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**E kore au e ngaro, he kakano ahau: Whakapapa sharing in the
context of therapy.**

A thesis
presented in partial fulfilment of the requirements for a
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in Clinical Psychology

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ABSTRACT

Māori experience disproportionately negative outcomes in mental health in New Zealand. The adaptation of therapeutic assessments and interventions to allow more culturally appropriate work with Māori occurs, however, little research promoting an understanding of client's experience of these adaptations exists. One such adaptation is the sharing of whakapapa (genealogy) between therapist and client. Whakapapa sharing involves a level of therapist self disclosure not yet investigated in psychological literature. This Māori centred analogue study investigates the client's experience of whakapapa sharing during the first session of therapy. A mixed, between and within subjects design was used, both quantitative and qualitative data were collected and analysed. 30 Māori women between the ages of 18 and 40 participated in two sessions of Acceptance and Commitment Therapy, participants were allocated to either a Whakapapa Sharing group or a Therapist Non-Disclosure group. All participants completed questionnaires measuring the therapeutic alliance, therapy expectancy, outcome of therapy and a cultural questionnaire measuring participant knowledge of their own whakapapa. Participants from the Whakapapa Sharing group also reported on their experience of the sharing. Quantitative analyses revealed no group differences in either the therapeutic relationship measure or the outcome measure. All participants from the Whakapapa Sharing group, regardless of their level of knowledge of their own whakapapa, reported the whakapapa sharing as a positive experience. Further analysis of the qualitative data revealed five main themes; the whakapapa sharing process reported to promote engagement, was perceived as important for Māori, allowed the establishment of connections between therapist and client, provided clients with information with which to form judgements about the therapist and the sharing was seen to be an equitable experience. These

themes were arranged into a theoretical model, in which, all five were hypothesised to have a relationship with the power imbalance inherent between therapist and client. Whereby four of the themes were hypothesised to contribute to a decrease in the imbalance of power and the final theme was seen as a result of the decrease in the power imbalance. These tentative findings suggest that the exchange of whakapapa between a therapist and client may serve to decrease the power imbalance in the therapeutic relationship, and as such, it is an appropriate process of engagement in a therapeutic setting with Māori clients, who often experience marginalisation.

NGA MIHI

He mihi mahana, he mihi maioha, he mihi aroha hoki ki te hunga tautoko o tenei ara roa. Ki te whakaaro ahau ki tenei mahi, ka puta mai te whakatauki “*Ma whero ma pango ka oti te mahi.*”

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TABLE OF CONTENTS

ABSTRACT	ii
NGA MIHI	iv
TABLE OF CONTENTS	vi
LIST OF TABLES.....	viii
LIST OF FIGURES	ix
FORWORD	1
CHAPTER ONE: INTRODUCTION	4
The Therapeutic Alliance	6
Cultural Competence	11
Whakawhanaungatanga	15
Therapist Self Disclosure.....	16
Research Objectives	19
CHAPTER TWO: METHOD.....	21
Participants and Recruitment.....	21
Design.....	22
Measures and Materials	23
Procedure	28
CHAPTER THREE: QUANTITATIVE RESULTS	35
Group Mean Differences	35
Correlations	47
CHAPTER FOUR: QUALITATIVE RESULTS	54
Descriptive Categories.....	56
Additional Feedback.....	60
Themes.....	63

Making a Connection.....	63
Importance of Exchange for Māori	65
Equitable Relationships	69
Perception of the Therapist.....	71
Improved Engagement.....	72
Model.....	74
CHAPTER FIVE: DISCUSSION	79
Implications	82
Limitations.....	86
Future Research	88
Summary.....	90
REFERENCES	93
APPENDICES	101
Appendix 1: Glossary	101
Appendix 2: Advertising Sheet.....	104
Appendix 3: Experience of Whakapapa Sharing Questionnaire	105
Appendix 4: Therapy Protocol	106
Appendix 5: Information Sheet	108
Appendix 6: Consent Form.....	111
Appendix 7: Whakapapa Sharing Script	112
Appendix 8: Koha Receipt	114

LIST OF TABLES

Table 1	Descriptive Statistics for the Overall Scores on the Working Alliance Inventory.	37
Table 2	Descriptive Statistics for the Goals Subscale of the Working Alliance Inventory.	39
Table 3	Descriptive Statistics for the Bond Subscale of the Working Alliance Inventory.	41
Table 4	Descriptive Statistics for the Tasks Subscale of the Working Alliance Inventory.	43
Table 5	Descriptive Statistics for the Symptoms Checklist - Revised - 10 Items.	44
Table 6	Descriptive Statistics for the Credibility/Expectancy Questionnaire.	46
Table 7	Pearson Product Moment Correlation Coefficient Between the Therapeutic Expectancy, Therapeutic Relationship and Outcome Measures at Time 1 and 2.	48

LIST OF FIGURES

Figure 1	Flow diagram illustrating the procedure for participant measure administration and intervention.	33
Figure 2	Group mean scores on the WAI after the first and second sessions of therapy.	36
Figure 3	Group mean scores on the Goals subscale of the Working Alliance Inventory after the first and second session of therapy.	38
Figure 4	The Non-Disclosure group and Whakapapa Sharing group mean scores on the Bond subscale of the Working Alliance Inventory at Time 1 and Time 2.	40
Figure 5	The Non-Disclosure group and Whakapapa Sharing group mean scores on the Tasks subscale of the Working Alliance Inventory at Time 1 and Time 2.	42
Figure 6	The Non-Disclosure and Whakapapa Sharing group mean scores on the SCL-R-10 prior to therapy and following therapy.	44
Figure 7	The Non-Disclosure and Whakapapa Sharing group mean scores on the Credibility/Expectancy Questionnaire prior to and following therapy.	46
Figure 8	The relationship between participants' mean scores on the WAI at Time 1 plotted against their mean scores on the CEQ at Time 2.	49
Figure 9	The relationship between participants' mean scores on the CEQ at Time 1 plotted against their mean scores on the WAI	50

at Time 2.

Figure 10	The relationship between participants' mean scores on the WAI at Time 2 plotted against their mean scores on the CEQ at Time 2.	51
Figure 11	The relationship between participants' mean scores on the WAI at Time 1 plotted against their mean scores on the SCL-R-10 at Time 2.	52
Figure 12	Participants' scores on the Māori Culture Questionnaire plotted against their mean scores on the Working Alliance Inventory.	53
Figure 13	Framework illustrating the relationship between the themes identified from the qualitative analysis.	74

FOREWORD

Ko Tokomaru rāua ko Paroa nga waka
Ko Taranaki rāua ko Piripiri nga maunga
Ko Arapāoa te moutere tapu
Ko Waitohi te awa
Ko Waikawa te whenua
Ko Waikawa te marae
Ko Te Atiawa te iwi
Ko Ngāti Pākehā te iwi i te taha o tōku matua
Ko Arna Mitchell ahau.¹

My ancestors came to New Zealand on the waka Tokomaru, they originally settled in Taranaki, then later migrated to Waikawa on the waka² Paroa.³ My mother's father was of Te Atiawa descent, he was raised by his mother and step father, who were both Pākehā.⁴ Grandad returned to our marae⁵ in Waikawa when his children were grown, to reconnect with our rohe⁶ and learn to carve. My mother's mother was of Scottish and English descent and my father's parents are both of English descent. I was born in Taupo and grew up in various towns and cities between Taupo and Invercargill. I am the second of five siblings, I have three brothers and one sister. During my intermediate years I attended Te Kura Kaupapa Māori o

¹ An explanation and acknowledgement of where I am from.

² Waka – Canoe.

³ Māori words will be explained in an English footnote after the first usage. Following the first use, refer to the Glossary in Appendix 1.

⁴ Pākehā – New Zealander of European descent.

⁵ Marae – The ancestral buildings and area of land that belong to a tribe.

⁶ Rohe – Area, region (of land).

Arowhenua⁷ in Invercargill and following that I attended a mainstream high school in Taupo. After high school, I completed a Bachelor of Arts, majoring in Psychology and Māori studies at Victoria University before transferring to Massey University to undertake a Bachelor of Arts Honours in Psychology. I am currently studying to become a clinical psychologist at Massey University in Wellington.

This is an example of the information I shared with participants in the present study when initiating the whakapapa⁸ sharing process. My interest in the sharing of whakapapa within a therapeutic context began during a volunteer experience at an iwi⁹ funded kaupapa Māori¹⁰ Mental Health service. I was invited by the clinician to share my whakapapa with tangata whaiora¹¹ when I sat in to observe therapy sessions. Although I wasn't able to fully comprehend the significance of this experience at the time, I did notice a remarkable change in the atmosphere of the room; tangata whaiora seemed more comfortable with my presence, and in turn I did not feel intrusive as an observer. I instead experienced a sense of inclusion and belonging in the session.

Sharing whakapapa is a Māori way of communicating who you are. I remember learning my whakapapa at an early age, reciting it formally at marae gatherings and sharing aspects of my whakapapa during more informal meetings.

As a result of my fair complexion, light hair tone and predominantly 'Pākehā' features, I am often initially identified as Pākehā, despite being raised within both Māori and Pākehā contexts due to my parents differing cultural backgrounds. Upon reflection and through carrying out this research, one of the many things I have come

⁷ Kura Kaupapa Māori are Māori language immersion schools.

⁸ Whakapapa – Genealogy.

⁹ Iwi – Tribe, extended kinship group.

¹⁰ Kaupapa Māori – An ideology incorporating Māori knowledge, skills, attitudes and values.

¹¹ Tangata whaiora – Term used to describe mental health consumers, meaning those who seek wellness.

to realise, is that sharing my whakapapa allows people access to a better understanding of who I am, thus allowing them to make a more informed decision regarding my appropriateness to work as their clinician—a decision which is not only based on my outer appearances or my role within the context of our meeting. In the present study my role in relation to the participants was researcher, therapist, and student. Sharing my whakapapa emphasised another role, that of a fellow human being.

It is important to acknowledge my experiences and perceptions of this research process, as despite my attempts to remain objective, a researcher's worldview will always influence the research they undertake (Scott & Garner, 2013).

CHAPTER ONE

INTRODUCTION

“Tangata takahi manuhiri, he marae puehu”

“A person who fails to respect his guest has a dusty Marae”

This whakataukī¹² outlines the importance of hospitality to Māori. When placed in a mental health context, it can be seen to apply to the establishment and continuation of relationships with Māori clients based on a Māori perspective of hospitality and respect. Although on the surface this seems like a basic concept, manaakitanga¹³ involves practices and attitudes that can be, and in certain services are, adopted when working with Māori. An attitude of manaaki¹⁴ is one of respect and caring, respectful and caring attitudes are conveyed through actions, such as providing food and physical comforts. An example of manaaki toward tangata whaiora might be the service provision of a communal wharekai¹⁵ for tangata whaiora and mental health workers alike. Although respect for individuals is a principle in the Code of Ethics for Psychologists Working in Aotearoa/New Zealand (New Zealand Psychological Society, 2002), the way in which we can show respect to our clients is less clear. Manaakitanga constitutes a Māori way of conveying respect and hospitality to others. This is just one example of how respect can be given from a Māori worldview that might differ from other non Māori perspectives.

¹² Whakataukī – Proverb.

¹³ manaakitanga – (Noun) Hospitality or promotion of others’ mana through active hosting and support.

¹⁴ Manaaki – (Verb) To support, take care of, give hospitality to, protect, look out for.

¹⁵ Wharekai – Dining hall.

In psychological practice, interventions and approaches are considered for implementation when they are found to be effective, through outcome based research. Culturally responsive adaptations to assessment and intervention recognise the influence of cultural patterns, understandings and values on diagnosis and treatment (Bernal, Jimenez-Chafey, & Rodriguez, 2009). An international review of studies evaluating the efficacy of culturally responsive treatments found some support for approaches that were adapted to address the needs of clients from ethnic minorities (Huey & Polo, 2008). However, within a New Zealand context, although the application of Māori perspectives in working with Māori is widely recognised as important, few outcome studies of the implementation of Māori perspectives, tikanga,¹⁶ and kawa¹⁷ in therapeutic settings exist. Te Pou o te Whakaaro Nui (2010), an organisation concerned with the development of the mental health workforce in Aotearoa, provide extensive discussion about culturally responsive practice when working with Māori in mental health settings based on expert opinion. However, Te Pou o te Whakaaro Nui also acknowledge the need for empirical research in this area. Perhaps, Māori perspectives will be more widely implemented in psychology training and practice when a better understanding of the experiences of tangata whaiora during these practices is gained.

The need for such understanding is considerable as health and socioeconomic status inequalities exist for Māori (Ministry of Health, 2008). In a mental health context low income members of minority cultures have been found to be less likely to seek help and more likely to prematurely disengage from treatment resulting in poorer outcomes (Agosti, Nunes, & O'Cepek-Welikson, 1996). Fortunately, dropout rates can be reduced when therapists and clients are able to develop a strong relationship

¹⁶ Tikanga - Custom, meaning, procedure, manner, convention.

¹⁷ Kawa - Marae protocol, customs of the marae.

(Sharf, Primavera, & Diener, 2010). Reviews of the role of the therapeutic relationship in therapy have consistently found that the therapeutic alliance is predictive of positive treatment outcomes (Horvath & Symonds, 1991).

THE THERAPEUTIC ALLIANCE

The therapeutic alliance is the relationship that exists between the therapist and client during assessment and intervention in mental health settings. The term therapeutic alliance in this document will be used interchangeably with the terms working alliance and therapeutic relationship. Research has consistently revealed a strong and robust relationship between a positive therapeutic alliance and positive outcomes of psychotherapy (Horvath, Del Re, Fluckiger, & Symonds, 2011). Horvath, Del Re, and Symonds conducted a study correlating results from over 200 research articles on the relationship between the therapeutic alliance and outcome and found that 27.5 per cent of the variance in outcome was explained by the therapeutic alliance.

Bordin (1979) proposed a model for the therapeutic alliance which outlined the three main components of the relationship and can be seen to be relevant across all approaches to psychotherapy. The three components include agreement between the client and therapist on the goals or purpose of therapy, agreement of the client that the tasks proposed during therapy will address the relevant problems, and the bond between therapist and client. Therefore, according to this framework, positive therapeutic relationships are those in which the client believes they are working towards a common goal with the therapist, agrees with the proposed method of reaching that goal, and feels a bond with the therapist. The bond aspect of this relationship has been difficult to define, in that it encompasses highly subjective and

emotional experiences such as a client's trust, acceptance and confidence in the therapist. A number of questionnaires aiming to measure the therapeutic alliance reflect Bordin's (1979) theoretical model and vary in their approaches to measuring each dimension. The Working Alliance Inventory (Horvath & Greenberg, 1989), a 36 item, Likert scale questionnaire, consists of three subscales designed to measure the three main components of the therapeutic alliance as defined somewhat objectively by a number of questions in each subscale. Alternatively, Miller et al. (2003) developed the Session Rating Scale, a 4-item visual analog scale designed to provide a measure of the client's perception of each therapy session. This scale is more subjective than the Working Alliance Inventory; clients are asked to rate Bordin's three theoretical components with a single item and are also required to give an overall rating.

Although some therapeutic approaches, such as a client-centred approach, view the therapeutic alliance as necessary and sufficient for positive treatment outcomes (Rogers, 1957), wide support for the therapeutic alliance, across different approaches as having a necessary but not sufficient role in therapy outcome has been found (Horvath, & Luborsky, 1993). Evans and Fletcher (2013) describe the relationship between the therapeutic alliance and therapeutic techniques as being similar to the relationship between synchronicity and technicality of ice skating duos. Although partners who are either strongly in sync or have a technical routine can be enjoyable to watch, the best performances are by those who are both strongly in sync and have a high level of technicality in their routine.

Various static variables such as client characteristics and dynamic variables such as therapist behaviours and therapeutic techniques have been shown to influence the therapeutic alliance (Ackerman & Hilsenroth, 2003). These characteristics, behaviours and techniques can inform clinicians and training programmes about the

variables that contribute towards a strong therapeutic alliance. Ackerman and Hilsenroth (2003) conducted a meta-analysis of articles researching the variables that impact upon the therapeutic alliance. One such variable, the client's interpersonal style or history of interpersonal conflicts, has consistently been found to predispose the client to develop a positive or negative therapeutic alliance. Therefore those clients with a pattern of poor relationships throughout their lives are more likely to experience a poorer therapeutic relationship. In a study testing the influence of pretherapy interpersonal problems on the therapeutic alliance, Muran, Segal, Samstag, and Crawford (1994) found that historical interpersonal problems that were related to client friendliness and submissiveness were predictive of stronger therapeutic alliances while interpersonal problems that were related to client hostility and dominance were predictive of weaker alliances. Similarly, Hersoug, Monsen, and Hoglend (2002) found that the therapeutic alliance was easily predicted in early sessions of therapy by clients' historical and present relationship difficulties. Similar results have even been found with parents of children in therapy—parents' alliance with the therapist was found to be predicted by their own attachment style (Taylor-Pickford, 2011).

A number of therapist characteristics and techniques have been found to have a positive influence on the therapeutic alliance (Ackerman & Hilsenroth, 2003).

A qualitative study involving 34 clients who were required to answer open-ended self report questionnaires about their perspective of the alliance at three different time points revealed 16 therapist characteristics which clients viewed as contributing factors towards a stronger therapeutic alliance. Therapist characteristics included common findings such as warm, agreeable, respectful, understanding and nonjudgemental, however, participants from this study also identified therapist level

of competence and therapist self disclosure as contributing towards a stronger therapeutic alliance (Bacheor, 1995).

A quantitative study of the effect of therapist expertise on the therapeutic alliance compared clinicians at three different levels of expertise; novices, advanced trainees and experienced clinicians (Mallinckrodt & Nelson, 1991). This study found that although clinicians were able to form a similar bond with clients regardless of their level of expertise, the clinicians differed in clients' ratings of their agreement about the tasks and the goals for therapy. Clinicians and trainees with more experience received higher scores on the tasks and goals scores.

Ackerman and Hilsonroth (2003) also reviewed research pertaining to therapist characteristics and techniques that have been found to be predictive of a stronger therapeutic alliance. Techniques found to be helpful include therapist exploration and accurate interpretation of client difficulties, demonstrations of support, facilitating and reflecting emotion expression, acknowledging success, and acknowledging and understanding client's experiences (Ackerman & Hilsonroth, 2003). Duff and Bedi (2010) developed a questionnaire measuring therapist behaviours as perceived by the client. They identified 11 therapist behaviours that were found to have a strong relationship with a positive therapeutic alliance. The behaviours included: exploration, encouragement, reflection of emotions, honesty, affirmations, validation of client experiences, eye contact, greeting clients with a smile, remembering and referring to details from past sessions, sitting still and facing a client directly. These findings suggest that therapists can learn and practice certain behaviours which clients will respond well to and will ultimately serve to improve the therapeutic alliance.

The literature on the role of culture in the therapeutic relationship is non-conclusive. Theoretical discussions and evidence-based studies often result in conflicting conclusions. A study assessing the effectiveness of client and therapist racial matching when working with adolescents found that although treatment retention rates were improved by racial matching the therapeutic alliance as reported by clients was not (Wintersteen, Mensinger, & Diamond, 2005). Interestingly, therapists in this study reported lower alliances with racially mismatched clients, therefore therapists' reports revealed differences in therapeutic alliance scores according to culture, but client reports did not.

Within a New Zealand context, a qualitative study carried out by Goldsbury (2004) investigated the therapeutic alliance and outcome with Māori tangata whaiora who had seen non-Māori psychologists. Semi-structured interviews with three male and seven female tangata whaiora were conducted, the findings revealed that Māori service users were able to form positive therapeutic alliances with non-Māori clinicians and achieve positive outcomes from therapy. Māori participants reported the relationship they were able to build with clinicians was influenced by a number of factors. These factors included their expectations and worries about the service and the clinician, the way the clinician addressed cultural identity, cultural differences and cultural issues, and showed respect for tikanga Māori. A number of psychologists' characteristics and techniques were also raised which were similar to those found in past research.

Although some research findings suggest that therapists can and often do work effectively across cultures, the cultural competency literature acknowledges the importance of cultural sensitivity, which allows practitioners to work effectively and overcome potential barriers in trans-cultural encounters. Examples of such barriers

include unintentional therapist bias and the imposition of a therapist's worldview that is not in line with that of their clients'. In the broad sense of culture, all therapeutic encounters involve therapists and clients from vastly different cultural contexts. And as such, findings that reveal the ability of psychologists to work effectively transculturally is encouraging, as is the recognition of the importance of therapist cultural competence as a core competency for psychologists in New Zealand.

CULTURAL COMPETENCE

The literature discussing the importance of cultural competence outlines potential barriers and approaches that serve to overcome them. Sue (1998) discussed the possible impact of cultural differences between therapist and client on the development of rapport and the therapeutic relationship and provided guidelines for the implementation of culturally competent practice. In a therapeutic context when working trans-culturally there is potential for misunderstandings and unjust judgements, which can result in discrimination and marginalization of clients (Garran & Rozas, 2013). Waldegrave (Tamasese & Waldegrave, 1993) outlined an example of a misunderstanding he observed involving a Pākehā therapist and a Māori whanau—an interaction observed by a Māori therapist using a one-way mirror. Following a separation, both parents had agreed on whanau living arrangements, however, the grandmother was unhappy with their intentions in regards to the children and the parents were discussing this problem with the therapist. The therapists' initial reaction was to advise the parents to ignore the grandmothers' wishes and act upon their own, however, the Māori therapist observing, was able to explain that a grandparents authority in the lives of grandchildren is viewed differently from a Māori worldview, and that ignoring this grandmothers' wishes could result in alienation from the

couples wider whanau. Although many therapists would refrain from giving a couple advice in this type of situation, this provides one example of how different cultural backgrounds can result in vastly differing perspectives and solutions to the same problem. Additionally, it is also important to emphasise that perspectives within a culture should be not be viewed as homogenous but rather as richly diverse.

La Roche and Maxie (2003) assert that cultural differences between therapist and client are inevitable. Instead of focusing on differing worldviews, La Roche and Maxie emphasise the socio-political importance of developing a culturally sensitive model to address differences within therapy in an open way. Similarly, Esmiol, Knudson-Martin, and Delgado (2012) focus on the importance of clinicians gaining an awareness of power differentials that occur within an individual's social context and how these impact on interpersonal relationship processes as well as on client presenting problems. Some variables that involve power differentials include a person's gender, ethnicity, sexual orientation, level of education, social class, status as a consumer of mental health services, socioeconomic status, and religion or spirituality. Esmiol, Knudson-Martin, and Delgado argue that having knowledge of power and privilege within a person's wider social, political, cultural, spiritual and historical context is not enough to inform culturally sensitive practice. They suggest that training culturally sensitive practitioners must involve training experiences with diverse populations in which trainees have opportunities to engage in self reflection, and have culturally safe and open discussions about power differentials with supervisors and teachers.

In order to ensure ethical practice across culturally diverse populations, cultural competencies exist to inform assessment and intervention approaches. Unfortunately, the often ambiguous nature of cultural competence concepts and the

lack of outcome based research on specific recommended practices result in a wide range of understandings and applications of the concepts. The American Psychological Associations Multicultural Guidelines (2003) describe cultural competence under three broad categories of understanding. The first pertains to psychologists developing an understanding of their own worldview and how it is informed by their unique values, experiences and beliefs. When working with clients, psychologists need to understand that their own worldview will differ from their clients and how that can impact their work together. Secondly, the ongoing development of specific cultural knowledge relating to the expectations and worldviews of clients is also recommended. Finally, psychologists need to develop a culturally sensitive stance by which they are able to provide culturally relevant assessment and interventions.

Sue (1998) argued the importance of operationalising these competencies in order to increase their usefulness for researchers and practitioners. Ten guidelines for culturally competent practice were provided, two of which included: treating clients as individuals in order to avoid stereotyping, and forming and testing hypotheses throughout the assessment and intervention process. Other authors also discuss practical approaches which can be applied in multi-cultural settings (Hays, 2003; La Roche & Maxie, 2003).

Hays (2003) provided ten practical recommendations that can be applied cross culturally and are specific to cognitive behaviour therapy. These recommendations aim to ensure that the therapist does not impose their own perspectives on the client. For example, when implementing cognitive restructuring techniques, thoughts can be viewed as unhelpful rather than invalid and clients can decide whether thoughts are unhelpful or not. La Roche and Maxie (2003) discuss the benefits of therapists

explicitly addressing cultural differences with their clients and provide ten recommendations for ways of doing so in a clinical setting. La Roche and Maxie outline the need for empirical exploration and validation of their recommendations. It appears that most of the practices and approaches recommended as culturally competent have little empirical validation. Potentially, the most important aspect of cultural competence is that cultural competence is not something that can be achieved or obtained; instead it should be seen as something mental health workers can continually work towards and develop (Nairn, 2007; Sue, 1998).

In a discussion of cultural competence within a New Zealand context, Nairn (2007) outlines practices and approaches that adhere to the Code of Ethics for Psychologists Working in Aotearoa/New Zealand, cultural justice and Te Tiriti o Waitangi.¹⁸ In order to work with Māori from a cultural justice perspective, it is important to understand how the current social, political and cultural dynamics within New Zealand have developed through historical injustices that are sometimes still present. The development of culture-specific knowledge and skills is also important while at the same time understanding that Māori, just as all cultural groups, exist within diverse realities (Durie, 1995). As such, importance is placed on approaching clients as individuals and avoiding stereotyping.

Although developing a wider stance of cultural sensitivity is important, La Roche and Maxie (2003) discuss the non-verbal and verbal ways, therapists can unintentionally inhibit clients' discussions of culturally relevant issues through subtle discomfort or even disapproval. Developing culture-specific knowledge and skills can allow therapists to portray explicitly to clients acceptance and respect for Māori

¹⁸ Te Tiriti o Waitangi – The Treaty of Waitangi is a document signed by Māori and the Crown in 1840 that outlines Māori self-determination under the Crown's governance.

culture, which can provide a culturally safe environment in which culturally relevant issues can be openly addressed. Te Pou o te Whakaaro Nui (2010) provide comprehensive guidelines for working with Māori in talking therapies, which are both general and specific. Although, Bennett (2009) adapted cognitive behavioural therapy practices for use with Māori clients, more outcome based and experience based research is necessary in order to gain a better understanding of how these practices influence Māori clients and therapy. The present study involves the investigation of an aspect of one of the guidelines outlined by Te Pou o te Whakaaro Nui (2010), a Māori cultural practice known as whakawhanaungatanga.¹⁹

WHAKAWHANAUNGATANGA

Whakawhanaungatanga in practice is used in research and therapeutic settings with Māori in order to establish rapport, form relationships between individuals or groups and improve client engagement in treatment (McClintock, Mellsop, Moeke-Maxwell & Merry, 2010). Little research has been carried out on the practice of whakawhanaungatanga in therapeutic settings; currently this practice is informed by expert opinion and only one study by Bennett (2009) has investigated its clinical use.

Bishop (1998) describes whakawhanaungatanga as the “process of establishing family (whānau²⁰) relationships, literally by means of identifying through culturally appropriate means your bodily linkage, your engagement, your connectedness, and therefore, an unspoken commitment to other people”. Some examples of how whakawhanaungatanga practices can be incorporated in a mental

¹⁹ Whakawhanaungatanga – (Noun) Process of establishing relationships or connections, relating well to others.

²⁰ Whānau – Family.

health setting include; hongī,²¹ sharing food, karakia,²² an adapted pōwhiri²³ or the sharing of whakapapa. Bennett's (2009) research focused on whakawhanaungatanga as a cluster of practices and not on its individual components. In Bennett's (2009) adaptation of CBT for Māori clients, an advisory group was established for consultation in order to discuss and develop culturally appropriate adaptations. This group identified whakawhanaungatanga as crucial for building a more personal relationship with tangata whaiora. The advisory group also identified appropriate therapist disclosure criteria in regards to whakapapa sharing; these criteria included the disclosure of iwi and hapū²⁴ affiliations, whānau background and working history. An example of the researcher's whakapapa, as prepared in accordance of these criteria can be found in the Foreword of this document.

The sharing of whakapapa between therapist and client is investigated in the present study. According to Tassell and Lock (2010), one's whakapapa is the cornerstone of one's identity; whakapapa establishes interconnectedness between people and their ancestors, the atua and the environment. This theoretical framework of whakapapa sharing suggests that it is an important process in establishing relationships between Māori; the current research will investigate this process in a therapeutic setting by exploring the client's experience of the therapist's whakapapa disclosure.

THERAPIST SELF DISCLOSURE

Te Pou o te Whakaaro Nui (2010) mentions the often-conflicting perspectives between Western approaches and Maori worldviews. One such conflict can be seen to

²¹ Hongi – A way of greeting, which involves pressing noses.

²² Karakia – Prayer.

²³ Pōwhiri – The rituals of encounter.

²⁴ Hapū – Subtribe, section of a large kinship group.

be present when considering whakapapa sharing from a psychological perspective. According to Māori tikanga the exchange of whakapapa can be seen as respectful, however, most psychological approaches recommend caution when therapists are deciding to disclose personal information. Therapist self-disclosure is now viewed as inevitable and not inappropriate as it once was (Farber, 2006). However, the frequency and content of therapist disclosure varies across approaches and as such, recommendations regarding judicious disclosure can be seen to be somewhat ambiguous. Farber (2006) provides ten guidelines to follow when deciding to self disclose; in general, it is recommended that therapists self-disclose infrequently and judiciously, the purpose of therapist disclosures should be to benefit and not harm the client (Knox & Hill, 2003).

Although Farber (2006) go on to describe a number of situations in which self-disclosure can be used to benefit the client, the use of self-disclosure for cultural purposes is not addressed. As a tikanga practice, the criteria outlined in Farber (2006) appear to be met, however, the lack of research about whakapapa sharing in therapeutic settings results in some uncertainty as to how it is experienced by Māori service users. One purpose of sharing whakapapa is to identify familial or iwi connections between a therapist and client, the early identification of such connections during whakapapa sharing can present an opportunity for therapists to explain confidentiality within the therapeutic relationship to ensure that clients feel comfortable with continuing in therapy.

One study exploring therapist self disclosure and the therapeutic alliance found that participants perception of therapists' disclosures were mediated by the strength of the therapeutic relationship (Myers & Hayes, 2006). When the relationship was perceived as positive, participants responded well to therapist disclosures. However,

when the relationship was perceived as negative, participants perceived disclosures as shallow. This study revealed no differences among ethnic minority groups in their responses to therapist self disclosure. The self disclosures in this study involved general disclosures and countertransference disclosures, not culturally meaningful disclosures, such as the sharing of whakapapa.

Similarly, a qualitative review of research articles on therapist self disclosure found no differences among ethnic groups responses (Henretty & Levitt, 2006). The effect of self disclosures on the therapeutic alliance was variable depending on the type and frequency of disclosures. The authors emphasised a need for further research in this area. Audet and Everall (2010) carried out a qualitative study in which both positive and negative themes were revealed in participant perceptions about therapist disclosures. Themes that were categorised as facilitative involved improved comfort, an egalitarian quality to the relationship, feeling attuned, close, understood and not judged. Themes that were categorised as hindering included confusion about the disclosure, seeing the therapist role as devalued by the disclosure, feeling misunderstood and overwhelmed and feeling impeded by the therapist talking too much about themselves in therapy. These findings reveal both positive and negative responses to therapist disclosure, and although no ethnic group differences in responses have been revealed, culturally specific disclosures, such as the sharing of whakapapa have not been adequately researched. As such, the present study will investigate client experiences of whakapapa sharing, a cultural practice involving therapist self-disclosure.

RESEARCH OBJECTIVES

The therapeutic alliance has been found to be an important mechanism of change across treatment approaches in psychotherapy. In New Zealand, Māori are over-represented in mental health service consumer populations and although recommendations and guidelines for engagement and practice with Māori exist, there is a lack of research investigating the effect of these practices on client engagement, the therapeutic relationship and outcomes. Te Pou o te Whakaaro Nui (2010) describes the importance of recognising the conflicts that arise between Māori worldviews and Western psychology perspectives. Whakapapa sharing, an integral aspect of whakawhanaungatanga, is one example of a Māori practice that is recommended in therapy for engaging tangata whaiora, but can also potentially be seen to be at odds with a Western psychology perspective as it involves extensive therapist self disclosure. The present study aims to explore the whakapapa sharing process within therapy, by way of an analogue study, so as to gain a better understanding of Māori clients' experience of this process and the effect that it has on building the therapeutic relationship and subsequent outcomes of therapy.

The present research aims to investigate the impact of whakapapa sharing when initiated by a therapist at the beginning of the first session of therapy. It was hypothesised that:

- Whakapapa sharing will promote a more positive therapeutic relationship after the first session of therapy than a standard introduction to therapy.
- Better therapy outcomes will be related to more positive therapeutic relationships.
- As such, whakapapa sharing will also promote better therapy outcomes than a standard introduction to therapy.

- Participants with more knowledge of their whakapapa and access to and engagement with Maori culture will form a stronger alliance with the researcher following the sharing of whakapapa than those with less knowledge and access to Maori culture.

In addition to these hypotheses, this research aimed to answer the question: How do clients perceive and experience the sharing of whakapapa when initiated by a therapist at the beginning of the first session of therapy?

CHAPTER TWO

METHOD

The aim was to investigate the effect of sharing whakapapa between therapist and client during the first session of therapy. A mixed quantitative and qualitative methodology was used to test the hypotheses and address the research question outlined in the previous chapter. Participants were assigned to one of two groups, either a Whakapapa Sharing group or a Therapist Non Disclosure group; this was for the purpose of drawing comparisons between the two groups on outcome and therapeutic alliance measures. In order to investigate the research question regarding participants' experience of the whakapapa sharing, a questionnaire was administered to participants in the Whakapapa Sharing group only. The questionnaire asked a series of open-ended questions and the participants' responses to it were analyzed using qualitative methodology. The quantitative and qualitative results are presented in the third and fourth chapters of this thesis respectively. This chapter will report participant demographics, recruitment procedure, research design, psychometrics, and general procedures used.

Prior to the commencement of this research, ethical approval was gained from the Massey University Human Ethics Committee.

PARTICIPANTS AND RECRUITMENT

Participants were 30 women of Māori descent between the ages of 18 and 39, with a mean age of 26 years. Participants were recruited by way of advertising posters (Appendix 2), which were distributed around major supermarkets and via email through various networks of Māori. For example, a Māori scholarship program

distributed the email to their recipients. Word of mouth was used as an additional means of recruitment which resulted in a snowball effect, whereby participants approached other potential participants from within their social or occupational networks. Potential participants were included in the study provided they met the age, gender and ethnicity criteria and were not currently involved with mental health services. Eight potential participants who initially expressed interest in the study eventually chose not to participate.

DESIGN

Mixed qualitative and quantitative methodology was used. For the quantitative analyses a mixed within and between subject design was employed, involving mixed-design repeated measures ANOVAs and Pearson's partial correlations. A questionnaire, the Experience of Whakapapa Sharing Questionnaire, was used to collect qualitative data regarding the Whakapapa Sharing group's experience of whakapapa sharing. Thematic analysis was used to analyse the qualitative data (Braun & Clark, 2006). The analysis procedure for the qualitative data will be outlined in the fourth chapter of this dissertation.

Mixed-design repeated measures ANOVAs were used to reveal differences between the two groups and differences within the participants scores across the time periods on the three outcome and therapeutic alliance questionnaires. The between-subject independent variable had two levels with participants assigned to one of two groups: the Whakapapa Sharing group or the Non-Disclosure group. The within-subject independent variable also comprised of two levels, which were the two separate points of time at which measures were completed. There were three

dependent variables derived from the three questionnaires designed to measure treatment influences (outcome) and the nature of the therapeutic alliance. Pearson's partial correlations were also used to reveal relationships between variables.

MEASURES AND MATERIALS

Five questionnaires were administered at different points in time throughout the study.

Working Alliance Inventory (WAI). Participant self-reported therapeutic alliance was measured using the Working Alliance Inventory (Horvath & Greenberg, 1989). Participants rated 36 items on a 7-point Likert scale indicating how true they believed each item to be. A more positive rating of the alliance is reflected by higher scores. The Working Alliance Inventory was initially developed to measure Bordin's (1980) conceptualisation of the therapeutic alliance. Bordin proposed that the quality and strength of all therapeutic relationships were dependent on three factors. These are the extent to which the tasks and the goals of therapy are perceived as being relevant and effective, and the formation of a positive bond between therapist and client. Three versions of the WAI, for the client, the therapist and an observer have been developed, significant common variance has been found between scale scores on the WAI and other alliance measures (Tichenor & Hill, 1989). The WAI Client form was used in the present study, as inter-rater reliability between forms has been found to be poor, as such, it was decided the clients' perspective of the relationship was the most relevant. The WAI Client form has three scale scores and a total score. The Bond Scale measures the client's perspective of the bond between themselves and the therapist; the Goal Scale measures the client's agreement with the goals for therapy;

and the Task Scale measures the client's agreement that tasks in therapy will address the problems raised. Initial estimates of internal reliability of the client version of the WAI were high, between .85 and .92 (Horvath & Greenberg, 1989). A factor analysis of the WAI revealed strong internal reliability of the overall measure and 12 nonoverlapping items which loaded strongly onto the three subscales of bond ($\alpha = .92$) tasks ($\alpha = .90$) and goals ($\alpha = .90$) (Tracey & Kokotovic, 1989). Hanson, Curry, and Bandalos (2002) carried out a reliability generalization study, involving 12 different WAI scales and 67 internal reliability estimates; they concluded that internal consistency was found to be stable across studies and across a range of different research populations, alpha estimates ranged from 0.87 to 0.93.

Credibility/Expectancy Questionnaire (CEQ). This questionnaire is a 12-item self report questionnaire containing two factors, intended for use in clinical outcome studies, that measure participants' expectancies regarding treatment outcome, and their perspective of the credibility of the therapy rationale (Devilley & Borkovec, 2000). The first ten items are measured on a 9-point Likert scale and ask participants to rate their belief in the credibility of the therapy rationale. The final two items are measured on a 11-point Likert scale and ask participants to rate the percentage of improvement they expect to experience as a result of participating in the therapy. The psychometric properties of this questionnaire are adequate; high internal consistency has been found, with Cronbach's standardised alpha being $\alpha = 0.85$ for both the expectancy and credibility factors (Devilley & Borkovec, 2000). Test-retest reliability over one week has also been found to be adequate at $r = 0.82$ and $r = 0.75$ for expectancy and credibility scales respectively.

Symptom Checklist –10 item Revised (SCL-10R). The symptom checklist – 10 item Revised was developed as a brief version of the Symptom Checklist – 90 item (SCL-90) to improve the psychometric properties and provide a more economical measure of psychological distress in psychiatric settings (Derogatis, Lipman, & Covi, 1973; Rosen et al., 2000). The SCL-10R has been shown to have strong convergent validity with the SCL-90, $r = 0.91$ and adequate internal consistency at 0.78 (Muller, Achtergarde, Furniss, Postert, Beyer, & 2010).

Māori Culture Questionnaire. The Māori Culture Questionnaire was comprised of 16 items from the lifestyle questionnaire, Te Hoe Nuku Roa (THNR) developed by Durie (1999). The THNR is a cultural indicators questionnaire that has been designed to measure identification, knowledge of and involvement with Māori culture and language. In order to increase the relevance of this questionnaire to the sharing of whakapapa, questions were selected if they related specifically to the participants' knowledge of their whakapapa, with the inclusion of some general questions about access to and engagement with Māori resources. The purpose in developing that form of a more comprehensive cultural questionnaire was to investigate the depth with which participants could engage in the sharing of whakapapa from their knowledge of and involvement with whakapapa and Māori protocol in general.

Experience of Whakapapa Sharing Questionnaire. Participants reported their experience of the whakapapa sharing on a questionnaire comprised of 5 open-ended questions which became progressively more specific (Appendix 3). The questionnaire was developed by the researcher and used despite the possibility that lengthier interviews about the participants' experiences could have resulted in more in

depth information. As the researcher in this study was also the therapist, there was a risk that the narrative content of oral responses could be unduly influenced by the researcher's presence. It was hoped that descriptive responses about participants' experiences of the whakapapa sharing process would be more valid and truthful if they were anonymous. Therefore, the questionnaire was used to provide participants with an opportunity to anonymously report their perception of the whakapapa sharing experience.

Acceptance and Commitment Therapy (ACT)

ACT is an intervention approach that aims to assist individuals to identify unhelpful aspects of everyday life they are unable to change and to accept those unhelpful, unchangeable aspects while engaging in behaviours that take them in valued directions and towards their goals (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). This approach can improve psychological flexibility and decrease experiential avoidance. Psychological inflexibility and experiential avoidance usually serve to maintain unpleasant emotional experiences and are phenomena that occur in non-clinical as well as clinical populations. Experiential avoidance occurs when an individual attempts to avoid unpleasant internal experiences by avoiding a stimulus that is expected to trigger these unpleasant experiences, the short-term relief serves to increase the individual's avoidance behaviour. ACT is comprised of a number of techniques that promote both acceptance and commitment. Acceptance techniques promote an improved ability to identify, accept and experience feared or unpleasant events when the avoidance of unwanted experiences is counterproductive and not in line with a person's values. Commitment techniques assist individuals to identify actions in everyday life that will lead to them living a valued life (Hayes et al., 2006). ACT was chosen for the present study because of the client-focused, non-judgemental

and holistic approach to thoughts, feelings, values and goal-oriented behaviour. This approach allows the individual and not the therapist to decide whether thoughts and feelings are unhelpful and counterproductive in their everyday lives. This decreases the opportunity for the therapist to impose his or her own worldview onto the client. Goals are also formed through the identification and discussion of client's own values. Goals are based on what the client wants for himself or herself, not what others, including the therapist, want for them. Values can be explored within the four aspects of Te Whare Tapa Whā.²⁵ The values exercise in the present study was slightly adjusted to ensure that participant's values were identified that related to whanau,²⁶ wairua,²⁷ tinana,²⁸ and hinengaro.²⁹ Although the acceptance techniques of ACT target cognitions and feelings, the commitment techniques target behaviours related to participant goals. These behaviours are focused on improving wellness, as defined by the participant, in all four areas of health. As such, it appears these attributes allow ACT to be used within a Te Whare Tapa Whā model of health. The ACT protocol in the present study teaches four main skill sets; acceptance of unhelpful thoughts and unpleasant emotions, as well as the identification of values and goals. The therapy protocol is described in Appendix 4 and was developed by the researcher using resources from a self-help book called The Happiness Trap and corresponding website (Harris, 2007).

In the present study, ACT was carried out over two sessions with a non-clinical sample. ACT was selected for this short intervention as it has been found to be effective in short-term therapy and in research with non-clinical samples (Ruiz,

²⁵ Te Whare Tapa Whā – Māori model of health (Durie, 1998)

²⁶ Whanau – Family, unit, kinship group

²⁷ Wairua – Spirit, psyche

²⁸ Tinana - Body

²⁹ Hinengaro - Mind

2010). Participants in the present research were individuals who volunteered to participate and were not identified on the basis of any particular need for therapy, ACT presents a useful approach to problem solving that can be relevant for any population. Using this holistic, value and goal oriented approach allowed participants to identify and prioritise the areas in their own lives they wanted to discuss in the limited time available.

Studies using brief ACT protocols have found favourable outcomes when compared with other cognitive and cognitive-behavioural interventions. One study involving brief therapy and a non-clinical sample investigated food cravings with chocolate, it was found that following treatment the group that underwent the ACT protocol reported higher cravings for chocolate than the control group, but the ACT group was better able to resist eating the chocolate (Forman, Hoffman, McGrath, Herbert, Brandsma, & Lowe, 2007). In two separate studies with pain tolerance tasks, ACT protocol groups displayed significantly higher pain tolerance than control groups (Gutiérrez et al., 2004; Takahashi et al., 2002). Numerous studies have investigated the effectiveness of brief ACT protocols on clinical populations and outcomes that favour ACT therapy have been revealed (Ruiz, 2010).

PROCEDURE

In response to the advertising posters, recruitment emails, or word of mouth information, potential participants made initial contact with the researcher via text, email, or phone. They were then informed of the participation criteria, emailed an information sheet (Appendix 5), and invited to contact the researcher if they were willing to participate in the research and believed they met the inclusion criteria. Verbal consent was obtained when organising the time for the first session of therapy.

Written consent (Appendix 6) was formalised at the first session prior to the commencement of the therapy itself; at this same time, all participants were asked to fill out the initial questionnaires. Figure 1 provides a flowchart depicting the order in which the questionnaires were administered to participants. Participants were randomly assigned to one of two groups, the Whakapapa Sharing group or the Non-Disclosure group, by flipping a coin. Those participants who were acquainted with one another were assigned to the same condition; this was in order to ensure participants remained blind to the conditions. One participant was reassigned from the Non-Disclosure group to the Whakapapa Sharing group when she herself initiated a formal whakapapa sharing process upon meeting the therapist. This resulted in an uneven number of participants in each group; there were 14 participants in the Non-Disclosure group and 16 in the Whakapapa Sharing group. The participant who was reassigned to the Whakapapa Sharing group did not complete the Experience of Whakapapa Sharing questionnaire and therefore her experience of the sharing was not included in the qualitative analysis. The rest of her data were included under the Whakapapa Sharing group data.

In order to study the whakapapa sharing process within a therapeutic setting, two sessions of Acceptance and Commitment Therapy (ACT) (Harris, 2008) were carried out with each participant. Both ACT sessions took place at the Massey Psychology Clinic, a small private clinic associated with Massey University's Clinical Psychology Training programme. The clinic has between 3 and 6 employees, is located on the University campus and has three small therapy rooms. The rooms in which the therapy was held were approximately three metres square. Each participant attended two sessions approximately one week apart (between six and eight days). Exceptions were made for four participants who, for various reasons, required an

additional week delay to participate in the second session. All participants who attended the first session also attended the second session and all sessions were video-taped to ensure treatment integrity across participants.

At the beginning of the first session of therapy, prior to the whakapapa exchange, all participants were given a verbal outline of the research and an opportunity to ask questions. This outline included a brief introduction to the researcher who was also the therapist; the information conveyed in this introduction had previously been outlined in the Information Sheet, received by all participants. At this time the consent form was introduced, participant permission was attained regarding the filming of therapy sessions. Participants were then asked to complete the SCL-R-10 and the CEQ. Following the completion of these questionnaires and prior to commencing the therapy participants were oriented to the nature of the therapy, which differed for each group. The Whakapapa Sharing group's introduction began with the therapist outlining details about her own whakapapa, which also included some familial and personal background information and academic history. The whakapapa sharing script can be viewed in Appendix 7. The criteria for the information shared were deemed appropriate for whakapapa sharing by the advisory group from Bennett's (2009) study. Following the whakapapa delivery, participants were given the opportunity to share their own whakapapa, with the majority of the 15 participants volunteering this information organically following the therapists sharing and one participant, initially assigned to the Non-Disclosure group initiating this process herself. Participants who did not spontaneously volunteer their own whakapapa were asked where they were from and in all cases this prompted participants to disclose aspects of their own whakapapa and background. Participants were given the space to disclose as much of their whakapapa and background as they

wanted at this time. During the whakapapa sharing process, both the therapist and participants would ask questions about certain aspects of the other's whakapapa, in attempt to make connections to people or places. The length of time spent sharing whakapapa varied between participants, as did the types of connections made between the therapist and each participant. Following this sharing the therapist gave a general outline of the therapy, including an outline of the limits of confidentiality in the context of this research and began the first session according to the ACT protocol (Appendix 7).

Participants from the Non-Disclosure group were not given an outline of the researcher's whakapapa, but were instead oriented to the session with a general introduction to the research, a disclosure of the researcher's relevant academic history, an outline of the limits of confidentiality within this study and some small-talk questions about their ability to find their way to the clinic, a comment about the weather and asking them how they found out about the study.

Figure 1 illustrates an outline of the procedures and questionnaire administration for each group in the form of a flow chart. Following the first session, all participants were asked to complete a WAI, which they were informed would remain confidential from the researcher. Participants were asked to be as honest as possible when completing all questionnaires. In order to reassure participants of the confidentiality of the completed forms, participants were given an envelope to seal the completed questionnaire. In order to ensure confidentiality, participants were assigned a code number, which the therapist marked each envelope containing their questionnaires with, data input was undertaken by a third party. In addition to the

WAI, the Whakapapa Sharing group was given the Experience of Whakapapa Sharing questionnaire following the first session of therapy.

After completing the second session of therapy all participants filled out a WAI, CEQ, SCL-R-10 and the Māori Culture questionnaire. Upon completion of these final questionnaires, participants were acknowledged for the time and personal stories they dedicated to this project by way of koha. They were given a VISA Prezzy card loaded with \$150. They were required by university administrative procedures to sign for the koha as proof of receipt (Appendix 8).

Video footage of the sessions was checked by an independent rater to ensure each of the four main components of therapy was included for each participant. These components included the acceptance of unhelpful thoughts through thought defusion techniques, the acceptance of emotions through an emotion-focused acceptance exercise, the identification of values, and goal formation.

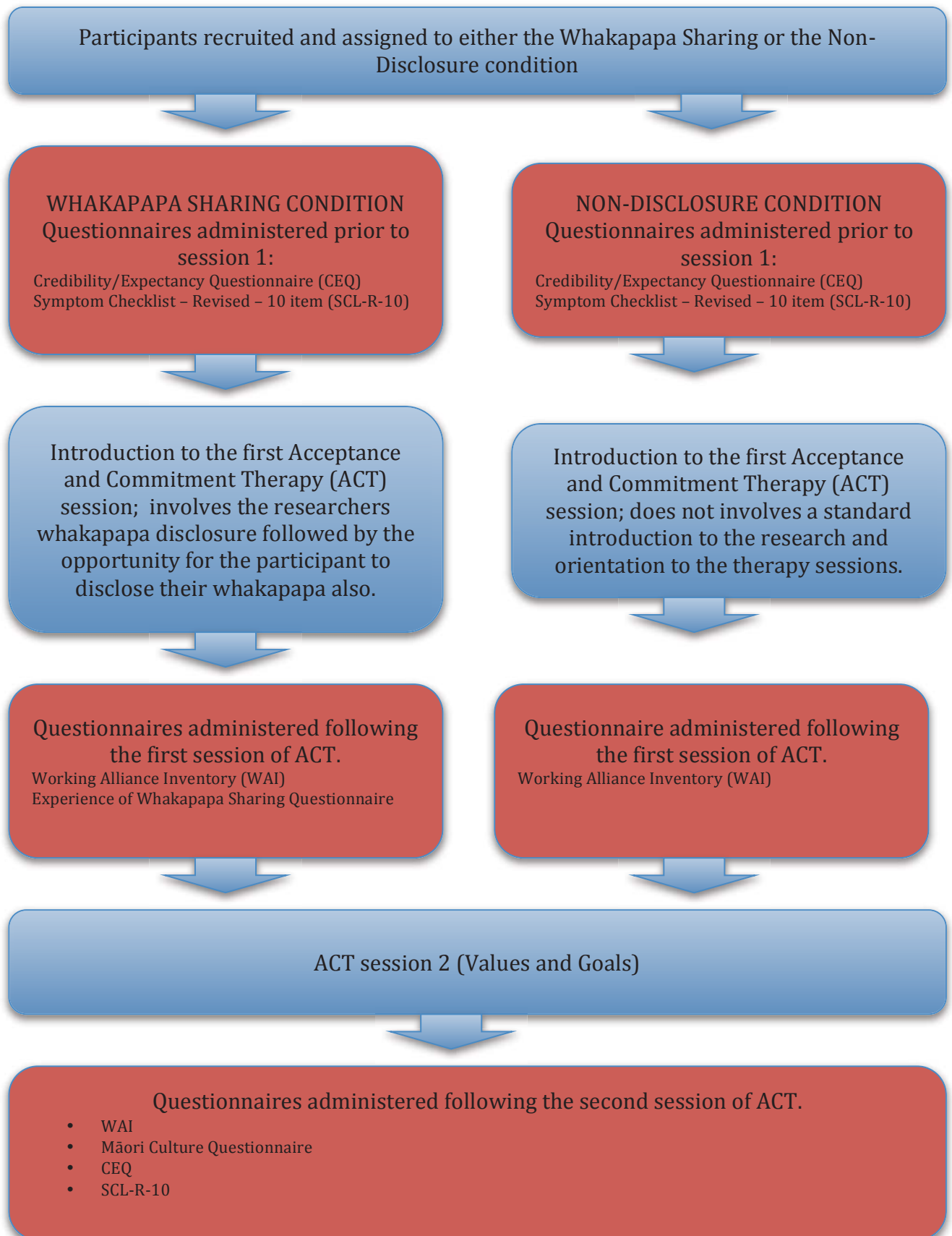


Figure 1. Flow diagram illustrating the procedure for participant measure administration and intervention.

All data were entered onto electronic spreadsheets by an independent person, with data analysis completed by the researcher. Qualitative data were analysed using thematic analysis, an in-depth description of the analysis procedure and the resulting themes is available in Chapter 4, the qualitative results chapter.

CHAPTER THREE

QUANTITATIVE RESULTS

This chapter outlines the results from the quantitative analyses of the data gathered by the outcome, cultural and therapeutic alliance questionnaires. It is important to note that not all participants filled out every questionnaire. It was made clear to participants that they were free to leave the study at any time and were not required to fill out all of the questionnaires or complete every question in any given questionnaire. In analysing the data, questionnaires that had selective responses missing were excluded from analyses. For example, some participants chose not to answer certain questions -- however, in a few cases, responses were missed because the participant had failed to notice the questionnaire's final page. In these cases, omissions were classified as random and the remainder of the questionnaire's data set was included in analysis.

GROUP MEAN DIFFERENCES

Participants' mean scores on the therapeutic alliance and outcome measures were analysed using two (Group: Whakapapa Sharing versus Non-Disclosure) by two (Time: Time 1 vs Time 2), between and within subjects mixed factorial Analysis of Variance (ANOVA). This analysis was used for each of the group mean scores on the WAI, the SCL-R-10 and the CEQ. The WAI scores have been broken down into the mean scores for the total scale, the Goal subscale, the Bond subscale and the Task subscale. Each analysis along with the descriptive statistics will be presented separately in this section.

A mixed-groups factorial ANOVA was performed to examine the effects of the whakapapa sharing in therapy for the participant's overall therapeutic alliance

mean scores at Time 1 and Time 2. Figure 2 shows the mean overall scores on the WAI at each time point and Table 1 shows the descriptive statistics for the groups at each time point.

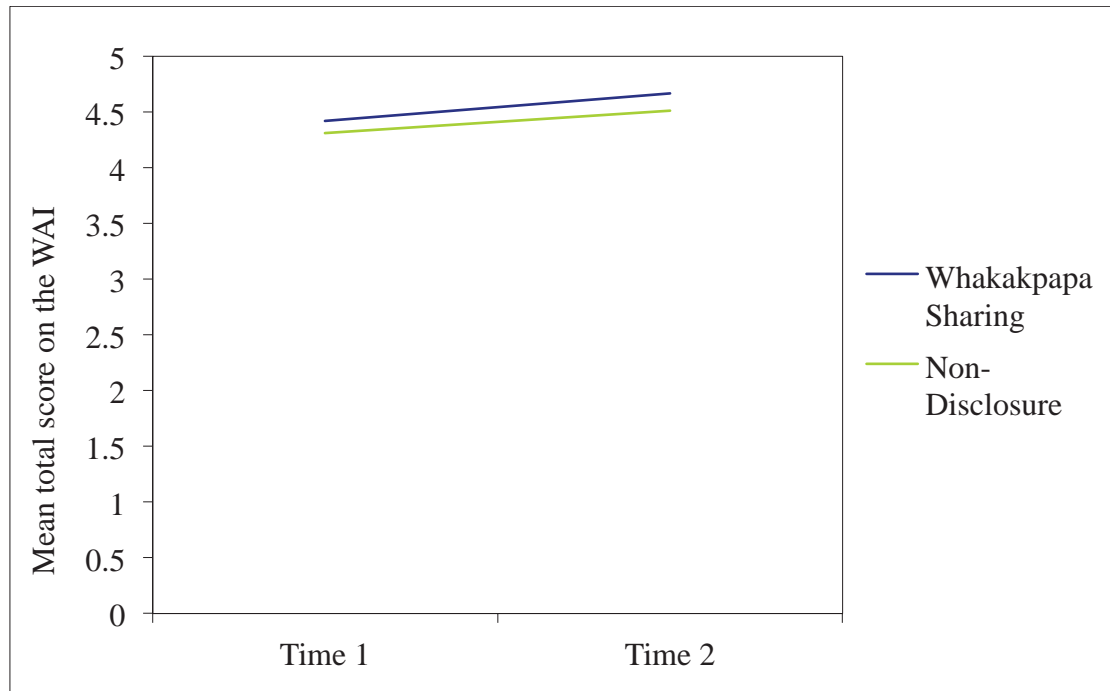


Figure 2. Group mean scores on the WAI after the first and second sessions of therapy.

Table 1

Descriptive Statistics for the Overall Scores on the Working Alliance Inventory

	N	Minimum	Maximum	Mean	Std.Deviation
Whakapapa Sharing					
Time 1	14	3.31	4.92	4.42	.49
Time 2	14	3.86	4.97	4.66	.29
Non-Disclosure					
Time 1	14	3.5	4.89	4.31	.39
Time 2	14	3.58	4.88	4.51	.36

The analysis for the overall mean scores on the WAI revealed no interaction between group and time $F(1,26) = .121$, $MSE = 0.50$, $p = .73$ indicating that the scores across the time periods did not significantly differ between the Whakapapa and the Non-Disclosure group. No main effect for group was revealed $F(1,26) = .59$, $MSE = .27$, $p = .45$. Thus, irrespective of the time of the measurement, there were no significant differences found between the mean overall scores on the WAI of the Whakapapa Sharing group ($M = 4.54$, $SD = .09$) and the Non-Disclosure group ($M = 4.41$, $SD = .10$). There was a main effect of time $F(1,26) = 13.83$, $MSE = 0.50$, $p < .05$ with overall higher scores on the WAI at Time 2 (after the second session, $M = 4.59$, $SD = .33$) than Time 1 (after the first session, $M = 4.37$, $SD = .44$). This increase in the overall mean WAI score over time occurred across both groups.

A mixed-groups factorial ANOVA was performed to examine the effects of the whakapapa sharing in therapy for the participants' mean scores on the Goals subscale of the WAI at Time 1 and Time 2. Figure 3 shows the mean scores on the

Goals subscale of the WAI at each time point and Table 2 shows the descriptive statistics for the groups at each time point.

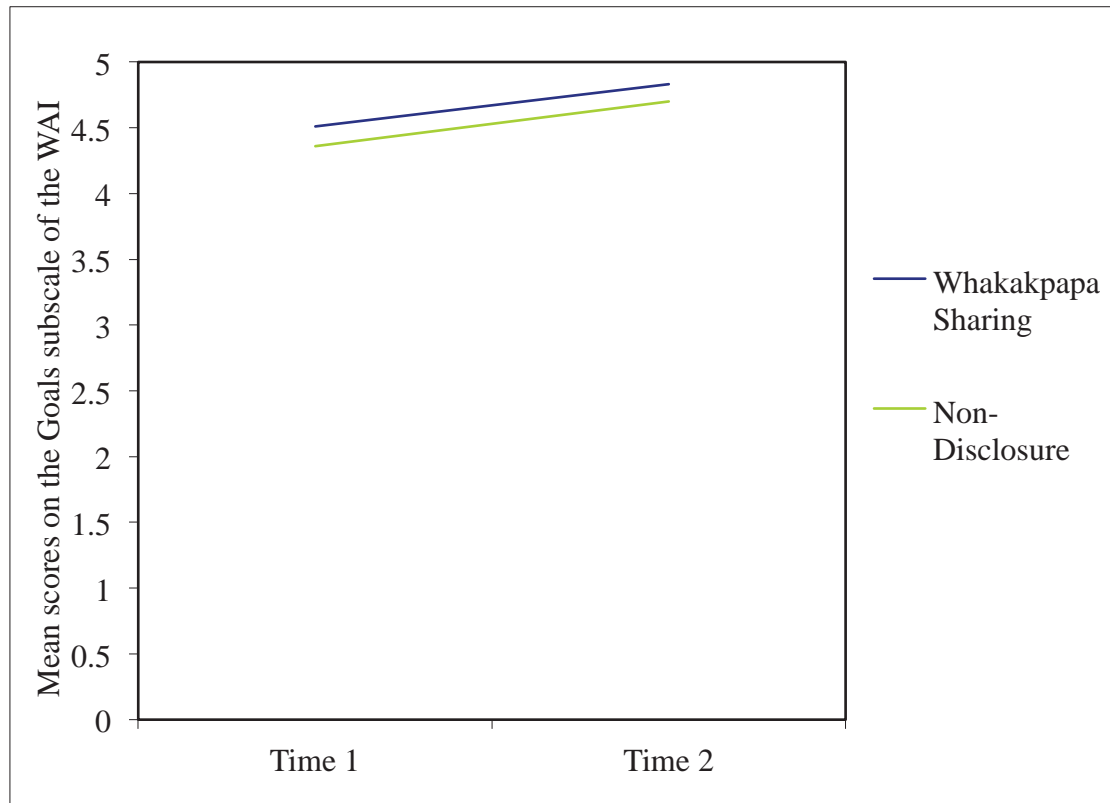


Figure 3. Group mean scores on the Goals subscale of the Working Alliance Inventory after the first and second session of therapy.

Table 2

Descriptive Statistics for the Goals Subscale of the Working Alliance Inventory

	N	Minimum	Maximum	Mean	Std.Deviation
Whakapapa Sharing					
Time 1	14	3.25	5	4.51	.54
Time 2	14	4.08	5	4.83	.25
Non-Disclosure					
Time 1	14	3.75	5	4.36	.37
Time 2	14	3.9	5	4.70	.34

The analysis for the mean scores on the Goals subscale of the WAI revealed no interaction between group and time $F(1,26) = 0.29$, $MSE = 0.76$, $p = .87$ indicating that the scores across the time periods did not significantly differ between the Whakapapa and the Non-Disclosure group. No main effect for group was found $F(1,26) = 1.10$, $MSE = .24$, $p = .30$ suggesting that, irrespective of the time of the measurement, there were no significant differences between the mean scores on the Goals subscale of the WAI for the Whakapapa Sharing group ($M = 4.67$, $SD = .09$) and the Non-Disclosure group ($M = 4.53$, $SD = .09$). There was a main effect of time $F(1,26) = 19.71$, $MSE = 0.76$, $p < .01$ with overall higher scores on the Goals subscale of the WAI at Time 2 ($M = 4.76$, $SD = .06$) than Time 1 ($M = 4.44$, $SD = .09$). This increase over time of the mean scores on the Goals subscale of the WAI occurred across both groups.

A mixed-groups factorial ANOVA was performed to examine the effects of the whakapapa sharing in therapy for the participants' mean scores on the Bond subscale of the WAI at Time 1 and Time 2. Figure 4 shows the mean scores on the

Bond subscale of the WAI at each time point and Table 3 shows the descriptive statistics for the groups at each time point.

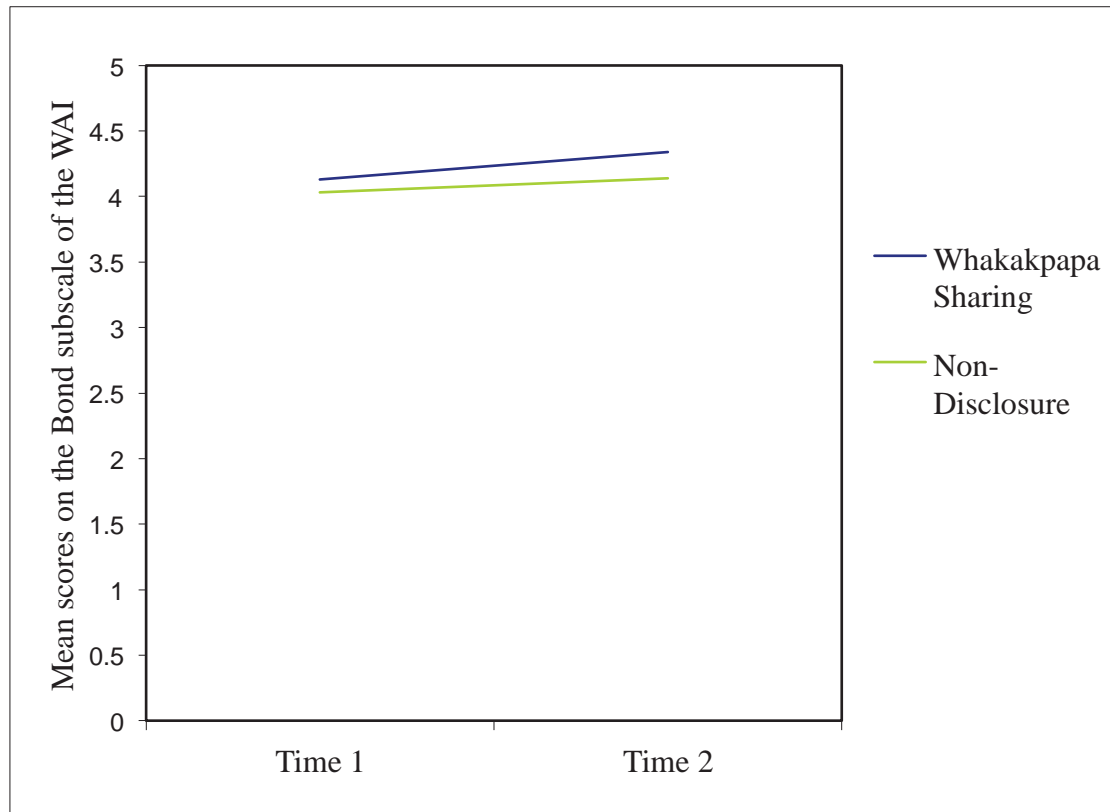


Figure 4. The Non-Disclosure group and Whakakpapa Sharing group mean scores on the Bond subscale of the Working Alliance Inventory at Time 1 and Time 2.

Table 3

Descriptive Statistics for the Bond Subscale of the Working Alliance Inventory

	N	Minimum	Maximum	Mean	Std.Deviation
Whakapapa Sharing					
Time 1	14	3	4.92	4.13	.63
Time 2	14	3.42	4.92	4.34	.40
Non-Disclosure					
Time 1	14	3.25	4.67	4.03	.47
Time 2	14	3.18	4.67	4.14	.51

The analysis for the mean scores on the Bond subscale of the WAI revealed no interaction between group and time $F(1,26) = 0.43$, $MSE = 0.79$, $p = .14$ indicating that the scores across the time periods did not significantly differ between the Whakapapa and the Non-Disclosure group. No main effect for group was found $F(1,26) = .38$, $MSE = .48$, $p = .54$ suggesting that, irrespective of the time of the measurement, there were no significant differences between the mean scores on the Bond subscale of the WAI for the Whakapapa Sharing group ($M = 4.24$, $SD = .12$) and the Non-Disclosure group ($M = 4.09$, $SD = .13$). There was no main effect of time $F(1,26) = 2.37$, $MSE = 0.79$, $p = .52$ for the mean scores on the Bond subscale of the WAI. Indicating that no differences were found between the mean scores on the Bond subscale at Time 1 ($M = 4.08$, $SD = .10$) and Time 2 ($M = 4.24$, $SD = .08$).

A mixed-groups factorial ANOVA was performed to examine the effects of the whakapapa sharing in therapy for the participants' mean scores on the Tasks subscale of the WAI at Time 1 and Time 2. Figure 6 shows the mean scores on the

Tasks subscale of the WAI at each time point and Table 4 shows the descriptive statistics for the groups at each time point.

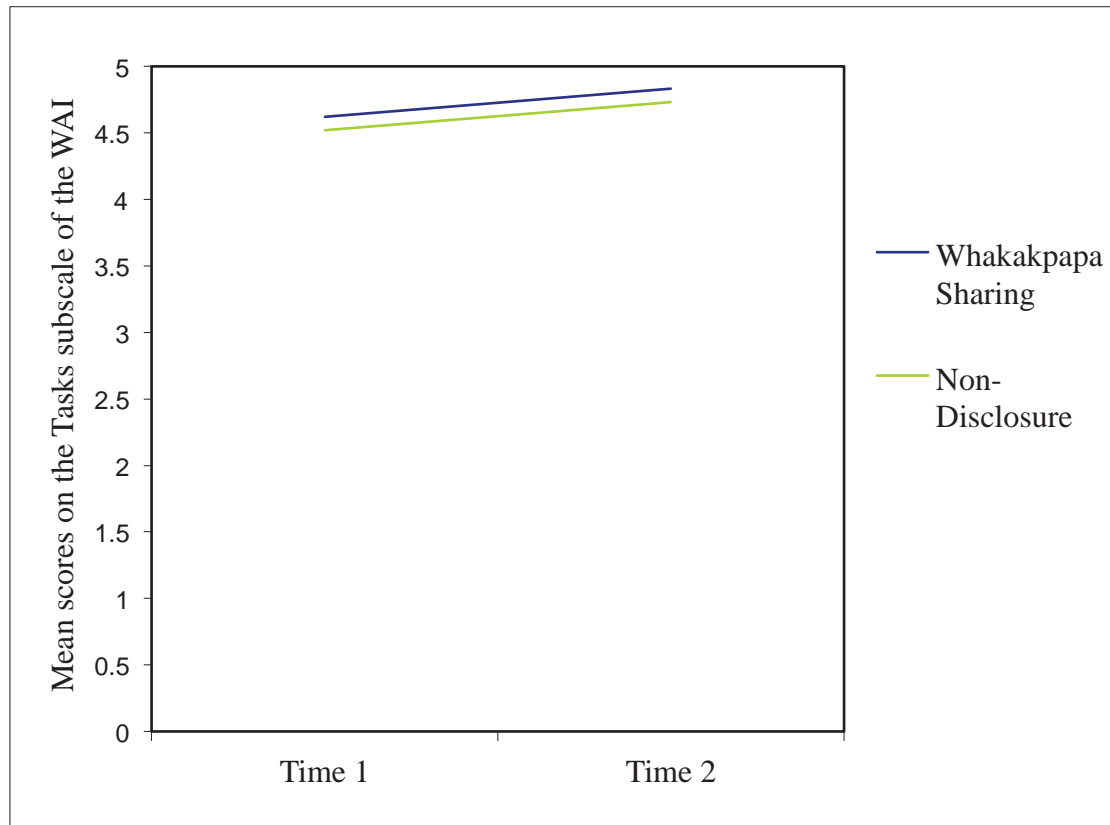


Figure 5. The Non-Disclosure group and Whakapapa Sharing group mean scores on the Tasks subscale of the Working Alliance Inventory at Time 1 and Time 2.

Table 4

Descriptive Statistics for the Tasks Subscale of the Working Alliance Inventory

	N	Minimum	Maximum	Mean	Std.Deviation
Whakapapa Sharing					
Time 1	14	3.67	5	4.62	.43
Time 2	14	4.08	5	4.83	.30
Non-Disclosure					
Time 1	14	3.5	5	4.52	.44
Time 2	14	4.17	5	4.73	.39

The analysis for the mean scores on the Tasks subscale of the WAI revealed no interaction between group and time $F(1,26) = 0.00$, $MSE = 0.75$, $p = .96$ indicating that the scores across the time periods did not significantly differ between the Whakapapa and the Non-Disclosure group. No main effect for group was found $F(1,26) = .18$, $MSE = .24$, $p = .68$ suggesting that, irrespective of the time of the measurement, there were no significant differences between the mean scores on the Tasks subscale of the WAI for the Whakapapa Sharing group ($M = 4.73$, $SD = .09$) and the Non-Disclosure group ($M = 4.6$, $SD = .09$). There was a main effect of time $F(1,26) = 9.45$, $MSE = 0.75$, $p < .05$ with overall higher scores on the Tasks subscale of the WAI at Time 2 ($M = 4.78$, $SD = .06$) than Time 1 ($M = 4.57$, $SD = .081$). This increase over time of the mean scores on the Tasks subscale of the WAI occurred across both groups.

A mixed-groups factorial ANOVA was performed to examine the effects of the whakapapa sharing in therapy for the participants' mean scores on the SCL-10R at Time 1 (prior to the first session and Time 2 (following the second session). Figure 6

shows the mean scores on the SCL-R-10 at each time point and Table 5 shows the descriptive statistics for the groups at each time point.

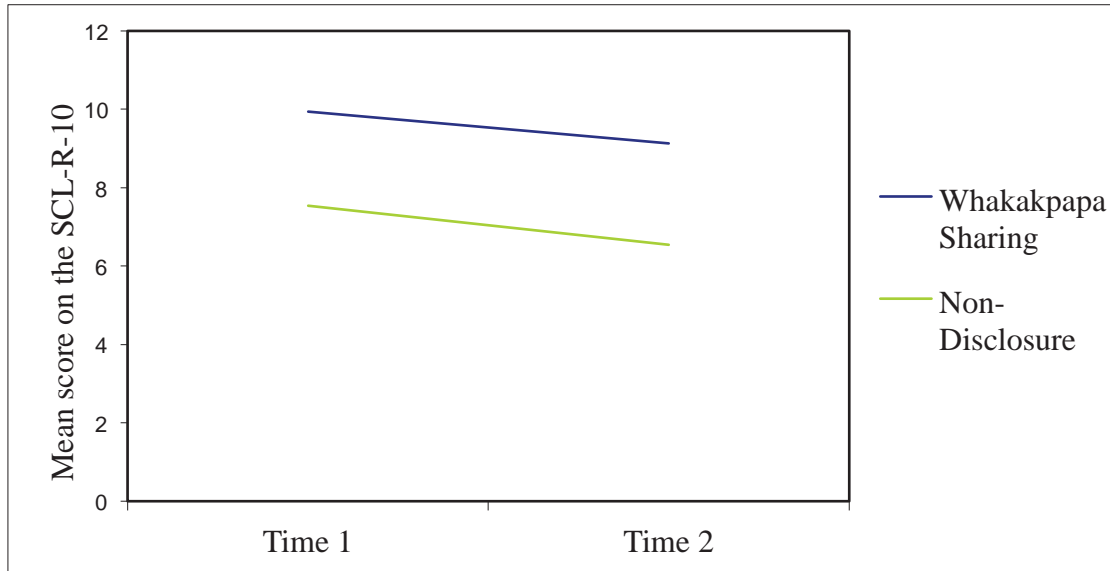


Figure 6. The Non-Disclosure and Whakapapa Sharing group mean scores on the SCL-R-10 prior to therapy and following therapy.

Table 5

Descriptive Statistics for the Symptoms Checklist – Revised - 10 items

	N	Minimum	Maximum	Mean	Std.Deviation
Whakapapa Sharing					
Time 1	15	2	19	9.94	5.94
Time 2	15	2	21	9.13	6.46
Non-Disclosure					
Time 1	12	0	16	7.54	4.99
Time 2	12	0	16	6.54	4.82

The analysis for the mean scores on the SCL-R-10 revealed no interaction between group and time $F(1,25) = .0$, $MSE = 14.12$, $p = .99$ indicating that the scores across the time periods did not significantly differ between the Whakapapa and the Non-Disclosure group. No main effect for group was found $F(1,25) = 1.91$, $MSE = 48.05$, $p = .18$ suggesting that, irrespective of the time of the measurement, there were no significant differences between the mean scores on the SCL-R-10 for the Whakapapa Sharing group ($M = 9.53$, $SD = 1.26$) and the Non-Disclosure group ($M = 7.04$, $SD = 1.4$). There was no main effect for time $F(1,25) = 1.09$, $MSE = 14.12$, $p = .31$ for the mean scores on the SCL-R-10. Indicating that no differences were found between the mean scores on the SCL-R-10 at Time 1 ($M = 8.74$, $SD = 1.03$) and Time 2 ($M = 7.832$, $SD = 1.08$).

A mixed-groups factorial ANOVA was performed to examine the effects of the whakapapa sharing in therapy for the participants' mean scores on the CEQ at Time 1 (prior to the first session) and Time 2 (following the second session). Figure 7 shows the mean scores on the CEQ at each time point and Table 6 shows the descriptive statistics for the groups at each time point.

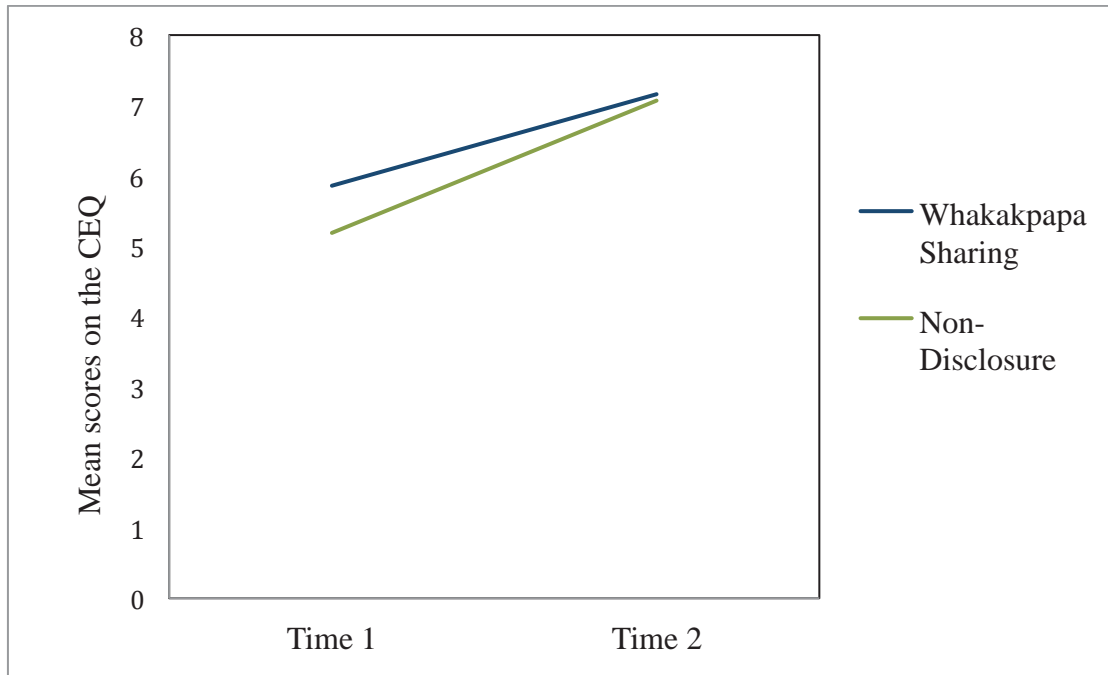


Figure 7. The Non-Disclosure and Whakakapapa Sharing group mean scores on the Credibility/Expectancy Questionnaire prior to and following therapy

Table 6

Descriptive Statistics for the Credibility/Expectancy Questionnaire

	N	Minimum	Maximum	Mean	Std.Deviation
Whakakapapa Sharing					
Time 1	15	4.45	12.28	8.35	2.06
Time 2	15	8.6	12.89	10.87	1.07
Non-Disclosure					
Time 1	13	3.64	11.38	7.64	2.39
Time 2	13	5.5	12.5	11.05	2.17

The analysis for the mean scores on the CEQ revealed no interaction between group and time $F(1,26) = 1.11$, $MSE = 2.52$, $p = .30$ indicating that the scores across the time periods did not significantly differ between the Whakakapapa and the Non-

Disclosure group. No main effect for group was found $F(1,26) = .18, MSE = 5.18, p = .67$ suggesting that, irrespective of the time of the measurement, there were no significant differences between the mean scores on the CEQ for the Whakapapa Sharing group ($M = 9.53, SD = 1.26$) and the Non-Disclosure group ($M = 7.04, SD = 1.40$). There was a main effect of time $F(1,26) = 48.44, MSE = 2.52, p < .01$ with higher scores on the CEQ at Time 2 ($M = 10.95, SD = 1.64$) than Time 1 ($M = 8.02, SD = 2.20$). This increase over time of the mean scores on the CEQ occurred across both groups, indicating that all participants' views about the credibility and expected usefulness of the therapy were more positive after completing the second session than their expectations upon going into the first session.

CORRELATIONS

Pearson product moment correlation coefficients were calculated to assess the relationships within the participants' mean scores on different measures across the different measurement points. Table 7 reports the results of the Pearson correlation analyses between the Working Alliance Inventory (WAI), the Credibility/Expectancy Questionnaire (CEQ) and the Symptom Checklist Revised – 10 items (SCL).

Table 7

Pearson Product Moment Correlation Coefficients Between the Therapeutic Expectancy, Therapeutic Relationship, and Outcome Measures at Time 1 and 2

Measure (<i>N</i> = 28)	WAI(T2)	CEQ(T2)	SCL-R-10(T2)
WAI(T1)	--	.45*	-.43*
CEQ (T1)	.63**	--	-.02
SCL-R-10 (T1)	.10	-.13	--
WAI(T2)	--	.69**	-.20
CEQ(T2)	.69**	--	-.25
SCL-R-10 (T2)	-.20	-.25	--

*significance level; $p < .05$, ** significance level; $p < .01$

Significant correlations between participants' scores on the WAI and the CEQ were revealed across the analyses at each time point. A weak but significant relationship was found between mean scores on the WAI at Time 1 and mean scores on the CEQ at Time 2, $r = .45$, $p < .05$, this relationship is depicted in Figure 8. This relationship indicates that participants who rated the therapeutic alliance more positively after the first session, perceived the therapy after the second session as more credible and expected it to be more helpful.

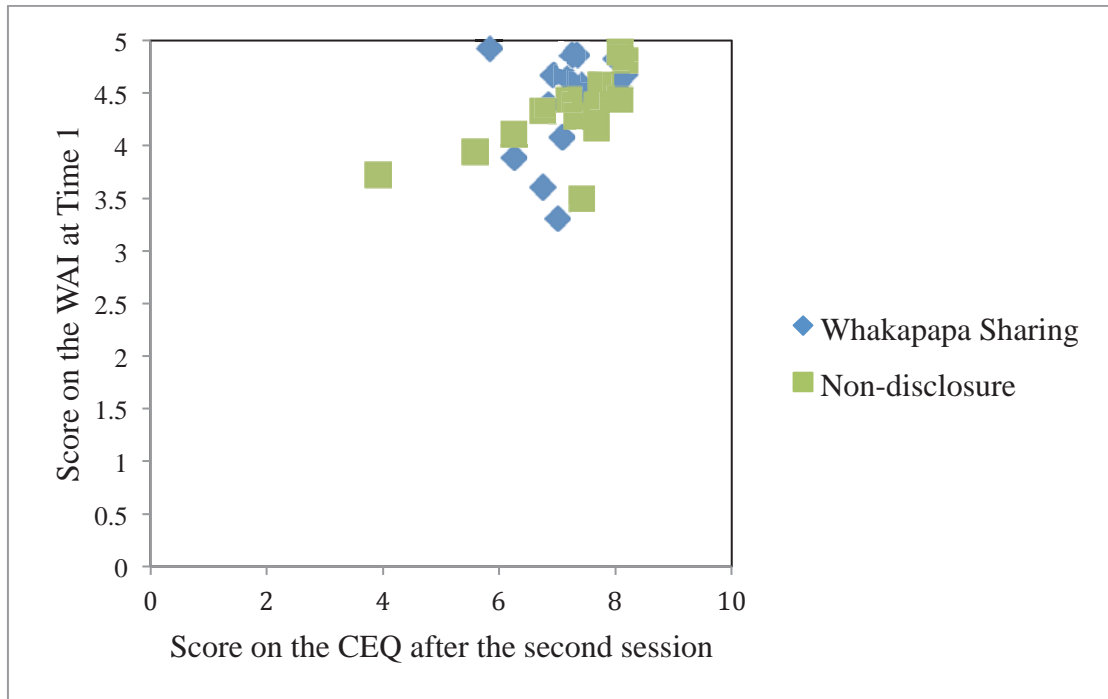


Figure 8. The relationship between participants' mean scores on the WAI at Time 1 plotted against their mean scores on the CEQ at Time 2.

A strong relationship was found between mean scores on the CEQ at Time 1 and mean scores on the WAI at time two, $r = .63, p < .01$, Figure 9 displays a scatter plot of this relationship. This relationship indicates that participants who went into the first therapy session expecting it to be helpful and seeing the therapy as credible were more likely to rate the therapeutic alliance more positively following the second session of therapy.

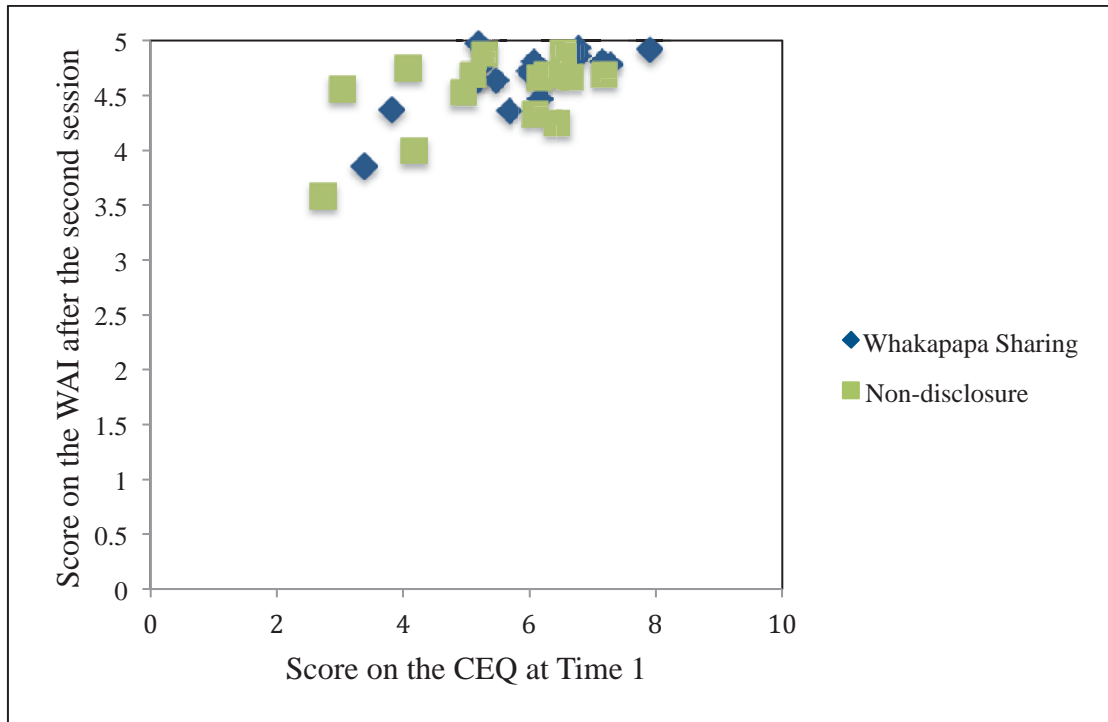


Figure 9. The relationship between participants' mean scores on the CEQ at Time 1 plotted against their mean scores on the WAI at Time 2.

A strong relationship was also revealed between the WAI and CEQ at time two, $r = .69, p < .01$, this relationship is displayed in a scatterplot in Figure 10. This relationship indicates that participants who rated the therapeutic relationship more positively after the second session of the therapy were more likely to also perceive the therapy as credible and expect it to be useful.

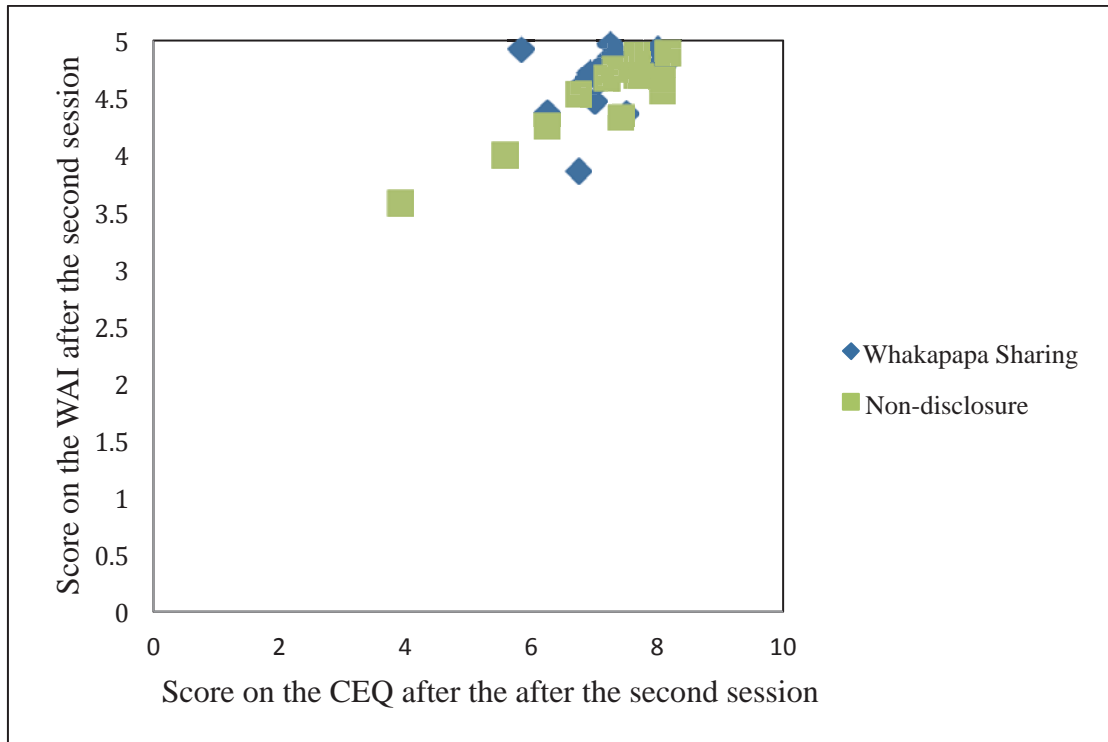


Figure 10. The relationship between participants' mean scores on the WAI at Time 2 plotted against their mean scores on the CEQ at Time 2.

A weak but significant correlation was found between mean scores on the WAI at Time 1 and the SCL-R-10 at Time 2, $r = -.43, p < .05$. This relationship is depicted in a scatter plot in Figure 11. This relationship suggests that participants who rated the therapeutic relationship more positively after the first session were more likely to report less symptoms after the second session on the SCL-R-10.

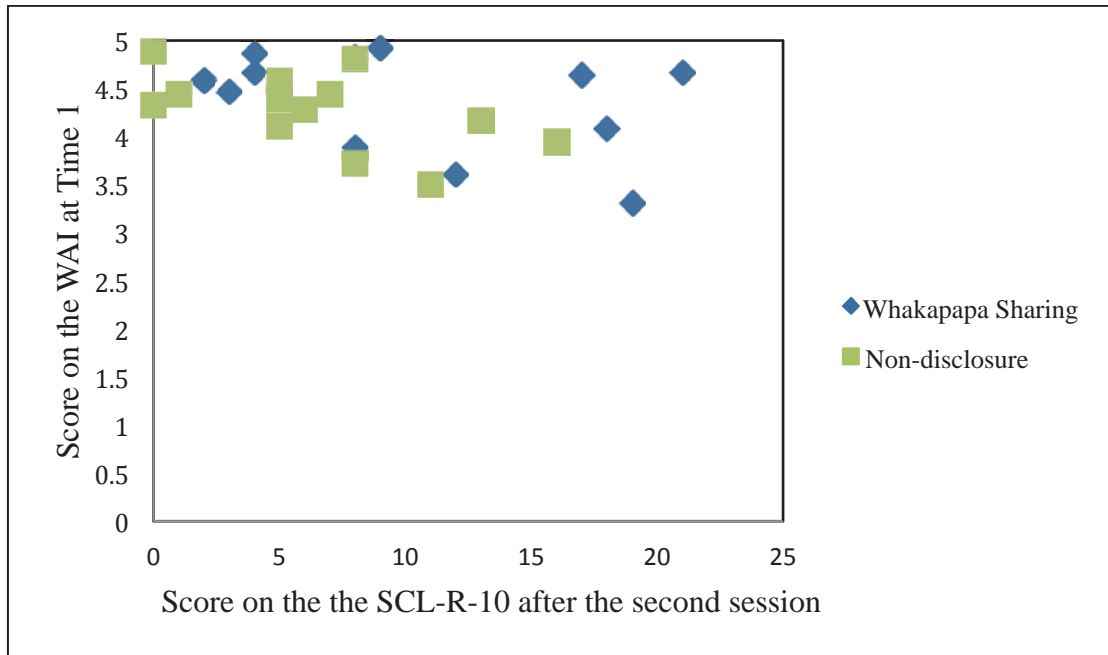


Figure 11. The relationship between participants' mean scores on the WAI at Time 1 plotted against their mean scores on the SCL-R-10 at Time 2.

The relationship between the participants' mean scores on the Working Alliance Inventory (WAI) and their total scores on the cultural questionnaire was also calculated using the Pearson product moment correlation coefficient. No significant relationship was revealed, $r = .27, p = .121$. Figure 12 displays a scatter plot of this relationship.

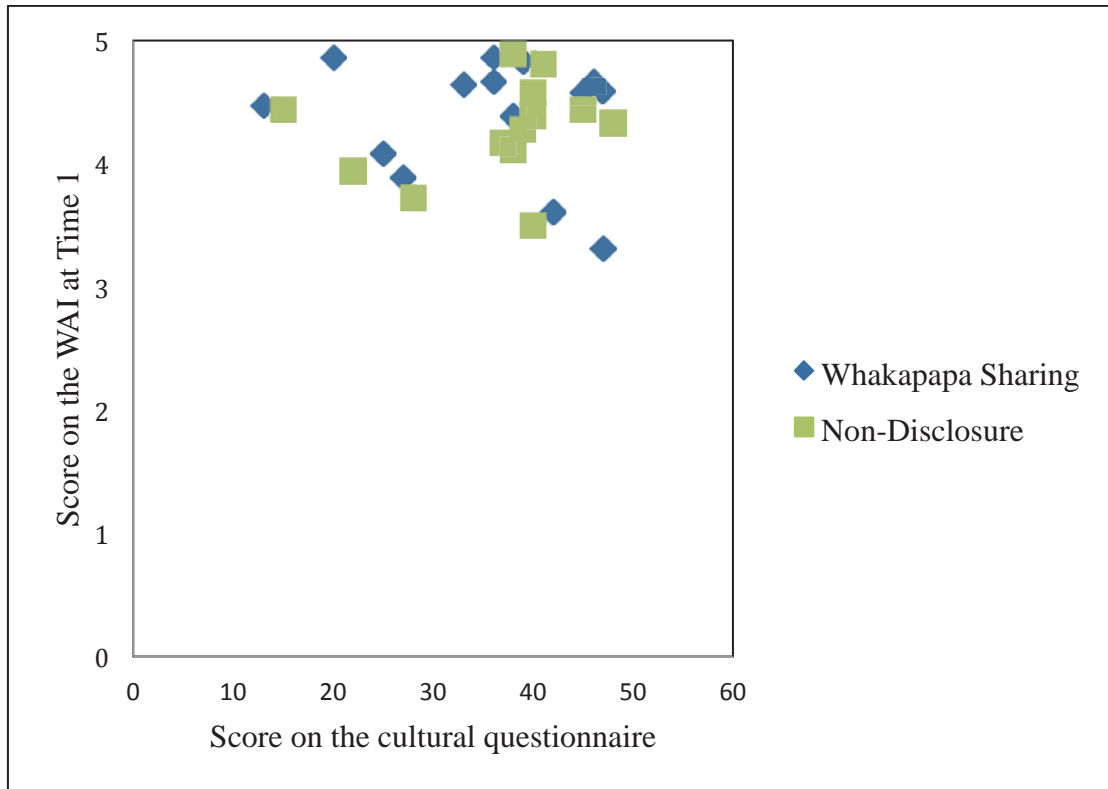


Figure 12. Participants' scores on the Māori Culture Questionnaire plotted against their mean scores on the Working Alliance Inventory.

This finding indicates that participants' ratings of the therapeutic relationship were in no way related to their knowledge of whakapapa or their access to cultural resources. This was found irrespective of the group that participants were in. Therefore, participants in the Whakapapa Sharing group were able to form a strong therapeutic relationship, irrespective of their knowledge of their own whakapapa. Additionally, all participants in the Whakapapa Sharing Group perceived this experience to be positive. Participants experience of the whakapapa sharing will be discussed further in the qualitative results chapter.

CHAPTER FOUR

QUALITATIVE RESULTS

Participant responses to each question on the qualitative questionnaire exploring their experience of the whakapapa sharing were analysed using thematic analysis as described by Braun and Clark (2006). Initially, responses were organised at a semantic level into descriptive categories by two raters who were familiar with Māori tikanga and Māori counselling models. Participants' responses were potentially categorised by the raters into more than one category under most questions. The definitive limits of the descriptive categories and the number of responses that fell within each category are outlined in this chapter. A note is made under questions that contain mutually exclusive categories, with examples provided of responses that fall within each category.

There were two raters who coded participants' responses according to these descriptive categories. Inter-rater agreement was calculated using the following formula:

Number of ratings the raters agreed on x 100/ total number of scored units.

$$\text{Inter-rater agreement: } \frac{107}{117} \times 100 = 91.45\%$$

The second level of the thematic analysis involved the organisation and interpretation of the descriptive categories and participant responses into five themes. In this way an inductive approach was used to identify themes. The themes were

derived from interpretation of the data itself, as opposed to theoretical themes derived from the literature. These interpretive themes are discussed in this chapter with examples given from participant responses, descriptive categories and the significance and meanings of the themes are also discussed in relation to the literature.

Finally, the themes were organised into a framework in an attempt to illustrate the theoretical relationship between all five themes. The framework was developed through an interactive process of discussion and exchanges with a senior colleague serving as a “critical friend” (Costa & Kallick, 1993), which in qualitative research refers to a person who asks provocative questions and clarifies ideas and supports reflection by the researcher. The framework is described in the final section of this chapter and discussed further in the fifth chapter of this thesis.

DESCRIPTIVE CATEGORIES

1. What did you think when the therapist shared her personal information with you? Six descriptive categories were identified as representing all the responses to this question.

1.1 Positive experience. Of the 15 participant responses to the first question, 12 referred to the whakapapa sharing as being a positive experience in some way. Responses that were categorised within this descriptive category included an explicit positive judgment about the experience. Some of the participant responses included: “...*It was good.*”, “*Felt appreciated, interested, happy....*”, “*I really liked it...*”, “*I really appreciated this...*” and “*Was a great way to start the session...*”

1.2 Connection/relationship. Eight of the 15 participants responses referred to their connection or relationship with the researcher. The connection or relationship theme could involve the identification of a similarity between participant and researcher; these similarities included personal interests or life experiences. Responses that identified a whakapapa or genealogical connection, a connection through a mutual acquaintance or a feeling of being connected were also categorised within this descriptive category. Responses under this descriptive category included: “*..also shared some interests, background information – felt more related to her.*”, “*Created a connection..*”, “*...assists in building relationship/rapport.*” and “*...gave you an opportunity to make a connection through people you know and similar background.*”

1.3 Promoted comfort/ease. Six of the 15 participants referred to feeling more comfortable as a result of the sharing. Responses within this descriptive category included “*... and also comfortable enough to share my personal information.*”, “*... made me feel more comfortable.*” and “*It’s a good icebreaker.*”

1.4 Promoted sharing/rapport. Four of the 15 responses fell within this descriptive category, with responses indicating the experience as contributing to rapport or an improved ability to share with the therapist. These responses included an improvement in the amount shared by the participant or the speed with which said sharing occurred. Responses included “... *and also comfortable enough to share my personal information.*” and “...*assists in building relationship/rapport.*”

1.5 Important Māori way. Three of the 15 participants referred to the whakapapa sharing experience as being important for Māori or being a Māori practice. Responses in this descriptive category included; “... *It was necessary for working with Māori women...*”, “... *Being Māori myself. It is important we get background info on a person...*” and “... *with Māori, I feel it is important to identify your geneology (whakapapa)...*”

1.6 Other. Of the 15 responses, eight contained aspects that raters did not believe were fully described by the other five descriptive categories. Responses included; “*It was creating a safe space*”, “*wasn’t expecting it*” and “*felt appreciated*”

2. What effect do you think that particular conversation had on your relationship with the therapist? Four descriptive categories were identified from the responses to the second question.

2.1 Promoted sharing/rapport/openness. Of the 15 responses, eight described the experience as contributing to rapport or improving their ability to be able to speak openly with the researcher. Responses in this descriptive category included; “*It made it a lot easier to talk openly with her...*”, “*I opened up to her quicker than I thought.*” and “...*easier to brag on about myself.*”

2.2 Promoted comfort. Six of the 15 participants responses referred to

increased comfort or ease as a result of the experience. Responses in this descriptive category included; “...made me feel comfortable and relaxed.”, “...made you feel comfortable, at ease.”, “... I felt relaxed.” and “...I felt a lot more comfortable with her.”

2.3 Connection/contributed to building a relationship. Out of the 15 responses, six participants referred to the whakapapa sharing experience as creating a connection or contributing to the relationship with the therapist. Responses in this descriptive category included; “It made me realise the things we had in common – (ethnicity)...”, “...start building on our relationship.” And “Identified a connection (e.g., being Māori, Te Reo etc.)...”

2.4 Other. Four of the Fifteen responses were rated as not being encompassed by one of the other descriptive categories. Responses in this descriptive category included; “Relaxed some initial reservations I had about being so vulnerable with my thoughts and feelings.”, “... I am often a little embarrassed about the fact I don’t know a lot about my Māori side but I didn’t feel this way with her.” And “Created the safe space...”

3. How did it make you feel when the therapist shared with you? Four descriptive categories were identified that described responses to the third question.

3.1 Positive experience. Of the 15 responses, 14 were rated as indicating the sharing provided a positive experience for the participant. The responses in this descriptive category could also be encompassed by another descriptive category; for example, responses that indicated being comfortable or willing to be open were also coded as being positive. Responses in this descriptive category included; “Good. Personal.”, “It made me feel welcome & respected.”, “Appreciated, glad.”, “At ease, relateable.” and “Willing to be honest and open.”

3.2 Relaxed/comfortable. Seven of the 15 participants reported that they felt relaxed, comfortable or at ease when the researcher shared with them. Responses in this descriptive category included; *“Comfortable.”*, *“It made me relax into the session easier.”*, *“At ease, relateable.”* and *“Much more relaxed and comfortable.”*

3.3 Promoted sharing/openness. Three of the 15 participants indicated in their responses that they were more inclined to share or be open with the researcher. Responses in this descriptive category included; *“It made me feel at ease to share my experiences.”*, *“Willing to be honest and open.”* and *“Pleased that she shared and I felt like it was polite of me to share back.”*

3.4 Other. Eight of the 15 responses were rated as not properly being fully described by any of the other three categories (3.1 through 3.3). Responses in this descriptive category include;

4. As a result of the exchange did you identify an existing relationship or connection with the therapist? Five descriptive categories were identified that described the responses to this question.

4.1 Affirmative response. Of the 15 participants, 13 responded affirmatively to this question. Responses were coded into this descriptive category where participants indicated they were able to identify a connection with the therapist. This could include any way that the participants perceived a connection with the researcher. *“I know the marae, I was there Sept/Oct 2010.”*, *“Yes, both from Te Atiawa iwi – Taranaki connections.”*, *“Same ethnicity – Māori /European.”*, *“Connection was that we both have traces of Māori heritage & live in Wgtn & are female.”*, *“Yes, we knew the same people.”*, *“Yes I feel and felt connected to therapist.”*, *“Yes – I know some people who attended the same kura as her.”* and *“Yes, her younger brother and sister are from the same iwi as myself.”*

4.2 Negative. Two participants indicated in their responses that they were unable to identify a connection.

4.3 Ethnicity. Four of the 15 responses indicated that a connection was made through shared ethnicity. Examples from responses categorised under this descriptive category included; *“Same ethnicity – Māori /European.”*, *“No but could just for being Māori.”*, *“Connection was that we both have traces of Māori heritage...”* and *“Identified a relationship through ethnicity – Māori.”*

4.4 Whakapapa. Four of the 15 participants identified whakapapa or genealogy connections between participant and researcher.

5. Did you think the sharing was appropriate?

5.1 Affirmative response. This descriptive category included affirmative responses that indicated the sharing was appropriate. All of the participants responded affirmatively to this question.

ADDITIONAL FEEDBACK

The following feedback quotes were written by the participants in either the Māori Culture Questionnaire or the Experience of Whakapapa Sharing Questionnaire, where participants were given the opportunity to make comments about the research.

“After not knowing what to expect – she managed to help me identify things in my life that I had not really dealt with which I want to focus on now with the techniques that Arna showed me. I don’t know if that was her intention but it was easy for me to share.” (Whakapapa Sharing Group)

“I appreciated her sharing and felt like it kind of “broke the ice”, which was good.” (Whakapapa Sharing Group)

“Arna was lovely and made me feel comfortable.” (Whakapapa Sharing Group)

“Very therapeutic to be able to unload without reservation and anxiety of being judged. Also alleviated a preconceived notion that the experience would be somewhat intimidating.” (Whakapapa Sharing Group)

“Perhaps the offer of a karakia (prayer) before starting. Either led by participant or therapist.” (Whakapapa Sharing Group)

“It was a good way to start the session. Made it relaxed.” (Whakapapa Sharing Group)

“It was good communication and flowed, wasn’t rushed and wasn’t slow.” (Whakapapa Sharing Group)

“Kia Ora Arna, Nga mihi nui ki a koe. Me to whakaaro and manaakitanga ki ahau. “Whaia te iti Kahurangi”!! Thank you Arna for the opportunity you have given me to help me with my journey ahead. Follow your dreams/goals. You will make a great psychologist.” (Non Disclosure Group)

“This experience has enlightened me on how I saw myself before I had participated in this research to now understanding how I can improve in areas of dealing with certain situations. Very positive tool to incorporate into creating positive outcomes. Tena koe Arna.” (Non Disclosure Group).

“I’ve enjoyed this therapy with Arna and more so that she has an understanding of the Māori world!! This is important especially to Māori!”
(Whakapapa Sharing Group).

THEMES

Following identification and classification of participant responses into the above descriptive categories, the raters organised the categories into interpretive themes. The themes were derived by interpretation of participant responses and are discussed below in relation to participant responses, the descriptive categories and the relevant literature.

Making a connection. This theme included responses that fell within the Connection/Relationship descriptive categories. Participants reported four ways in which a connection could be formed through the whakapapa sharing process. Firstly, some participants were able to identify a link to the researcher's genealogy; these links could be direct whakapapa links, (*"We're both from Te Atiawa iwi with Taranaki connections," "We both have connections to Taranaki."*) with indirect links also occurring. Indirect connections included *"I know her marae, I was there September/October 2010," "Her younger brother and sister are from the same iwi as myself"* and *"We identified a link through whakapapa."* Indirect connections were also made by identifying a mutual acquaintance through knowledge of another's whakapapa. Although this did not happen during the whakapapa sharing in the present research, a number of participants asked the researcher whether she knew other members of her iwi or kaumātua³⁰ from her rohe who were personally known to the participant.

Although the form of whakapapa sharing in this therapeutic setting was somewhat different to a traditional setting, the purpose of the sharing was similar. Whakapapa recital in a marae setting has been described in the literature as a way of strengthening ties between iwi (Te Rito, 2007). Traditional approaches and extensive

³⁰ Kaumātua – Elder.

knowledge of whakapapa can result in far more intricate connections being established. Sir Apirana Ngata (1972) described a number of traditional techniques to trace whakapapa in order to establish a connection and better understand one's relationship with another person according to shared whakapapa. The connections made in the current research were more general than those described by Ngata. Additionally, the tohunga³¹ Hohepa Kereopa (Moon, 2003) described visualising whānau, iwi and hapū connections based on an individual's name alone. Although neither the researcher nor the participants in the present study were able to make whakapapa connections with anything approaching this degree of specificity and expertise, connections were still able to be made.

Other than through whakapapa links, participants were able to identify connections through similarities they shared with the researcher's background information or life circumstances. These similarities could be general or specific, *"Same ethnicity – Māori European," "We both have traces of Māori heritage and live in Wellington and are female."* and *"Fair skinned, immersed in Māori culture/cultural environment/up bringing."* This process of identifying connections through similarities, not just through whakapapa connections is also identified by Bennett (2009) as a goal of the whakapapa disclosure in his research which adapted CBT for use with Māori.

A third type of connection was the identification of mutual acquaintances through the background information that was shared. *"We knew the same people,"* and *"I know some people who attended the same kura as her."* This is significant because despite the widely-acknowledged importance of one's whakapapa, Hohepa

³¹ Tohunga – chosen expert, priest, skilled person, a person chosen by the agent of an atua (god) and the tribe as a leader in a particular field because of signs indicating talent for a particular vocation.

Kereopa in Moon (2003) describes the importance of our associates, other than those we are related to, in contributing to who we are. In describing the relationships that contribute to a developing tohunga he states that “blood may be thicker than water, but it was the waves of non-blood relatives that were just as necessary in carrying a tohunga forward in his work.” (Moon, 2003, p. 42,).

Finally, connection through whakapapa sharing was also perceived as being a feeling, regardless of whether or not an actual connection, such as the ones above, were identified. For example “*I felt more related to her.*” Although no participants explicitly described a spiritual connection, this theme could also encompass the client’s perception of the wairua in the session. A feeling of connectedness between client and therapist was also described by participants in Goldsbury’s (2004) study, in which mental health service users were interviewed about their experiences with psychologists. They reported feeling a “connection” with the psychologist, however, the descriptions of this feeling did not come about as a result of a whakapapa sharing, but during the general course of therapy.

Important for Māori. There were two ways in which participant responses indicated that the whakapapa sharing process was viewed as important for Māori. Responses that fell within the Important Māori Way descriptive category were relevant to this theme and responses that indicated the sharing conveyed respect for the participant or for Māori culture were also included in this theme.

Although the literature outlines a number of specific ways in which whakapapa sharing has significance to Māori, participant responses in the present study described whakapapa sharing as being generally important or being a specifically Māori method. Such responses included; “*In sharing such information it is a very “Māori way” and demonstrated – whanaungatanga (kinship)...*”, “*... It was*

necessary for working with Māori women...”, “I really liked it. Being Māori myself, it is important we get background information on a person...”, “ I really appreciated this as with Māori, I feel it is important to identify your geneology (whakapapa)...” and “This is important especially to Māori!”

One manner in which the significance of whakapapa is discussed in the literature is the role the continuation of whakapapa plays in one’s personal and cultural identity (Love, 2000). An individual can be seen as the most recent link in a chain that stretches back to the atua, both a product of and a reflection on their tipuna. Although participant responses were less specific, there is a general sense of the important role of whakapapa. In Moon (2003), although Hohepa Kereopa asserts that we are the summation of our ancestors, he also makes clear his understanding that our whakapapa contributes to only a part of our human worth and does not determine the whole of our value. Kereopa asserts that Māori need to take responsibility for discovering what makes us special. Barlow (1991) explains that knowledge of one’s whakapapa is one way Māori can develop pride and a sense of belonging.

The importance of whakapapa was also acknowledged by the advisory group in Bennett’s (2009) study; one of the adaptations the group considered to be important for CBT was the incorporation of Genogram development with clients. The Genogram was seen as a means to more collaborative investigate the clients’ knowledge of their whakapapa and their iwi. The Genogram can be means to open discussion about cultural identity. Although the present study did not involve the development of Genograms with participants, the whakapapa sharing process in a number of cases led to discussions about the clients’ cultural identity and iwi affiliation.

Whakapapa also holds a spiritual significance for Māori--Barlow (1991) describes whakapapa as extending to cover natural history, rather than relating simply to the history of humans. People and all living things have a whakapapa which extends genealogically back to the Gods. Even non-living things such as the elements are closely tied to Māori mythology and have whakapapa to the Gods (Reed, 1999). Whakapapa can be seen as the structure of knowledge that Māori have passed down through the generations regarding the creation of all things, and depicts how we are related--not only to one another, but regarding our link to the world as a whole (Ballara, 1991).

Given the importance of this knowledge, people who can recite whakapapa are often taught to do so in a particular manner in order to preserve the tapu associated with it (Ballara, 1991). In this way, the recital and sharing of whakapapa, not only plays an important role in relationships, identity, and spirituality, but also serves as a means of preserving knowledge throughout the generations.

Participants also referred to whakapapa sharing as a display of respect, not only for themselves as individuals but also as being of importance in communicating an understanding and respect for Māori culture. For example: “... *showed she had an understanding and appreciation of tikanga*” and “*I’ve enjoyed this therapy with Arna and more so that she has an understanding of the Māori world!!*” When asked how the experience made them feel, some participants responded by saying they felt appreciated and respected - “*It made me feel welcome and respected.*”, with one client noting that whakapapa sharing helped to create a safe space for her in this therapeutic setting. “*It created the safe space to share my mihimihi and to answer future questions...*”

These responses can be seen to reflect the expectation that a Māori worldview would not be assumed, understood or respected in this way. Consedine and Consedine (2012) define “white privilege” as being the assumptions that guide European societies’ understanding of what is “neutral, normal and universally available” (p. 200). These assumptions often result in the marginalisation of Māori and other indigenous cultures as invariably a worldview is assumed in which Māori are seen as ‘the other’, resulting in Māori worldviews oftentimes being unwittingly ignored or undermined. A discussion of the historical, economic, and political impact of white privilege is beyond the scope of this research, however, the concept of white privilege has relevance to whakapapa sharing and other cultural practices in a therapeutic setting with Māori clients. It appears initiating whakapapa sharing with clients is one way a therapist can model and “normalise” a Māori worldview. This process can be perceived by clients as an act of respect toward the Māori culture. Whakapapa sharing is not in and of itself sufficient in assuming a Māori worldview, however inclusion of this sharing assists in effectively communicating the therapist’s acceptance and respect for Māori tikanga. This inclusion works to create a safe space for further exploration of not only personal but cultural issues the client may not otherwise feel able to discuss. When asked about the effect of the whakapapa sharing conversation on the relationship with the researcher, one participant reported: *“I am often a little embarrassed about the fact I don’t know a lot about my Māori side but I didn’t feel this way with her.”*

There are many other ways a clinician can adopt practices that serve to normalise rather than marginalise culture for Māori clients. Bennett (2009) provides examples of adaptations to Cognitive Behavioural Therapy. The offer of karakia is a change to the perceived ‘normal’ approach; two of the participants in the present

study reported that they would have appreciated the offer of a karakia before commencing each session. Understandably, for some clinicians, practicing Māori tikanga can be difficult and feel uncomfortable or forced, which in turn can make tangata whaiora uncomfortable. As such, it makes sense that the manner in which cultural practices are adopted can serve to highlight the perception of Māori as ‘the other’. For example, consider the differences between the following two requests:

“Some of my clients prefer to have a karakia or prayer before and after sessions, is this something that you would want for us to do?”

“I like to start and end my sessions with a karakia, is that ok with you?”

Although essentially offering the same thing, the second request normalises the practice of karakia while the first request perpetuates the perception of Māori or spiritual practices as being different, or of ‘the other’. This example highlights the importance of adopting tikanga in genuine ways that do serve to further alienate tangata whaiora. In the present research the participant was not asked if they wanted to engage in a whakapapa sharing, with the researcher instead normalising this sharing by willingly offering her own whakapapa to the participant as part of the introduction to the first therapy session.

Equitable relationships. There were two types of responses that fell within this theme. Less frequent were responses that described the whakapapa sharing as changing the nature of the therapeutic relationship to being more personal and more frequent were responses which described the reciprocal nature of the relationship. One of the former responses included – *“Just the fact that I identified some common ground with her made her seem like more of a person instead of a psychologist.”* This participant identified the relationship as being more human than professional and attributed this difference to the commonalities identified through the whakapapa

sharing. This is a sentiment shared by Johnson and Sandhu (2010) who reported that forming personal connections by finding commonalities, even in the context of “multiple cultural differences allows us to relate on a more basic human level” (p. 124). Similarly, the advisory group in Bennett (2009) described the important role of therapist self-disclosure as a means of developing a more personal relationship with Māori clients. A more personal relationship was seen by the advisory group as being important for Māori tangata whaiora. Although Yalom (2002) does not discuss the therapeutic relationship in the context of culture, he too stressed the importance of the therapist being seen by all clients as a fellow human being.

Responses within this theme also acknowledged the bidirectional nature of whakapapa sharing. The significance of a bidirectional interaction can be understood from both a tikanga and psychological perspective. From a cultural perspective, the concept of utu³² can be seen to play a role within this sharing. Utu is often referred to as a series of actions put in place to make a payment or restore balance, whether it be through giving a gift or avenging a wrong that has been done (Moon, 2003). Utu provides balance within relationships and is seen as responding to or replying to the actions of others--this often occurred traditionally in an escalating manner, with reciprocal obligations being created through actions directly leading to the establishment and maintenance of relationships (Moorfield, 2011). Within the context of this research, it appears that utu played a role in whakapapa sharing through the creation of a reciprocal obligation which began with the therapist’s self-disclosure. Through the disclosure of personal information to another person in a therapeutic setting, a measure of imbalance is created. The person sharing becomes vulnerable to the other party and trust is placed on the person receiving the information. In a

³² Utu – reciprocity, an important concept concerned with the maintenance of balance and harmony between individuals and groups and order within Māori society.

therapeutic setting, even following the sharing of whakapapa, the vulnerability and trust between the therapist and client is decidedly uneven; whakapapa sharing therefore works to allow the therapist to establish the relationship by placing trust in the client, which allows the client to feel more able to return that trust through their own self disclosure. Participant responses in this theme included: *“It allowed me to let her see who I am.”*, *“She shared, I shared.”* and *“Pleased that she shared and I felt like it was polite of me to share back.”*, *“Relaxed some initial reservations I had about being so vulnerable with my thoughts and feelings.”*

From a psychological perspective whakapapa sharing can be seen symbolically as an acknowledgement that the therapist is not a blank slate and will contribute to the relationship from their own cultural, academic and personal background. Psychoanalysis has a history of criticising the unidirectional nature of the therapeutic relationship, acknowledging that a lack of therapist disclosure leads to an inequitable relationship which has the potential to perpetuate certain maladaptive relationship styles and serves as a protective and defensive stance that leads to idealization of the therapist (Jacobs, 1999; Renik, 1995). In a New Zealand study (Goldsbury, 2004), a Māori participant reported that when a mistake was made by a psychologist, it was important the problem could be repaired by admitting the mistake, the participant was able to see the psychologist as fallible and human. This provides an example of a bi-directional expectation of responsibility taking that may have served to create a more equitable therapeutic relationship.

Perception of the researcher/therapist. This theme included responses from participants that involved judgements about the the therapist they were able to form as a result of whakapapa sharing. As can be expected from therapist self-disclosure, clients are given information regarding the therapist from which they can make

informed judgements directly influenced by said information. Judgements about the therapist could be either positive or negative, and may prove to be accurate or inaccurate. Some of the participants' judgements included, "*I saw her as a more trustworthy individual*", "*it showed she had an understanding and appreciation of tikanga.*"

The judgements reported by participants within the present study were composed of positive feedback; all participants reported self-disclosure was appropriate in this setting. Participants judgements extended to their perception of similarities they shared with the researcher. A variety of similarities were identified by different participants, and interestingly, the following examples provide almost opposite descriptions. "*Fair skinned, immersed into Māori culture/cultural environment/up bringing.*" and "*Both of our families aren't heavily involved and don't know a lot about their Māori sides.*"

If non-disclosure can be seen as contributing to an inequitable relationship serving to protect the therapist from potential criticism (Renik, 1995), so too can disclosure be seen as opening up the therapist to potential judgements. However, as clinicians we need to ask ourselves if we find this degree of vulnerability acceptable, and if not, why. Many clinicians strive to maintain a non-judgemental stance with clients; however judgements are inherent in most psychological approaches. Clinicians own judgements of clients come about during a psychological assessment interview (and throughout the course of therapy), therapist judgements are informed by their own schema which are influenced by their worldviews and training within the field of psychology.

Improved engagement. The final theme of engagement is relevant to participant responses falling within the descriptive categories relating to increased

comfort and the ability to share. These responses were the most common, with participants reporting that whakapapa sharing led to improved rapport, comfort with the researcher, and improved ability to be open within therapy. This was perceived as having a positive impact on the speed and amount that the participants found themselves able to share. Participant responses relevant to the theme of improved engagement include: *“It was a good way to start the session. Made it relaxed.”*, *“I wasn’t expecting it but it did make me feel comfortable – and comfortable enough to share my personal information.”*, *“it made me feel more comfortable.”*, *“I think it made it easier to talk to her...”*, *“It made me realise the things we had in common (ethnicity), which in turn made me feel comfortable and relaxed.”*, *“...I opened up more.”*, *“Assisted in forming rapport, made you feel comfortable and at ease.”*, *“Made me feel a little more comfortable.”*, *“It made it a lot easier to talk openly with her and I felt more comfortable with her.”*, *“I opened up to her quicker than I thought I would.”* And *“I felt relaxed – so easier to brag on about myself.”*

Engagement through rapport and comfort is an important aspect of the therapeutic relationship, and was measured within the Bond subscale on the Working Alliance Measure (Horvath & Greenberg, 1989). Interestingly, this was the only theme identified in the qualitative analysis of the reported effect of whakapapa sharing that was also captured by the quantitative therapeutic alliance measure.

MODEL

Using a thematic analysis approach, the independent raters organised participant responses into descriptive categories, with strong inter-rater reliability. Descriptive categories and responses were then organised with reflection supported by the critical friend into five themes with reference to the relevant past literature for each theme. A theoretical framework depicting a possible causal relationship between the five themes is outlined below in Figure 13.

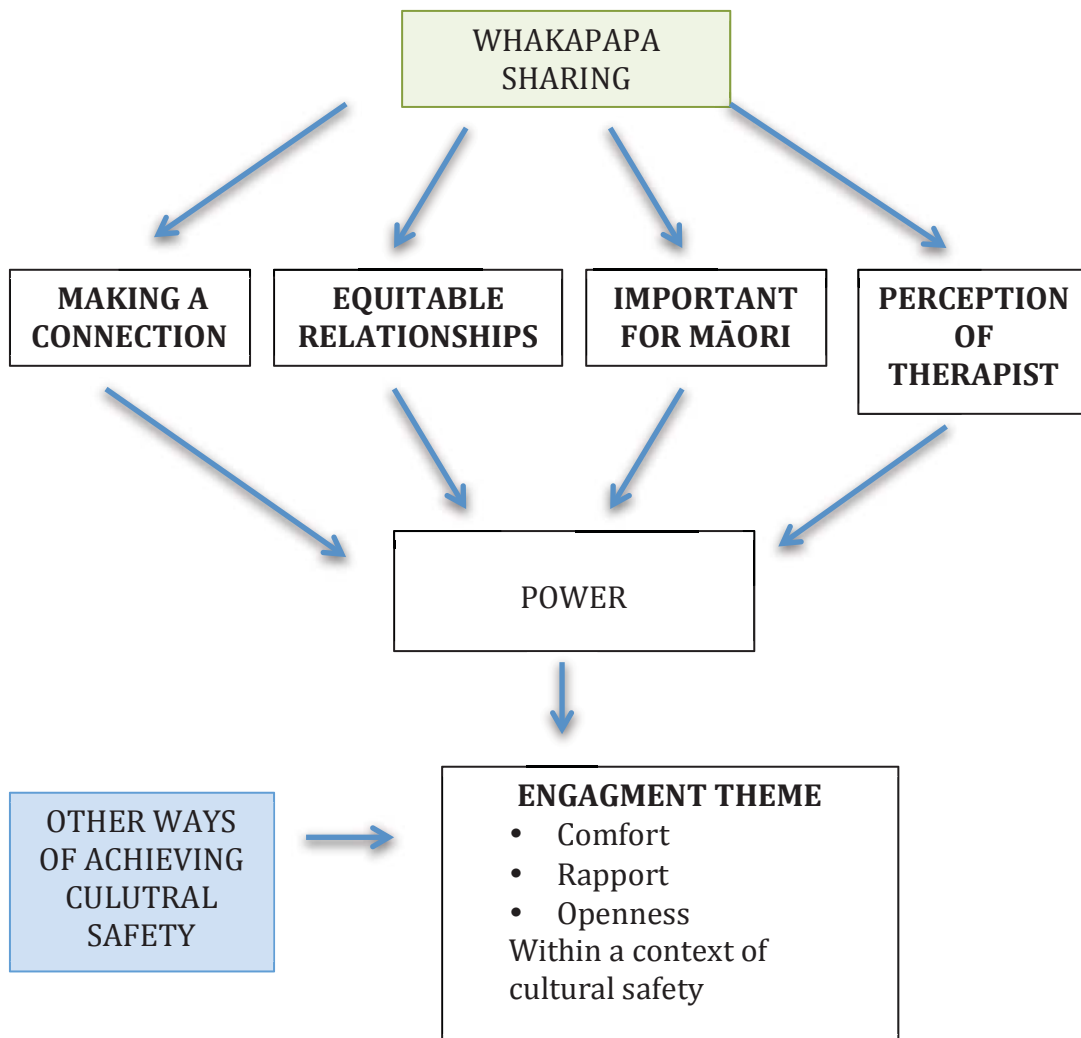


Figure 13. Framework illustrating the relationship between the themes identified from the qualitative analysis.

Figure 13 illustrates a theoretically causal pathway between the whakapapa sharing and participant engagement. The engagement theme is proposed as the outcome variable; engagement in this model refers explicitly to the rapport, comfort and openness participants reportedly experienced as a result of the whakapapa sharing. It is important to note that engagement in this model refers to the type of engagement that occurs with Māori clients within a context of cultural safety, which has been defined as “an environment which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening” (Williams, 1999, p. 213).

This framework is a way of understanding the whakapapa sharing experience, and does not posit that whakapapa sharing is the only way to achieve cultural safety and engagement with Māori clients within a therapeutic context. Reports from Māori service users in Goldsburys’ (2004) study indicate that clients were able to feel understood and respected as Māori when the clinician was Pākehā and presumably, did not initiate whakapapa sharing with the service user. La Roche and Maxie (2003) provide 10 recommendations therapists can apply in consideration of cultural differences between themselves and their clients – although these considerations have not been empirically validated. La Roche and Maxie surmise that by therapist initiation of discussions about cultural differences, clients become more open and thus able to address relevant sociopolitical and cultural issues in relation to making changes in their lives within therapy discussions. Additionally, no group differences in the present study were revealed on the Bond subscale of the WAI, which measured comfort and openness. This suggests that the engagement achieved with both groups in this study was similar regardless of the implementation of whakapapa sharing.

However, cultural safety was not explicitly measured, so no comparisons can be made between the groups in regards to this construct, which may be different from the construct measured by the Bond subscale.

The theoretical framework in Figure 13 proposes that the latent construct of *power differential* between the client and therapist is the mediating variable by which the other four themes lead to engagement and cultural safety. Power was not mentioned in any of the participant responses, however, it is inherent in all therapeutic relationships, with the potential for more pronounced power differences occurring between majority and marginalised cultures (Abrams & Moio, 2009; Garran & Rozas, 2013).

It is important to emphasise that the power differential within the therapeutic relationship can swing both ways; not all therapists hold more power than their clients and vice versa. The power dynamics between clients and therapists are influenced by issues of privilege and power within the life of the client and the therapist. Differing statuses as perceived by the client and therapist relate to gender, race/ethnicity, cultura, class, sexual orientation, socioeconomic status, job, personality as well as those related to the clients and therapists perception of the hierarchy of the their roles as client and therapist.

Two of the nine sources of power in a therapy context discussed by Zur (2014) appear to be affected by the sharing of whakapapa. The power imbalance that comes about through an imbalance of knowledge between therapist and client, as well as, the power imbalance that comes about through the positional or role of the therapist in relation to the client. The sharing of whakapapa appears to effect these two sources of power within a therapeutic relationship. This theoretical framework proposes that the first four themes, derived from participant responses, resulted directly from the

whakapapa sharing, and that all four serve to decrease the power differential within the relationship in the following ways:

1) The whakapapa sharing allows the client and therapist to establish connections with one another, either through whakapapa, mutual acquaintances, similarities or a feeling of connectedness. These connections serve to decrease the power differential by actively seeking to decrease the distance between client and therapist. Additionally, there is a shift in the role of therapist and client, through the provision of a context to the relationship that is not simply based on the therapist and client or researcher and participant roles.

2) The second theme proposes that a more equitable relationship is established through the bidirectional and reciprocal nature of the whakapapa sharing. This theme relates directly to the power derived from knowledge of the other (Zur, 2014). Power is more balanced following the sharing of whakapapa because the client holds more knowledge of the therapist.

3) The whakapapa sharing when initiated by the therapist was perceived as respectful and important to the participants as individuals and as Māori.

Normalising cultural practices can lead to a decrease in the power differential, as can displays of respect between individuals. Zur (2014) discussed referent power, which is the display of admiration or respect between individuals, which contributes to power differentials within a relationship. Participants' perception of the whakapapa sharing as being a show of respect and important for them as Māori suggests that the power differential is less following the whakapapa sharing.

4) The fourth theme incorporates participant responses that were judgements of the therapist. It appears that the whakapapa sharing involves therapist disclosures which change the client's perception of the therapist; the client is trusted with information from which they can make judgements about the therapist. This process is oppositional in nature to a usual therapeutic approach and although the therapist in this study was perceived as being more trustworthy, self disclosure can leave the therapist open to criticism and negative judgements. Clients will always form opinions about therapists - however, the whakapapa disclosure provides clients with more information from which to form opinions, thus decreasing the power differential in the relationship.

According to this framework, by establishing a therapeutic relationship in which the power difference is decreased the client's initial engagement with the therapist is improved within a context of cultural safety. The whakapapa sharing is a step towards creating an environment for Māori clients that is culturally sensitive, as well as respectful and open to cultural issues.

CHAPTER FIVE

DISCUSSION

The purpose of this study was to explore the process of whakapapa sharing between therapist and client in a therapeutic setting, and to analyse the effect this sharing had on the therapeutic alliance and outcome of therapy. The effect of whakapapa sharing was investigated through both qualitative and quantitative analyses of participants' responses on a number of questionnaires which were administered at different points throughout the research procedure. For the purpose of this research, participants were allocated to either a Whakapapa Sharing group or a Non-Disclosure group. In relation to participant responses on the Māori Culture Questionnaire, it was expected to find that participants in the Whakapapa Sharing Group who indicated higher levels of whakapapa knowledge, and access to and engagement with cultural resources would report a stronger therapeutic alliance; however, no direct relationship was found between participant scores on the Māori Culture Questionnaire and the Working Alliance Inventory. Additionally, all participants, regardless of cultural knowledge, reported the whakapapa sharing process was a positive one for them.

It was hypothesised that participants from the Whakapapa Sharing group would report a better therapeutic alliance than those in the Non-Disclosure group, however this hypothesis was not supported. No differences were found between the groups on the therapeutic alliance measure. A number of therapist variables and techniques, such as warmth and empathic statements have been found to contribute towards the development of strong therapeutic relationships (Ackerman & Hilsenroth, 2003). It is possible that these variables were stronger contributors to the therapeutic alliance in the present research than the sharing of whakapapa.

Past research has found a strong relationship between the therapeutic alliance and therapy outcome, as such it was hypothesised that the Whakapapa Sharing group would have better therapy outcomes than the Non-Disclosure group. However, no group differences were found for either the outcome measure or the perception of therapy measure.

Both groups reported a small improvement in the therapeutic alliance between the first and second session of therapy. This improvement was found to remain consistent across each of the three subscales of the Working Alliance Inventory. The improvement in the therapeutic relationship across the initial two sessions was found in spite of high overall mean scores on the Working Alliance Inventory across both time periods (mean scores were between four and five out of a possible five), working to create somewhat of a ceiling effect. There were no differences found between the time periods relating to participant scores on either the outcome measure or the perception of therapy measure.

A number of relationships were revealed within participant scores on the various measures. The therapeutic alliance after the first session for all participants was found to be weakly related to their score on the outcome measure, indicating that higher scores on the therapeutic relationship measure after the first session corresponded with better scores on the outcome measure following the second session. This finding provides support for a large body of literature that has also found a strong positive relationship between stronger therapeutic alliances and better therapy outcomes (Horvath & Symmonds, 1991).

A positive relationship was found between the therapeutic alliance and the participants' perception of the therapy as being credible. This relationship does not permit an inference of direct causation, as the relationships between alliance and

therapy expectancy measures were consistently found across the different time points, irrespective of the direction of the analyses. Therefore, the nature of the relationship between the alliance and therapy expectancy can be seen as a two way causal relationship, whereby a stronger relationship formed between therapist and client results in the client being more likely to perceive the therapy as useful. Or inversely, should the client perceive the therapy as credible and hold expectations regarding the practicality of the sessions then she may perceive the therapist as being more credible and competent, thus leading to the development of a stronger therapeutic relationship. Similar non-linear relationships have been described in the literature as ‘means-ends’ relationships (Evans & Fletcher, 2013), a concept developed by Staats (1975) and expanded upon by Evans (1985). Evans (2013) described the interdependent relationship between the therapeutic alliance and therapy outcome, whereby a positive therapeutic relationship is seen as both contributing to and resulting from positive therapeutic outcomes. The example given by Evans and Fletcher (2013) involves symptom reduction and the resulting increased engagement in proactive behaviours leading to further symptom reduction.

Another explanation for the strong and consistent relationship between the alliance and expectancy measures over the different time periods is the possibility of an overlap in the constructs being measured by each questionnaire. The credibility and expectancy questionnaire includes questions regarding participant expectations for the therapeutic relationship. However, this explanation is unlikely, due to the fact that similar relationships across both measures were not found with other measures (such as the outcome questionnaire). Unlike the therapeutic alliance, the participants’ scores on the therapy perception measure were not related to outcome; therefore participants who reportedly expected the therapy to be more helpful and viewed it as

more credible were not likely to have better outcomes. This finding does not support past literature about the role of expectations in psychotherapy (Evans & Fletcher, 2013).

The qualitative analyses of participant reports regarding the experience of whakapapa sharing revealed five main themes which were organised into a theoretical framework depicting the manner in which all five themes might be related to the power differential within the therapeutic relationship. The first four themes (making a connection, equitable relationships, important for Māori and perception of the therapist) were seen to reduce the power difference in the relationship, while the fifth theme of engagement was conceptualised as coming about as a result of the reduction of the power difference itself.

IMPLICATIONS

The quantitative results from this study did not support the hypotheses that whakapapa sharing would improve the therapeutic alliance. There were no group differences on any of the alliance or outcome measures. When coupled with the qualitative results, this finding is unsurprising, as the qualitative analysis revealed that whakapapa sharing is a complex experience involving constructs which did not fall within those that were measured quantitatively in this research. Participant reports about their experience of the sharing were unanimously positive and the qualitative analyses revealed themes that were seen to be related to the minimisation of the potential power difference within the relationship. Of the five qualitative themes, only the engagement theme was partially measured by the Working Alliance Inventory within the Bond Subscale. However, the theoretical framework developed from the qualitative responses proposes that the engagement theme may refer to comfort and

openness experienced by Māori clients within a context of cultural safety; this form of engagement may differ somewhat to the construct of engagement measured by the Working Alliance Inventory.

The therapist in the present study was able to develop a strong therapeutic alliance with participants in both groups, suggesting that whakapapa sharing is not necessary in forming a strong therapeutic alliance with Māori clients. This conclusion remains consistent with the findings of Goldsbury's (2004) study, which found that non-Māori clinicians were able to achieve positive outcomes and form positive therapeutic relationships with Māori service users. The findings of the present study suggest whakapapa sharing is an activity that serves to reduce the power differential within the relationship, giving rise to a number of issues necessary for contemplation when considering the study's application within a therapeutic setting. In general, importance is placed on the need for therapeutic approaches and practices that are evidence-based, however, exploration of participant's experience of whakapapa sharing identified benefits that were not related explicitly to outcome or to the therapeutic alliance.

In discussing the implications of the Code of Ethics and the principles of Te Tiriti o Waitangi within psychological practices in New Zealand, Nairn (2007) emphasises the need for all clinicians to provide services that are culturally just. One manner in which the principles of both these documents can be applied in practice involves the need for psychologists to develop awareness regarding their own personal and professional cultural preconceptions and the manner in which the historical and present social context impacts their clients and their shared relationships. Tamasese and Waldegrave (2003) discuss power differences as being closely related to social injustice. In a therapeutic setting they outline the need to

promote client self-determination and address power differences within the therapeutic relationship as well as within approaches to therapy. When placed within context, the findings from the present study indicating the whakapapa sharing process contributes to a reduction in the power differential and can be seen to have importance in relation to culturally sensitive and thus ethical practice when working with Māori (Evans, Fitzgerald, Herbert & Harvey, 2010).

There was an overwhelming positive response to whakapapa sharing in this study. Additionally, it appears that whakapapa sharing is appropriate from an ethical and cultural perspective. However, it is important to also discuss the implications of therapist self disclosure from a psychological perspective. Although self-disclosure is no longer perceived as taboo in psychological practice, and is even recommended as a tool for intervention in some approaches, what constitutes judicious and helpful self-disclosure can be seen as ambiguous and difficult to judge (Farber, 2006). As discussed in the introductory chapter, Farber (2006) outlines 10 guidelines to take into account when considering therapist self-disclosure. While the sample population from this study was non-clinical, the findings indicate that the self-disclosure involved during whakapapa sharing adheres to these guidelines. A number of the recommendations emphasise the need for mindfulness relating to boundary crossing through self-disclosure; one theme revealed within the current research relates to the identification of connections with clients through whakapapa and mutual acquaintances. When and if these relationships are identified during whakapapa sharing, the therapist has the opportunity to explicitly address potential dual relationships with the client during this process. Farber (2006) also recommends that disclosures be tailored to individual needs. Although reducing power differentials and creating a context of cultural safety is important, this raises a question about the

appropriateness of sharing whakapapa with clients who are in immediate distress. During therapy (as in all human relationships) there is a need for flexibility and for therapists to respond appropriately to clients in the moment. In the present study the sharing of whakapapa was an organic rather than a rigidly structured process, unlike formal powhiri, which follow strict protocols. As such, therapists are free to make decisions about how to prioritise whakapapa sharing, especially in situations in which a client's in the moment distress is high and the act of sharing whakapapa might be experienced as invalidating there present emotional distress.

One of the themes outlining the effect of whakapapa sharing was the perception of the therapist theme; participants were able to form judgements regarding the researcher based on information disclosed during whakapapa sharing. Although the researcher in this study was perceived as being more trustworthy, knowledgeable and respectful of Māori culture, it is possible that negative perceptions of a therapist can also be formed as a result of sharing. This self-disclosure act entrusts the client with information to form judgements about therapists and make self-determined decisions - judgements may include negative conclusions, which is to be expected when taking into account historical and present day social contexts. It remains however, the responsibility of the therapist to encourage self-determination within the therapeutic relationship and respect the outcome of that process. In effect, the whakapapa sharing process can help a therapist to reduce the power differential within the relationship by effectively 'taking a step down' from a position of comparative power by allowing clients to make more informed judgements about therapists. This process allows therapists to become culturally accountable to their clients and begins the therapeutic relationship with a genuine bi-directional interaction.

Finally, La Roche (2003) discusses the subtle cues that therapists can give to a client such as discomfort or a lack of response to certain issues, resulting in client avoidance of certain topics in future sessions. Such cues can sometimes result in discrimination and marginalization of clients. It appears that whakapapa sharing is an explicit practice that in the present research served to provide Māori clients with a clear message of acceptance and respect for Māori cultural practices and tikanga. In the present study, the whakapapa sharing allowed and even promoted discussions with participants about cultural identity and other culturally and clinically relevant topics. It seems whakapapa sharing may be seen as a way of assisting client comfort and provide a safe space for clients to engage in not only clinically but culturally relevant discussions also.

LIMITATIONS

There are a number of limitations relating to the present research which should be considered in discussing the outcomes and possible implications for practical application. The formation of assumptions based on the wide-spread application of the results of the study is difficult for a number of reasons. Whakapapa sharing is a highly personalised and variable experience, with variation occurring when different individuals identify different connections to any part of the information disclosed. These connections are then explored, resulting sometimes in further self disclosure relating to a certain aspect of the information revealed. This study only involved 15 participants who reported their experiences of whakapapa sharing with only one therapist, and although the participants reported a range of whakapapa and cultural knowledge on the cultural questionnaire, the sample was comprised of women, from a non-clinical population, all residing within one rohe, between the ages of 18 and 40.

This selection was not random, and the sample cannot be seen to be representative of all Māori consumers of mental health services in Aotearoa or even in Wellington. Additionally, whakapapa sharing was initiated by only one therapist; although the whakapapa sharing process can be seen as similar between differing therapists, the content of this sharing will vary dramatically across individuals, effectively decreasing the ability to arrive at wider-branching conclusions relating to the findings of other therapists initiating this sharing.

A qualitative questionnaire was used to record the participants' accounts of the whakapapa sharing experience. Although the information gathered allowed for the identification of themes which were then able to be organised into a theoretical framework, it should be noted that a structured interview may have allowed for more in depth exploration regarding participant experiences of the whakapapa sharing.

Finally, whakapapa sharing is only one aspect of what is perceived as culturally appropriate practices in therapy settings when working with Māori tangata whaiora. In practice, whakapapa sharing is not and should not be separated from other whakawhanaungatanga practices. For the purpose of this research it was utilised in isolation to gain an understanding of the participants' experiences of the whakapapa sharing in and of itself. Therefore generalisation of the quantitative findings from this study is cautioned against. Although no support was found for the hypothesis that the whakapapa sharing would improve the therapeutic alliance, this does not consider the impact of whakawhanaungatanga practices when employed collectively as they are intended to be.

FUTURE RESEARCH

The findings of this study raise questions and considerations that could inform future research in this area. The theoretical framework that has been developed from this research could be tested through further quantitative and qualitative research. According to this framework whakapapa sharing has an effect on the power dynamic within the therapeutic relationship; future research in order to measure and compare participant perspective regarding the power differential prior to and following whakapapa sharing is recommended. Utilisation of semi-structured interviews rather than reliance on open-ended questionnaires could reveal more in-depth information regarding participant experience of whakapapa sharing. Although no group differences were found on the therapeutic alliance measure, participants from the Whakapapa Sharing group reported they experienced enhanced feelings of comfort, openness and found themselves better able to share with the therapist as a direct result of whakapapa sharing. The theoretical framework proposes that this sharing was related to the culturally safe environment created by the sharing; future research measuring the therapeutic relationship might also consider measuring the participants' perceptions of cultural safety, thus testing the findings of this study.

The Miller et al. (2003) Outcome Rating Scale and Session Rating Scale are short measures of the effectiveness of therapy and the therapeutic relationship which are less specific and more subjective than the Working Alliance Inventory used in the present study. These short measures are also briefer, with only four items in each, as opposed to the 36 items featured within the Working Alliance Inventory. The Miller rating scales could save participant time and provide added benefit when measuring the relationship and outcome in future research.

In order to generalise the findings from this study further research needs to focus on increasing the number of participants, including participants who are from a clinical population, in addition to working with a sample population who have a diverse range of Māori identities. The present study used a non-validated cultural questionnaire to measure participants cultural and whakapapa knowledge; a recent study featuring 492 Māori participants carried out by Sibly and Houkamau (2013) provides support for the reliability of The Multi-Dimensional Model of Māori Identity and Cultural Engagement which was developed as a Māori specific identity measure (Houkamau & Sibley, 2010). Future research could utilise this measure of Māori - specific identity.

Additionally, it could be beneficial to involve a number of therapists in future studies, thus allowing analyses with a variety of different therapist whakapapa self-disclosures and a range of different therapist cultural identities. Analyses from this research indicate that participant access to and engagement with cultural resources (as measured by the cultural questionnaire) had no bearing on the therapeutic relationship. This finding is in line with Goldsbury's (2004) study, which found that non-Māori practitioners were able to form positive therapeutic relationships. This suggests that the ability to form a strong therapeutic relationship is not dependent on culture, giving rise to the question. 'do cultural practices, such as sharing whakapapa, when initiated by non-Māori have a similar effect as when they are initiated by Māori?'

Within the New Zealand context, many non-Māori clinical psychologists work with Māori service users. If future research could involve non-Māori therapists, the general application of these findings would be greatly improved. Outcomes of the present study led to a hypothetical model, which suggest that whakapapa sharing is an

activity that decreases the power differential within the relationship. And although one should not assume that all clients are less powerful than their therapists, practices that decrease power differentials may be more important when clients come from an indigenous culture and therapists from a majority and/or colonizing culture.

In future research, it may be helpful to gather more indepth qualitative data regarding a participant's experience of the whakapapa exchange. This could be achieved by way of an interview rather than the questionnaire that was used in the present study. The responses provided by participants were brief and a semi-structured interview with an independent researcher might provide a deeper understanding of participant's experiences. For example, participants in the present study did not explicitly mention any wairua aspect of the experience, although, it is possible that one participant who reported "feeling" connected to the therapist, may have referred to wairua, it is not clear, an interview would allow further exploration of the "feeling" and provide a clearer understanding. Māori kawa and tikanga often have spiritual significance and therapy from a Māori worldview might involve wairua experiences. Unfortunately, this was not a element mentioned by participants in the questionnaire and in the future an interview might explore this aspect explicitly. Additionally, past research into therapist self disclosure by Audet and Everall (2010) found both positive and negative themes. A semi-structured interview might allow further exploration of potentially negative as well as positive aspects of the whakapapa sharing experiences.

SUMMARY

This research set out to explore the practice of whakapapa sharing between therapist and client in a therapeutic context. The impact of the sharing on the

therapeutic alliance and the outcome of therapy was measured, with participants describing their experience of the sharing in an open-ended questionnaire. Although no group differences were found on either the therapeutic alliance or the outcome measures, the qualitative responses of participants revealed the complex nature of the sharing and the role it plays in reducing the power difference between therapist and client in establishing a relationship within a context of cultural safety. In discussing cultural competency within a therapeutic context, some theorists have raised the importance of deconstructing the power and privilege inherent within the relationship when working with minority and/or marginalised cultures (Garran & Rozas, 2013). Recommendations for how a therapist can begin such a task are often ambiguous and open to interpretation; the findings in the current study propose that whakapapa sharing, is a practical way in which the power differential within the relationship can be implicitly reduced without explicitly addressing the power dynamics of the therapeutic relationship. These findings provide support from an ethical and cultural perspective for the value of this practice in a therapeutic setting.

Although the findings support the use of whakapapa sharing in practice, further research is necessary to test the theoretical framework and the generalised application of these findings. Additionally, although reducing power differences in the relationship can be seen to be important, practitioners need to remain considerate toward the individual needs of clients, and work to identify and prioritise client distress and safety. Practitioners should also be aware of potential boundary issues; circumstances in which dual relationships are identified can then result in therapists gaining the opportunity to address these boundaries explicitly with the client.

It is the researcher's hope that the findings from this study will serve to inform practice, provoke thought about cultural justice and power differentials among

practitioners, as well as serve to encourage further research in this area and enable Māori tangata whaiora in New Zealand to experience culturally just mental health interventions.

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APPENDICES

Appendix 1: Glossary

Aotearoa	Used as the Māori name for New Zealand
Hapū	Subtribe, section of a large kinship group
Hinengaro	Mind, thought, psychological
Hongi	A way of greeting, which involves pressing noses.
Iwi	Tribe, extended kinship group
Kawa	Marae protocol, customs of the marae and meeting house
Karakia	Incantation, ritual chant, pray, prayer
Kaumātua	Elder
Kaupapa Māori	An ideology incorporating Māori knowledge, skills, attitudes and values.
Kura Kaupapa Māori	Māori language immersion school
Manaaki	(Verb) To support, take care of, give hospitality to, protect, look out for
Manaakitanga	(Noun) Hospitality or promotion of others' mana through active hosting, kindness and support
Māori	Indigenous person belonging to Aotearo/New Zealand
Marae	The courtyard of a Māori meeting house

Pōwhiri	To welcome, invite, rituals of encounter, welcome ceremony on a marae
Tangata whaiora	Term used to describe mental health consumers, meaning those who seek wellness
Tikanga	Custom, meaning, procedure, manner, convention, ethics, values, correct way of doing something
Tinana	Body
Tohunga	Chosen expert, priest, skilled person, a person chosen by the agent of an atua (god) and the tribe as a leader in a particular field because of signs indicating talent for a particular vocation
Utu	Reciprocity, an important concept concerned with the maintenance of balance and harmony between individuals and groups and order within Māori society
Wairua	Spirit, psyche
Waka	Canoe
Whakapapa	Genealogy, Family tree, Kinship
Whakawhanaunga	Relation, relative, allied
Whanaungatanga	Relating well to others
Whakawhanuangatanga	(Noun) Process of establishing and maintaining family-like relationships or connections
Whānau	Family, extended family, unit, kinship group

Wharekai

Dining hall

Whakataukī

Proverb, saying

Appendix 2: Advertising Sheet

MASSEY UNIVERSITY
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AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

**MĀORI WOMEN ARE WANTED TO TAKE PART IN RESEARCH INVOLVING
ACCEPTANCE AND COMMITMENT THERAPY.**

Kia ora, I am inviting Māori women between the ages of 18 and 40 to participate in two free sessions of counselling at the Psychology Clinic at Massey University in Wellington. Participants will be asked to attend two therapy sessions and fill out questionnaires about the therapy and the therapist. The therapist is a trainee in clinical psychology currently undergoing her 7th year of study. Participants will be provided with a \$150 koha in the form of a VISA Prezzy Card that can be used at EFTPOS terminals. Persons who are presently or have previously undergone therapy will not be eligible to participate in this study; a screening questionnaire will be administered prior to the commencement of the therapy.

The techniques that will be presented in the Acceptance and Commitment Therapy (ACT) will aim to assist in reducing stress and worry. ACT also aims to clarify a person's values and help them to focus their efforts into activities that align with these values. The therapy that will be used has been shown to be effective with a range of client groups.

What is involved?

1. Participation in two free therapy sessions to be scheduled one week apart
2. Filling out questionnaires at the clinic before and after the therapy sessions and posting or emailing one questionnaire to the researcher two weeks after the final therapy session (total time involved around 3 hours).

Where?

1. Both sessions of therapy will take place at the Psychology Clinic at Massey University, which is situated at 24 King Street, Mt Cook, Wellington.

Many thanks in advance. Your participation is greatly appreciated.

If this sounds interesting to you, or you know someone who may be interested, please contact Arna Mitchell for more information.

Arna Mitchell contact details:

Cell: 027 696 6211

Phone: 04 801 5799 ext 62324

Email: arna.mitchell@gmail.com

Te Kunenga ki Purehuroa

Massey University, School of Psychology – Te Kura Hinengaro Tangata

PO Box 756, Wellington 6140, New Zealand T (04) 4801 5799 F (04) 4801 2692 www.massey.ac.nz

Appendix 3: Experience of Whakapapa Sharing Questionnaire

The following questions are to do with the conversation you had with the therapist at the beginning of the therapy session. The therapist talked to you about her family background and I would like to know what you thought about this exchange. Space is provided under each question for you to write your answers. To preserve your anonymity please place this questionnaire in the envelope provided to you and seal it.

1. What did you think when the therapist shared her personal information with you?

2. What effect do you think that particular conversation had on your relationship with the therapist?

3. How did it make you feel when the therapist shared with you?

4. As a result of the exchange did you identify an existing relationship or connection with the therapist? Eg. Are you from the same iwi?
 - a. If so, how do you think this relationship effected your therapy, your relationship, or the amount and type of information you shared with the therapist?

5. Do you think the sharing was appropriate?

Appendix 4: Therapy Protocol

SESSION ONE

1. An overview of ACT was described to each participant; this included an explanation of the different components of ACT and their practical integration. A metaphor was used to assist this explanation.
2. Participant difficulties were initially identified and explored by way of a brainstorm covering aspects of their lives they currently associated with strong unpleasant emotions.
3. Using examples identified during the brainstorming activity, participants were given education about an ACT perspective of unhelpful thoughts and unpleasant emotions.
4. Participants were taught four thought defusion techniques and practiced one emotion acceptance exercise with the therapist. These techniques were described by Harris (2008b) in his book “The Happiness Trap.”
5. Participants were asked to identify situations during the coming week where they might be able to impliment the techniques.

SESSION 2

1. Participants were asked to give feedback about their implementation of the techniques from the previous session.
2. Participants were given an explanation about the components of ACT that would be covered in the present session.
3. Participants collaboratively filled out the Values worksheet (Harris, 2008a) with the therapist to identify their valued directions.

4. Participants collaboratively filled out the more general “Bullseye” Values worksheet (Harris, 2008a) with the therapist.
5. Participant responses on the values worksheets were used to identify areas in which they would like to form goals.
6. Participants collaboratively filled out the SMART Goals worksheets (Harris, 2008a) with the therapist, to identify their immediate, short, medium and long-term goals.
7. Participants chose one difficult goal to fill out a Willingness and Action Plan worksheet (Harris, 2008a) collaboratively with the therapist. This allowed the therapist and participant to identify barriers to reaching the goal and ways to overcome those barriers. Overcoming barriers often involved the acceptance strategies taught during the first session.
8. Participants were given a verbal summary of the sessions and the written materials.

Appendix 5: Information Sheet

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THE THERAPEUTIC ALLIANCE IN ACCEPTANCE AND COMMITMENT THERAPY WITH MĀORI PARTICIPANTS

Information sheet

Kia ora, thank you for your interest in my project. My name is Arna Mitchell and I am a trainee in clinical psychology at Massey University. This research is being carried out as part of my Doctorate work. I am working under the supervision of Prof Ian Evans, Dr Ruth Gammon and Dr Averil Herbert. This research aims to investigate Acceptance and Commitment Therapy and the therapeutic alliance with Māori clients. Following is an outline of the research process that you will undergo should you choose to participate.

Who can participate?

You will be eligible to participate if you are a Māori woman who is between 18 and 35 and you have not been diagnosed with a mental illness or undergone therapy in the past. If you are currently taking psychiatric medication you will not be eligible to participate.

What will you be asked to do and how much time will be involved?

You will be asked to attend two x 1 hour therapy sessions at the Psychology Clinic at Massey University in Wellington. The sessions will be approximately one week apart and they will be arranged at times that are convenient for you. The therapy sessions will be video recorded; the recordings will be used to rate the consistency and the integrity of the therapy across participants and none of the information from the therapy session will be used in analysis. You will have the option of having your therapy tapes returned to you following the research. Alternatively, they will be destroyed when the project is finished.

You will also be asked to fill out questionnaires at four different times during this research; before and after the first session of therapy, after the second session, and two weeks after your second session. The first questionnaire is a screening questionnaire to ensure that you fit the criteria of the project; the last questionnaire will assess how useful the therapy was for you. Altogether, approximately 3 hours of your time will be needed. Following the second session of therapy participants will be given a koha of \$150. The koha will take the form of a VISA Prezzy Card which can be used like an EFTPOS card.

Why is this research important?

Acceptance and Commitment Therapy has been researched extensively overseas and has been found to be effective. We are interested in investigating its effectiveness in a New Zealand context with Māori clients.

What is Acceptance and Commitment Therapy?

The therapy that you will participate in is based on the book; “The Happiness Trap” by Dr. Russ Harris. Acceptance Commitment Therapy (ACT) is a therapy that has been found to be helpful with a range of client groups. ACT aims to assist in reducing stress and worry, it also aims to clarify a person’s values and help them to focus their efforts into activities that align with these values. For more information please visit this website: www.thehappinesstrap.com

What can you expect from the researcher?

The Massey University Human Ethics Committee statement of participants’ rights is as follows:

You are under no obligation to accept this invitation to participate in the research. If you agree to participate, you the right to:

- Withdraw from the study at any time
- Not answer any questions that you do not want to answer
- Ask any questions about the study at any point in time
- Access a summary of the results.

Whether you take part in this study or not will have no bearing on any services you receive or your membership within any bodies within the university, nor will it have any influence on your enrolment or progress in any particular course of study. The information you provide will be held in complete confidence by the researcher and her supervisors, and will be used only for the purposes of this research. If you wish, a summary of the findings of the research can be provided to you. We will send this to you at the conclusion of the project if you request it.

If following this information you are still interested in taking part in this study please contact me to arrange your appointment times. Alternatively, feel free to contact me if you are unsure about your eligibility or if you need more information. If you have any queries or concerns about your rights as a participant in this study, you may wish to contact; Prof Ian Evans, or Dr Ruth Gammon (see contact details below).

Arna Mitchell (researcher)	027 696 6211 (04) 801 5799 ext 62324 arna.mitchell@gmail.com
Prof Ian Evans	(04) 801 5799 ext 62125
Dr Ruth Gammon	(04) 801 5799 ext 62029

“This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 10/59. If you have any concerns about the conduct of this research, please contact Dr Karl Pajo, Chair, Massey University Human Ethics Committee: Southern B, telephone 04 801 5799 x 6929, email humanethicsouthb@massey.ac.nz.”

What will happen to the information you provide?

- This research will ensure strict confidentiality
- If you would like one, the researcher will send you a summary of the project when it is complete.

Thank you very much for your consideration of this project!

Te Kunenga ki Purehuroa

Massey University, School of Psychology – Te Kura Hinengaro Tangata

PO Box 756, Wellington 6140, New Zealand T (04) 4801 5799 F (04) 4801 2692 www.massey.ac.nz

Appendix 6: Consent Form

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The Therapeutic Alliance in Acceptance and Commitment Therapy with Māori Women

PARTICIPANT CONSENT FORM

I have read the information sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time. I also understand that I am free to withdraw from the study at any time.

I agree/do not agree to the therapy sessions being video recorded.

I wish/do not wish to have a copy of the summary of the findings sent to me when the project is finished.

I agree to participate in this study under the conditions set out in the information sheet.

Signature: _____ Date: _____

Full name (printed): _____

Please provide your postal address if you would like to have a summary of the findings or your recordings returned to you.

Postal Address: _____

Alternatively, a summary of the findings can be sent to you via email.

Email: _____

Appendix 7: Whakapapa Sharing Script

The whakapapa information shared by the researcher was encompassed within three categories. Information pertaining to whakapapa, to family back, and to relevant educational background. In order to promote flexibility, the information was not presented in any particular order or with an exact script. Outlined below is the information that was conveyed to each participant in the whakapapa sharing group.

1. Whakapapa

- a. I am of Māori and Scottish descent on my mother's side.
- b. My iwi, Te Atiawa, originally settled in Taranaki and then migrated to Waikawa (in Picton) on the waka Paroa.
- c. Waikawa is my marae.
- d. My father is of Pakeha descent, his parents both have ancestors from England.

2. Family background

- a. My grandfather was raised by his Pakeha mother and step father. He reconnected with his Māori heritage later in life when he returned to our marae and learnt to carve there. This encouraged my mother to reconnect with her Māori heritage also.
- b. I was born in Taupo and grew up between there and Invercargill.
- c. I am the second of five siblings, I have three brothers and one sister.
- d. During my intermediate years I attended Te Kura Kaupapa Māori o Arowhenua in Invercargill and following that I attended a mainstream high school in Taupo.

3. Relevant education background

- a. I completed a Bachelor of Arts, majoring in Psychology and Māori studies at Victoria University
- b. I postgraduate study at Massey University, completing a Bachelor of Arts Honours in Psychology in 2009. I am currently studying to become a clinical psychologist.

Appendix 8: Koha Receipt

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

The Therapeutic Alliance in Acceptance and Commitment Therapy with Māori Women

RECEIPT OF KOHA FORM

I _____ have received a \$150 VISA
Prezzy Card as a koha for participation in this research.

Session dates: _____ and _____

Signed: _____

Date: _____

Researcher Signature: _____