and taha whānau (family health), (Durie, 1994). Durie's model highlights the need for better understanding of the holistic nature of Māori well-being. The strength of this model is that it can be used for any ethnicity accessing mainstream services (Fletcher, Green, MacDonald, & Hoskyn, 2014). However, McNeill (2009) argues that Te Whare Tapa Whā does not define the uniqueness of te ao Māori, the Māori world, as the model can be applied for any cultural group. McNeill (2009) points, this model is essentially a personality profile which does not consider important variables that have an impact on Māori mental health, such as the socioeconomic position of Māori resulting from colonisation, loss of land, language, and the traditional ways of being (McNeill, 2009).

Literature using Māori models of health is very limited, even regarding the more commonly used Te Whare Tapa Whā. Marie, Forsyth, & Miles, (2004) used Te Whare Tapa Whā framework in their non-Māori study, and concluded that there are no essential differences between Māori and non-Māori ways of approaching health problems. Researchers employed 205 participants who were randomly selected from the general and Māori electoral rolls. To judge the differences between Māori and non-Māori participants a vignette methodology was employed, and target stimulus were used to identify the minimum DSM-IV-R criteria for a major depressive disorder. The findings suggested illness perception and treatment preferences were similar for Māori and non-Māori participants. Arguably, this conclusion has several limitations. Te Whare Tapa Whā model is a generic framework that can be used for Māori as well as non-Māori or any cross-cultural evaluations of well-being. This model has a universal application (McNeill, 2009). However, as pointed out by Houkamau and Sibly (2014) research defining Māori identity is a complex and multi facet concept. For example, what exactly distinguishes Taha hinengaro (mental health), or Taha wairua (spiritual health) between someone who is non-Māori or Māori can be influenced by the factors such as self-concept of Māori, spirituality, socio-political consciousness, beliefs, ability to speak te reo Māori, perceived appearance and few more. All these aspects of being Māori, including socio-economic status, lifestyle, and subjective perception of being Māori are linked to Māori wellbeing. Furthermore, Marie et al. (2004) findings are at odds with the well documented theories of cultural identity playing a critical role in mental health (Casar, Vasques, & Ruiz de Esparzo, 2002; Casas, Suzuki, Alexander, & Jackson, 2016; Kleinman, Eisenberg, & Good, 2006; La Roche, 2012; Lyons & Chamberlain, 2006; Yeh, Parham, Gallardo, & Trimble, 2011; Vasquez 2007; Tao, Owen, Pace, & Imel, 2011; Soto, Smith, Griner, Rodriques, & Bernal, 2018; Murray, 2014; Wampold, 2007). Nevertheless, the Marie et al. (2004) research is the only study using Te Whare Tapa Whā to compare perceptions of mental health and illness of Māori and Pākehā. Further, it is not a Māori research.

Another New Zealand study compared the perceptions of mental health of Māori-diagnosed with schizophrenia, with their non- Māori counterparts' perceptions, and concluded that there were no significant differences in how mental health was perceived (Sanders, Kydd, Morunga, & Broadbent, 2011). Similar attitudes were found about the causes of the illness, medication, consequences, perceived control over the illness, understanding of the illness and emotional reaction to the illness. Five Māori patients noted spirituality influenced their illness, however that was not considered significant by the researchers. Results showed Māori believed their illness would last a shorter duration than non-Māori did. Some methodological issues with these findings can be pointed out which arise from the fact that only traditional, Western diagnostic criteria were used. Cultural identity and factors that constitute identity, such as beliefs and traditions, were not included. Among them is

spirituality which is a core element of te ao Māori. Spirituality is highly relevant to mental health. It is a factor that structures human experience, influences behaviour, values, and impacts on illness patterns (Turbott, 1996).

Spirituality has always played an important role in the form and content of mental illness; however, it is continuously ignored and pathologized by mainstream psychology (Lukoff, 1992, Tse, Lloyd, Petchkovsky, & Manaia, 2005). Taitimu, Read, and McIntoch (2018) argue Māori experiences of psychosis and schizophrenia are subjected to the Western psychiatric theories at both individual and collective level. Further, clinical practice along with the research was done upon indigenous peoples by non-indigenous using the Western paradigms. Taitimu, et al. (2018) research found the predominant explanations for experiences of psychosis or schizophrenia in Māori patients were spiritual and cultural.

Rammohan, Roa, and Subbakrshna, (2001) found that spirituality played an important role in patients diagnosed with schizophrenia, even more so for the family members who cared for them. Consequently, this study suggested spirituality and religion should be included in intervention to enhance therapy outcomes. Multiple studies show inclusion of spirituality can have a positive impact on mental health including, reduction of symptom ratings, and being health-enhancing (Durie, 1998; Larson, Sayers & McCullough, 1998; Smith, 1999; Townsend, Kladder, Ayele, & Mulligan, 2002). Another issue in the Sanders, et al. (2011) schizophrenia perception study, is that Māori living in the cities may feel disconnected with their wider whānau and iwi. Participants in this study were predominantly from Auckland, a total of 111 users of mental health services (68 Māori, 43 New Zealand European). Western/colonial health systems were enforced on Māori, therefore it can be argued that there is a need for research that looks at the use of te ao Māori frameworks that account for variables such as culture, historical trauma, effects of colonization, relocation, poverty, language, beliefs, spirituality, and traditions. Moreover, more studies targeting diverse realities and diverse range of Māori are needed. Te Ara Whakamana is a cultural framework which incorporates and considers the above factors. Further, results from Marie et al. (2004) and Sanders et al. (2011) suggest the need for further investigations of the mental health perception between Māori and non-Māori as knowledge about these differences provides an opportunity to create more frameworks designed to ensure effective clinical interventions for Māori.

#### **2.4 Culturally adapted Cognitive Behavioural Therapy (CBT)**

Te Ara Whakamana: Mana Enhancement framework is a growth model, in other words it is a collaborative model that works alongside existing, well validated and evidence-based models such as

Cognitive Behavioural Therapy (Marshall, 2019). CBT was developed to alter and restructure maladaptive thought patterns that cause symptoms of psychological disorders such as depression or anxiety (Beck, 2011). CBT assumption is that cognition facilitates dysfunctional behaviours and symptoms. To help the client, the dysfunctional beliefs are thoughts are restructured and replaced with more realistic ones (Dobson & Dozois, 2001). CBT targets specific problems and applies certain strategies to collaboratively work with a client; is a goal-oriented approach. In CBT the client is taught the key elements of this approach, its gains and how their own thought processes influence their perception of self and their mood; it is an educational model. Different activities are performed with the client and included in the intervention, for example, homework. At the end of the therapy, clients should have developed strategies that will help them become their own therapist. CBT has empirical significance and is time-limited and thus cost-effective (Beck, 2011). The two principal domains in CBT are cognitive restructuring of disordered thoughts and overcoming behavioural deficits responsible for maintaining the symptoms (Beck, 2011). Several studies and meta-analyses support the efficiency of this approach (Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Parker, Roy, & Eysers, 2003). CBT is also found to be superior to pharmacotherapy and behavioural therapy for the treatment of depression (Gaffan, Tsaousis, & Kemp-Wheeler, 1995).

Research demonstrates that the structured and evidence based nature of CBT makes it a very effective approach, however this model can neglect the dynamic relationship between a client and a clinician, which is essential for an effective practice of CBT (Beck, Rush, Shaw, & Emery, 1979). At the heart of effective therapy is a relationship and therapeutic alliance (Hewitt & Coffey, 2005). Understanding the client's culture is critical for the development of the therapeutic alliance (Soto, et al. 2018). The philosophy and the principles of Te Ara Whakamana: Mana Enhancement may help clinicians develop better relationships with their clients and their families. Antoniadis, Mazza, and Brijnath, (2014) point out CBT is a culturally adaptive method, however, there are very limited studies exploring this area, even less so in the context of New Zealand populations and Māori. Bennett, Flett, and Babbage (2014) were the first to investigate the effectiveness of a culturally adapted cognitive behaviour (CBT) therapy for clinically depressed Māori clients. The researchers adapted CBT treatment incorporating processes inherent to Māori mental health approaches including Māori processes of engagement, spirituality, family involvement and metaphor. This study is of significant importance as it is looking at whether CBT is culturally acceptable and efficient for Māori.

As a response to these issues a culturally adapted CBT treatment programme from Bennett (2018) was developed using culturally relevant literature and CBT research. An advisory panel involved in creating the manual consisted of experienced Māori and non-Māori clinical psychologists. Bennett's

(2018) culturally adapted treatment identified issues within clinical diagnosis of depression that further highlighted the importance of cultural identity as a protective factor in depression and mental illness for Māori. For example, valuing identity has shown psychological benefits (Hirini, 2005). Also, Bennett (2018) pointed out there are limitations to the empirical validity of Western models, from Western cultures applied to non-Western populations. Lastly, Bennett's (2018) culturally adapted CBT is a response to existing research that offers no direct comparisons between adapted and standard interventions with minority groups. Nevertheless, Bennett, (2018) study showed significant reductions in depressive symptoms and negative cognition in Māori clients as measured by Beck Depression Inventory-II (BDI-II) and Automatic Thought Questionnaire (ATQ). Mean depression scores decreased from a pre-treatment mean 28.69 (S.D. =11.15) to a mean of 10.71 (S.D. = 13.86) post treatment. This reduction was sustained after 6 months. Whilst this is a naturalistic study with no control group, the results provide strong evidence to support the culturally adapted CBT for a Māori population. Another key point highlighted in the research was the importance of whanaungatanga/relationship and connection between professional and the service users. In addition, there has been limited progress in adopting and validating CBT for Māori population and this study is a promising one.

Mathieson, Mihaere, Collings, Dowell, and Stanley (2012) adapted guided self-management intervention that was CBT based for Māori in a primary care setting. This was the first brief psychological mental health intervention designed specifically for Māori. Researchers used a collaborative approach in the process of adaptation which included review of the literature, face-to-face and group interviews with primary care clinicians and individual face-to-face interviews. Literature shows a collaborative approach to therapy with adaptations, such as essential aspects of Māori wellbeing and culture being incorporated, can be more easily accepted by Māori (Durie, 1994: Bennett, & Flett, 2001; Hirini, 1997). For the purpose of Mathieson et al. (2012) study, the following were included: Whakawhānaungatanga (the process of forming relationships); whānau (family) and iwi (tribe); te reo (Māori language); as well as spirituality and promotion of cultural identity. K10 scores showed improvement in patients using intention-to-treat rated global psychological distress following intervention. Although, the improvement was not statistically significant, researchers highlighted that the confidence intervals showed that the true mean improvement was likely to be greater than zero. Nevertheless, the strength of this investigation is that it promoted a talking therapy which is highly credible among clinicians and patients. Proponents of Cognitive Behavioural Therapy, Dialectical Therapy, Behavioural Therapy, and Motivational Interviewing all agree that an effective therapeutic relationship is fundamental for positive therapy outcomes (Luborsky et al., 2002; Stiles et al., 2002) and the strength of therapeutic alliance can determine the therapy outcomes (Martin, Garske, &

Davis, 2000). Nevertheless, participants and clinicians were in favour of the culturally adapted programme and provided positive feedback in Mathieson et al. (2012) study.

Kohn, Oden, Munoz, Robinson, and Leavitt, (2002) compared CBT to a culturally adapted CBT for depressed African American women in US, African American Cognitive Behavioural Therapy AACBT. The intervention was a modification of a manualised CBT group treatment protocol for depression. The key changes applied to the existing CBT were based on theoretical literature, publications of treatment approaches used with African American women, and consultations with clinicians who had experience working and treating African women. This approach is a strength of this study as it allows the identification of possible barriers of the non-adapted treatments (Kohn et al., 2002). An adapted version included changes in the structure and process of CBT and in the content of the material to be covered each week. For example, meditation was added as well as a termination ritual at the end of the 16-week intervention. Some changes in the language were made, for example, the term “homework” was replaced with the term “therapeutic exercise”. This research is an important contribution to the study of culturally adapted models as it compares CBT with culturally adapted CBT. The post-treatment results showed improvement in both CBT and AACBT groups and a drop in symptoms’ intensity as shown in the average BDI II scores in the last week of treatment. The African American group, which used adapted CBT, showed 12.6 points from pre-treatment 34.4 to post-treatment 21.8 as compared to 5.9 points decrease in the CBT group. This research highlighted the initial BDI scores for African American women were higher than scores reported in meta-analytic reviews across 28 studies with similar patients. Therefore, there is some evidence that African American women do not seek professional help until the symptoms are more severe. Improvement scores for AACBT, being twice as high, demonstrates the need for further culturally adapted treatments.

More relevant to the Māori population is a study conducted by Whealin et al. (2017) who reported positive results with their culturally adapted mental health intervention for Pacific Island veterans with PTSD and their families. Pacific Islanders are an ethnic group that are often overlooked in the literature (Pole, Gone, Kulkarni, 2008). Researchers in the Whealin et al. (2017) study used the 5-stage Map of the Adaptation Process; assessment, selection, preparation, piloting, and refinement as the framework for guiding the intervention. The core cognitive-behavioural components were integrated and key aspects of cultural values including relationship, family, and spirituality were incorporated. The intervention was called “Koa,” which has various meanings in native Hawaiian languages including: brave, fearless, and hero. The results of the clinical intervention showed participants and their families found all components of the intervention to be highly valid, useful, and

relevant. Participants highlighted that the programme was particularly effective as it included “the island way of things”. Some rated the intervention as “excellent” and would refer a friend or a family member. Researchers highlighted that relationship problems are sometimes the result of PTSD (Miller et al., 2013). In this context it is important to note that Pacific Islanders, similarly to Māori represent collectivist culture, with family being integral element of wellbeing and individuals will always place themselves within the family context. Pasifika people often value family before their individual needs and the therapy outcomes for individual will often be influenced by the degree of the support offered by the family (Suaalii-Sauni, Samu, 2005). *Koa* intervention facilitated connection, trust, and engagement into mental health practise and made a significant difference for both patients and their families. Whealin et al. (2017) highlighted previously used intervention targeting the same population were a mainstream US models which lacked cultural needs of the Pasifika veterans and their families. No other studies of such nature had been found and the high acceptability of such culturally centred framework indicates culturally adaptive models should be developed and made available as a treatment option. Lastly, psychological practice requires use of the multiple models that are indicated at different times, circumstances, and for different cases. Including models that are culturally appropriate and able to meet the clients’ needs (Marshall, 2019).

## **2.5 Conclusion**

The primary aim of this chapter was to review the literature relating to cultural competence of psychologists working in Aotearoa New Zealand as well as reviewing the studies contributing to the understanding of the effectiveness of culturally adapted models and indigenous models that integrate aspects of Western models such as CBT, lastly targeting culturally adapted Cognitive Behavioural Therapy (CBT) as an example of culturally centred framework and its potential. This is especially relevant for the context of Aotearoa New Zealand and when working with Māori clients.

## Chapter Three

### **Methodology**

#### **3.1 Introduction**

The aim of this chapter is to set out the methodological approach undertaken to discover psychologists' experiences of using Te Ara Whakamana: Mana Enhancement framework with their clients. This chapter will present the aim of this research and the methodological approach adopted. It will present the sample which was selected and set out the method used for data collection along with the process of data analysis. Finally, it will present ethical issues and limitations associated with this study.

This research is a part of my academic journey to become a psychologist. I am a non-Māori researcher, who is originally from Poland. I have lived in Te Tairāwhiti/Gisborne for ten years now, where the population is 51% Māori. Throughout the completion of my studies, I have developed a strong awareness of the need for my perspective and skills to be culturally inclusive and culturally responsive. I have also developed a passion for learning about Māori models and frameworks within psychology. Cultural competence for psychologists in New Zealand is necessary under Te Tiriti o Waitangi (New Zealand Psychologist Board, 2011). However, if I am to be an effective psychologist in Te Tairāwhiti with our population here, cultural competence with Māori is mandatory. This was what brought me to the desire to find out more about Te Ara Whakamana: Mana Enhancement and led me to this research topic. I am extremely grateful that I received the support of Māori psychologists in supervision and mentoring roles. I have had to consider my approach and perspective as a non-Māori researcher conducting Māori research throughout the entire process.

#### **3.2 Aim of research**

The purpose of this study is to explore the following key research questions:

1. How is Te Ara Whakamana: Mana Enhancement applied by psychologists?
2. How does utilising Te Ara Whakamana: Mana Enhancement impact on psychologists' practice?
3. What are the possible challenges of incorporating Te Ara Whakamana: Mana Enhancement in psychological practice?
4. How does use of Te Ara Whakamana: Mana Enhancement impact on the relationship between professional and client?

### 3.3 Ethical considerations

Several ethical issues and concerns were considered while conducting this research. Any type of research will have an impact on participants and on society as a whole and the researcher must be aware of such possibility at all times and should therefore act accordingly (Kumar,2005). Semi-structured interviews are in-depth interviews that are often subject to enquiry by ethics committees. In depth interviews aim at uncovering details of the interviewee's experience of the subject being studied. Whereas, in the questionnaire, commonly used in quantitative research, such experiences would be undisclosed (Allmark et al., 2009). Interview based research cannot be completely regarded as low risk and some issues are of particular importance including privacy, informed consent, and identifying possible harms to both participants and researcher (Allmark et al., 2009).

A research proposal was submitted to the researcher's supervisor, and then approval from the conduct of the research was obtained from Massey University Human Ethics Committee prior to commencement of the recruitment. The principles of Māori centred research and Kaupapa Māori theory were explored for this thesis. This was done by exploring and discussing issues that are of high relevance and importance to Māori and by ensuring Māori voice was positioned as central in this research (Tuhivai-Smith, 2006). The researcher aimed at advancing Māori solutions based on the principals of Kaupapa Māori theory which supported this research processes. By honouring and including Māori knowledge, Māori reality, and epistemological foundation the researcher aimed at exploring a model that can advance and improve Māori wellbeing. A local Māori Cultural Adviser was approached to provide advice on how to ensure adherence to the principles of the Treaty of Waitangi. Voluntary, informed, written consent from the psychologists was obtained prior to commencement of the study. Data was collected and coded, with identification codes stored separately, to ensure privacy (Massey University Human Ethics Committee, 2010). All data is stored in a secure manner and only the author has access to the raw data.

Informed consent was ensured from all participants stating that they were willing to participate in the interview while also ensuring their confidentiality and anonymity throughout the process. The issues of privacy and confidentiality were discussed, and participants were aware that there was no obligation to answer questions that they felt uncomfortable with. It was also made clear that their participation was voluntary, and they were free to withdraw from the study at any given time. Prior to the interview, participants received information that this study was being carried out, which also contained the research outline, the type of information that was required, and the aims of

the research. The length and the time of the interview was indicated prior to the commencement of each interview and participants were given sufficient time to ask questions before and after the interview.

### **3.4 Qualitative approach**

A qualitative research approach was chosen as the research method for this study. All definitions of research suggest that research is a process of investigation that is methodological and aims at gaining new insights and understanding that constitute knowledge about the world (Langdrige, 2014; May, 1997; Stangor, 2015; Weathington, Cunningham, & Pittenger, 2010; Willig, 2019). Psychological research involves gaining knowledge related to human behaviour and experience (Willig, 2019).

Qualitative research arrives at its conclusions by involving a systematic series of steps, known as the process of induction. Specifically, qualitative research seeks to provide an understanding of human experiences and how people make sense out of their experiences (Willig, 2019; Hays & Wood, 2011). Willig, (2019) concludes *meaning* is the aim of most qualitative studies. Qualitative research aspires to describe how peoples' feelings and thoughts affect their behaviour (Sutton & Austib, 2014). Further, qualitative research postulates that reality, society, and science are phenomena that are shared and/or shared by human lived experiences, reflections, thoughts, interactions, discourse, language, institutions, and storytelling (Hays & Woods, 2011).

Qualitative research and specifically thematic analysis was considered most suitable to undertake this research as it allowed in-depth explorations of meanings participants assigned to their experiences of Te Ara Whakamana: Mana Enhancement. As clarified by Clarke and Braun (2018), thematic analysis TA is a term that encompassed not one but many approaches to qualitative analysis. It is best understood as an umbrella term for many approaches that typically share an assumption that TA is a method rather than methodology, and that it is a flexible method in terms of theoretical application. In terms of analytic procedure and philosophy this thesis was based on Clarke and Braun (2006) school of TA which is positioned within the qualitative paradigm. In depth engagement in data enables quality coding and development of themes and subthemes (Clarke and Braun, 2006).

Qualitative approach enabled the inclusion of participants beliefs and feelings. Qualitative research methods also help to provide far-reaching details by including participants emotions and viewpoints (Denzin, & Lincoln, 1994; Denscombe, 2010; Minichiello, 1990). The narrative approach

provided space for careful consideration of one's social position, cultural identity, values, and beliefs and how these possibly influenced the way psychologists approach their clients and whānau (Murray & Poland, 2006). Human actions are related to the social context in which they occur, and individual development is largely influenced by the culture in which a person grows up and lives in (Lantolf, 2017). In other words, the mind is *mediated* by the context in which a person exists. The context is critical in how people make sense of their experiences and it contributes to the development of the higher order functions such as critical thinking, reasoning, or decision making (Lantolf, 2017). Quantitative research on the other hand is more numerically based, broader in scale, and more structured, therefore was considered not suitable for the purpose of this research.

### **3.5 Interview**

Semi-structured interviews were selected to carry out this research study as they are flexible and versatile data collection method (DiCicco-Bloom & Crabtree, 2006). They allow reciprocal relationship between researcher and participants, providing space for them to elaborate and give unique and personal answers (Galletta, 2012). Semi-structured interviews allowed topics and areas to be narrowed down thereby reducing the risk of topics and themes being too broad and not closely related to the research questions being explored (Rabionet, 2011). Such a risk can be present when using completely un-structured interviews (Fontana & Frey, 2003). Another advantage of interviewing is its ability to explore complex and often sensitive areas by giving the participants an opportunity to prepare before asking the questions and to explain them in person if need be (Kumar, 2005).

Throughout the interviewing process and data collection the researcher aspired to adhere to the values and principles of tikanga Māori, which ensured 'right ways of doing things with Māori' (Tuhiwai-Smith, 2006). The principles of tikanga Māori helped the researcher to endure respectful collaboration, and it allowed participants to define their own space. Interviews were conducted in a cautious, safe and reflective way including protection of the mana and dignity of the participants (Tuhiwai-Smith, 2006). Interviews allowed psychologists working in Aotearoa New Zealand to include their social context and provided the space to embrace their own social structure in which they live. The process of narration can unlock and communicate human qualities such as love, anguish, disappointment, or conflict (Cortazzi, 2001). Psychologists, like most of us, change their perspective on their experiences as they engage in dialogue with other people and gain new experiences (Heikkinen, 2002). Stories are not isolated abstractions, they are rooted in cultural context (Bruner, 1984) and therefore knowledge and human identities are continuously constructed and modified (Heikkinen, 2002).

While the interview process has many benefits there are also some disadvantages. Similarly, to quantitative survey research, semi-structured interviews rely on the participants ability to provide honest and adequate recollections of the issues that they are being asked about (Esterberg, 2002). The interview process can also prove to be time intensive, costly, and emotionally taxing (Kumar, 2005). Data can be affected by the skills, experience and commitment of the researcher. Lastly there are risks associated with a small sample which can affect the reliability of the data as well as researcher bias (Kumar, 2005).

### **3.6 Sampling and selection**

As pointed out previously exploring the topic in depth is a primary strength of the qualitative research approach (Carlsen & Glenton, 2011). Information gathering and methods of analysis will influence selection of participants and when the sampling should stop (Cleary, Horsfall, & Hayter, 2014). Purposive sampling method was chosen in selecting participants. Qualitative research methods are commonly described as *purposive* because the selection of participants should have a clear justification and specifically correspond to the research questions (Collingridge & Gantt 2008).

The inclusion criterion was based on participants who are registered and practicing psychologists in Aotearoa New Zealand and who have received training in Te Ara Whakamana: Mana Enhancement framework and have used it or intend to use it with their clients. In undertaking this study, the researcher chose to interview individuals. Individual interviews have the ability to generate a large breath of items ( Aldag &Tinsley, 1994; Coenen, Stamm, Stucki, & Cieza, 2012; Guest, Namey, Taylor, Eley & McKenna, 2017.) The majority of empirical research is consistent with the findings that in terms of data collection, focus groups and individual interviews can both generate unique information. However, focus groups require more time, resources, and 6-10 times more participants per data collection than individual interviews. Focus groups are also difficult to schedule and can require more than one researcher to collect and transcribe data. Participants were sought through personal contacts of the researcher. Eleven participants were recruited to be interviewed and all of them participated in the research.

### **3.7 Data collection**

Data collection took place in July, August, and September 2019. The author of this thesis aimed at working with participants in a collaborative dialogic relationship. A dictaphone was used to record the interviews and all interviews were fully transcribed verbatim. Data gathering and analysing was conducted concurrently, which adds to the depth and quality of data analysis (Chamberlain, Camic, & Yardley, 2004). Three of the eleven participants were acquaintances of the researcher; the other eight

were recruited through third parties known to the researcher and word of mouth. All participants were contacted through email and received the participants information sheet containing details of the research along with informed consent. The interviews took place in Gisborne and two interviews were conducted via emails. The researcher studied the research topic in advance as interview questions should be based on previous knowledge (Wengraf 2001; Kelly 2010). The interview schedule was prepared covering the main topics of the study in the general form of the interview with series of questions. Such format provides focused structure for the discussion during the interviews but the sequence of questions can be varied and the schedule does not have to be followed strictly (Holloway & Wheeler 2010). The interview schedule guides participants on what to talk about. It enables probing and exploring additional questions and has freedom to investigate the research area by gathering similar information from each participant. At the same time semi-structured interviews have capacity to allow for rapport and empathy to develop between the researcher and the participants (Holloway & Wheeler 2010). Each participant was presented with a similar set of questions relating to their overall experiences of Te Ara Whakamana: Mana Enhancement framework. An example of an open-ended question included in the interview schedule is 'What are the main challenges you face in your work with the models you are currently using with Māori (tamariki/whānau/adults)? And others who are not Māori? Are there any models you used in the past that you stopped using and why? What are the models you find effective for your practise?'

### **3.8 Data analysis**

First and for most analysing and managing the data needs to be true to the participants (Sutton & Austin, 2015). The researcher kept in mind that conducting qualitative research is about the world from the perspective of the participants and putting oneself in their shoes. The main goal of this data analysis was to hear and capture the voice of the participant so that their experiences could be interpreted and reported on for others to read and learn. Once data was gathered and recorded the author immersed herself in the data to obtain a sense of the whole by reading and rereading (Polit & Beck, 2003). The data was then transcribed, coded, analysed, interpreted and verified. Repetitive listening and reading helped the researcher gain better understanding of the subjects as well as correct any spelling or other errors. Once all the data was fully transcribed and checked the coding process took place. 'Coding refers to the identification of topics, issues, similarities, and differences that are revealed through the participants narratives and interpreted by the researcher' (Sutton & Austin, p. 228, 2015). Coding helps the researcher understand the world from each subject's perspective (Sutton & Austin, 2015).

The data was then analysed, categorised, and organised into themes and further sub-themes which emerged through the coding process. The themes which were identified were assigned a specific code accordingly. The next stage involved interpreting the data by identifying any reoccurring themes throughout and highlighting any similarities and differences in the data. The final stage involved data verification, this process involves checking validity of understanding by rechecking the transcripts and codes again, thus allowing the researcher to verify or modify hypotheses already arrived at previously (Sarantakos, 1998)

### **3.9 Conclusion**

This chapter discussed the methodological approach undertaken in the research. It outlined the research questions, the method employed for data collection, the sampling methods, and how the data was analysed along with ethical considerations and the limitations of the study.

## Chapter Four

### Findings

#### 4.1 Introduction

This chapter presents the main themes and findings from the interview process and data analysis. The demographic overview of the psychologists is presented. The key themes identified following data analysis were; psychologists wanted to grow their knowledge and skills around culturally inclusive models, Te Ara Whakamana: Mana Enhancement was used by most of the psychologists, and they reported the model is effective, and it positively influenced their practise; almost all psychologists identified structural and organisational barriers to train in the model and facilitate the model; this model is effective for both Māori and non-Māori clients and has a potential to be used more with adult clients. All of the themes are interconnected.

**Table 1.**

*Themes and Subthemes*

<b>Themes</b>	<b>Subthemes</b>
4.3 Rationale for participating in Te Ara Whakamana: Mana Enhancement training	4.3.1 Cultural competence 4.3.2 Structural barriers from the past 4.3.3 Relationship building 4.3.4 Presentation on the model
4.4 The feedback on the training	4.4.1 Importance of attendance 4.4.2 Diversity and workshop delivery 4.4.3 Cohesion with other trainings
4.5 The application of the model	4.5.1 In everyday practise 4.5.2 Being creative with the model 4.5.3 For young clients 4.5.4 In complex cases 4.5.5 The potential

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## 4.2 Participants

Eleven participants took part in this study. Ten psychologists were female, and one was male. Four of the participants are Māori and four were trained abroad. All participants are currently registered in New Zealand, ten are working in New Zealand, and one is abroad at present. The majority are working in the Te Tairāwhiti/Gisborne region. One was an intern psychologist who successfully completed her internship before this study was completed. One psychologist and two clinical psychologists were trained overseas. With an exception of the intern psychologist, the experience in working within the field of psychology ranged from 6 years to 21 years. The areas of employment for participants varied from Ministry of Education, ACC, Courts, CAMHS and private practice. All participants had participated in Te Ara Whakamana training.

### 4.3 Rationale for participating in the Te Ara Whakamana: Mana Enhancement training

Almost all participants took part in the training because they were interested in gaining more knowledge and understanding about models that are culturally inclusive and culturally grounded. Most decided to participate in a Te Ara Whakamana: Mana Enhancement two-day workshop as they believed they needed more culturally appropriate tools to offer in their practise. Some believed they had limited resources to offer when working with Māori clients.

#### 4.3.1 Cultural competence

One of the participants was trained as a clinical psychologist abroad and she acknowledged she needed to upskill in order to work meaningfully with the New Zealand population:

*I was looking for sort of culturally approachable tool to use in New Zealand and to build my own knowledge base to work with people from different cultures.*

*(Participant 2).*

Some of the participants moved to New Zealand from overseas and found it challenging to ensure their work was meaningful, so they were open to gain more confidence as psychologists practising within diverse New Zealand populations. One participant felt the need to be more culturally grounded with people. She had learned some Māori customs like Pepeha and Karakia as a way of showing her clients that she is making an effort. However, she felt that she needed something more that would enhance her relationships with clients and result from collaboration, while not being affected by her background:

*With the accent that I have and who I am I don't want people feel that they are in the outs. I want to be able to build a therapeutic alliance as quickly as we can. Being someone who is not from New Zealand I wanted to find ways to practise in something that is more culturally grounded.*

*(Participant 3).*

Another participant who emigrated from abroad felt similar:

*My main challenge is that I am from the UK so everything was new to me – I have found that the students I have used the model with have enjoyed being able to teach me about the Creation Stories and the Māori Ātua and correcting my pronunciation.*

*(Participant 6).*

Participant one sought to attend the training because of their positive impression of how Te Ara Whakamana: Mana Enhancement was implemented by one of the schools she works with, and the way the school applied cultural elements of the model to everyday life of the students. For example, the school implemented new strategies, tools, and changes to their environment. She also highlighted that the school talked a lot about Te Ara Whakamana: Mana Enhancement:

*I liked their approach. I liked the Atua garden, the zen table, and how they had their kind of restorative questions that they did with the young people and they talked a lot about Te Ara Whakamana: Mana Enhancement model. I guess I am passionate about the things that are culturally inclusive, and I wanted an opportunity to be able to use it in my practise. I wanted a tool that I can use with students to find out the solutions and then to support the teachers to understand that.*

*(Participant 1).*

One participant wanted to use a culturally grounded model to find new ways of interacting with children. A model that was engaging and would:

*Broaden their culture that also make them proud of their culture in a way.*

*(Participant 3).*

Another participant wanted to use Te Ara Whakamana: Mana Enhancement model as a therapeutic framework to ensure cultural sensitivity and to integrate other approaches into her practise.

Some of the participants took the training because they heard positive feedback about Te Ara Whakamana: Mana Enhancement from their colleagues and the importance of participating in the training in person.

#### **4.3.2 Structural barriers from the past**

Interestingly five of the participants had known about the model for some time and wanted to be trained in the past, however due to structural issues within their previous jobs they were unable to:

*Since I graduated, so almost 10 years ago, I've been aware of Mana Enhancement and have wanted to be trained however MOE was not keen on using the framework. I still can't understand the rationale there. So, I had to wait 10 years and having left MOE to actually do the training.*

*(Participant 7).*

*I learned about the model in 2014. A number of our RTLBs were trained in the model and were using it. I was coworking with them and I was very impressed by what I saw. So, we tried to persuade our service to train in it and our big manager said we were not allowed to because it*

*was not evidence based even though our Kaitakawaenga found it effective and most of us found it effective. So, I went and trained in my own time, and have been using it since 2014.*

*(Participant 11)*

#### **4.3.3 Relationship building**

Some participants pointed out how important the first session with a client is and how being able to facilitate the model could support the process of relationship building:

*I also wanted to know how to facilitate Mana Enhancement and how to bring it into that one-on-one place when you are gathering the data from the student. There really is quite a therapeutic nature to that interaction to that interview. And I wanted to see how Te Ara Whakamana went about that process.*

*(Participant 7).*

#### **4.3.4 Seeing the presentation on the model**

For some of the participants the rationale to undertake the training was seeing the presentation on the model by the creators of it:

*I had seen a presentation by the creators and loved what this offered.*

*(Participant 8).*

One participant undertook the training after being told by his colleague that this model would be particularly helpful in their work. They had no expectations of the training and were just curious about it.

#### **4.4 The feedback on the Te Ara Whakamana: Mana Enhancement training**

All participants spoke positively about the two-day training/workshop and described it as ‘very good’, ‘interesting’, ‘helpful’, ‘meet expectations’, or ‘even better than I thought’. Two of the clinicians highlighted how they particularly valued the break between day 1 and day 2 of the workshops:

*It was good. I liked the gap actually. I liked doing the training in the model one day and having the chance to practise it and then coming back to talk about struggles that we had. Consolidating that learning. I felt like I applied it more in that way and made adjustments that you wouldn't have done doing two days back to back.*

*(Participant 3).*

*I like that it was done over two days and that the second day there was quite a lot of time in between. I found that really helpful. I thought it was a good, hands on, practical training. I left the workshop confident that I can use the tool.*

*(Participant 2).*

#### **4.4.1 Importance of attendance**

Some of the participants spoke about the importance of participating in the training in person, and how participation changes the understanding of the model, rather than learning it from others or trying to train oneself by using resources such as manuals:

*I found the training even better than I thought I would, because I purchased a manual and read it before I even went to the training, so, I was very familiar with the material that I was using. But one of the things about the Te Ara Whakamana: Mana Enhancement is part of the wairua aspect of it; actually, being in the room with workshop trainers and talking about it and acknowledging the wairua. That made a real difference to me than just get the book and read about it.*

*(Participant 11).*

#### **4.4.2 Diversity and workshop delivery**

Other participants spoke a lot about the diversity of the people participating in the training and the number of people attending:

*We had really good diverse bunch. We had people from all over the country. I realised people coming up from Rotorua from Wanganui from Palmerston North and I thought my goodness this really is popular. But it was also a really, really good bunch of people. Lots of different backgrounds.*

*(Participant 8).*

Another participant valued how the workshop was delivered:

*It was a wonderful mix of intellectual challenge, cultural relevance, and sensitivity. And to be learning all of that in relation to how essentially assist kids in changing behaviour... I really liked the presentation I saw.*

*(Participant 7).*

#### 4.4.3 Cohesion with other trainings

Some participants noticed that Te Ara Whakamana: Mana Enhancement training fitted easily and complemented the other trainings they take part in. Participant one noted:

*The training was really good. I like the concept, and I like how it lines in. I am one of the key facilitators for the Understanding Behaviour Responding Safely and that's the one day training we do in Ministry of Education. And Mana Enhancement dovetails really beautifully. That training is given to all the teachers.*

*(Participant 1).*

#### 4.5 The application of the model

##### 4.5.1 Everyday practise

Six of the participants used the model in their everyday practise as one of the tools offered to their clients. Participant seven is currently working abroad and therefore unable to use the model. Three of the participants are not currently using the model themselves due to the nature of their work responsibilities but are recommending it to others when appropriate and continue to support the wider use of it. Participant four intended to use the model as a part of their professional development in supervision.

The majority of the participants completed the initial sessions as homework including practising the framework with someone they knew to gain more confidence before using it with clients. The practise sessions were completed with family members, friends, or work colleagues. The homework was then brought back for the second day of the training to review and discuss.

*I have used it as side try with my whānau first. It was interesting seeing how my boy responded. That was really cool, and I actually learned something about him. So that was great.*

*(Participant 1).*

Participant one noted even though the model is a part of her daily practice it is not for all of her clients:

*I am using this model in everyday mahi. It's just a part of the practice. It's not for all my kids that I work with but it's definitely for some of them. The ones that I think get a lot out of it.*

*(Participant 1).*

Participant eight used the model regularly in her previous job but at the time of the interview she has just changed jobs and was adjusting to the new workplace and tasks. She was planning to return to the model and use it as her everyday tool:

*I found that it worked with a lot of kids. After using it with that boy I realised I can use it with that kid and that kid. At the time I was working in (XYZ) it was my everyday thing.*

*(Participant 8).*

#### **4.5.2 Being creative with the model**

Participant one spoke about using additional visual resources when applying the model and how being creative in utilising the model helps clients get more out of it:

*I got a YouTube video clip that I play, with music and amazing graphics and it tells the creation story so, I played that as well and we discuss it before we get to the model, before we start. It's really cool with kids with challenging behaviour. So even that first boy that initially struggled with the model, we then did it with his mum and I had heaps done and I use it with the teacher as part of our planning for him as he is returning to the mainstream school.*

*(Participant 1).*

A few of the psychologists created their own visual templates to help their clients complete the sessions. They pointed out this was especially helpful for clients who struggled with writing and speaking:

*I have done like an extended Mana enhancement plan template and shared it with a school staff as they were all happy to share it because it is easier to share the information that way.*

*(Participant 2).*

A few participants spoke about using the model in a flexible way with individuals but also in a family setting:

*By the end of it he actually did complete the model as a whānau, and we came up with some strategies around what he could do.*

*(Participant 1).*

Participant two spoke about how she challenged herself in applying the model with the family and highlighted a case when she completed the model with a dad and a son at the same time.

*I did it with a dad and son sort of simultaneously and we did it over an extended period over eight sessions. We completed a little component and reflect on that and did goals setting around*

*when we were completing the bottom half- the Papatūānuku, talking about the places you feel safe and the people. The dad, and the family had a really good relationship and we explored what is it that creates those good connections? How do you facilitate them as a relationship that you want to repair and then we did sort of repair relationship, and maintaining them.*

*(Participant 2).*

She also noted that she had the best results when taking the time to complete the model:

*The most effective way I ever used the tool is not rushing it.*

*(Participant 2).*

Another way a participant applied the model was in a group setting with five students from a Kura Kaupapa Māori (Māori immersion school) who all completed their own Mana Enhancement plans and then as a group went through the concepts to explore them in different ways. The group explored together each of the different Atua, identifying their strengths and what are the things they need to be aware of and linked it back to their own characteristics.

Participant one collaborated with another professional to use the model with a boy who had a significant trauma background and struggled to describe certain things when going through the model. She collaborated with a speech therapist to design visual reminders to assist him:

*What I did is I spoke to speech language therapist, a friend of mine, and there is strategy they use where they use a whole lot of visuals (...). So, what we came up with was the speech therapist came up with different categories which is about thinking about each section. So, when we hit each section, we are going to give visual reminders of who could be in there.*

*(Participant 1).*

#### **4.5.3 For young clients**

A few participants used the model mainly with young clients. One participant described using Te Ara Whakamana: Mana Enhancement mainly with young male clients but she made it clear that this model is also suitable for adults. She particularly liked seeing parents being very involved in the sessions, assisting their children in the room, and helping the children complete the sessions.

*I had one mum who we did Te Ara Whakamana: Mana Enhancement with and she really liked Rūamoko and really identified with this idea of volcano around anger, so we drew up a volcano leading on from that and described anger that is something very explosive. She came back the next session, she taken photos of what we've done, and she had shared it with her sister whose an adult as well and she really got it too. She really got it. So, it was really interesting to see the mum grasp that but then shared the principals with another adult.*

(Participant 3).

*I think it would be hugely effective with adults. I personally believe that every CAMHS service and every mental health and drug and addiction service in the country should be offered training in the model, so it is a tool they have in their kete. I also believe in the justice system should have it too. It is very diverse model that can be used in many different ways.*

(Participant 11).

#### **4.5.4 In complex cases**

Some participants who work with disability noted that when working with a disability caused by brain damage, it is important to adapt the environment around the client and hence necessitates the presence of family or caregivers. She believed the application of Te Ara Whakamana: Mana Enhancement could support these processes:

*With the kids with Fetal Alcohol Spectrum Disorder (FASD) they really need their whānau or their caregiver to be involved. Because first of all we need to understand where their brain injury is, because they might struggle with their verbal memory or their attention. So, we have to be scaffolding. And when we have their family or caregiver with them it's really important that the caregivers are on board and to take charge of implementing it. Because those kids are not going to individually implement it, but they need someone else to take responsibility to do it for them.*

(Participant 11).

One participant asked the creator of the model to interview and create a plan for a client:

*I had a young man who was on my case for a couple of years and he ended up having a diagnosis of autism. He was really hard to talk to about stuff because he didn't have insight into his own thoughts and feelings. We got Sue to do a Mana Enhancement plan with him and honestly, I've known this kid for 2 years and knew 10 times more about him after that hour.*

(Participant 11).

#### **4.5.5 The potential**

Participant eleven spoke about the potential of the model that is yet to be explored:

*Being a psychologist is not just going into a room and using the model. It is about the whole part of how we hold ourselves, and how we manage the emotions in the room and everything that is going on. There is a whole level how Te Ara Whakamana could be utilised therapeutically that is barely even been touched because there are not enough psychologists that are using it and are aware of that. Because it has been developed with schools in mind it is mainly being used with young clients.*

(Participant 11).

Interestingly participant four found a unique way of applying the model as part of their professional development.

*As a psychologist we are required to do continuous competency practise called CCP. And one of the goals that I have made myself for this until March next year is to offer some pair supportive reflective supervision /protocol with one of my colleagues, that is doing similar work to me. We both going to go on a journey with it me as supervisor and him being supervisee. See whether it's a workable framework to offer reflective practise. So, offering supervision as a psychologist is a part of my practise and that's how I am going to use Te Ara Whakamana: Mana Enhancement.*

*(Participant 4).*

Participant eleven has been using the model since 2014 and from her experience she was able to point out what are the best ways of using the model:

*Te Ara Whakamana: Mana Enhancement and what it allows us to do as psychologists is it provides an easy framework to talk about thoughts and feelings and helps us to help the clients put things into words that are really hard to put into words (...). I think this model makes it easier for people to look at Rongo-mā-Tāne, look at Ruaumoko, and apply that to themselves. In each of the cases I spoke about, Te Ara Whakamana: Mana Enhancement framework would be part of helping the person to explore their thoughts, and feelings, and behaviours and put this into practise.*

*(Participant 11)*

She also pointed out that with adults there is a lot of valuable verbal information that arises during the session which you can then put aside and explore it later.

One participant spoke about her role in the field of clinical neuropsychology within the high courts and how it involves working with some of the most dangerous young offenders in the country, such as those who have killed. She believed Te Ara Whakamana: Mana Enhancement can be effectively applied in her complex cases:

*We talk about the multitude of problems over many generations and you know severe trauma. With this kid I am not just sticking a plaster on gangrene. You need to go in and think about much more, and it's not just chose a symptom with one technique. You need to get to the root of the problem. I am not saying Te Ara Whakamana: Mana Enhancement will, as there is so much to the problem, but at least it would be a start (...). So, I am not saying that Te Ara Whakamana on its own will solve the problem, nothing on its own will. But I see it as something that fits right in there with other things we do.*

*(Participant 10).*

#### 4.6 Te Ara Whakamana: Mana Enhancement for Māori clients

It was apparent from the analysis of the data that most of the psychologists wanted to train in a framework that was meaningful for Māori clients. For the majority of the participants Māori constitute a large portion of their clients.

*In Gisborne 51 % population identifies as Māori and CAMHS is even higher than that with percentage of Māori clients we have. So, I wanted to have a model that I felt like I could use with people that are Māori, that is respectful to their culture, but also engaging, and would work with children.*

*(Participant 3).*

Participant five spoke about Māori children as being the majority of their clients as her practice is also based in Gisborne:

*Most of my clients are Māori students here in Gisborne. To me it was a no brainer.*

*(Participant 5).*

Some participants knew about Te Ara Whakamana: Mana Enhancement model for many years and saw the implication of it over time and how it was implemented. One trained in the model once they left their job and started private practice as they felt they wanted to offer more for their Māori clients.

*We are very restricted in terms of the kinds of frameworks we can use. There are prescriptive templates. In terms of assessments, progress reports, then completion reports. Very prescriptive in terms of the psychometrics used. In my ACC work the huge challenge is that it doesn't feel in any shape or form like it has any cultural sensitivity whatsoever and it worries me that I can't use some sort of Māori framework and make it more relevant. I guess what I can do is make my intervention a lot more culturally sensitive because this is one part that I have more control over. For one client at the moment, you know we dealing with low mood and depression, and we are using karakia and it is nice to see her responding to all of those and it would be nice to have all of that or part of the aspects included in the assessment process.*

*(Participant 7).*

Participant seven highlighted Te Ara Whakamana: Mana Enhancement enabled her Māori clients to feel empowered to collaborate and by including their voices they were able to tailor the model to suit the need of their clients.

#### 4.6.1 Empowering

One of the participants pointed out how the model could empower her Māori clients:

*We work with quite a few Māori children, not all of them, but many Māori children and families and you know we're working in a medical field.*

*(Participant 10).*

Most of her clients are children affected by FASD which is brain damage, and often leads to increased aggression and extreme emotional dysregulation. She has not previously found a model that could help these children and the people supporting them learn emotional regulation skills, other than to change the environment around them, which she believes is critical for their wellbeing. This participant believed that it is vitally important to have models that take into consideration the importance of upholding and restoring the mana of children who have these difficulties and rather than deficit thinking about them, focus on being able to have another perspective. She also pointed Te Ara Whakamana: Mana Enhancement can help families and others to understand these children and thereby changing public perceptions around them as being problematic:

*We've got a group of kids that are highly volatile. They need a lot of things, they need good care, they need good education, many of them ended up on the streets. They need to be managed according to their disability. They also need, especially Māori kids, which there are a lot of, they need to have services around them that are culturally appropriate. Services that consider factors like their mana and their connection to their culture. And I think this is a model that, as well as doing that, might also help them regulate themselves. Not that I expect them to, it just might give some skills to think differently about how they behave and that might also give the families ways of thinking differently about them. A lot of it is sort of around blame, punishment. This model sets you out in a different way of thinking. And I think it's a much more helpful way of thinking.*

*(Participant 10).*

One psychologist who works with many young Māori offenders highlighted their responses to the cultural aspects of the model that they were familiar with:

*When you are talking about Māori Ātua and mana and Rangī and Papa they get it and they are into it! And for them, it can still work really well even if they are gang prospects. Te Ara Whakamana is much better way of connecting with our young people.*

*(Participant 11).*

She also noted that her young clients respond positively to Māori tikanga/values and metaphors:

*I've used it with a 15-year old boy with an intellectual disability, who really struggled, but he was still able to do it at his level and that was really nice to see. His mana section reflected his whānau and their papakainga, mountain, awa etc; and then Papatūānuku showed a mixture of this whānau grounding and the gang related thoughts and behaviours. It was like you could see his inner conflict between the two right there on the paper, and he was able to see it too for the first time.*

*(Participant 11).*

Another participant pointed out the familiarity with the context used in the model is helpful for her Māori clients:

*Some of the students already have lots of knowledge regarding Atua, especially Kura Kaupapa Māori students, this provides them an opportunity to take the lead.*

*(Participant 1).*

#### **4.6.2 Structured**

Participant eight is a Māori clinician who found Te Ara Whakamana: Mana Enhancement helped her structure the way she approaches Māori whānau.

*As a Māori practitioner I already think a lot of those things that are used in the model and I do incorporate them into my practise anyhow. However, when I was using the mode, I was using it in a far more sort of structured way. And my interviews would have been more structured around the model itself.*

*(Participant 8).*

#### **4.6.3 Applied with cautiousness**

One of the participants spoke about her Māori client who did not want to use the model as being Māori has negative implications for him. This client refused Māori models due to an internalised negative stereotype about being Māori. He believed there were colonised messages about Māori models being inferior to the Western models.

*I had one client who did not want 'anything to do with it', wanting to distance himself from Māori heritage due to conceptualised personal trauma. In a way it's strong association with being Māori and Māori became something with a bad connotation to him and being in a phase of wanting to distance, avoidance. And it's not to do with Te Ara Whakamana. It's the same with other models like Mahi-a-Atua, Te Whare Tapa Wha. It's the same reaction, same response.*

*(Participant 9).*

One participant spoke a lot about being careful when working with Māori whānau and how to ensure that non-Māori practitioners are culturally sensitive and competent when using Māori Atua and Māori gods

*The danger I fear that can be, is if you are working with Māori whānau you might know a lot more about that than I know. I would be quite cautious with some of these aspects with Māori whānau to be really honest. You need to be really sure what you are talking about. For me being Māori and working for Māori whānau to assume that we on the same understandings of it or to even assume that this is going to be beneficial for them, to expose them to some of that thinking. To me you have to feel very sure and be very self-assured yourself and know what these elements or aspects of these god like people really mean and how relevant they are for here and now in this situation.*

*(Participant 4).*

Other participants pointed out how very limited training on Māori culture is offered by New Zealand educational providers who train psychologists.

*Out of 13 classes I had on the campus at University only one focus broadly on Māori culture.*

*(Participant 3).*

#### **4.7 Using the model with Pākehā /non-Māori clients**

Six participants spoke about their experiences of using the model with non-Māori clients. These participants reported the model being suitable and effective for non-Māori clients. Two psychologists spoke about adjusting the elements of the model to fit the needs of their client.

*I have used it with Pākehā clients and used the parts of the model where it's not connected to the Ātua. We kind of identify something else that represents escalation, so it loses that cultural component, but they still sort of connect to the visual of it. Which is still being effective I found.*

*(Participant 2).*

*Just on Wednesday one of my kids with behaviour challenges did this and it was amazing. I got him to write the bottom section, because I thought it was important for him to see his words reflected. So, he wrote all of the bottom section and when we came to the top section and I asked about the particular animal that reflects when he is in Rongo-ma-tane he chose a dinosaur. So, then we went on this journey looking up and googling different dinosaurs and he actually made his wheel with different dinosaurs representing the sections of the wheel. So, when he is in Tūmataunga stage he is a T Rex. I was like oh mean and he explained that when he gets to Tawhirimatea just afterwards he is a reptile because he wants to run away, and then the Tangaroa phase, we thinking about all of the calming things, what do you need to do to return to Rongo-ma-tane he chose a pterodactyl because if he could fly that could calm him down. So, I did that on Wednesday and feedback to the DP this morning. She's taken the photos of this and will work through this with the teachers etc because you have a clear understanding that he knows what he looks like in each phase.*

*(Participant 1).*

One psychologist described her experiences of working with a Pākehā girl who suffered high anxiety. The girl was on her case for over a year before she learned Te Ara Whakamana: Mana Enhancement and was able to implement it:

*Te Ara Whakamana is just as effective for Pākehā kids as it is for Māori kids, because they get it. This little Pākehā girl was very anxious, she did not know what it felt like to not be anxious. She never knew how to describe it, or how to talk about it and I got so much information out of her with Te Ara Whakamana I couldn't believe it. Because with such anxious kids it can take them a long time to open up and sometimes when they actually do open up, they freak out that they've opened up too much, and then they retreat inside themselves again. So previously I had difficulty to get her to come back and talk about it more.*

*(Participant 11).*

#### **4.8 Whānaungatanga-relationship building and therapeutic alliance**

Ten out of eleven psychologists reported Te Ara Whakamana: Mana Enhancement influenced their relationship building in some ways. A few clinicians spoke about the positive impact of this model on their relationship with Māori clients.

##### **4.8.1 Connecting with Mātauranga Māori and Te Ao Māori**

Participant eleven spoke a lot about the incorporating of learning and applying mātauranga Māori/Māori knowledge and te ao Māori/Māori worldview into her practise:

*It influenced my practice a lot in big ways and little ways. It is so important that we understand mātauranga Māori and te ao Māori. It's not just about offering karakia it's about trying to have karakia everytime I start with the client and if they are not comfortable with it, still saying it in my head. So that I am protecting myself and I am protecting the space. Going through the training reminded me and reinforced that. I had got a bit sloppy on those things. It reminded me about working in te ao Māori alongside te ao Pākehā or a clinical world.*

*(Participant 11).*

Similarly, another psychologist spoke about Te Ara Whakamana: Mana Enhancement being a tool that helps to connect with Māori clients and guides a relationship building between Māori and Pākehā worlds.

*It also helped me in terms of connecting with te ao Māori and wanting to further develop my te reo Māori skills. It has been positive to offer the model as an alternative to Māori families as a*

*true Māori model rather than a westernised one. It supports the building and connection of relationships between Pākehā psychologist and Māori clients.*

*(Participant 7).*

#### **4.8.2 Respect and collaboration**

Participant five also commented on this model being important for her relationship building process:

*Yes, most definitely. Especially with a young Māori person because you are making an effort to enter their world. Or to meet them where they are at rather than, you know, there is so many situations like youth offenders. Seeing the struggles, they go through to enter the justice system that is just imposed on them. They often have no clue what is going on.*

*(Participant 5).*

One participant described using a Māori framework as a means of respect for Māori culture and therefore making an effort that is appreciated by her Māori clients:

*I feel like it bridges barriers. It overcomes barriers because they can see I made an effort. I don't think it's harder being a foreigner here in doing therapy. I think that for Māori there is a level of respect that you can show by putting in effort, by learning more about their culture, have a respect for that, have a passion for that. So, any time you can pronounce the name properly, and it all forced me to do that, I've got a young person that has a longer Māori name and I can actually say it properly now. I had a boy the other day, his name is K... and I've heard that name a lot from Te Ara Whakamana: Mana Enhancement. He was like 'oh she can say my name properly!'*

*(Participant 3).*

Participant eight shared her experiences working with a boy with significant FASD who she described was 'practically written off':

*When I used the model with him, honestly his responses were incredible and totally unexpected. Well unexpected in the sense that I had no idea of the extent of his creativity. His areas of interests and his passions. I actually had to take a lot of notes because when we did the circles we run out of room because he had stories to tell me about everything and I showed it to my colleagues because some of them had known him from when he was younger. Generally speaking, this boy had been practically written off. I didn't know him at all and people had very low expectations of him. As a sort of 'oh well he is always going to be like that'. As it turned out we had him with correspondence school and he has been doing a lot of artwork and correspondence school teachers were developing his interests and a lot of it had come from those conversations that we had when we were doing the Te Ara Whakamana model. Even his parents were amazed.*

*(Participant 8).*

Other psychologists reported the model helped them to ‘develop deeper understanding and sense of collaboration’; ‘unique strength-based safety plans’; ‘opportunity to role model and taking a risk with learning’ and experiencing ‘expressed gratitude by the clients.’

Two participants reported the model did not influence their relationship building, however one of them noted that:

*I engage with whānau the way I have always done. What I do have is another tool in my kete when it comes to talking about feelings and behaviour with students and their whānau.*

*(Participant 1).*

#### **4.9 Te Ara Whakamana: Mana Enhancement strengths**

Most psychologists pointed out Te Ara Whakamana: Mana Enhancement’s key strengths include ‘cultural inclusivity’; ‘collaborative approach’; ‘being specific’; ‘based on well validated models’; ‘unique’; ‘engaging’; ‘collective’; and ‘includes Wairau/spirituality’:

*It is a culturally inclusive model that allows my Māori families to feel I value their culture and want to work alongside/with them rather than the more traditional expert-client model.*

*(Participant 2)*

*What I find with Te Ara Whakamana is that it is far more specific than some other models I used.*

*(Participant 8)*

##### **4.9.1 Collective approach to wellbeing**

Some participants spoke about how Te Ara Whakamana: Mana Enhancement acknowledges the collective and multi-layered approach to wellbeing that is inherent to Māori. One participant noted:

*A lot of general psychology models don’t take into consideration the collective. With Māori whānau there is a collective thinking vs. individualistic thinking that psychology is developed around, and that not only has the influence on thinking but also your behaviour and your emotions and everything. With neuropsychology it is very difficult because a lot of our tests are normed overseas. The WISC and the WIAT do now have New Zealand and Australian norms, which is fantastic, but you know some of the other ones are I guess socially and culturally made for other groups of people. But also, even though they are normed closer to home, the tests are still measuring Western concepts in Western ways. For the last 15 years 80 % of my clients have been Māori and so in my head I compare to other kids that I know and other kids that I’ve seen in my clinical experience, as well as the norms on paper. It is not as black and white as norming against what’s on paper, we have to constantly be thinking of this child within their context, their community, their whanau, their school, and what we expect to see here in New Zealand for their age and developmental level*

(Participant 11).

#### 4.9.2 Wairua/spirituality

She also reported spirituality as being one of the strengths of the model:

*A lot of our models are about the individual person not about everyone around them and a lot of our models don't include wairua or spirituality. A lot of our tamariki with emotional dysregulation problems can inadvertently cause hurt to people around them. Sometimes they can stomp on other people's mana when they are upset. We have to think about the implications of that when we are helping them to learn to regulate themselves, or things won't improve as they should because we have not addressed or acknowledged a crucial part. We are aiming to enhance the mana of those in their day-to-day contact, as well as their own mana. And to do this meaningfully we cannot leave their wairua out. With Te Ara Whakamana the wairua is implicit as well as overtly integrated*

(Participant 11).

#### 4.9.3 Unique and engaging

Other participants appreciated the model being especially engaging with young clients:

*I think for me Te Ara Whakamana is really engaging for kids, it's got imagery component, I like the colour, I like the animal and I like getting them to think about how it feels, and how it would look like. So this boy that initially struggled, I said to him, 'If I didn't know you and I came in to class and you are having a T-Rex moment what would I see?'*

(Participant 1).

Participant eleven spoke a lot about how Te Ara Whakamana: Mana Enhancement differs from other frameworks. Aside from the mātauranga Māori/ Māori knowledge and cultural relevancy, the other key differences she believes lie in how much collaboration and self-involvement this model allows. She pointed out the goal setting is also different as clients set those goals themselves:

*There is a difference between talking to someone vs sitting down together, talking with someone and co-constructing a plan together. And that is a really, really important thing. This model is practical, and it is tangible, it is something clients can physically take with them afterwards. Te Ara Whakamana: Mana Enhancement is not just that though. As you walk away from the session you actually made some goals. And it's not someone telling you your goals, 'go and do deep breathing', 'go and learn relaxation'. It's actually goals that people have identified themselves when they are looking at their own Papatūānuku section, what nurtures you and what sustains you. They're connecting the decision to take those actions with their mana and their beliefs and seeing on the paper what they are doing to their mana when they get out of*

control. There is a real power when people are doing it themselves and are making their own decisions.

(Participant 11).

#### **4.10 Structural issues and possible limitations to utilising Te Ara Whakamana: Mana Enhancement**

In terms of the possible limitations and barriers related to the model many psychologists spoke about structural issues within organizations and their current or previous employers. One psychologist spoke about recommending the model to some specific agencies working with young offenders but having no results every time she tried:

*I hit a brick wall actually with (XYZ) whenever I've rerecommended it for the people that desperately need it and hasn't been picked up... but I live in hope that with time and as more practitioners are using it, and see such benefits of using it, that it will become more widely accepted. I have probably recommended it to about six different people and families. I explained to them about this model and how it might be helpful. And they all said: 'Oh wow that could be cool'. Then I recommend it to a social worker. I am going there only to do one-off assessment but sometimes I see people two three times and then I wrote a report and recommendations. And probably about 6 times I had this written about Te Ara Whakamana: Mana Enhancement. In some cases when children are really emotionally volatile how I think it would be of benefit, and how I like it and I put, even you know, my address but I haven't heard from anyone.*

(Participant 10).

##### **4.10.1 Māori models can be seen inferior to Western models**

She also pointed out she felt this model is been disregarded because it is a Māori model and she raised the concerns about other models that are not New Zealand based have more attention:

*I have the impression that people think oh it's just another Māori model. But what makes other models more valid than our own cultural practises? I think it is this kind of mentality.*

(Participant 10).

Another participant had similar experiences and concerns about funding the frameworks or models that are created overseas and have no cultural relevance to New Zealand population, especially Māori. These psychologists spoke about models such as Te Ara Whakamana: Mana Enhancement being overlooked:

*There is a program called (XYZ) which someone in America put together and it's been used with kids with FASD, which was found to be effective with FASD kids along with FASD informed care, not just in isolation. It is a program about how your engine runs and about learning to be more self-aware about what's going on in your body. When there is a red light, or orange light, and yes that's cool but my youth justice kids who are gang prospects they have no interests in traffic lights and how their engine is running. You have to work really hard to get these kids on board.*

*Whereas when you are talking about Māori Atua and mana and Rangi and Papa they are engaged.*

*(Participant 11).*

#### **4.10.2 Collaboration is essential**

Participant seven spoke about the model being successful when it is implemented by the entire school and with the support of all the staff rather than a client being completely in charge:

*I did my training with a Hawkes Bay school. There the principal insisted the model was used school wide with all staff (caretaker included) participating in the full training and the model being given priority for implementation school wide the next term. He led the initiative from the top.*

*(Participant 2).*

Similarly, psychologists two and five noted the support of others is important for the successful implementation of the model for some of her young clients:

*Everyone is able to identify better ways of facing challenges when they come and most people, I would be expecting, in my cases, so they are able to do that on mana enhancement plan too. But in reality, when we stressed we don't always have an access to that information and to be able to access it, it has to be repeated, embedded into us in sort of day to day practise. So, the success of the tool is been: one the individual's engagement and that lightbulb moment while completing it that sort of psychoeducation, along the way and it also depended on a team's commitment around the tool. I had one case where we didn't have a successful outcome because having a completed plan in a child voice made the school believe that from then on, the child should make the right decisions. You came out with that plan and you are responsible for it, which is not fair.*

*(Participant 2).*

*Like I said before in the context of the team setting with one person who is been trained and is doing the assessments intervention and all that kind of thing I think that transferring all that knowledge to the team I think it is a very crucial process if the whole team is to use it. Having done the training, myself now I get it. The thing is kids with behaviour challenges and there are so many in educational and mental health settings you are usually working with interdisciplinary team or multimember team in terms of whānau, in terms of support.*

*(Participant 5).*

Other participants pointed out some agencies and organisations have set processes and systems that psychologists are obligated to focus on as priority:

*Our pathway and how (XY)Z tries to standardize pathways into our data base and sometimes the report writing. There are all these requirements that you need to consider.*

*(Participant 4).*

*At the XYZ there is so much bureaucracy and processes around a lot of things. The work is focused on the system, where's for example in CAMPS it is about the person and the family.*

*(Participant 11).*

Amongst other possible limitations were time and money constraints:

*So, to do it in a meaningful way it takes some time and people pay privately or it's paid for 4 or 5 sessions or ACC with 8 sessions.*

*(Participant 9).*

*I can't see that there would be any barriers. My work is pretty flexible. If I felt that it was appropriate to use Mana Enhancement with a child, then I could. I guess time may be a potential barrier.*

*(Participant 6).*

Another participant noted at her workplace not many people know about the model which made her believe more professional development should be taking place withing workplaces:

*In my work at the moment one of the barriers is that not many people heard of it. In my office no one has heard of it which I find annoying to be honest, I sort of wonder did these people not look at things, not listening when someone is trying to tell them something? Maybe they are just too busy. Too fixed in their own ways of doing things.*

*(Participant 8).*

Participant three believed more female Ātua (female gods) would make the model more relevant for female clients:

*I know it works well with girls' tool but because it's predominantly male Ātua I need to find some more female atual feel. So, I predominantly use it with Māori young males. I've got two female atua that I've been sort of talking about. They are more local, Gisborne stories for kids and bringing that into that space. I've got Papatūānuku which is nice at the beginning, but I need to find some more female.*

*(Participant 3).*

Participant one noted the only limitation to applying the model is how much creativity psychologists are prepared to use:

*You're only limited by your own imagination. It is about being creative. I struggled with two boys, but it was about go and get their mum and that helped. With the other boy I asked myself. Does he need to take more of the lead with it? Does he need more scaffolding to successfully complete it? So, with the kids doing it with him, he can see the relevance of it, as we are doing scaffolding, he can see what he can put in there. So, the barrier is us and whether we are creative or have no time. Because this is an excuse people use, that they have no time.*

*(Participant 1).*

#### **4.11 Conclusion**

The purpose of this chapter was to highlight the findings which emerged from the interviews that were carried out. It is clear from the findings of this research study that psychologists are open to learn about Māori mental health models and are looking for frameworks that can enrich their cultural competence and are willing to use them as one of their tools. As the narratives have shown, psychologists who are using the model found it to be helpful in their practise and those who were unable to use it expressed the interest of returning to the model or using it when their circumstance allows. Structural issues within organisations as well as limitations when working privately continue to prevent some of the clinicians from using the model or seeing it being used when they recommend it. Some barriers to applying the model include lack of funding and reluctance by the organisations to implement the model.

## **Chapter Five**

### **Discussion**

#### **5.1 Introduction**

The main objectives of this research were to explore New Zealand psychologists' experiences using Te Ara Whakamana: Mana Enhancement, an emotional regulation and behavioural modification tool, which is centred in te ao Māori (the Māori world) and how this framework impacts psychologists' practice with their clients, what are the framework's strengths and what are the possible barriers and limitations. This chapter will provide an interpretation of the findings obtained; it will illustrate why the findings are relevant to the research and relate the findings to other research carried out. The findings of this study are based on the interpretation and analysis of data obtained through the process of semi-structured interviews of eleven psychologists.

#### **5.2 Understanding the findings in relation to the research questions**

As expected, broadening cultural competence and learning new culturally inclusive tools emerged as a main theme across all eleven interviews. All participants reported that cultural competence was of significant importance and that they valued culture in their practice, hence their reason to train in Te Ara Whakamana: Mana Enhancement. All participants shared positive experiences of the training sessions and the workshop structure. Some participants expressed that they felt confident in practising culturally grounded psychology in their everyday practice whilst others felt that they needed additional training to gain more knowledge and confidence in order to apply culturally inclusive models. Some participants reported having limited training around Māori mental health and expressed disappointment in their educational providers for not offering more extensive training on indigenous wellbeing. One participant expressed concerns for others, especially non-Māori practitioners who intend to use Māori mental health frameworks and models without being adequately prepared and holding enough knowledge of Māori culture. These findings concur with Pitama et al. (2017) who emphasize that cultural competencies are necessary when working with Māori and other ethnic minorities, yet limited training is offered by educational providers on Māori health perspectives. The findings also highlight psychologists are increasingly expressing interest in new models and are more aware of cultural competence as being vital in their practise (Tao, Owen, Pace, & Imel, 2011). The experiences of the clinicians highlight the literature showing an ongoing issue

with the lack of culturally appropriate service provision for Māori and other indigenous populations (Baxter et al., 2006; McLeod, King, Stanley, Lacey, & Cunningham, 2017). Findings of this research also point out; psychologists are reaching out for tools that are culturally meaningful. Research shows Western diagnostic standards lack capacity to meaningfully measure diverse Māori and other indigenous populations (Karlson et al., 2005; Casar, Vasques, & Ruiz de Esparzo, 2002).

As the findings of this study show, Te Ara Whakamana: Mana Enhancement can be utilised in a variety of contexts and situations. Participants reported using the framework with whānau/families and in group settings. These participants noted that the support from others is often a key factor to the successful application of the model, and some patients are more willing to engage in the model and complete it while being supported by their family or others. King et al. (2012) show how vital it is to include the presence of whānau/family when working with Māori whose approach to mental health is holistic and reflects collectivist culture, and collective historical trauma.

Some participants adapted Te Ara Whakamana: Mana Enhancement to meet the needs of their clients, whilst others extended the model by incorporating additional visual resources such as cards or video clips about the Ātua and creation stories to familiarise clients with the content. Most participants reported the importance of family involvement and the need to implement the model within wider social context including family, school, and caregivers. Some participants spoke about the model being a tool that helps to get a lot of information about the person in one session and that this framework helps clients talk about feelings and thoughts in a much easier way than other models they have used. Some participants reported this model works well with young offenders and children with Fetal Alcohol Spectrum Disorder as it is 'mana enhancing' and designed including cultural practises inherent to New Zealand. One participant especially valued how cultural relevance of this model helps to structure the therapy even when you are an experienced Māori practitioner. Another participant decided to use the model in their supervision as part of professional development.

As the findings of this study highlight, all psychologists considered the model to be culturally inclusive therefore experienced positive responses from their Māori clients. Most practitioners also pointed out this model being equally effective with non-Māori clients. The inclusion of the cultural elements and practices in the model that are inherent to New Zealand was considered essential by the psychologists who reported the model positively influenced their practise. For many participants this framework is their everyday tool they use and proved to be an effective way in ensuring their cultural competence as proposed by Soto, Smith, Griner, Rodriques, and Bernal (2018). For most participants inclusion of cultural context was seen as significant for the therapy outcomes because as

pointed out by Kleinman, Eisenberg, and Good (2006); Murray (2014); Lyons and Chamberlain (2006); and Wampold (2007) it helps to understand and include the unique ways in which their clients view their behaviour, emotions, and thoughts and ensures therapeutic healing is grounded in cultural context.

It is clear from the findings and literature review that the relationship building process and therapeutic alliance is supported when psychologists are honouring a client's culture, and when they include cultural background, and experiences. The majority of the participants reported these aspects of the framework positively impacted relationships with their clients, improved therapeutic alliance, and therapy outcomes as proposed by Casas, Suzuki, Alexander, and Jackson (2016); La Roche (2012); Yeh, Parham, Gallardo, and Trimble (2011); and Vasquez (2007). ). The above findings also aligned with whakawhanaungatanga (relationship building) which is highlighted in literature as being essential to any health or therapeutic work with Māori (Pitama et al., 2017).

Findings show the use of the model was also helpful in terms of the relationship building process between Māori and Pākehā/non-Māori practitioners. One participant however, opted out from using the model with the clients, as they believed using Māori Ātua and creation stories requires a lot of knowledge and skills from the practitioners, however this participant decided this model could be used in professional development. Some participants reported the model helped them connect with Māori and gain better understanding of mātauranga Māori/Māori knowledge and te ao Māori/Māori worldview to their practice. As highlighted by Le Grice, Braun, and Wetherell (2017) mātauranga Māori is an essential element of Māori wellbeing, which includes the knowledge and wisdom relating to Māori. These elements of Māori wellbeing have been continuously disregarded and suppressed in psychological paradigms (Le Grice, Braun, & Wetherell, 2017). Mātauranga Māori includes the practice of whanaungatanga that is relationships, connection, and practices among a family (collective), which has also been devalued in the process of colonisation (Cunningham & Stanley, 2003).

As pointed out in the literature review Māori experience trauma in a distinct way which is related to the processes of colonisation, discrimination, and racism as well as ongoing negative stereotyping (Durie, 2003; Jackson, 1992; Mikaere, 1999; Orange, 1987). Some participants felt that the model is continuously disregarded, or that other non-indigenous models are favoured and more likely to be implemented, as opposed to a Māori framework. One participant noted some of her Māori clients rejected the use of the model because being Māori was negatively perceived by them. This

relates to the issue around internalising negative stereotypes that society can hold of Māori and Māori knowledge due to colonisation, cultural imperialism, and marginalisation of knowledge as inferior to Pākehā/British knowledge systems (Pihama, 2017; Department of Corrections, 2018; Ministry of Health, 2018; Oakley-Browne, Wells, & Scott, 2006).

Further, research shows Māori experience historical trauma, which is cross-generational, inter-generational and multi-layered (Wirihana & Smith, 2014). Therefore, treating Māori using Western models that represent individualistic approaches does not adequately address the needs of whānau/collective needs, historical and intergenerational trauma, and does not include Māori models of wellbeing as guaranteed in Te Tiriti o Waitangi/The Treaty of Waitangi (New Zealand Psychologists Board, 2011). Findings show participants recognise that Te Ara Whakamana: Mana Enhancement offers a collective, whānau inclusive and multi-layered approach to wellbeing. Amongst the strengths of the model participants also reported the framework is unique, creative, specific, engaging and it differs from other Māori models with its structure, and by enabling collaboration and self-involvement with clients and whānau.

Another theme emerging from the study findings was the acknowledgement of spirituality/wairua. Participants shared their thoughts on spirituality and spoke about the importance of karakia. Some also pointed out wairua is inherent in the model, as well as the training/workshop sessions, which they believed changed the dynamics of their work. As reported by some participants inclusion of wairua in the model is a part of acknowledging and honouring mātauranga Māori/Māori knowledge and te ao Māori/Māori worldview. Taitimu, Read, and McIntoch (2018) found in their research that explanations for experiences of psychosis or schizophrenia in Māori patients could be spiritual and cultural despite colonisation and the imposition of western clinical constructs. In the present research, some participants reported the use of karakia/prayer positively impacted on their relationship with Māori clients and that the workshop sessions reminded them of the importance of Karakia in their practice in order to acknowledge and settle wairua. Research shows the therapeutic value of karakia relates to conceptualisation of Māori health and wellbeing which interconnects elements such as mind, body, spirit, family, and land (Mark & Lynos, 2010).

A consistent theme throughout the interviews relates to the structural issues within organizations, employers, and agencies as possible barriers and limitations of the model. Participants reported that their workplaces previously made it difficult for them to train in the model or were not willing to fund the training. A few participants trained in their own time and paid for the training themselves. Others felt that they were not able to apply the model because of the nature of their current position or role. One participant reported continuously recommending the model for the agencies that look after her

young clients but had no response from the agencies. Some participants expressed that their work was focused more on the systems within organisations than the person and the family. Having limitations or barriers to explore and broaden cultural knowledge in the context of New Zealand is not in agreement with principals of the Health Practitioners Competence Assurance Act (HPCA, 2003) that psychologists are required to adhere to. Some of the HPCA principles include recognising diverse worldviews of both practitioners and their clients as well as having an adequate knowledge regarding the cultural practises, historical, and political influences, and understanding of self as culture bearer. A psychologist's own culture influences how they practice with others from cultures that are different to their own.

### **5.3 Limitations of the study**

Some of the possible limitations to this study may include a small number of participants. The author was aware that the sample size decreases statistical power of the research findings and therefore the data analysis and generalising the findings was conducted in a careful manner. A small sample size makes it difficult to extrapolate the results to wider population with the same degree of certainty that quantitative research can. However, this is an exploratory study and the aim of this research was not to test how statistically significant the results are but to accurately and truthfully narrate the experience of New Zealand psychologists who trained in Te Ara Whakamana: Mana Enhancement model. Also, the concept of saturation was included in this research to determine that adequate data from a study developed a robust and valid understanding of the studied issue (Bowen, 2008). The use of semi-structured interviews helped to understand and explore the issue in depth and with details. Semi-structured interviews proved very useful in identifying central themes and main concerns. The interview process can be time consuming and costly, however this study aimed not at reviewing Western psychological theories, models, and frameworks but at exploring a new framework. In other words, gaining meaningful insights into participants personal experiences of using Te Ara Whakamana: Mana Enhancement framework.

The researcher is aware of the possibility of researcher bias that can occur in any type of research. Although, it is impossible to eliminate researcher bias, acknowledging the limitations of the research and describing them in the study shows the researchers awareness of the issues that can affect the study. One of the issues may be that the researcher is a Tauwiwi (foreigner) doing Māori centred research that is on a Māori model. It is important to note however, that this research was supported by a Māori supervisor who ensured the ethical issues related to a non-Māori conducting Māori

research were approached carefully and with an appropriate understanding of the issues discussed in this thesis. Cultural support and mentoring by Māori clinicians was also provided to the researcher during the process of this study being completed.

#### **5.4 Conclusion**

The aim of this research was to explore Te Ara Whakamana: Mana Enhancement framework. An emotional regulation and behavioural modification tool, which is centred in te ao Māori (the Māori world). This research looked at the experiences of psychologists who use the model in work in various contexts with both Māori and non-Māori clients. The foregoing chapters examined how this model impacted their practice, how it has been applied, how it influenced their relationship building process, and to identify possible barriers or limitations to the model.

The research questions were examined through a qualitative approach in the form of semi-structured interviews. The use of semi structured interviews allowed for more in-depth insight into psychologists' experiences of using the model. The use of semi-structured interviews allowed for meaningful data analysis and interpretation as psychologists were able to share their unique observations and reflections of the model. A review of the literature was presented corresponding to the research topic on the use of indigenous mental health frameworks and models. Finally, an interpretation of the findings obtained was provided, along with why the findings were relevant to the research. Limited research on indigenous, culturally centred, and culturally adapted models of mental health is present and no other research on Te Ara Whakamana: Mana Enhancement framework was found.

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## Appendixes

### Interview Schedule:

Te Ara Whakamana: Mana Enhancement in the mahi of New Zealand psychologists'

Welcome

Karakia

Whakawhanaungatanga /Introduction

Background information about the researcher. Pepeha. Who am I, what am I doing? The purpose

1. What type of work do you do within psychology?  
What other positions have you worked in previously as a psychologist?  
How long have you been a psychologist for? / What training/qualifications do you have?
2. What brought you to participate in Te Ara Whakamana : Mana Enhancement training?
3. What did you expect to get out of it?  
How did you find the training?
4. What are the main challenges you face in your work with the models you are currently using with Māori (tamariki/whānau/adults)? And others who are not Māori?  
Are there any models you used in the past that you stopped using and why?  
What are the models you find effective for your practise?
5. How do you utilise Te Ara Whakamana : Mana Enhancement?
6. How has Te Ara Whakamana : Mana Enhancement influenced your practise so far?
7. Can Te Ara Whakamana : Mana Enhancement be successfully added on to or incorporated in to the existing psychological frameworks you use?  
How do you think that could be done? / Why not?
8. In what ways has Te Ara Whakamana changed your client/practitioner relationship/  
whanaungatanga building process?
9. How would you describe therapy outcomes since using Te Ara Whakamana : Mana Enhancement?  
Have you used models such as Te Whare Tapa Whā or similar?  
How would you describe these models in terms of being mana enhancing for the client, or touching on wairuatanga/holistic wellbeing (hinengaro, whānau, tinana, wairua)

10. What are possible barriers and limitations to using Te Ara Whakamana: Mana Enhancement in your work?  
How could these issues be best targeted?
11. What kind of feedback have you received from clients, their whānau and others (e.g. teachers, schools other services) since using Te Ara Whakamana : Mana Enhancement?  
How do clients react to this model?

### Participants information sheet

*Te Ara Whakamana: Mana Enhancement Framework in the mahi of New Zealand Psychologists’.*



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Kia ora,

My name is Monika I am completing Master of Arts in Psychology at Massey University. You are invited to take part in a study that explores Te Ara Whakamana: Mana Enhancement. This framework is an emotional regulation and behavioural modification tool, which is centred in te ao Māori (the Māori world).

This research aims to explore the efficacy of the model with psychologists who work in various contexts with both Māori and non-Māori clients. This will be done by recounting the experiences of psychologists who recently underwent training in the model and are utilising this framework in practice with clients. Interviews will allow participants to explore how they are using the model, what are its strengths and what are potential barriers. Further, this study aims at describing the key ideas that emerged while practitioners were engaging Te Ara Whakamana: Mana Enhancement.

The author of this thesis aims at working with participants in a collaborative way. Using interviews will allow participants to use their own words when sharing their experiencing. Ethics approval was granted by the Massey University Ethics. This research aligns with Treaty of Waitangi research principles. Voluntary, informed, written consent from the psychologists will be obtained prior to

commencement of the study. Data will be collected and coded, with identification codes stored separately, to ensure privacy (Massey University Human Ethics Committee, 2010). All data will be stored in a secure manner and only the author will have access to the raw data.

Should you wish to participate, please complete the attached consent form and return it to me. Please feel free to contact me or my supervisors at any time if you have any questions in relation to this project. This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

Ngā mihi

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*Te Ara Whakamana: Mana Enhancement Framework  
the mahi of New Zealand Psychologists'.*

in



### **PARTICIPANT CONSENT FORM - INDIVIDUAL**

I have read, or have had read to me in my first language, and I understand the Information Sheet attached as Appendix I. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I

have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

1. I agree/do not agree to the interview being sound recorded.
2. I wish/do not wish to have my recordings returned to me.
3. I wish/do not wish to have data placed in an official archive.
4. I agree to participate in this study under the conditions set out in the Information Sheet.

**Declaration by Participant:**

I \_\_\_\_\_ hereby consent to take part in this study.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_