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**Cultural competencies for complex systems (family, school, and community):  
Perspectives on training clinical child psychologists in Aotearoa New Zealand<sup>1</sup>**

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### **Abstract**

Training clinical child psychologists in a bi-cultural country necessitates close attention to the importance of developing cultural competencies. Māori perspectives on children's mental health needs tend to be holistic and to emphasise the role of the extended family. To accommodate the expectations, values, and hegemony of both the indigenous Māori and the numerically dominant European populations requires service providers to acknowledge a broad interpretation of evidence-based clinical practice, as well as a focus on the systemic influences of home, school, and community, for the benefit of all children. In terms of scientific progress much of our future best practice will require a rapprochement between the values and expectations and traditional knowledge of the indigenous culture and the perspectives and empirically-derived insights of psychology as an international discipline. Since both indigenous and locally-derived mainstream practices in New Zealand are easily overshadowed by still more powerful influences from American and European scholarship, our ability to train highly competent clinical child psychologists in Aotearoa New Zealand is going to depend on establishing models of respect and understanding that enhance the best insights from different, yet in the end intertwined, world views.

### **Preamble**

When one of us (IE) first started training as a clinical child psychologist (at the Belmont Hospital Children's Unit, London) we were still in the era of the interdisciplinary team that the great child psychiatrist Leon Eisenberg referred to as the Holy Trinity. The social worker looked after the family and community needs, the psychologist did the psychometric testing, and the psychiatrist (God the Father) made the diagnosis and prescribed medicine. Treatment, such as it was, was really secondary to "services" which occasionally contained useful programmes. To Evans' way of thinking the major change in this type of model came about at exactly the time he started graduate training—the rapid acceptance and subsequent success of behavioural interventions derived from the principles of classical and operant conditioning as well as modelling (imitational learning) and the importance of language and cognition in regulating behaviour. Simple but powerful techniques of behaviour change created a dramatic new role for clinical child psychologists. Active and effective treatments evolved from the experimental study of learning, not from the dominant concepts of psychometric and projective testing or medical and psychoanalytic models of psychopathology.

One of the morals of this early experience, we believe, is that it is important not only to train child clinical psychologists for currently standardised roles in the mental health services, but to train them so that they will be able to develop new and better services and methods for working with children and families. To some extent the current service provisions for children in a country like New Zealand should be considered largely irrelevant to the formulation of training models and the design of educational curricula. However, in any given country, there surely will be social, political, financial, and professional conditions that will shape the opportunities, needs, and priorities for the best trained clinical child psychologist practitioner. In this paper, we identify some of the conditions that seem particularly significant in contemporary New Zealand, and we will focus on those that seem most salient but also relatively unique or novel with respect to international experiences.

## INTRODUCTION

### Brief Historical Background

Before examining in depth the interesting forces that currently do--or should--shape professional practices and training in our country, it is necessary to introduce the social/political context, the basic organisation of services for children, and how training is managed.

*Aotearoa* (“land of the long white cloud”) is the name first given to New Zealand by the original peoples who migrated from central Polynesia in extraordinary canoe voyages during the 14<sup>th</sup> Century (Howe, 2003). These Māori peoples established a distinctive and flourishing culture of complex social organisations and conventions with major strengths in oratory, art, navigation, fishing, and knowledge of natural resources. European contact repeated the typical Pacific pattern, starting with voyages of “discovery” (Abel Tasman, 1642; James Cook, 1769), followed by whalers, missionaries, and eventually large scale colonisation by British settlers in the 1800s. Called “*pākehā*” by Māori, the earliest settlers came predominantly from England, Scotland, and Ireland.

Friction between undisciplined colonial settlers and the indigenous tribes (*iwi*), together with a fear that French influence might be increasing, led the British government (“the Crown”, in the reign of queen Victoria) to develop a treaty with the *tangata whenua* (“people of the land”). After only one day or two days for discussion, the Treaty was signed at Waitangi in 1840 by those tribal chiefs present and later taken around the country to be signed by most of the others. The *Tiriti o Waitangi* was written in Māori and English, with the Māori version (the one understood by the majority of the signatories) now considered the most valid. In three articles the Treaty: (1) recognised the authority of the British Crown; (2) gave Māori people full

sovereign rights over lands and treasured possessions or *taonga*; and (3) conveyed the rights of British citizenship (Orange, 1987). While these are essentially legal and constitutional provisions, the principles of the Treaty are usually represented as partnership, protection, and participation, which can be translated into important parallel professional and service delivery principles, as will be explained presently.

Settlers violated the Treaty from the very start, with illegal land confiscations, deceptive commercial practices, harsh suppression of uprisings, challenges to the authority of the chiefs, and disrespect of traditional healers (Walker, 1990).

Discrimination in many forms, loss of lands and customary means of economic support, prohibitions on the use of the Māori language (*te Reo*), and racist attitudes (including failure to recognise the inherent value of the culture) combined to decimate the Māori population and greatly damaged the social fabric. When a leading contemporary Māori politician, giving an invited key-note address to the annual conference of the New Zealand Psychological Society, described the effects of colonisation on Māori as a “holocaust” creating post-traumatic stress (Turia, 2000), she was vilified in the media but supported by many social scientists.

Although hanging by a thread, Māori culture survived, and numbers increased to approximately 16% overall and 25% of the child population at the present time. *Te reo Māori*—now an official language—is increasingly spoken even among younger people. This renaissance was strongly influenced by the Māori initiative that established Māori language-only preschools: *kōhanga reo* (literally “language nests”). This was followed with Māori immersion schools, *kura kaupapa*, and eventually *wānanga*, tertiary educational institutions. New legislation in the 70ies firmly established the Treaty in law, and a judicial body, the Waitangi Tribunal, started the slow process of redressing historic injustices, partially returning lands to their original

owners and making financial reparations, which although limited have led to flourishing businesses and investment. Today the Treaty is recognised as a founding constitutional document and its principles are embodied in all official government activities. Hence, cultural competence and bi-cultural acknowledgment are now more than simply good professional practice--they are imperatives that demand recognition. This is stated very clearly in the preamble of the recently adopted revised Code of Ethics for Psychologists Working in Aotearoa/New Zealand (2002): “In giving effect to the principles and values of this Code of Ethics there shall be due regard for New Zealand’s cultural diversity and in particular for the provisions of, and the spirit and intent of, the Treaty of Waitangi” (for a discussion, see Nairn, 2007).

### **Formal Services for Children**

Modern New Zealand has a state-funded public health system. Mental health services for children are largely organised around free “child, adolescent, and family” outpatient clinics affiliated with hospitals and conducted by the public health service. There are limited inpatient facilities within each of the major hospitals around the country, with specialised programmes for high-risk adolescents, eating disorders (including obesity), and early onset (first episode) psychosis. Referral to all of these services is from general family medical practitioners (GPs’ visits are free for all children under 6 years of age), but there are relatively strict admission criteria that restrict specialised therapeutic services to a small percentage of those with the most severe needs. Psychologists make up a very small proportion of the total professional workforce

Children who have a history of severe conduct disorder involving criminal offences are assessed and treated by Child, Youth, and Family services (CYFS). CYFS is also the national care and protection agency, so they deal with child physical

and sexual abuse, neglect, foster care, and so forth. CYFS is a social welfare agency that uses a broad model of family preservation and, in cases of criminal behaviour, restorative justice, which was pioneered in this country. The major vehicle for this model is the Family Group Conference, designed as an alternative to court involvement (diversion), holding young people accountable, and involving victims, families and young people in decision making (Coombes & Te Hiwi, 2007). Serious or repeat criminal offenders, or the needs of older children and adolescents for incarceration, are managed in specialised Youth Units attached to the major prisons. Psychological services in these cases are provided by Psychological Service, a division of the state's Department of Corrections.

Children and adolescents who have experienced physical or sexual abuse are able to access free counselling services through the public accident insurance agency, Accident Compensation Corporation (ACC). Given that a wide range of professional practitioners are eligible for reimbursement for treatment provided, the ACC recently commissioned evidence-based practice guidelines (Woolley et al., 2008; all four authors of this paper were members of the team that developed these guidelines).

Regional hospitals also conduct Child Development Clinics for the assessment and management of infants, toddlers, and young children with known or suspected birth defects and developmental disabilities. Early intervention services for children with developmental needs are provided by Group Special Education (GSE), a division of the Ministry of Education. GSE also provides all school-based services as well as family interventions. Its psychologists are largely educational psychologists (equivalent to school psychologists in the USA), but some are clinically trained as well. GSE psychologists' services are restricted to children with more intensive needs who must meet stringent referral criteria; children with less severe behavioural or

learning difficulties are served by special education personnel supported by consultant teacher specialists (Resource Teachers of Learning and Behaviour).

At least four different government ministries are involved in the services described: Health for mental health, Education for school and special education services, Social Welfare for care and protection, and Corrections for severe juvenile justice needs. Thus, there have been various efforts to synchronise services more effectively. The High and Complex Needs initiative, for example, coordinates communication and inter-sectoral cooperation for cases requiring the involvement of at least two agencies, such as, for example, a child with Asperger's syndrome who has been physically abused, has a chronic medical condition, is failing academically, and aggressive towards peers at school.

Within all these major service agencies there are in-house or regional cultural advisors offering specialised services with links to iwi and urban Māori advisors. Where no Māori-conducted programmes exist, Pākehā psychologists, including practicum students and interns, can almost always access consultation from an experienced cultural advisor. Trainees need to learn how to make proper use of this opportunity as a formal and integral part of assessment and treatment planning--not as an afterthought or as a token gesture.

### **Professional and Educational (Training) Structures**

Clinical psychology emerged as a graduate specialisation in New Zealand universities in the early 1950s, strongly influenced by the Maudsley Hospital (University of London) training model of M. B. Shapiro and H. J. Eysenck (Evans, 1999; Evans & Fitzgerald, 2007). Following the original British model of the time, clinical psychology training in New Zealand was customarily at Master's degree level. Trainees complete a 3-year Bachelor's degree with a major in Psychology and

are then admitted to post-graduate training. For a long time this has consisted of course work in the first year (Honours), which might include formal courses on child development and child psychopathology, but not inevitably. During this year there will be a few practicum placements, and this is then followed by a year of thesis research accompanied by more intensive practicum training resulting in the award of a Master's degree, followed by a year of full-time supervised internship culminating in an intensive final examination and the resultant award of a Post-Graduate Diploma in Clinical Psychology. Successful completion of these three years of practical and academic training results in immediate eligibility for registration (licensing) as a psychologist under the Clinical scope of practice. Many students will go further in their education and complete a PhD; however, again following the European/British tradition, that PhD is purely a research degree with no "taught" components (required course work).

Despite being fully under the aegis of university departments of psychology, training has tended to be non-specialised. An exception to this is the newly established Child and Family Psychology Programme at the University of Canterbury (see France, Annan, Tarren-Sweeney, & Butler, 2007). None of the longer-established clinical training programmes have specialty child clinical tracks and the amount of clinical experience with young people actually gained will depend to a large measure on the type of internship the student selects or is assigned. Despite New Zealand having conducted two of the best known longitudinal studies in child development (the Dunedin and the Christchurch studies), the findings from this work have little influence on trainees intending to pursue clinical child psychology practice.

Recently some university psychology departments have shifted to a 4-year graduate training programme awarding a professional doctorate, called Doctor of

Clinical Psychology (DClinPsych). It is very similar to degrees of the same name in the UK and Australia, and somewhat similar to the PsyD qualification in the USA. The research thesis tends to be slightly smaller in scale than the PhD dissertation and has a more clinical focus. However, regardless of the qualification and the programme details, all training is designed according to the “scientist-practitioner” Boulder model, although it could be argued that the PostGraduate Diploma is not really preparing trainees for future research careers (Evans & Fitzgerald, 2007). Those who intend to pursue that option must fit a conventional PhD somewhere into the mix. Similarly, it can be argued that the DClinPsych, like the PsyD in the USA, is really more focused on producing scholar-practitioners, in accordance with the ideas expressed at the Vail Conference regarding professional practice.

## **HOW GOOD IS THE EVIDENCE?**

### **Culture and Research**

To be true to the stark judgment of science, this question might better be posed as “How good are the outcomes?” Will drawing on the accepted international standards of evidence in clinical child psychology result in better outcomes for all young people in New Zealand? The fundamental dilemmas for any Boulder-model training programme is always going to be the quality and relevance of the evidence that students are expected to draw from, and how applicable generalisations are to individual cases (e.g., Evans, 1996). A yet more basic challenge for evidence-based practice in Aotearoa New Zealand—and, it follows, for training future clinicians—is that a great deal of the empirical evidence comes to us from overseas, mostly the USA, but also quite strongly from Britain.

Reflect for a moment on the effects of this simple fact. How many trainees or practicing child psychologists in the United States or the UK have been required in their training to read, review, and synthesise research findings from New Zealand? As the answer must essentially be none, it would be salutary for those same individuals to realise--just to pick on American psychologists for the moment—that virtually everything they read and accept as valid comes from American researchers, publishing in American journals, on studies of American populations of children, identified by American-derived diagnostic criteria. As a result it would be very hard to recognise that the evidence they are relying on is entirely bound by context—not universal or absolute.

A not uncommon response for dealing with this from those on the outside is to decry all empirical knowledge and the assumptions of positivist science in favour of a post-modernist, social constructionist view of reality. Superficially, this alternative perspective appears to be sympathetic towards the idea that there needs to be much greater recognition given to traditional or indigenous knowledge. And a few Māori scholars have also challenged the universality of science and scientific methods by claiming, for example, that it should be viewed with caution, being associated with colonisation and oppression (Smith, 1999).

### **Science and Treaty Principles of Best Practice**

Clinical trainees in New Zealand are urged to base their work on the literature, raising two fundamental questions. Is the literature from elsewhere up to the task? And how exactly should the literature be applied in the absence of assurances that the conditions or the manner of service delivery is appropriate for the clients being served?

Regarding the second question, it is generally accepted that empirically validated treatment protocols must be delivered in a sensitive and flexible fashion, with the relationship between therapist and client of considerable importance for success. What is somewhat less recognised, and more likely to be uncritically assumed and taken as a “given”, is that the service delivery context must also be conducive to client wellbeing and progress.

Some of the relevant variables are quite simple. For example, are clients attracted to the service in the first place—is the setting conducive to attendance? Under the Treaty principle of partnership (good government by the Crown) government departments and those of us working in them are obligated to provide services that meet Māori needs. What sorts of settings are children and their families likely to find comfortable, convenient, and welcoming? We already design child-friendly clinical settings with suitable pictures and toys, and we recognise the need for accessibility to public transport and flexible clinic hours when children must be brought by working mothers. So the general idea of being culturally welcoming cannot really be too unusual. A second crucial variable is retention. It is all very well to get families to come to the clinic, but will they come a second time? Again this widely recognised challenge is not unique to our cultural context. What aspects of an initial professional contact convince a child and his or her parents that treatment is for them, something they need and want, that their concerns have been listened to, and that an experience with this particular clinician will be safe as well as valuable?

A somewhat similar set of variables relates to the acceptability of the assessment strategy and conclusions as presented to the client, and then the acceptability of the treatment outlined. Acceptability of treatments has been much more thoroughly explored in the research literature, largely because acceptability was

introduced as a component of social validity by Wolf (1978). Acceptability was further emphasised when particularly intrusive intervention techniques were advocated by behaviour analysts (Kazdin, 1980). Acceptability of assessment methods and conclusions has not received much attention, but it is in the cultural context that the issue becomes particularly critical. For example it was the use of standardised intelligence tests with minority groups in the USA, such as African-American and Latino children, that led to major restrictions on their use in states like California (see Evans, 1991). One could generalise and argue that standardised psychometric tests have never been looked on with much favour by indigenous peoples and by minorities who are well aware that the results of such testing invariably favours the dominant white cultural group (Flynn, 2007).

In New Zealand, Māori professionals have also been vocal in challenging and criticising over-reliance on psychometric tests. Sometimes this is stated on grounds of the standardisation process and available norms, sometimes on the grounds that a culture which is predominantly oral and prefers face-to-face interactions will not find paper-and-pencil instruments conducive. However, Māori mental health researchers have developed written questionnaires and surveys, once again demonstrating that how test instruments and other clinical tools are used, by whom, and for whose benefit, may be the more salient issues. Thinking about how a functional analysis might overcome some of these issues, Evans and Paewai (1999) suggested strategies for re-interpreting psychometric standards such as reliability and validity in terms of cultural acceptance.

Generally there is an onus on professional psychologists to ensure that the circumstances surrounding treatment practices are beneficial to Māori, but in the process this provides a valuable lesson for all trainees. Should not every client have

the benefit of services that are sensitive to their needs and values? The Treaty also guaranteed Māori the rights of all British citizens, now, of course the rights of all New Zealand citizens. So for those individuals who wish for the same sorts of services as any other client, the usual range of patient rights and service responsibilities must also be in place; services should not discriminate against any cultural group.

Under the Treaty principle of sovereignty, there is a third need, that of protection (of possessions and traditional treasures): to encourage Māori-managed and Māori-delivered services. Since these services will be for Māori and by Māori, the role of non-Māori professionals shifts to ensuring that they are not placing barriers in the way of such developments and are supportive of them if and when invited. Even where fully Māori services are available, mainstream professional clinicians cannot abrogate their responsibility to ensure that other services are both suitably modified and suitably accepting.

These requirements do raise questions regarding the responsibility of trainee clinicians, who cannot be expected to be too concerned about service or programme design. However it is in the training programmes that certain values, skills, and understandings are instilled. Programmes need to ensure that Māori students feel as safe and supported as their non-Māori counterparts. Non-Māori students should be taught some of the essential elements of Māori protocol necessary for them to function in ways that make Māori clients feel comfortable and welcomed. The latter might include such basic skills as being able to understand protocols when welcomed on to a *marae*, introduce themselves briefly in te reo Māori, begin a session with a *karakia* (prayer) if requested, and sing appropriate *waiata* (hymn or song) at formal occasions. Even more important is the need, early in their careers, for trainees to understand how cultural consultants work and to begin to establish networks and

relationships with cultural advisors on whose wisdom and knowledge they can draw. True partnerships do not involve consultation and discussion as an afterthought, but prior to and as part of planning and decision making.

Will these various elements and levels of cultural adaptation make a difference to outcomes? There is evidence that programmes failing to acknowledge culture are simply not effective. They have low participation rates, low retention even if participation is initiated, and low acceptability of the therapeutic activities. These realities are reflected mostly in statistics regarding outcomes, which on the whole are more negative for Māori (Durie, 1999). More direct evidence, however, is needed of the benefits of culturally sensitive programmes. One excellent example is a comparison of two very similar CBT-oriented treatment programmes for child sex offender in different prisons in New Zealand: the programme that explicitly introduced culturally relevant elements had better outcomes. There is urgent need for more studies such as this to convince sceptics and inform training and practice. We know of no comparative evidence for programmes involving child clients.

There is one final issue that must be recognised, and that is the manner in which research is conducted. As explained, our clinical child psychology training is supposed—as elsewhere in the world—to be evidence based. One of our leading child mental health programmes, located in a medical school, recently published a review of “evidence-based age appropriate interventions” (Dunnachie, 2007) to guide practitioners. But there is a need for a more expansive view of knowledge. As Macfarlane (2008) has written:

“A counter narrative proposes that the word ‘evidence’ means different things to different people; that one’s culture, worldview and experiences all play a significant part in determining how particular groups interpret and rationalise details around assessment, analysis and programme planning. It is argued that conventional streams of knowledge, while having immense merit, might be strengthened if the concepts of *tika* (the protocol of research), *pono* (the

validation of cultural expertise) and *manaaki tangata* (humanitarianism) were to be offered authentic locations in the schema. What constitutes evidence – and who decides? Are particular forms of evidence accorded more privilege?...[I] argue for a balanced integration between the conventional and indigenous knowledge systems in a counter-narrative pursuit of a more solid foundation for wellbeing.”

As will be mentioned later, Herbert (2001) has provided a detailed example of a research style or *tika* that incorporated these values. But the basic issue is simple: will a well-established, empirically validated parenting programme, such as Triple P (Sanders, 1999) work with parents and families who have lost their sense of cultural identity or trust in service providers? Empirically validate programmes cannot possibly “work” if the intended clients never receive them or escape from them after initial exposure.

### **THE HOLISTIC TRADITION AND THE RECOGNITION OF SYSTEMIC INFLUENCES**

Many of the challenges to current American or European assumptions and practices concerning clinical psychological services to children are, of course, neither new nor unique to indigenous cultures in New Zealand or elsewhere. Consider the dissatisfaction with the medically-oriented diagnostic nosology in widespread use; three examples come immediately to mind. An early powerful critique of labelling children was made by Nicholas Hobbs in 1975. Skinnerian behaviourists have repeatedly emphasised that the form of an undesirable behaviour is not a suitable way of defining its function, or its harm to the perpetrator of the behaviour or his/her social environment. The American Association on Mental Retardation has redefined levels of mental retardation in terms not of the child’s deficits, but of the supports that a child would need in order to function in everyday society.

### **Alternatives to the Medical Model**

For twenty years or more, beginning in about 1968, behavioural assessment was considered the essence of good clinical practice, in terms of defining target behaviours for treatment (not symptoms), understanding how inappropriate or undesirable behaviours were inter-related rather than simply being separate symptoms of a given syndrome, developing new rules (social validity criteria) for deciding when improvement had taken place, and recognising that mental health in children was more than simply the absence of symptoms (Evans & Nelson, 1986). However behavioural assessment has declined as a rigorous professional standard: the major journal by that name ceased publication, and possibly in response to requirements from American funding agencies (such as the NIMH), US clinical researchers are once again focused on the valid treatment for a given syndrome. Since our funding for treatment research is not bound by such criteria, New Zealand psychologists should have been able to promote a more behaviourally-oriented model, recognising children in context and analysing the function of their behaviours rather than the fit with DSM-IV criteria. Yet the power of professional imperialism is not to be underestimated. The textbooks that teach our students the principles of abnormal child behaviour are largely from the USA or the UK, and are, in the main, medical-model, syndrome oriented. Our child mental health services have adopted the DSM model, or occasionally the ICD-10, as the means of collecting information, reporting incidence figures, or determining eligibility for services. Even good CBT-oriented treatment manuals for childhood disorders are organised around specific syndromes.

## Māori Values

All of this, of course, is entirely our own fault. If we uncritically adopt the wisdom of American textbooks, research findings, and visiting workshop presenters, it is entirely our responsibility. If we fail to reflect on and incorporate insights gained from indigenous people, then mainstream child clinical psychology in Aotearoa New Zealand will simply stay a vapid imitation of ideas from elsewhere. What might we, or have we, learned from Māori ideas and practices? Although clearly an oversimplification, there are basically three principles that are prominent in Māori culture which are especially relevant to training and practice in clinical child psychology (Herbert, 2001).

**Whanaungatanga.** This refers to family connections. *Whānau* means something like “extended family,” but in the more collectivist Māori culture it represents much more than simply one’s remote relatives (Metge, 1995). *Whānau* implies a social support structure in which parenting roles are often blurred between biological parents and other members of the family, such as aunts or grandparents—it was common practice in the past for grandparents to raise the first-born child, sometimes in quite formal fostering types of arrangements. One of Herbert’s (2001) interviewees stated:

“For three years I stayed at my auntie’s and uncle’s...It was like a long, long weekend. I think I went there to ride the horses and I had kai (food) and slept there...My Mum knew where I was...I liked my uncle’s cooking better than my mother’s...” (p. 50)

**Whakapapa.** One of the key concepts in Māori culture is *whakapapa*, or the genealogical descent of all living things. The meaning of *whakapapa* is “to lay one thing upon another.” Whakapapa provides for a sense of belongingness that brings

comfort: “We feel at home with our own. One’s grief is everybody’s grief” (Herbert, 2001, p. 65). In Herbert’s (2001) marae-based parenting programme mothers would introduce themselves by identifying their tribal connection, the region in the country (their mountain, lake, or river) they came from, and older women living on the marae could then identify families and relatives, reminisce about the young parents’ grandparents, and share other stories of kinship.

*Awhinatanga*. This refers to helping, or more psychologically speaking to support. It implies sharing, not just practical care-giving but also shared joy and pride in family members. As one of Herbert’s family member respondents said “Everyone holds on to the baby. You pick them up” and “Instead of [just] a cup of tea, you get a meal” (p. 64).

### **Holistic Metaphors**

A number of thoughtful, symbolic, and evocative metaphors have been put forward by leading Māori scholars to convey the holistic and broad influences on indigenous perspectives of mental illness. Since the dominant, medical model of psychiatry is not in any case adhered to strongly by clinical psychologists with their more behavioural or cognitive-behavioural orientation, these metaphors have met with widespread approval. Possibly one of the best-known metaphorical models is that of the four structural corners of the traditional meeting house or *whare*. *Te whare tapa whā* refers to a view of causality when considering dysfunctional states such as mental illness or drug addiction. Articulated by psychiatrist and scholar Mason Durie (1998) it uses the four supports as a meaningful symbolic analogue of the four important features of a stable individual—spiritual (*wairua*), familial (*whānau*) physical (*tinana*), and mental (cognition and emotion, *hinengaro*). As a model of mental illness it emphasises the important need to consider more than just biology, but

to see how different elements of influence need to be considered and also translated into supports in any treatment plan.

Another valuable metaphorical concept was introduced by Pere in 1991: *Te Wheke*, the octopus and the eight tentacles that collectively contribute to waiora or total wellbeing. The eight elements Pere identified are spirituality, the mind, physical health, the extended family, life force (*mauri*), unique identity, the “breath of life” from ancestors, and the open expression of emotion (*whatumanawa*).

### **IMPLICATIONS FOR SYSTEMIC INTERVENTIONS: FAMILY, SCHOOL, AND COMMUNITY**

The recognition that children and youth function within systems and systems of influence is not a new one for psychology. With respect to children, the conceptual writings of Urie Bronfenbrenner (1979) had a profound influence on the field with his articulation of intermeshed circles of influence at different levels of directness—micro, meso, exo, and macro. Behaviour modification theory immediately recognised that parents, other family members, and influential people in the community are the ones who have direct influence over children; therefore, they needed to be the agents of change, not the direct intra-psychical sway of the therapist. Tharp and Wetzel’s (1969) *Behavior modification in the natural environment* is one of the earliest books describing the importance of community influences on children. A modern embodiment of these ideas can also be seen in Multisystemic Therapy (MST) which explicitly recognises the need to understand and change family, school, and community influences (Henngler et al., 1998).

**Family/Whānau**

As will be apparent by this time, Māori and perhaps perspectives from other indigenous cultures strongly reinforce the systems perspective, for which the family is the classic exemplar. Even so it takes time for the power of ideas that extend the understanding of family to compete with other important insights. Consider for example, attachment, one of the most important concepts in child development for understanding how mother-child relationship shape personality, emotional needs, and eventually the next generation of mothering. These are valuable insights, but in a society where the infant “belongs” to a larger kin group, secure attachment may not be tied so exclusively to mother (or biological parent).

Another example arises from the predominantly American literature on mentoring, a popular community-level or preventative intervention when family, particularly parental, support is limited for a particular child at risk. Standard mentoring programmes in the USA such as Big Brothers or Big Sisters typically involve a single volunteer adult endowed with socially valued skills and competencies who spends time on a one-to-one basis with a child who has experienced less than optimal parenting. So fundamental is this basic structure to the very definition and criteria of what a mentoring programme is, that it is difficult for those implementing or researching mentoring programmes to imagine that they could function an entirely different way in a different society. There is evidence, however, that Māori families find the idea of an outside mentor supplied by a volunteer agency to be quite foreign. Instead, they look to mentor-rich environments where older and responsible adults from the same *iwi* or local community become more involved with children, not necessarily on a one-to-one basis (Evans, Jory, & Dawson, 2005). The elements of influence would be the same as for a conventional, American type of programme:

opportunities to model, enabling the young person to identify with a larger cohort of adults, direct guidance and chances to learn new skills, engaging the young person in wholesome leisure pursuits, offering motivation to excel and creating a vision of a more hopeful future. However the structure whereby this might be achieved would be more systemic and less based on individual relationships.

Family therapy is another intellectual tradition that has fully considered the way families function dynamically, in fact systemic therapies of all kinds really originated in family therapy (Fitzgerald & Galyer, 2007). Many years of research and practice have given us valuable insights into how all the members of the family influence the overall system. Family therapists are unlikely to isolate the child who is the identified client as the problem. The family becomes the client, and this may be considered the treatment of choice for culturally diverse client groups (Knight & Ridgeway, 2008)

Durie (2003) advocates for a *whānau* based intervention model, called *paiheretia* or relational therapy, within which the *whānau* therapist can engage all relevant family members in a range of culturally compatible interactions with the aim of reducing risk, enhancing known protective factors, and assisting in the acquisition of skills. Clearly this is a concept no different to family therapy, but it emphasises the need to recognise that “normal” family functioning is socially and culturally constructed and evaluated. Therapists must avoid classifying family interaction patterns as pathological simply because they deviate from arbitrary social norms that may be culturally biased (Fitzgerald & Galyer, 2007).

From both an ethical and an outcomes perspective, the international empirical literature and Māori values combine to support the fundamental importance of involving the family (as defined by the clients) in all clinical child mental health

services: “Partnership is achieved when families are included in all aspects of service delivery, including decisions made about the goals and processes of any intervention undertaken with their child and/or themselves” (Fitzgerald & Galyer, 2007, p. 46).

But this still raises the critical issue for the present symposium regarding how best to train clinical child psychologists to achieve that partnership as a matter of routine.

### **Schools**

Schools represent one of the most pervasive systemic influences on children, not only for their academic development but also for their social and emotional development (Harvey & Evans, 2003). At a practical level there is a major need in New Zealand when Māori youth are expelled or suspended from school at three times the rate of non- Māori, and 40% leave school with no qualifications. The range of influences from the school experience on children’s mental health is vast. Among the most obvious are peer relationships, including friendships, pro-social skills such as empathy, cooperation, tolerance, and the opposite extreme, such as bullying and peer rejection. Relationships with teacher are fundamental, as is the child’s relationship with academic work, where histories of success or failure shape self-efficacy beliefs, motivational style, and self concept. Finally there is the influence of the culture of the school as an organisation—does it support engagement or contribute to alienation; does it promote positive emotional development or contribute to hostility and aggression? We will offer some simple examples of programmes designed to change school culture following the bicultural imperative that requires acceptance of the legitimacy of other world views.

Macfarlane (2007) has described how a classroom programme for children described as having behavioural and learning problems incorporated standard knowledge of good classroom management with an enrichment element that

emphasised Māori words, symbols, and values, and a teacher who valued each child and was able to “work the crowd”, ensuring all students were given attention equally and simultaneously. After obtaining extensive narrative accounts of young Māori school-children’s attitudes towards schools and teachers, Bishop and colleagues (2003) developed a large-scale programme to shift attitudes and raise student achievement. This programme is called *Te Kotahitanga* (the word means “unity”) and has been implemented in a large number of New Zealand schools. A fundamental underlying principle has been to avoid deficit theories, and the key intervention strategy is through teacher professional development. The critical ingredients are raising teacher expectations of students and enhancing relationships with students through mutual trust, respect, and concern.

Our own programme, *Te Aniwaniwa*, is somewhat similar in goals but is not directed towards any particular cultural group. It evolved from observations that well-developed behavioural intervention plans designed by psychologists for classroom teachers failed to have any impact on children’s disruptive behaviour unless the teacher was also able to implement a general class atmosphere that fostered positive emotional development and regulation (Harvey & Evans, 2003). From this starting point, based on extensive classroom observation and interviews with children and teachers, we have developed a five-component model of the specific ingredients that make up an emotionally positive classroom environment (Evans, Harvey, Buckley, & Yan, 2008).

We concluded from initial studies that the *emotional relationship* between teacher and pupil is the central concept of emotional climate in the primary (elementary) classroom (Harvey & Evans, 2003). It is the glue that holds other concepts together in one framework, or the hub from which other emotional spokes

can radiate. In our approach, the emotional climate is made up of emotional transactions between teacher and pupil in which the teacher can gauge the feelings of students and respond according to a plan or a principle. To be skilful in such transactions may require *emotional awareness*: being able to differentiate children's emotions and their causes. Teachers must also be able to understand and manage their own emotional reactions to situations. Without being un-genuine, aware teachers manage their own affect in a planful way: they show annoyance if it is warranted and show annoyance in proportion to the provocation, and they express joy and pleasure when genuinely positive events occur and do not exaggerate the positive feeling if that will embarrass the recipient. Notice that this latter example might be rated globally in a climate measure by students on (hypothetical) items such as "our teacher laughs and jokes with us when something funny happens in the classroom" which could be contrasted with a negative climate item such as "our teacher does not seem to take teaching seriously," or "our teacher makes fun of students, laughs at them rather than with them, or seems to think that teasing is funny."

This approach is grounded in the feelings that pupils engender in teachers, but also in the feelings that teachers engender in pupils. Furthermore, students come to school with certain moods and feelings, things happen in classrooms unrelated to the teacher's behaviour that cause children to feel in different ways, and even curricular material can upset, delight, or frustrate children. How the teacher validates and responds to these spontaneously occurring feelings is another major aspect of emotional climate not clearly identified in the classroom climate research. The nearest description of these processes comes from the empirical literature on how parents validate the feelings of their children in everyday situations. A special aspect of such validation is helping the child to deal with a feeling once it is clearly identified and

recognised. In the parenting literature this is called *emotion coaching*, which is considered to be a major element in how children learn to manage or regulate their own emotions (Gottman, Katz, & Hooven, 1997). Parents skilled at emotion coaching show respect for their child's feelings, suggest strategies whereby the child can soothe his or her own emotions, are interested in the child's experiences, and have given some thought and effort to understanding what the child comprehends about emotions. We have observed identical processes and skills being actively exhibited by classroom teachers.

In the parenting literature, particularly in the work of Gottman, Katz, and their colleagues, an important construct has been "parental meta-emotion philosophy (PMEP)," a reference to parents' organised set of feelings and thoughts about their own and their children's emotions. Some parents have a PMEP in which emotions are not considered important, are uncomfortable talking about emotions, and feel that negative emotions must be changed as rapidly as possible. Other parents see a child's negative emotion as an opportunity for intimacy, a chance to validate feelings, and an occasion to talk about their own. Mothers of children with conduct problems are less aware of their own emotions and engage in less coaching of their children's emotions than mothers of children without conduct problems (Katz & Windecker-Nelson, 2004). We have used the label *emotional intrapersonal beliefs* to describe the wide range of ideas about emotions that teachers report comprising their meta-emotion philosophy.

The analogy with parenting is useful in some ways, but of course teachers are not parents. There are limits to emotional intimacy, there is responsibility to not one or two children but to the entire class, and there is the primary task of teaching academic content. And so a final, fifth construct we have proposed relates to

emotional boundaries, avoidance of over-involvement, and having standards needed for boundaries with the group. These include fairness, willingness to set limits, and exercising discipline while refraining from manipulative or underhanded strategies. We have called these *emotional interpersonal guidelines*. Although the effectiveness of this model for training teachers as an intervention for behavioural difficulties is not yet known, we do consider this approach a viable one for improving the ability of clinical child psychologists to work more effectively in classroom and school contexts.

### **Community**

Community systemic influences are often much harder to bring into clinical treatment models, but the influence of neighbourhoods on children's development is a thoroughly researched topic (Leventhal & Brooks-Gunn, 2000; Roosa, Jones, Tein, & Cree, 2003). Trainees are challenged to think of systemic-level community influences including media influences and their effects on children's perceptions of sexualised behaviour, ideal body weights, and societal influences that we understand well with respect to eating disorders and other social problems. By the same token, it is important to recognise that international forces equally "colonise" the youth of New Zealand, whatever their cultural background—in fact such influences can over-ride an ethnic or cultural identity. It could be argued that some of the difficulties faced in providing for contemporary New Zealand youth arise from the overwhelming influence of rap music from America, gangster language and styles from Asia and the USA, or dress code (e.g., baseball caps worn backwards is *de rigueur* for New Zealand youth, though baseball is virtually nonexistent in this country). Graffiti, drag racing, and assorted other anti-social activities come directly from the universal youth cultures of the Internet, film, TV, and music videos.

Whether social dysfunction can be attributed proportionately to these three systems of home, school, and community, the youth of New Zealand present the typical indices of societal problems to a degree generally no worse than other countries in the OECD. While rates for drug and alcohol abuse, school truancy and drop out are slightly lower; teen pregnancy is the second highest, as is child obesity; sexually transmitted diseases and juvenile crime are comparable (UNICEF, 2007). Where New Zealand has particularly disturbing statistics is in the area of youth suicide and in the experience of physical violence, both with respect to domestic violence and bullying at school. We have the worst statistics in the developed world for children under the age of 19 killed in accidents, family violence, murder, and suicide. These are issues that trainees need to take careful heed of. After having one of the very highest rates worldwide, the situation with respect to youth suicide has improved slightly, perhaps due to the implementation of prevention strategies supported by research (Beautrais & Surgenor, 2007). The most controversial aspect of these strategies is a policy in which mention of suicide is discouraged and school based policies refrain from glamorising suicide. However in a mental health context it would be important for trainees to keep the risks of suicide, as well as bullying at school and domestic violence at home, very much in the forefront of their clinical assessment.

Since prevention is obviously an important process, we might expect clinical trainees to be exposed to a variety of community strategies designed to have a broad impact on children and youth. While Australia has implemented population-wide school based programmes to combat depression and anxiety (Barrett, Farrell, Ollendick, & Dadds, 2006; Neil & Christensen, 2007; Spence et al, 2008), there are no similar programmes in New Zealand. One reason for this may be that most

systems-wide programmes, particularly those introduced in the schools, are promoted by government officials who have little understanding of basic psychology and a distinct lack of regard for evidence-based procedures. Programmes in New Zealand are launched on the whim of politicians and agency officials and are typically evaluated too soon after they have been implemented, and then just as hastily abandoned if the evaluation data are not as promising or spectacular as hoped. We can point to a number of such programmes that we have personally been involved in evaluating—one designed to assist young people no longer able to live at home, another designed to prevent juvenile crime, and another designed to inform teachers better about the nature of autistic spectrum disorder. The latter project is still being assessed, but the other two were quietly dropped even though the evaluation did not allow enough time for the programmes to iron out their various difficulties. It is hoped that clinical child psychology trainees will have enough appreciation of the potential as well as the challenges of these community-based efforts to be able to provide better evidence-based guidance to those responsible for their design and implementation.

## **CULTURAL COMPETENCE**

### **General Competencies**

Today, most trainees in clinical psychology programmes in this country would be aware of basic principles for culturally sensitive practice we have been describing--at least at the abstract, cognitive level. But can they turn these concepts into culturally proficient and ethical practice? What sort of training experiences might enhance that process?

The ideas of Stanley Sue (1998) regarding cultural competence have had a significant influence on our clinical training programmes. Sue proposed that there

were certain habits of mind that were critical for working across cultures: some essential knowledge of the beliefs, values, and practices of the cultures the practitioner may be working in; the ability to resist making generalisations about these cultures and assuming that an individual will have culture-specific characteristics; and scientific mindedness, which is the importance of testing hypotheses *and* ideas with clinical evidence. But faced with the enormous challenges of actually being able to work across cultures, is such abstract understanding sufficient?

### **Teaching Cultural Competency in New Zealand**

Certain strategies that have been developed in some training programmes (see, especially, Herbert, 2002) involve very practical procedures such as asking trainees, when working in a given region of the country, to go out and learn about the history of the region. This new social understanding would be focused on prior ownership of the land, the degree to which historic injustices have been addressed, the current conflicts over tribal rights, and which people in the community are the real movers and shakers. With less emphasis in the past on formal academic qualifications as opposed to practical experience, most communities have highly regarded elders with detailed knowledge not only of local custom and history but who also have experience-based wisdom. Simple social behaviourism principles would dictate that in order to marshal the kinds of influences that are likely to change behaviour, it is necessary to determine who in the community actually has the *mana* (power, authority, prestige) to shape others' behaviour.

Another strategy involves trying to link well-respected Māori concepts with their possible equivalents from mainstream psychology. An example of this approach can be found in Evans and Paewai (1999) in which the concept underlying the functional analysis of a behaviour problem was redefined in terms of the social

validity of the assessment findings for a given family or community, and the degree to which one's case formulation of the child's need "rang true" with the people who were going to be asked to implement the intervention.

A further example of translating mainstream (American and British) concepts into those that might be more suitable for a local client population was provided by Herbert (2001) in her implementation of behavioural parent training in a *marae* setting with high risk Māori mothers. In this example, Herbert also demonstrated that there were features of the ethical practice of treatment outcome research that reflected standards and values of the Māori community. For example, she spent considerable time with experienced elders, who, even if not directly involved in the research, needed nevertheless to know what she was planning and to give it some level of approval. As a related example, she argued that research participants, and the communities from which they were drawn, merited some sort of return in the form of a direct benefit.

When minority groups have been subjected in the past to research by mainstream scholars, the outcome has not always been to their advantage. As a result, indigenous peoples and colonised populations have become understandably suspicious of research. Students planning research with children with clinical needs might easily assume that because their intentions are honourable, there is no risk of abuse of the research findings. One way to counter this assumption, now required by most university ethics committees in New Zealand, is to ask whether research that might involve Māori children has been designed in prior conjunction with relevant Māori scholars or community leaders. That is the principle of partnership. If the research does not involve Māori children who might actually benefit, the trainee researcher must explain why not. That is the principles of participation—Māori

children have the right to be included in research, not excluded simply because the consultation required is too onerous. Finally, if the research addresses an issue of fundamental relevance to Māori, should it not be done by Māori clinicians? If the sovereign rights of Māori are being protected, then some research should be done by Māori for Māori, exactly the same way that it is incumbent on the majority professionals, as representative of “the Crown” in the Treaty, to facilitate Māori professional and scientific autonomy where possible.

### **Increasing the Number of Māori Practitioners**

The need to foster Māori-directed practice makes it clear that a fundamental role for the university-based training programmes is to strive to increase the number of Māori professionals. As a Director of Clinical Training in a very white state university in the USA, one of us (IE) was constantly faced with the challenge of recruiting African-American students to clinical training. This requires a host of complex considerations, including supports available to minority students, affirmative action selection criteria that adhere to performance standards, and the atmosphere of the training programme as one that encourages and respects diversity.

Somewhat similar issues confront training programmes in New Zealand, especially with the recent creation of Māori tertiary institutions (*wānanga*) that are very attractive to young Māori students. We have to examine what barriers become obstacles for Māori students (Levy, 2005), and these might include monocultural curricula, the atmosphere of the university programme, the attitudes of the academic faculty and fellow students, the availability of relevant practicum settings, and so on. Many Pākehā academics struggle to improve their bi-cultural competence, but most Māori students are already bi-cultural, very much at home in the Pākehā world while having a strong cultural identity and parallel experience in the Māori world. Because

they can fluidly transition from one to the other, it is easy to forget that many aspects of functioning in the environment of a “mainstream” clinical programme may still be quite uncomfortable for them, even though these students may be skilled in the dominant majority culture.

There is a hint throughout this discussion that educational qualifications will always be controlled by the conventional institutions of the majority population into which Māori students are expected to fit. That, however, does not sound much like an equal partnership. If the “spirit and intent” of the Treaty is being adhered to, it would be equally important to foster the development of kaupapa Māori training programmes, grounded in a Māori worldview and conducted primarily in the wānanga (Milne, 2005).

### **LESSONS FOR THE INTERNATIONAL COMMUNITY OF CLINICAL CHILD PSYCHOLOGY TRAINERS**

We conclude this discussion with suggestions that illustrate how the ideas presented have relevance beyond the immediate practical issue we face of improving child clinical psychology practice and ensuring child psychologists in New Zealand are culturally and professionally proficient. We are fortunate in having the power of the Treaty of Waitangi behind us. It provides a potent moral force that reminds us that biculturalism in practice (and multi-culturalism when looking at child clinical work with other non-Māori cultures), is not just a good thing to aspire to. In Evans’ experience of 25 years of clinical training in the US, there was always recognition that we needed to be more sensitive to “minorities”, to encourage more “minority” professionals to take up clinical psychology training, and to include “minority” populations in research. But at no time was this presented as anything more than

something desirable, something to meet criteria for APA accreditation, or to look good on a research application. This does not mean that valuing culturally-competent practice was not a genuinely held belief by very well-meaning people. But in the end there was no requirement to do so. The Treaty changes that for us and converts the principles of partnership, protection, and participation into ethical and legal requirements.

A second lesson to be learned is that members of a power group do not always recognise when power is being abused. There are no checks and balances in US and UK academic circles that allow trainees to stop and question the generalisability of what is being learned as best practices, or even the absolute truth. Re-examination of international practices, such as is happening in this symposium, is invaluable reflection.

Third, we recognise that the issues raised are not unique to New Zealand or foreign to many in the audience. Māori best practices for professional child clinicians are based on sound principles of knowledge development—trial and error, good observation, careful measurement. The injustices that minority groups and colonised people have experienced undoubtedly colour their perceptions of what is valuable, and the rejection of ideas and principles that appear to be essential components of imperialism is a natural consequence. The social psychological principle of reactance tells us that no-one likes to be dominated by others or have ideas pushed down one's throat—even if they are very good ones—as any adolescent can tell you. However rejection of good ideas from elsewhere is not particularly useful, and one of the tasks of majority psychologists is to be sensitive to this so that good integration of concepts can occur without denigrating the ideas of the minority. Translation of one person's concepts into the vernacular of another is not likely to meet with ready approval.

One of the fundamental challenges facing us, both Pākehā and Māori psychologists, is to be able to draw on the wealth of available knowledge and experience. In this presentation we have tended to emphasise the lessons that can be learned from considering a more holistic worldview where traditional knowledge is respected. At the same time there is a significant challenge for Māori to be able to make full use of international research and understanding accumulated over more than a century of scientific psychological research across the world. There is pressure on all of us to identify that which is relevant or worthwhile. International scholarship is not the enemy of effective services for children.

There are four equally important principles regarding professional intervention programmes that should allow clinical child psychology trainees to make progress towards mutually desired goals (Herbert, 2001). The first of these is the cultural responsiveness of the programme, which really defines when and how an intervention reaches different target groups and how professionals plan for and accommodate different client social expectations. Second, there needs to be recognition that even the most rigorous science incorporates values-based assumptions; for child clinicians in this country there are existing and relevant concepts or values regarding child and whānau functioning in the Māori community. Third it is important to teach trainees our best possible understanding of principles of learning and child development drawn from the ever-evolving mainstream empirical literature. Finally it is essential to understand the subtleties of client receptiveness to treatment. What do children, parents and the extended families perceive as appropriate help and from whom? Do they enjoy and value a programme, and has it met their goals regardless of professional definitions of a good outcome?

In the end, therefore, we think that there are sound ideas that can be utilised across the spectrum of clinical child psychology. Holistic principles are valuable, and trainees who can place a child client in context will do better than those who seek simply the best diagnostic label. Family--nuclear or extended--is of fundamental importance to children's well-being. Children go to school where both their peers and their teachers are of profound influence, not just for academic development, but for emotional development as well. Trainees who can draw on the very best and most rigorous research findings, but not be rigidly bound by them, will be able to take advantage of the best ideas culled from many smart people. All of these standards will improve practice, to the benefit of children.

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