

Kei te whetewhete mai ki ngā matua
Parent Whispering

PCIT -The art of empowering

parents to change to improve tamariki behaviour.

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*A thesis submitted in complete fulfilment of the requirements for the degree of Doctor
of Philosophy, The University of Auckland, 2020.*

Karakia

Kia tau te rangimarie (May peace prevail)

Aio ki te Aorangi

Peace to the universe

Aroha ki te aorangi

Love to the universe

Koa ki te aorangi

Joy to the universe

Pono ki te aorangi

Truth to the universe

Kia tau te kahukura

May the violet flame

Te wairua kore here

the spirit of freedom

te kawē i te tika

that upholds justice

me te pono

and truth, prevail

Na Rangimarie Rose Turuki Pere

Abstract

Research has shown that significant behavioural problems in early childhood that are left untreated are linked to conduct disorder, and a range of poor outcomes later in life including academic, social, emotional and employment problems. In New Zealand, Māori are diagnosed with conduct disorders at almost twice the rate of non-Māori. However there are gaps in our current understanding of how best to support Māori who have tamariki with conduct problems and there are currently no kaupapa Māori interventions. One effective programme (Parent-Child Interaction Therapy, PCIT) was developed and tested in the USA. It has not been tested by and for Māori.

To address these gaps in our understanding and develop effective treatment for Māori, this doctoral research used a mixed methods approach. This consisted of a pre-post trial of PCIT-Māori that was conducted across two tertiary services (a residential parenting service and an infant mental health service) to see if it improved tamariki and parenting behaviour. A qualitative study followed and investigated the acceptability of PCIT-Māori.

Participants in the pre-post study were 24 Māori parents ($n=24$; aged 22-50, 96% wahine) and their tamariki ($n=24$; aged 2-6; 54% kotiro), with severe behaviour problems (92%) and history of abuse (83%). Parents had multiple and significant challenges (83% lived in areas with a social deprivation index of 10; 60% had no school qualifications; 83% reported mental health problems; 100% had a mean yearly income below \$31,000).

Results from the pre-post test, showed whānau could be retained in therapy (88%) and that tamariki behaviour significantly improved on the ECBI-I ($t(23) = 10.45$, $p < 0.001$) with a large effect size ($d = 2.63$), maintained at 4-month follow-up. Secondary outcomes indicated high treatment satisfaction on the TAI (49 out of 50), significant improvement on the Hua Oranga-Child ($t(23) = 8.30$, $p < 0.001$) and Hua Oranga-Parent ($t(23) = 8.95$, $p < 0.001$), both showing a large pre- to post- overall effect size ($d = -1.82$).

Results from the qualitative study indicated that PCIT-Māori was acceptable to Māori parents and that this approach facilitated a useful therapeutic journey from hopelessness pre-treatment to hopefulness post-treatment.

The current study led to three important outcomes. Firstly, a “by and for Māori” approach can lead to excellent engagement and good outcomes for whānau who have major challenges and are typically hard to engage, in evidence-based interventions. Secondly, programmes that are culturally tailored (PCIT-Māori) are successful and welcomed by Māori parents. Thirdly, adapting evidence-based programmes from non-indigenous frameworks is a useful step and providing indigenous programmes are also important so that whānau who have challenges also have choice in the types of parenting support programmes they would like to engage in.

Sensitivity Warning: First Nations peoples and Aboriginal peoples should be aware that this thesis may contain names of people who have since passed away.

Acknowledgements

To my whānau who have supported me through this journey. To my mum Beatrice and my brother Kelvin, thank you for supporting my passion and helping keep us close together not further apart. To my tamariki Matt, Nathan, Ali and Natalia who saw me constantly on my laptop but forgave me and encouraged me to keep going, even when we were devastated by the loss of the two Mikes in our lives.

To the beautiful whānau Māori who consented to being involved in these studies, I owe you so much, and acknowledge how amazing you were to have made this intervention work for your whānau. I hope I have been able to represent your strength and desire to do the absolutely best for your tamariki in this thesis. I also hope that it might go on to help others in the future. To Danielle Bell, who journeyed with me as a therapist on this project, thank you so much, this is a tribute to the work we did together at Whakatapu Ora, for our people.

To my supervisors Professor Trecia Wouldes and Professor Sally Merry many thanks for being so understanding and supportive of this piece of work which took longer than we all wanted. Thanks also for acknowledging and supporting the importance of Māori *kawa* in my work.

To my tauwiwi family Professor Cheryl McNeil, West Virginia University (my PCIT mentor) and Professor Beth Troutman, University of Iowa (my attachment mentor) for helping me to fall in love with this intervention and allowing me to visit every year, so that we could be inspired together. Special thanks to my soul sister Associate Professor Sarah Hetrick, for the book clubs, for reading drafts and taking care of me over the last few months, your friendship and mentorship has been an absolute blessing. Blessing's also to Andrew McGregor who came into my life at exactly the right time. I credit you with being able to project manage me so that this finally got completed. Your kindness, encouragement and love have meant so much to me.

To my He Paiaka Tōtara whānau, as Māori clinical psychologists we all know how fortunate we are to do this mahi, you kept me grounded in our kaupapa, and every day I feel the aroha we have for the whānau we support. Thanks so much Ainsleigh Cribb-Sua, Hilda Hemopo, Sharon Rickard and Waikaremoana Waitoki.

Finally to my Kaumatua, Rawiri Wharemate, and his whānau, for sharing him with me. You have always been my cultural and spiritual mentor. Thank you for your patience and perseverance and unquestionable aroha. You will always be such an important part of life matua. Tēnā koe matua mō tō korowai manaaki ki ahau, moe mai rā I te Rangatira.

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Chapter 1: Introduction

“Nā te moa I takahi te rātā.”

“The young rata trodden on by a moa, will never grow straight.”

(Brougham, Reed, & Kāretu, 1987)

1.1 The Importance of Parents

Having spent the last 10 years of my life working as a Māori clinical psychologist in an infant mental health service within my community, I know how important Māori parents¹ are in the lives of their very young tamariki. The Māori proverb “*Nā te moa i takahi te rātā*” [the young rata, trodden on by a moa, will never grow straight], serves as a reminder to whānau, that parenting when tamariki are very young is extremely important and that the quality of this parenting has long lasting consequences. When parenting is warm, loving and responsive, our tamariki thrive and have the opportunities to realise their full potential. However, there is overwhelming evidence that when parenting is poor, it can have a deleterious impact on child developmental outcomes, which can have far-reaching consequences (Ranson & Urichuk, 2008; Ruiz-Casares, Drummond, Beeman, & Lach, 2017; Ryan, O'Farrelly, & Ramchandani, 2017; Sameroff, 2010; Shonkoff & Phillips, 2000).

There is now a wealth of evidence which documents that poor parenting is amenable to intervention, especially when intervention occurs early in the child's life (Bonin, Stevens, Beecham, Byford, & Parsonage, 2011; Edwards, Ceilleachair, Bywater, Hughes, & Hutchings, 2007; Gardner et al., 2019; Keown, Sanders, Franke, & Shepherd, 2018). There have been systematic reviews conducted on the types of positive parenting practices that have been shown to be effective in improving child behaviour and hence the outcomes for children (Barlow & Coren, 2018; Knerr, Gardner, & Cluver, 2013; van Aar, Leijten, Orobio de Castro, & Overbeek,

¹ Parent is a general term used for primary caregiver of a child.

2017; Vlahovicova, Melendez-Torres, Leijten, Knerr, & Gardner, 2017). There have been systematic reviews looking at established evidence-based parenting programmes such as Incredible Years (Menting, de Castro, & Matthys, 2013), Triple P (De Graaf, Speetjens, Smit, de Wolff, & Tavecchio, 2008), and Parent-Child Interaction Therapy (Cooley, Veldorale-Griffin, Petren, & Mullis, 2014). These parenting programmes are available to help parents who want to make positive changes in their relationships with their children. Many of these parenting programmes focus on parent-child interactions as the mechanism to improve child behaviour (Barlow & Coren, 2018).

1.2 The Importance of Attachment

John Bowlby (Bowlby, 1969) drew our attention to the importance of the mother-child relationship and the severe consequences that could result from the disruption to this early relationship and perceived loss by the child. His work in orphanages and pediatric wards led him to observe and describe the process that happens for an infant in the wake of parental loss (Dignam, Parry, & Berk, 2019). He also showed that in orphanages where the staff were warmer and more maternal with their infants that there were fewer deaths and infants survived the ordeal much better. Supporting the idea that humans are a very socially oriented species and that the formation of and maintenance of relationship is crucial for young children.

Bowlby postulated that the attachment system, which provides a secure base to the infant, is supported not only by the caregiver's physical presence but also by their emotional presence. He showed that young children seek out the comfort of their parent when they are frightened, worried, or vulnerable. Later others reported that infants possess an innate, evolutionary-shaped propensity to become attached to caregivers, regardless of their specific cultural niche or biological sex (Mesman et al., 2009; Mesman, Van IJzendoorn, Sagi-Schwartz, & applications, 2016; van IJzendoorn & Sagi, 2001).

Attachment was defined as an emotional bond that emerged during the first year of life in repetitive interactional situations between an infant and an adult caregiver (often the mother). The emotional bond was said to result in the feeling of security or trust that an infant develops in him/herself. A secure relationship was expressed by the child seeking proximity to the attachment adult when the child feels stress or anxious. An insecure relationship is expressed either by avoidance or by a conflict between approach to and avoidance of the attachment figure in stressful or anxious situations (Ainsworth, Blehar, & Waters, 1978). Later Mary Main added a fourth category of disorganized attachment when child reacts bizarrely by freezing or displaying confusion (Main & Solomon, 1990).

Put simply, children's relationships with an attachment figure forms the basis for an "internal working model" of relationship, which becomes the way in which they interact socially as an infant, but also it sets the foundation for future peer relationships (Moran, Forbes, Evans, Tarabulsy, & Madigan, 2008).

There have also been studies looking at the relationship between the type of attachment strategy of the child compared with that of their mother (Haltigan et al., 2019). However the mechanism for this cross generational transmission is still unclear and because of this the debate related to attachment in general continues.

For example, there is increasing concern that attachment theory has predominantly been based on literature and evidence generated from western, educated industrialised, rich and democratic countries (Keller et al., 2018; Morelli et al., 2017; van IJzendoorn & Sagi, 2001; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999) and therefore has failed to consider the important role culture has to play in parent child relationships. This calls into question the claims of universality (Keller, 2018; Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000). Certainly there is evidence to show that attachment behaviours differ in other cultures

(van IJzendoorn & Sagi, 2001). Keller and colleagues (2013) have questioned this idea of universality because in many cultures, children are cared for by multiple adults (Keller, 2013). Therefore the need for culturally responsive theories of attachment to be developed (Mikahere-Hall, 2020).

1.3 The Importance of Parent-Child Interactions

Social interactional theories link the quality of parent-child interactions during early childhood with children's social relationships and behavioural adjustments in middle childhood and adolescence (Shaw, Owens, Vondra, Keenan, & Winslow, 1996) and into adulthood (Law, Plunkett, Taylor, & Gunning, 2009). Put simply, children learn strategies for interacting with others from the interactions they have had with their parents. As a result, negative parent-child interactions are likely to lead to similar negative interaction patterns with a range of significant others, including peers and teachers. Research has shown that these relationships can be repaired using evidence-based parenting interventions (O'Connor, Matias, Futh, Tantam, & Scott, 2013; O'Connor & Zeanah, 2003).

Toddlerhood or infancy (1-3 years of age) is a particularly vulnerable period for parent-child interactions and behavioural problems. This period is marked by rapid physical, cognitive, and emotional developmental processes occurring within infants, including notable changes in mobility and independence. These processes necessitate a more active and responsive parenting style (Bridgett et al., 2009; Lorber & Egeland, 2011). Toddlerhood is also a period when severe behavioural problems (e.g., wilful noncompliance, aggression, tantrums) and problems of parenting (e.g., harsh, neglectful, abusive or coercive parenting practices) may first become apparent and require additional specialist support or intervention (Mesman et al., 2009). If left untreated, serious disruptive behaviour in toddlers can lead to delinquent behaviours in later childhood and adolescence (Barlow & Coren, 2018).

Parent-child interactions, characterised by intense hostility and negative emotionality, promote coercive interaction cycles through a process of mutual reinforcement (Eddy, Leve, & Fagot, 2001; Patterson, 1982). Scaramella and Leve (2004) proposed an Early Childhood Coercion Model (ECCM) where a parent's behaviour (request for child compliance) inadvertently reinforces difficult child behaviour (resistance); difficult child behaviour (resistance) similarly amplifies parental negativity (parental anger) and a vicious cycle is enacted (parent gets angrier, child gets more resistant) and generates an even more conflictual situation (Scaramella & Leve, 2004).

1.4 Early Behaviour Problems and Conduct Disorder

There is substantial New Zealand and international research which shows that young people with conduct problems are at increased risk for a wide range of adverse outcomes in adolescence and young adulthood including crime, substance abuse, mental health problems, reduced life expectancy, domestic violence, poor educational achievement, unemployment, welfare dependency, and conflict with parents and teachers (Boden, Fergusson, & Horwood, 2010; Fergusson, Boden, & Hayne, 2011). These problems not only impact the child but also their parents and society as a whole. In New Zealand, prevalence rates for conduct disorder are estimated to be between 5-10 percent of children, and the intensity of problems appears to be increasing (Boden et al., 2010; Church, 2003). However, for Māori the prevalence rate is estimated to be at least double that of non-Māori which has significant consequences for whānau Māori (Boden, Sanders, Munford, & Liebenberg, 2018).

Fergusson and colleagues (2011) recommended that the government make substantial investments in the prevention, treatment, and management of conduct problems (Fergusson et al., 2011). Later in 2013, the Advisory Group of Conduct Problems (2013) underscored the need to invest in early evidence-based interventions. The focus was placed on young children, since interventions to reduce the population prevalence of conduct problems are more effective

and more economically viable when delivered to children early in their development (Edwards et al., 2007; Fergusson & Boden, 2010; Gluckman, 2018; Heckman, 2006; Hutchings et al., 2007).

With one in four children in New Zealand being Māori (Statistics New Zealand, 2013) and with the importance of early relationships between parent and child well documented (Sameroff, 2010; Shonkoff & Phillips, 2000), parenting of young tamariki is an important issue for whānau Māori. Supporting parenting through evidence-based interventions may be an effective and efficient way to support the well-being of tamariki.

1.5 Evidence-Based Parenting Interventions Available In New Zealand

Having worked for over 20 years within our Māori communities, with whānau Māori who were struggling with mental health issues in the context of extremely challenging socio-economic environments, I have been searching for evidence-based interventions which support Māori parents with their young tamariki. In addition, I wanted to be able to help whānau implement change as quickly as possible.

The New Zealand government set up an Advisory Group to investigate effective programmes for treating and preventing conduct disorder. The Advisory Group produced a report noting three levels of programmes: Universal, Targeted, and Intensive. The Intensive programmes were identified for severe behavioural problems. The report listed four programmes based on the available evidence: The Incredible Years Advanced Programme, Triple P, Multidimensional Treatment Foster Care (Oregon type), and Parent-Child Interaction Therapy (PCIT) (Blisset et al., 2009).

The New Zealand government's review of the empirical, parent-training literature did not identify any kaupapa Māori parenting programmes which have had effectiveness trials completed (Durie, 2005a; Mead & Mead, 2003). Instead, Māori practitioners, who have been trained in Western evidence-based parenting programmes (e.g., Incredible Years, Triple P,

Mellow Parenting, PCIT), have discussed making the programmes more culturally responsive (Cargo, 2008a, 2008b; Herewini, 2014; Keown et al., 2018; Morawska et al., 2012; Penehira & Doherty, 2013). Having been trained in all of the above interventions, I felt that interventions involving both parents and their children working together and using “live” methods might be better suited to the whānau that I worked with, because of the practical component and the ability to work as a whānau rather than as an individual.

PCIT was the intervention which more closely represented the type of support I believed would align with some of our cultural values of whānaungatanga [family connection and kinship], manaakitanga [support and respect] and kaitiakitanga [guardianship]. I had also seen a case where PCIT was used with African-American parent and her son and I wondered whether PCIT might have something to offer Māori whānau here in Aotearoa.

PCIT is a short-term, familial-behavioural intervention that usually requires approximately 14-16 sessions. Progression through treatment (from phase one to phase two) is based on skill mastery assessed via a standardised coding system; therefore, the exact length of therapy varies according to parental skill, relationship improvement, and positive changes in the child’s behaviour. PCIT is concluded when the parent masters both the Child Directed Interaction (phase one) and the Parent Directed Interaction (phase two) skills. In addition, the child’s behaviour must improve to well below the non-clinical threshold. Finally, parents need to report that they feel confident to conduct the techniques independently of the therapist for successful completion of PCIT.

I believed that a live coaching model like PCIT would be a good fit for Māori parents who have traditionally learnt about parenting via the *tuakana-teina* [older sibling-young sibling] mentoring model (Callaghan et al., 2018).

Given the research demonstrating higher rates for family violence and trauma for Māori compared to non-Māori the intervention needed to be one that had proven effectiveness with

high-risk, vulnerable families with histories of child maltreatment, intimate partner violence, and trauma. PCIT met these criteria, it had research demonstrating it could reduce family violence and could be adapted to provide evidence-based treatment to address childhood trauma (Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011; Chaffin et al., 2004; Hakman, Chaffin, Funderburk, & Silovsky, 2009a).

As discussed earlier, an active, experiential parent training approach (i.e., one that involved more than just talking in a group) might be more appealing for whānau who identified with a Māori model of learning. Nathan and McMurchy-Pilkington (1997) stated that the preferred learning styles of the Maori women interviewed in their study were visual and hands-on. Many of them preferred activities that involved manipulating equipment and the use of games, describing them as interesting and fun (Nathan & McMurchy-Pilkington, 1997). In addition the use of a coaching mentor, may also fit with how the tuakana-teina teaching relationship works in parenting (Glasgow & Rameka, 2017). PCIT qualified as an active intervention in that it focuses on coaching parents in real time as they play with their young children.

I also had some reservations about the intervention. There were two main concerns. Firstly, this therapy is based on American family values. As an indigenous clinician, I was concerned that I might be helping to propagate the stereotypical view that western knowledge is privileged over indigenous knowledge (L. T. Smith, 2013). In particular, I was worried that the fundamental “PRIDE” (i.e., praise, reflect, imitate, describe, and enjoy) skills of PCIT (Funderburk & Eyberg, 2011) may not align with Māori parenting values. Secondly, I was concerned that the focus of therapy is on one parent with one child. This was concerning because Māori families in New Zealand are more likely than non-Māori to have more children in their family group. Statistics New Zealand reported in 2015 that total fertility rate was 2.5 for Māori women, compared with 1.9 for non-Māori women (Statistics New Zealand, 2015). I

was worried about the utility of PCIT with the target population of Māori families who are often in multi-adult homes and parenting multiple children.

Despite some cultural concerns, the overall strengths of the PCIT and what I had observed, interested me and I wanted to investigate whether this American parenting therapy would work for whānau Māori managing multi-challenging environments and parenting young tamariki. In particular, I was interested in whether PCIT would prove effective with a population of Māori parents from the most challenging backgrounds and their tamariki, many with serious behavioural problems, who have a relatively poor prognosis with respect to expected social-emotional, mental health, and academic outcomes.

1.6 Current Study

My motivation to carry out this open trial study arose from my experience of working in the Infant Mental Health area with whānau Māori who were struggling with a range of mental health and environmental risk factors. Yet, there were no interventions that had been shown to be effective and engaging for this population. In addition, Māori and the government had become increasingly concerned with trying to provide interventions that were both evidence-based and culturally responsive (Fergusson, Boden, & Horwood, 2006; Keown et al., 2018; Ministry of Health, 2018b; Taonui, 2010).

Therefore, this research is informed by my work as an Infant Mental Health specialist working for a providing assessment and treatment to a ICAMH service and a Residential Parenting service. Both services are located in a low-decile, large urban community where large numbers of whānau Māori reside. I was interested in whether PCIT could work with whānau Māori and how they felt about the treatment. Specifically, this study was designed to examine results when Māori PCIT-trained therapists deliver PCIT to whānau Māori in high-risk communities. Using an open trial design, I hypothesised that PCIT provided by Māori therapists would result in good outcomes for whānau, such that the percentage of children with

post-treatment behaviour problem scores in the clinical range would decrease consistent with the positive results found in other international studies (Leung, Tsang, Heung, & Yiu, 2008; McCabe & Yeh, 2009).

1.6.1 Thesis Outline

Chapter 1. This chapter provides a summary of the importance of parenting and the parent child relationship, a summary of conduct problems in young children, evidence-based parenting interventions and the need for culturally responsive interventions for indigenous families who want their family to experience good mental health and wellbeing.

Chapter 2. This chapter gives the reader the context and understanding of Māori as the indigenous people of *Aotearoa*. It describes traditional Māori parenting values, the impact of colonisation on parenting and then looks at the current situation for *whānau* Māori. It provides a summary of conduct problems in young children, effective treatment programmes and the need for additional enhancement for families with additional risk factors.

Chapter 3. This chapter provides the background on the importance of parenting including key parenting theories from western and indigenous frameworks and evidence-based parenting programmes. The chapter ends with a look at those interventions that have been designed specifically for Māori.

Chapter 4. This chapter is a systematic review and meta-analysis of studies evaluating the efficacy of PCIT that has been conducted with indigenous and ethnic communities. This review followed the PRISMA statement (Moher, Altman, Liberati, & Tetzlaff, 2011) and was undertaken to examine the characteristics of effective interventions for improving child behaviour outcomes with indigenous or ethnic minority communities.

Chapter 5. This chapter is the first of two results chapters. It presents the results of quantitative data analysis of PCIT delivered to *whānau* Māori. It gives detailed descriptions of the statistical analysis, demographic characteristics of participants, and the results of primary

and secondary outcomes in terms of child behaviour. Additional factors explored were retention and engagement, ethnicity and mental health, parent satisfaction and confidence. This chapter concludes with a summary of main findings.

Chapter 6. This chapter is a qualitative analysis of parents' experiences with PCIT. It gives a voice to whānau by capturing their narratives and the meaning they gave to their experiences. It presents the themes uncovered during follow-up group sessions. This section highlights the extreme challenges whānau faced in committing to PCIT and allows the stories of these whānau to be heard.

Chapter 7. The final chapter provides a discussion of the strengths and weaknesses of this study with suggestions for future research. This chapter concludes with a summary of the main findings and places this research in the context of the literature currently available on treatments that improve outcomes for our most vulnerable whānau. It highlights the gap that this research addresses and identifies some implications for service providers and policy makers.

Chapter 2: Māori as the Indigenous People of Aotearoa

“Inā kei te mohio koe ko wai koe, I anga mai koe I hea, kei te mohio koe, kei te anga atu ki hea.”

“If you know who you are and where you are from, then you will know where you are going.”

(Brougham et al., 1987)

2.1 New Zealand/Aotearoa

New Zealand is formally a bicultural nation, which incorporates many aspects of both Māori and New Zealand *Pākehā* [European] culture into national iconography (Sibley & Liu, 2007). Māori arrived in New Zealand from Polynesia approximately 800 years ago, establishing a unique culture. European settlement began slowly following the “rediscovery” of New Zealand by Captain Cook in 1769, with Māori still being in the majority and in control of most of the country. This lasted until 1840, when Te Tiriti O Waitangi (The Treaty of Waitangi) was signed, which guaranteed partnership, participation, and protection to Māori. However, this did not eventuate, and the period from 1840 to 1870 was marked by warfare and conflict as *Pākehā* settlement proceeded in full force. By the 1870s, a firm process of colonisation had been set in place, with land confiscation and cultural alienation for Māori to follow until the civil rights movement and Māori renaissance of the 1970s reinvigorated biculturalism and lead to the Treaty of Waitangi Act 1975, formally giving equal rights to Māori as the Indigenous people of New Zealand (Orange, 2015).

New Zealand is a similar size to the United Kingdom and sits on the Pacific Rim, in the southwestern Pacific Ocean. As a small island nation with around 4.7 million people ([Statistics New Zealand, 2015](#)), New Zealand operates from a binary framework (Ritchie, 2008) where

the two main cultures, Māori, who comprise 15 percent of the population, and Pākehā, who comprise around 74 percent of the population.

2.2 Pre-colonisation parenting and tamariki

In pre-colonial times, Māori had extensive protocols for the care and protection of their mothers and infants. The period of pregnancy was traditionally a special and sacred time. The mother was encouraged to talk with and sing to her baby so that the whakapapa and other important historic relationships and traditions could be passed on to the baby well before it was born (Pere, 1987; Royal, 1997). Caring for the expectant mother and her unborn child was the responsibility of kinswomen, to ensure a successful prenatal experience. It was a time when the expectant mum was surrounded by her kinswomen and preparations for the birthing experience began (Jenkins & Harte, 2011; Pere, 1987). These women folk not only supported the mother before the infant was born, but continued to help as part of her collective parenting network, where they responded to the infant as if they were the infant's mother (Pere, 1979).

The birthing process was the most sacred time when karakia and incantations were performed by kaumatua during the final stages of the birthing process, so that the infant was welcomed into the world immersed in their culture (Royal, 1997). Family would gather around the mother and infant and bestow upon the infant his or her potentialities, often reflected in the name choice for the infant. Family members would also remind one another of their responsibilities to protect and nurture the infant.

Parenting was a shared responsibility and allowed for multiple adult-child relationships (Best, 1907; Shortland, 1854). Jenkins (2012) suggested that this helped to ensure the safety of the infant through having many eyes on the child and many opportunities for the care of the infant. Following the birth, the mother was cared for in a special temporary whare, built so that her kinswomen could nurture and support the mother to bond with her infant (Pere, 1987) and

consolidate kinship connections. Māori tamariki were viewed as sacred gifts, as links between past and present that must be nurtured, loved unconditionally, protected, and kept safe (Best, 1907; Shortland, 1854). This sacredness was also reported by Pere (1979) to be epitomised by the name given to children, tamariki. *Tama* originating from the ancestor, Tama-te-ra the sun, which literally means the divine spark and *ariki* referring to those of a more senior status and *riki* meaning a smaller version. In this way, children are said to be *tapu* (sacred) because they represent smaller versions of our important ancestors (Pere, 1979). Tamariki were therefore afforded their own mana and treated with respect (Jenkns & Harte, 2011).

Once the infant could walk, a different strategy was employed. Pre-colonial observations by historians showed that child-rearing practices and the associated values for Māori and European children were very different. Most obviously, Māori parents tolerated more active, boisterous, and independent behaviours from their children than did European parents (Polack, 1838; Shortland, 1854). Pre-colonial Māori parents valued physical and psychological prowess. Children were raised to be bold, brave, and independent in both their physical duties and their cognitive processes. This was encouraged and supported as an important step in ensuring Māori survived (Shortland, 1854). Children were constantly busy and engaged in an active learning environment alongside other adults, for example there are hand drawn sketches showing children weaving alongside their parents and/or alongside them in vegetable gardens. Pre-colonial Māori parents kept their infants close to them, either swaddled to them in woven flax pikau or beneath their korowai (Shortland, 1854). This was also a non-gendered task, with photographic portraits showing male figures carrying infants and watching over and protecting their women folk as they breast-fed their children.

In addition, there were no documented reports of the physical assault of children. Indeed, early Pākehā explores were concerned by the lack of physical discipline they observed in their travels to New Zealand believing that this would lead to a spoilt child (Polack, 1838).

Instead it is reported that any assault on a Māori child was dealt with by the extended whānau, who would expect *murū* [revenge] (Polack, 1838; Shortland, 1854). This was because to hurt a child was considered to be the same as an injury to an ancestor. This respectful and positive parenting model was the cornerstone to Māori pre-colonial parenting, where children were adored, treasured and raised as part of a shared parenting community.

2.3 Te Tiriti O Waitangi

The Treaty of Waitangi Act 1975 (Ministry of Justice, 2016), is based on *Te Tiriti O Waitangi* (the Treaty of Waitangi) that was signed between Māori chiefs and the Crown in 1840. The Treaty is considered to be the founding constitutional document of New Zealand, and its principles, spirit, and intentions continue to guide the relationship between the Crown and Māori. There are two versions of the Treaty, a Māori version (which was signed by Māori) and an English version, which served as the translation. However, there are major differences between the two versions of the Treaty. In the Māori version, Māori retained their full rights and power over their land, yet in the English version, the Crown was given full dominion over Māori land. This important difference has led to continual grievances between Māori and the Crown, which are managed by the Waitangi Tribunal (New Zealand Ministry for Culture and Heritage, 2017).

The Waitangi Tribunal is a standing commission of inquiry. It makes recommendations on claims brought by Māori relating to legislation, policies, actions, or omissions of the Crown that are alleged to breach the promises made in the Treaty of Waitangi. The Waitangi Tribunal provides a place for Māori grievances to be settled (Hayward & Wheen, 2016). While most settlements are with regard to land grievances, there are now a variety tribunal claims where the intention is to rectify the inequities that exist for Māori (e.g., health, mental health, education and socio-economic outcomes) and restore Māori well-being as an indigenous people (Charters, 2017; Healey et al., 2017; Muriwai, Houkamau, & Sibley, 2015).

2.4 Post-colonisation Māori parenting

2.4.1 Risk factors for tamariki Māori.

Risk factors for tamariki Māori begins even before birth, with their mothers experiencing a lack of accessible, culturally appropriate infant and perinatal health services (DeJoux, 2012; Ratima & Crengle, 2013). This may explain some of the reasons that Māori mothers were not only less likely to access antenatal education, but also to access it much later in their pregnancy. Māori mothers reported little need to learn about childbirth and a shared feeling that the antenatal classes didn't reflect whānau Māori realities, in particular there was no understanding of collective parenting. Ratima and Crengle (2013) reported that the maternity care needs of Māori women are much greater than for non-Māori women and inequalities in birth outcomes between Māori and non-Māori persist. For example, once born, Māori infants were more likely to be premature and have a low birth weight (Ratima & Crengle, 2013).

Once taken home, Māori mothers had fewer postnatal home visits from their midwives and/or less than the minimum number of postnatal visits, where issues or challenges for the mother or infant would be more likely to be picked up or reported (Ratima & Crengle, 2013). While there have been significant increases in Māori babies surviving infancy, thanks largely to Māori designed education programmes, Sudden Infant Death Syndrome (SIDS) is still more than three times more likely to claim a Māori infant and the Māori infant mortality rate in 2019 continued to be higher than for non-Māori (Statistics New Zealand, 2019). Ratima and Crengle (2013) provided supportive evidence that adverse birth outcomes not only affect babies' health outcomes but also reach forward into childhood and adult outcomes, which is documented in systematic reviews. Clearly, these increased risk factors are likely to impact negatively on the health and psychological well-being of both the Māori mothers and their babies (Ratima & Crengle, 2013).

Reid, Robson, and Jones (2000) have identified three gaps that exist for Māori: the distribution gap (i.e., Māori are not distributed evenly across all deprivation deciles but are over-represented in the very deprived neighbourhoods), the outcome gap (i.e., Māori health outcomes are worse even after controlling for deprivation), and the gradient gap (i.e., socioeconomic hardship impacts more heavily on Māori), suggesting that ethnicity itself may be a determinant of health inequalities (Reid, Robson, & Jones, 2000). It is clear that 20 years on these disparities continue (Ministry of Health, 2018b)

Because of these gaps, Māori infants are more vulnerable to the impact of poverty (Perry & Conners-Burrow, 2016). The following risks are associated with poverty: (1) Health risks, such as being more susceptible to diseases of poverty (Dale, 2017); like respiratory and infectious diseases (Boston, 2014); (2) Familial risk factors including higher rates of exposure to aggressive peers, family instability and family violence (Lievore, Mayhew, & Mossman, 2007); (3) Nutritional risks, where inexpensive foods which are often less nutritious make up a larger proportion of children's diets (Bhattacharya, Currie, & Haider, 2004); and (4) Environmental risks such as residential instability, overcrowding, and exposure to toxins like lead, tobacco and alcohol, which are more likely to be in in areas of poverty.

It has been reported that 23 percent of Māori families lived in the most economically disadvantaged regions, compared with just seven percent of Pākehā (Ministry of social development, 2016b). In addition, more than one-third (35 percent) of Māori children live in single parent homes where the median income is considered to be below the poverty line (Ministry of Health, 2015). Poverty has also been found to affect children setting the stage for extensive challenges in parenting, such as exposure to more negative, harsh, neglectful, unresponsive and insensitive parenting (Bigelow, 2006; Slack, Holl, McDaniel, Yoo, & Bolger, 2004).

Māori teen pregnancy rates are four times higher than for non-Māori (Statistics New Zealand, 2013). This is important because the international literature on early parenthood has shown risks both to the young mother (e.g., educational underachievement, socioeconomic disadvantage, welfare dependence, marital difficulties, mental health issues, and less optimal parenting) and their babies, such as risk of antenatal complications, mortality, and less optimal development (Chen et al., 2007; Paranjothy, Broughton, Adappa, & Fone, 2009).

Depression has been shown to have a profound impact on the relationship between parent and child. Depressed parents are often less positive in their interactions, increasing the likelihood of more negative parent-child relationships (Feldman, 2007a; McCartney, 2006). Māori mothers had depression rates of almost double those of non-Māori (Ministry of Health, 2013).

2.4.2 Tamariki Māori in state care

Māori children were the most vulnerable to being under child protection services and to be living in households with multiple risk factors. The Vulnerable Children and Families Report (2010) used data from the New Zealand General Social Survey to examine households with vulnerable children. They used 11 indicators (related to poor child outcomes) to identify households with at-risk children. Indicators included smoking cigarettes, being a victim of crime/discrimination in the previous 12 months, living in a high deprivation area, feeling isolated some/most of the time, suffering from poor physical or mental health, living in low economic standards, having more than one housing problem, living in an overcrowded house, and experiencing limited access to facilities. The more risk factors one had determined their level of risk. Māori comprised 43 percent of the high-risk households, although they comprised less than 15 percent of the population. Māori children are more vulnerable than their non-Māori counterparts, with the Ministry of Social Development (2016) reporting that around six out of

ten vulnerable children are likely to be Māori even though they represent only a quarter of all children in New Zealand (Ministry of social development, 2016a).

In April 2015, the Minister for Social Development established an Expert Panel to investigate how to transform the lives of vulnerable children. They found that in 2015 around 230,000 children under age 18 experienced vulnerability at some point during their childhood, and six out of ten of this group were described as likely to be Māori (Ministry of social development, 2016b). Two key challenges identified were how to reduce the number of vulnerable Māori coming into contact with the system and how to work better with them (Ministry of social development, 2016b).

Māori leaders have been calling for a cultural response to child abuse since 1988 with the release of John Rangihau's Puao-te-ata-tu (Daybreak) report, a Ministerial Advisory Committee report which provided a Māori solution to Māori children being taken into state care, (Nixon, 2016). In addressing these issues, it is important that any intervention which aims to support vulnerable Māori families in New Zealand take into consideration traditional Māori values. Interventions must be useful, culturally responsive, and help families feel connected (Clark et al., 2011).

2.4.3 Tamariki Māori and conduct disorder

Māori researchers such as Durie (2005), Cherrington (2009) and Pihama (2014) have described how the process of colonisation and alienation from the land and systemic racism have put *tamariki* Māori at increased risk for being diagnosed with conduct problems. They argued that this alienation supports a sense of disconnection from cultural identities and may make *tamariki* more vulnerable to stress due to the lack of culturally responsive services (Cherrington, 2009b; Durie, 2005a; Pihama et al., 2014). Cherrington (2009) in a by and for Maori report looked into what a Kaupapa Māori approach to conduct problems would be. She made 23 recommendations but stated that her report needed to be a beginning first step into the

process of developing a Māori view on conduct problems and a “desire to achieve the best outcomes for Māori tamariki, *taiohi* [adolescent/teenager] and whānau experiencing conduct problems”(p 94, Cherrington, 2009a)

Durie (2005) and Cherrington (2009) defined a Māori approach to conduct problems which should be focused on prevention and on addressing school, family, and social factors in a model where the child is placed at the centre and where the *whānau* works together to create the best possible outcomes for the child – including the development of a secure Māori identity with access to language, culture, and customs (Cherrington, 2009b; Durie, 2005b; Pihama et al., 2014).

2.4.4 Cultural protective factors for tamariki Māori

Although there are a variety of risk factors for whānau, there are also cultural protective factors for Māori infants. First, Māori were three times more likely than non-Māori children to grow up in an extended family (Jenkins & Harte, 2011), where Māori can draw on a variety of familial members for support, a concept shared by other indigenous populations which utilise a kinship approach to parenting (Sharma & Fischer, 1998). Māori children were almost twice as likely to be in kinship care than are non-Māori children (Worrall, 2006). The practice of *Whangai* [informal family adoption] emphasises nurturing and cementing relationships between individuals, families, and broader relational networks. It has continued to be an important concept in contemporary Māori society (McRae & Nikora, 2006).

2.5 Māori as the Indigenous People of Aotearoa

Māori are the indigenous people of Aotearoa. In relation to Pākehā, Māori have a relatively youthful population with a third of all Māori being under 15 years of age. The majority of Māori (86 percent) live in the North Island, and just under one-quarter (23.8 percent) live in the Auckland region, the largest city in New Zealand. In the 2013 census data, the three largest tribal groups were *Ngāpuhi* [tribal group of Northland] (125,6001), *Ngāti*

Porou [tribal group of the East Coast] (71,049) and *Ngāti Kahungunu* [tribal group of south east of the North Island] (61,626). Over a fifth of all Māori were bilingual in English and Māori and were able to carry out a conversation in Māori (Statistics New Zealand, 2013). While Māori life expectancy has increased overall, Pākehā still live around seven years longer than Māori (Statistics New Zealand, 2016).

2.5.1 Social, economic and health inequities

The Taskforce on whānau-centred Initiatives (2010, p. 15) describes socio-economic determinants as a key driver of whānau Māori vulnerability, both in and of themselves and also because “in response to socio-economic hardship, a range of problems are likely to co-exist within the same household”. Māori and Pasifika children experience significantly higher poverty rates than Pākehā children with almost a third of Māori children living in poor households (Simpson et al., 2016). The risk of poverty increases in sole-parent households and households without paid employment or on welfare assistance (Rashbrooke, 2014; Wicken, Richardson, Adams, Duncanson, & Oben, 2019).

Māori adults receive income support at higher rates than Pākehā (30.4 percent compared to 13.8 percent) and are more likely to be on income tested benefits (20 percent compared to 6 percent). Māori continue to have poverty rates almost double that of Pākehā, regardless of the measures used (Marriott & Sim, 2015). In terms of housing, Māori were much more likely to have lived in rented, over-crowded homes located in the most impoverished areas (23.5 percent compared to 6.8 percent). Their homes were more likely to be without any telecommunication device (including internet access) nor motor vehicle access (Ministry of Health, 2018b). The median income for Māori was \$22,500 and \$30,900 for Pākehā while the unemployment rate for Māori rose to 15.6 percent, up from 11.0 percent since the previous census (Statistics New Zealand, 2018).

Since 2012, the government has monitored annually, child poverty in New Zealand and in 2018 the Child Poverty Reduction Act and Children’s Amendment Act (2018), showed the government’s commitment to reduce child poverty and improve child wellbeing (Wicken et al., 2019). Compared to Pākehā, Māori children are more disadvantaged on a range of economic indicators and experience poorer access to, and outcomes from, universal services (e.g., health and education). The poverty experienced by many Māori is often intrinsic to the communities in which they live i.e. “neighbourhood poverty”, with 24 percent of Māori, compared to seven percent of non-Māori, living in the most deprived areas of New Zealand (Kahukura, 2015).

In addition the Government also convened a Welfare Expert Advisory Group to review New Zealand’s welfare system. While Māori comprise only 28 percent of the child population, they account for over 50 percent of the notifications made to child protection services and more than 60 percent of the children in statutory care (Ministry of social development, 2016a).

Durie (1999) stated that the risk of child maltreatment increases when children and their families face economic disadvantage (poverty, unemployment, poor housing), social disadvantage (racism, discrimination), and community disadvantage (socially excluded, disadvantaged, dangerous), which marginalises them from being able to fully participate in society. This disadvantage is symptomatic of the unequal distribution of goods and services within our society, whereby Māori experience inequities in both access to, and outcomes from, what are purported to be universal services such as the healthcare and educational system (Hobbs et al., 2019).

2.5.2 Education

Being able to retain students into senior secondary schooling is linked to the achievement of higher levels of skills and knowledge, higher income levels and significant less

likelihood of being unemployed (Organization for Economic Cooperation Development, 2017). In 2018, the proportion of Māori students remaining at mainstream school to age 17 (senior school) was 70.6 percent compared with 84.1 percent of Pākehā students (Ministry of Education, 2019). In addition, those students engaged in Māori Medium Education had higher rates of school retention at 76.9 percent. There is a clear correlation between the socio-economic mix of the school and the retention. Schools in the lowest quintile (deciles 1 and 2) draw their students from communities with the highest degree of socio-economic disadvantage and only 73.5 percent of students remained at school until age 17 compared to 91.9 percent of students from schools in the highest decile (deciles 9 and 10).

Māori are less likely to leave school with a formal qualification than Pākehā students where 91.3 percent of Pākehā leave with a NCEA level 1 qualification (the lowest level of senior secondary school attainment) compared to 79.7 percent of Māori students. This inequity continues where 56.4 percent of Pākehā students attain Level 3 (the highest secondary school qualification) compared with only 35.3 percent for Māori. A formal school qualification is a measure of the extent to which young adults have completed the basic prerequisite for higher education, training and many entry-level jobs, with clear links to labour force status and income (Scott, 2009). In 2015, New Zealanders with a tertiary education earned around 40 percent more than their counterparts with only an upper secondary education (OECD, 2017). So prioritising education is an important tool for supporting Māori wellbeing.

2.5.3 Health inequalities

The extent of the health inequity between Māori and Pākehā continues to be problematic (Came, Doole, McKenna, & McCreanor, 2018) and unacceptable (Walsh & Grey, 2019). The New Zealand Health Survey (2016; 2017) found that Māori had higher rates of mental health diagnoses and experience more severe psychological distress than Pākehā. In addition, Māori were significantly more likely than non-Māori to be hospitalised for intentional self-harm, with

young Māori having the highest suicide rates and almost double those of non-Māori (Ministry of Health, 2015).

2.5.4 Racial discrimination

Racial discrimination refers to the experience of an ethnically motivated personal attack (physical or verbal) and experience of unfair treatment on the basis of ethnicity in health care, housing, or work. New Zealand is often portrayed as a harmonious, multicultural society; however, the evidence shows that like other colonised people, Māori experience racial discrimination at more than twice the rate of Pākehā (Harris et al., 2012; Harris et al., 2006; Ministry of Health, 2013). Houkamau and colleagues (2017) described the distinction between blatant racism (obvious race-based bigotry, discrimination, and social exclusion) and latent racism (when racism is present but not explicitly articulated or clearly expressed, both at the personal and institutional level (Houkamau, Stronge, & Sibley, 2017)). Research using the large-scale New Zealand Health Survey data (2012) showed a link between racial discrimination and poorer physical and mental health within New Zealand. Results showed a “dose–response” relationship, where more experiences of discrimination relate to poorer mental health, self-rated physical health, and physical functioning, as well as greater likelihood of smoking, risky drinking, and cardiovascular disease (Harris et al., 2012).

Anecdotally, qualitative studies found participants were exposed to latent and institutional racism on a day-to-day basis, for example portraying Māori negatively via the media (Coxhead, 2005; Gregory et al., 2011) and Māori experience additional surveillance from police (Pack, Tuffin, & Lyons, 2016). Participants reported that racism made them feel distressed, anxious, angry, and with a sense of shame and embarrassment that they were Māori. Racism in New Zealand is a common experience for Māori, it is an experience that produces harmful outcomes for indigenous wellbeing (Huria, Cuddy, Lacey, & Pitama, 2014).

2.5.5 Cultural wellbeing

Despite the disparities described above, most Māori report that they feel that they have a good overall sense of cultural well-being. In Te Kupenga (a report of Māori well-being), four important cultural well-being indicators were identified. Firstly, the study found most Māori knew their iwi (tribal group) and had been home to their marae (89 percent). Secondly, 70 percent of Māori had been involved in Māori culture in some way. Thirdly, for 75 percent of Māori, spirituality was identified as important to their sense of wellness. Finally, the report indicated that participation in a range of cultural activities, such as speaking Māori (55 percent), performing in cultural arts or crafts (56 percent) and watching Māori television (75 percent) helped them to define a sense of cultural well-being. Te Kupenga showed that even with all the disparity, Māori cultural actions help to make them feel culturally well (Cormack, Harris, & Stanley, 2020). Thus supporting Māori as a resilient people.

2.5.6 Diverse Māori identity

Māori are a dynamic and politically active people who have survived the process of colonisation. Many Māori live in two worlds: *te Ao Māori* [the Māori world] and *te Ao Pākehā* [the Pākehā world]. Although they may position themselves differently in each of these worlds, they are, by virtue of descent, Māori (Nikora, 2007). Durie (1994) described three Māori subgroups: those who are culturally Māori, bicultural Māori, and marginalised Māori (Durie, 1994). Williams (2000) had similar ideas but described one group of Māori as being traditional and residing in rural settings, a second as primarily urban and bicultural, a third as unconnected to their tribal affiliations, and a final group who were socially and culturally indistinguishable from Pākehā (Williams, 2000). Houkamau and colleagues (2020) suggested that this diversity in cultural identity poses significant challenges for agencies who are trying to implement effective strategies for Māori and stated that there was a need for greater diversity (Matika, Houkamau, & Sibley, 2020).

Macfarlane and colleagues (2014) suggested that a blended scientific and indigenous framework could hold a unique answer. In the He Awa Whiria (braided rivers) approach, Macfarlane viewed Māori cultural knowledge and Western cultural knowledge as two separate rivers, which have smaller streams that allow for the cross-fertilisation of ideas and values, each informing and being informed by the other, yet, existing separately. However, in order for this He Awa Whiria approach to work, there is a need for respect and a shift in focus away from Western science programmes that are adapted for Māori to programmes that originate from and are rooted within a Māori worldview (Macfarlane, Macfarlane, & Gillon, 2014).

The diversity in cultural identity is challenging when considering how best to support Māori parenting. In order to ensure support is delivered appropriately, it is important to encapsulate the full range of Māori identity (Greaves et al., 2017; Houkamau & Sibley, 2010). Therefore, a diverse range of interventions is required to cater for Māori diversity.

2.6 Māori parenting

2.6.1 The impact of colonisation on Māori parenting

Fundamental changes to the social structure of the traditional Māori whānau model occurred as a result of colonisation. Smith (2013) described in detail how Māori were subjected to the colonisation of their land, culture, and denial of their sovereignty by a colonising society that dominated and shaped the quality of life (L. T. Smith, 2013).

Historians have described how once the colonial government was established, capitalism, industrialisation, and urbanisation followed in rapid succession (Spoonley, Bedford, & Macpherson, 2003). These factors had a cumulative effect on traditional conceptualisation of whānau as an intergenerational kinship model because before long it was replaced by the nuclear family model. Walker (2004) described how the nuclear family model became functional, because it meant that it could meet both the needs of an industrial society,

where capitalism and individual competitiveness necessitated individualistic values, rather than kinship values supported by a whānau perspective . From this perspective the intergenerational whānau model was considered an impediment to industrialisation as it philosophically worked for the collective benefit.

Naturally then, the focus on the nuclear family and individualism was also reflected in the way Māori whānau raised their children. Caregivers became disconnected from their traditional knowledge and kinship practices. Parenting practices were further influenced by the ever-increasing influence of Christianity in New Zealand. Most notably, Christian values influenced Māori parenting with regard to physical discipline. In Proverbs 13:24, the Bible states, “He that spareth his rod hateth his son: but he who loves him chasteneth him betimes.” This is more widely known as “Spare the rod and spoil the child.” The introduction of corporal punishment aligned with the New Zealand educational policies of the time, which allowed the use of corporal punishment in the classrooms.

The assimilation policies of the government after the signing of the Treaty of Waitangi also helped to subjugate Māori parenting practices and reinforce the use of corporal punishment (Simon, 1998). The increase in the use physical punishment amongst Māori was described as the greatest interruption to Māori parenting values (Cameron, Pihama, Leatherby, & Cameron, 2013). It was the most damaging of all the colonising practices, because its effects were felt by the most vulnerable and most important assets tamariki (Pihama, 1993).

2.6.2 A Contemporary view of Māori parenting

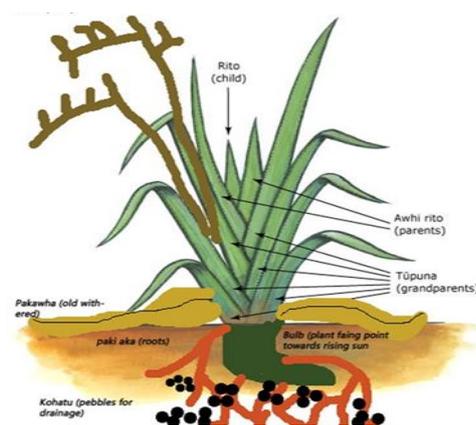
Shared, collective, or multiple parenting is a type of parenting wherein other adults have the same rights and responsibilities to children as do biological parents. This type of parenting continues in modern Māori society, often as a way to help alleviate the stressors associated with parenting. Māori grandparents often play important roles in the education of children,

especially of firstborn children, to whom specific cultural roles were assigned (Mead & Mead, 2003; Metge, 2014).

In addition, the traditional roles of *tuakana-teina* ([older-younger] relationships) continue. Here, the elder siblings (of the same gender) are expected to support the development of the younger siblings. This can be seen in the way younger children are often cared for by their older siblings. This is often viewed negatively in Western parenting literature as parentification (Chase, 1999) where the child is given parental responsibilities, which is regarded as inappropriate. However, for Māori, these practices are culturally important for the transfer of cultural knowledge and values of responsibility and tolerance (Sharpley, 1989).

Rokx (1998) used the harakeke to symbolise where a Māori child sits in the context of the family. The *rito* [young shoot of the harakeke plant], represents the child and is embraced on either side by two other main shoots, the parents (Rokx, 1998). Like harakeke, families share common roots and get strength and stability from their wider extended whānau, who serve as the main social unit to keep relationships and connections strong. The essence of this analogy is that the child is nurtured and protected by all the whānau members who surround them. While many Māori continue to thrive in the context of these traditional family systems, the negative effects of colonisation leave other Māori parents particularly vulnerable, as they may struggle to negotiate these differing values.

Figure 1 Harakeke Diagram of the Māori Concept of Whānau



2.6.3 Māori parenting research

Although parenting is an important issue for Māori, there are currently no Māori parenting programmes which have received systematic evaluation. Randomised control trials (RCTs), are considered in Western science to be the gold standard of research design and they are expensive and time-consuming to run. In addition, they are often highly restrictive in the variables that are able to consider (i.e., they often do not reflect the very communities they are hoping to help). Naturally then while there are some Māori parenting programmes available many have not had the funding to allow them to have been studied using an RCT framework.

Atawhaingia Te Pā Harakeke [Nurture the Family] was developed in 1993 by *Te Komako* [the Māori training and support unit within Early Childhood Development, Ministry of Education]. *Atawhaingia Te Pā Harakeke* (ATPH) was based on traditional Māori cultural beliefs, values, and activities. ATPH was a new adaptation of two previous Māori programmes. *He Taonga te Mokopuna* [a programme to assist tamariki who have witnessed domestic violence] and *Hākorotanga* [originally designed as a Māori fathers parenting programme]. The programme was extended to include both mothers and fathers and renamed to reflect this (*Hākuitanga/Hākorotanga*). Although there was still a focus on the reduction of family violence, there was now much more of a positive parenting focus and delivered using *te reo Māori me ona tikanga* [Māori language and culture]. In 2001, Minister Turia heralded *Atawhaingia Te Pa Harakeke* the “new and dynamic approach to addressing the depth of the impact that domestic violence has on whānau, hapū and iwi and their development. Not only does it address the needs of parents and caregivers to meet their obligations and responsibilities to their children, it also works with the children to assist them to learn non-violent ways of behaving and responding to violence” (Turia, 2001).

ATPH was delivered by *Te Komako*, but the contract was managed by the then Department of Child Youth and Family Services. ATPH was contracted to be delivered to up

to 15 iwi providers per year, using a train the trainer model. The content and structure of ATPH training programme was independently evaluated by the University of Auckland's International Research Institute for Māori and Indigenous Education (IRI) and found to be “a Māori model of evidence-based practice” which was highly effective and enjoyable for the trainees. However, there were never any formal intervention studies conducted .

It was delivered nationally, on marae, by Te Komako over 4 weeks. Te Komako delivered ATPH to more than 200 Māori hapū and iwi service providers throughout New Zealand. Uniquely, the ATPH training programme travelled with a *Kahui* [a group of Māori elders] who supported the ATPH staff to ensure the cultural integrity of the programme was maintained. Once trained in ATPH, the trainees were expected to take the programme back to their services and to deliver it to the families they saw where family violence was a key issue. The agencies were supported post-training for a year by Te Komako staff who provided mentoring and support to the services as they delivered the ATPH programme. This helped to maintain the integrity of the programme and Te Komako were able to provide good parenting resources, educational handouts, CDs, and videos designed specifically for Māori. Originally there was funding attached to delivering the programme, however, once this funding stopped and the contract changed to be managed by Te Puni Kokiri, many providers could no longer continue to deliver ATPH.

Whānau Toko I Te Ora (WTITO) [a national parenting programme for Māori whānau] was delivered by *Te Ropu Wahine Māori Toko I Te Ora* [the Māori Women's Welfare League]. WTITO focused on positive parenting skills and used tikanga Māori principles to support whānau with tamariki under five years of age. There were three main objectives of the programme 1) to promote and improve positive parenting skills, 2) to support the development of confident parenting and 3) to improve the relationships, learning and developmental outcomes for tamariki. The programme was aimed at whānau with medium to high needs and

was delivered through both home visiting and a group programme. The workers who delivered the programme were local community members who were able to develop individual whānau plans and then link whānau into a range of useful services such as early childhood providers, and health and social service providers, whilst being able to deliver whānau learning sessions based on the needs of the whānau. The whānau learning programme included sessions on literacy, house care, cooking and hygiene, financial management, child development from a Māori perspective, and other relevant cultural topics.

WTITO was evaluated by Livingston (2002) using reports from 16 case studies (67 percent completion rate). The case studies were individualised reports made by whānau and their case workers. The anecdotal data showed that 10 out of 16 (62 percent) parents in the study “made considerable gains in respect to parenting skills and confidence” and those who had not improved were all whānau “involved with alcohol and drug abuse” (Livingstone, 2002, p. 64).

Herbert (2001) developed two culturally adapted Matuatanga Model (MM) parenting programmes, which were added to enhance a standard parenting programme in Rotorua. The first was the Matuatanga Relationships Model (MRM), which emphasised the quality of parent and child interactions and relationships within the context of understanding the areas of child development, communications, and positive interactions. The second culturally adapted programme, the Matuatanga Values Model (MVM) was developed to recognise Māori values. The values that were identified as important included whakapapa, whānaungatanga and *awhinatanga* [support]. Herbert found that, although there were no statistically significant differences between the outcomes of the different programmes, there were qualitative differences, such as having increased family and community support and a sense of feeling culturally validated, which appeared to improve parent self-efficacy.

2.7 Summary

Before colonisation, Māori parenting practices were reported to be supportive and non-abusive and collaborative shared experience with other female relatives.

Colonisation led to the undermining of Māori values and cultural practices. Traditional Māori parenting practices were no longer supported and the dominant non-Māori practices of a much harsher manner of parenting was promulgated and practiced.

Post-colonisation saw a range of social inequities and racism develop which have been shown to be related to a range of negative, harsh, and punitive parenting practices and ultimately led to much poorer outcomes of children. This inequity continues and Māori whānau carry an unfair burden of risk, with tamariki being those who are most negatively affected by these inequities. It is imperative that we find a solution that can support Māori in parenting their tamariki in a manner that supports traditional values of aroha, manaaki and awhi, but which also recognises the modern context that Māori live in, so that our tamariki can flourish and reach their full potential.

Chapter 3: Parenting Interventions

“E tipu e rea mō ngā rā o te ao

Ko tō ringa ki ngā rākau a te Pākehā hei oranga mō tō tinana

Ko tō ngākau ki ngā taonga o ō tipuna Māori hei tikitiki mō tō mahunga

Ko tō wairua ki te Atua nāna nei ngā mea katoa”.

“As you grow fulfil the desires of your generation

Take hold of the opportunities of this world, never forgetting the value of your ancestry

Let the past guide you knowingly into the future

And let your spirit be guided by God who is the creator of all things.”

(Brougham et al., 1987)

3.1 Behaviour problems in Aotearoa

The New Zealand Health Survey (NZHS), is a continuous survey conducted yearly since 2011 which provides information about the health and wellbeing of New Zealanders. The 2017/2018 NZHS, reported that 57,000 children (8 percent) of New Zealand children aged between 3 and 14 were reported to have significant behavioural problems. Other longitudinal data suggest that behavioural problems in young children are reported in up to 10 percent of children (Boden et al., 2010; D’Souza, Underwood, Peterson, Morton, & Waldie, 2019).

The NZHS stated that younger children (those in the three-four year-old age group) were the most at risk and Māori parents were more than twice as likely to report concerns about their child’s behaviour. In addition, Māori families in areas of high need and high deprivation were more than three times more likely to report concerning behaviours (Ministry of Health, 2018a).

Not only are they at risk for current behavioural issues but also for later behaviour problems such as conduct disorder. There is now substantial evidence to show that early onset conduct disorder can lead to serious and long-lasting impairment (Blisset et al., 2009; Boden

et al., 2010; Fergusson et al., 2011; Fergusson & Boden, 2010). Therefore, supporting the recommendation by Fergusson and colleagues (2011), that intervening early to prevent, treat, or manage conduct problems in children is important. In their longitudinal study they found that New Zealand children with significant conduct problems are at increased risk of later difficulties including crime, substance abuse, mental health problems, suicidal behaviours, teen pregnancy, involvement in family violence and poor physical health (Boden et al., 2010; Fergusson et al., 2011; Fergusson & Boden, 2010). Fergusson and colleagues (2011) declared conduct problems to be the most significant childhood condition because of the far-reaching consequences demonstrated for personal health, development, and general wellbeing. Given the rates for Māori are almost double those for non-Māori, supporting Māori tamariki with these challenges and their whānau must be a priority.

Supporting parenting, through parenting programmes, has been shown to be an effective way to support families where children have serious behavioural problems (Blisset et al., 2009; Fergusson, Stanley, & Horwood, 2009; Sanders, 2002; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998; Webster-Stratton & Reid, 2011). Parenting programmes aim to help parents improve the quality of parenting that their child receives and in turn, the child's development and behaviour. Parenting programmes have been credited with being developed in the 1960s, by researchers at the University of Oregon (Dishion, Forgatch, Chamberlain, & Pelham, 2016; Hanf, 1969; Kaehler, Jacobs, & Jones, 2016; Patterson, 1982). These founding researchers focused on how children's conduct problems developed and were maintained within families and then focused their attention on developing parenting programmes based on a range of psychological theories.

3.2 Key parenting theories.

3.2.1 Operant conditioning.

Skinner (1938) is regarded as the father of operant conditioning. His work was based on Thorndike's (1898) law of effect. According to this principle, behaviour that is followed by pleasant consequences is likely to be repeated, and behaviour followed by unpleasant consequences is less likely to be repeated. Skinner believed that behaviour that is reinforced tends to be repeated (i.e., strengthened), whereas behaviour that is not reinforced is less likely to be repeated (i.e., weakened). Punishment is the opposite of reinforcement as it weakens or eliminates a response rather than increases it. It is an aversive event that decreases the behaviour that follows.

Skinner focused on observable behaviour rather than internal cognitions. He was interested in how the behaviours of children could be modified based on how their parents responded to them. Behaviour modification was one of the first techniques used to modify children's behaviour and continues to be an important part of many evidence-based parenting programmes (Dishion et al., 2016; Forehand, Lafko, Parent, & Burt, 2014; Patterson, 1976; Webster-Stratton & Reid, 2011).

3.2.2 Social learning theory

Bandura's and Walters social learning experiments (1977) demonstrated that children's observations of their parents' behaviours may lead them to imitate or copy them. The famous Bobo doll experiment showed that children exposed to adults exhibiting aggressive behaviour toward a doll were more likely to imitate this aggression. Social learning theory (SLT) is based on the premise that children acquire behavioural strategies that they have observed from significant adult figures (Bandura & Walters, 1977). The way this behaviour is learnt is through imitation and reinforcement processes (Gardner, Burton, & Klimes, 2006).

In addition, SLT is based on the idea that we learn from our interactions with others in a social context, which includes observing the behaviours of others. After observing the behaviour of others, children assimilate and imitate that behaviour (Bandura 1977). This includes the strategies they use for managing emotions, resolving disputes, and engaging with others. Muro and Jeffrey (2008) described SLT as a bridge between behaviourist learning theories and cognitive learning theories because it encompasses attention, memory, and motivation (Muro & Jeffrey 2008).

Many of the modern evidence-based parenting programmes, such as Incredible Years, Triple P and PCIT utilise social learning theory as one of their founding principles (Gardner et al., 2019; Kaehler et al., 2016; Leijten, Melendez-Torres, Knerr, & Gardner, 2016).

3.2.3 Coercion theory

Developed by Gerald Patterson and colleagues at the Oregon Social Learning Center (OSLC), coercion theory described how aggressive and antisocial behaviours develop in children. Patterson and colleagues at OSLC used extensive behavioural research and structured observation and measures to understand the moment-to-moment interactions in families. The coercion model specified how ineffectual parental responses to problem behaviour resulted in escalating aversive and aggressive behaviours in children in the short-term. It also describes how frequent repetitions of such coercive cycles result in a progressive worsening of aggressive behaviours in both variety and intensity, coincident with lack of parental control over the aggression. For example, a perceived lack of success (in the use of harsh strategies) leads the parent to believe that their strategy has not be successful and so they then stop trying to correct the behaviour, which in turn leads the child to continue the behaviour. The child learns that the parent may initially use harsh strategies but will then give up, so their behaviour either continues or escalates to try and get the parent to intervene (Reid et al., 2002). Patterson's group at OSLC were seen as pioneers in this work in parent training (Patterson, 1976) and

many of the evidence-based programmes available today are based on the findings of Patterson and colleague's work (Eyberg, Boggs, & Algina, 1995; Sanders, 1999; Webster-Stratton & Taylor, 2001).

Scaramella and Leve (2004) proposed an early childhood coercion model (ECCM) where coercive parent-child reciprocities emerge through a process of mutual reinforcement. For example, a child who reacts to a parental request with anger, resistance or noncompliance evokes similar angry and hostile emotions from the parent, causing the parent to intensify their angry response to the child. The more frequently these types of interactions occur, the more likely the child is to become difficult. The more uncooperative the child becomes, the less likely they are to receive positive attention and positive feedback from the parent when they are being appropriate. Thus, a negative and often aggressive parent-child interaction dominates the relationship.

3.2.4 Cognitive-behaviour theory

Cognitive-behaviour theory attempts to explain the relationship between subjective experience (including cognition and affect) and behaviour. The term cognitive-behavioural reflects the importance of both behavioural and cognitive approaches to understanding and helping human beings. It brings together the hybrid of cognitive processes and behavioural strategies, with the goal of achieving cognitive and behavioural change. The focus is on the role that cognitions play in the development and maintenance of psychological problems.

In cognitive-behavioural theory the emphasis is placed on an individual's beliefs and the social context in which behaviour is learned (Pallett, Scott, Blackeby, Yule, & Weissman, 2002). Thus, the focus is placed on the individual who is seen to be actively involved in judging and interpreting everyday events. Parenting programmes based on CBT attempt to explore the way parents think about a situation and explore the impact that this has on how they behave in

the social situation. The focus on thoughts parents and children have about a situation was the new component CBT added into the parenting literature.

Parenting interventions based on cognitive-behavioural principles are aimed at helping parents to learn how to reframe their distorted cognitions or cognitive misattributions about their children by equipping parents with problem-solving and anger management techniques to address these cognitions (Macdonald, 2004). Once parents are able to reframe their thinking about their child and their child's behaviour, they are more likely to be able to manage interactions with their children. They are then taught how to use behaviour management techniques to reinforce the types of behaviours they want to see more of and how to use effective discipline models to help ensure better compliance.

3.2.5 Attachment theory

John Bowlby and his student Mary Ainsworth are considered the mother and father of Attachment Theory (Bretherton, 1992). Bowlby's work was influenced by the study of animal behaviour such as Harlow's work (Harlow, Dodsworth, & Harlow, 1965) with rhesus monkeys (showing the impact of separating infant monkeys from their mothers) and Lorenz's work (Lorenz, 1937) on imprinting and critical periods seen in baby geese and their connections with their mothers.

Mary Ainsworth (1970), a student of Bowlby, developed the Strange Situation Procedure (SPP), which is used to identify the attachment classification of infants (Ainsworth et al., 1978). The SSP involved a series of separations and reunions between the child, their mother and a stranger. The separations get more and more stressful for the child. This stressful situation is required in order for the attachment behaviour to be evoked, but the focus for assessment is on the child's reunion behaviour. Her original work on normative samples of children and parents identified three patterns:

Type B, securely attached children. These children protest upon their parent's disappearance but are then easily pacified on their return and resume their exploratory play behaviour. Caregivers show attuned, warm parenting behaviours which are predictable and responsive to the child's need for arousal, closeness, or room for exploration.

Type A, insecure-avoidant children. These children appear not to protest overly when their parent disappears, but upon the parent's return they appear to be warily or unconcerned. Their play may or may not continue. Caregivers usually exhibit a dismissive parenting style, where they are less responsive especially to their child's need for nurturance, often trying to distract their children away from the need for emotional support.

Type C, insecure-ambivalent children. These children protest sometimes very emotionally, and upon the parent's return cannot be pacified. During their play, if they return to it, they are clingy and/or there is a resistance to play. Carers usually exhibit an enmeshed parenting style, but it is inconsistent or unpredictable and so the child tries to stay close to them but are often not fully satisfied in their relationship.

In Ainsworth's study there were still children who could not be classified, as they appeared to have strange and contradictory behaviours. Later, Main and Solomon (1990) added Disorganised infants (Type D) as a classification type for a small group of infants (5-10 percent of infants) who did not fit easily into the A/B/C categories (Main & Solomon, 1990). Disorganised infants have been shown to be extremely high-risk for developing psychopathology and to be a larger subset of children who have been maltreated (51 percent), of which 25 percent of children are from low income families and 43 percent of children mothers had abused alcohol or drugs (van Ijzendoorn et al., 1999).

According to attachment theory, children who experience sensitive-responsive caregiving will, over time, internalize a sense of the attachment figure as responsive and

available and of themselves as worthy and lovable; these children are described as developing a secure internal working model (IWM) of the self and other. In contrast, children who have experienced insensitive parenting develop an insecure working model and an insecure base for exploration.

In addition the attachment literature shows clear links between adult and infant attachment styles. More recently attention has been directed to the psychological underpinnings of caregiver sensitivity—originally thought to be the mechanism of transmission—as indicated by caregivers’ ability to keep in mind children’s mental states when interpreting children’s behaviour, or reflective functioning (Rostad & Whitaker, 2016). Reflective functioning is a caregiver’s ability to understand and interpret her child’s behaviour in terms of the mental states—intentions, feelings, thoughts, motivations, and beliefs of herself as mother and of the child.

Most of the adult attachment work has focused on the work of Main and Goldwyn’s Adult Attachment Interview (AAI). This tool assesses adult attachment representations from a very thorough analysis of structured interviews. There is significant correspondence between the attachment status of parents on the AAI and the attachment status of their offspring in infancy and the later attachment style of those infants in adulthood. The AAI also confirms that it is not the fact alone of neglect, trauma or triangulation in childhood that distorts development, but the manner in which that experience is processed.

AAI “Dismissive” adults distance themselves from the emotional significance of experiences: narratives are curt, factual, lacking depth. This is the equivalent of infant insecure-avoidant.

AAI “Preoccupied” adults provide lots of incoherent or contradictory facts, with a bias to emotional exaggeration, the equivalent of infant insecure-ambivalent.

AAI “Autonomous” adults are balanced or secure and provide a coherent, integrated narrative, acknowledging good and bad, fact and emotion, their own perspective and that of others.

The AAI “Unresolved” also identifies a group who are ‘unresolved’ with respect to loss or trauma. This manifests as discontinuities and dissociative features. Originally seen as a discreet category (the adult equivalent of disorganised), they can usually still be ‘forced’ into one of the three major groups, or combinations thereof.

However there have been concerns expressed that given the predominant interest in the intergenerational transmission of attachment patterns. The majority of research on the AAI has focused on primary caregivers, who are overwhelmingly female and white. Thus leading to the question of the applicability of attachment theory to non-western samples (Keller, 2008; Keller, 2018; Keller et al., 2018). Others such as Morelli and colleagues (2017) have also suggested that attachment theory should be recognised as predominantly a western frame of reference, given the limited research studies with other cultural groups (Morelli et al., 2018; Morelli et al., 2017).

Attachment based parenting interventions focus on increasing parents’ sensitivity to their infants (Ainsworth et al., 1978). This consistency in sensitivity over time helps the infant to develop a secure internal working model of the self and of others (Allen, 2011; Meins, 1999). This secure sense of self is said to make the child feel able to separate from their caregivers, thus the caregiver acts as secure base from which the child can venture into the world, knowing that when they return they will be welcomed back (Ainsworth et al., 1978).

All attachment based parenting programmes share an emphasis on building the child–caregiver relationship, increasing the caregiver’s ability to identify the child’s emotional needs

and respond consistently to the child in a nurturing way, and building the child's own emotion regulation skills through the relationship with their caregiver (Allen, 2011).

3.2.6 Summary of key parenting theories and implications for Māori.

Many of the parenting programmes available in New Zealand are based on some or all of the parenting theories described above. For example in a parenting programme based on cognitive-behavioural theory (combines both cognitive and behavioural components), the behavioural components draw on operant learning theory, while the cognitive dimensions encourage the parent to reflect on their relationship with their child (attachment theory). These new parenting skills are then practiced by the parent in a social context, where principles of social learning theory come into play. As a parent in relationship with their child, they will need to hold in mind the principles of coercion theory so that they are aware of how their responses can inadvertently reinforce negative behavioural responses from their child which can then become self-fulfilling.

But what are the implications for these parenting theories and the resulting parenting programmes, which have predominantly been developed in white, western and industrialised countries for indigenous communities, such as Māori. Morelli and colleagues (2018) suggests that parenting programmes such as those based on attachment principles may actually run “counter to the different ways many people with other lifestyles care of their children” (Morelli et al., 2017). While Mikahere-Hall (2019) a Māori researcher focused on trauma-informed interventions for Māori children and discussed what a contemporary Māori idea of attachment might be, there were no clinical trials or measures of attachment studied. Instead a qualitative piece was constructed and discussed, based on interviews with Māori mothers. What has been

acknowledged is that there are different rates of attachment security classification in different countries (Haltigan et al., 2019; Rothbaum et al., 2000; van IJzendoorn & Sagi, 2001).

3.3 Efficacy of parenting programmes

In the last decade, the government has made a large investment into the importation of overseas designed parenting programmes into New Zealand as there has been increasing interest in the use of effective interventions to both prevent and treat child conduct problems. This is outlined in four best practice reports, produced by the Advisory Group on Conduct Problems (Blissett et al., 2011, 2009a, 2009b and Church et al., 2013). In addition, a Māori report compiled by Cherrington (2009) also documented a cultural process for Māori conduct problems (Cherrington, 2009). Most specifically, Given the significant risk that Māori children are under, it is important that any evidence-based intervention imported into New Zealand is acceptable and has utility with *whānau* Māori.

Below, four parenting programmes available in New Zealand are described and the most recent evidence around efficacy is reported.

3.3.1 Circle of security programme

Circle of Security (COS) is a parenting programme based on attachment principles and developed by Robert Marvin, Glen Cooper, Kent Hofman and Bert Powell. COS is a 20-week, small group-based, parent education, and psychotherapy intervention originally designed to shift patterns of attachment-caregiving interactions in non-clinical families. The intervention contains both educational and therapeutic components and has five key goals: (a) establish the therapist and the group as a secure base from which the caregiver can explore his or her relationship with the child; (b) increase caregiver sensitivity and appropriate responsiveness by providing caregivers a map of children's basic attachment needs; (c) increase caregivers' capacity to recognise and understand both the obvious and more subtle verbal and nonverbal

cues that children use to signal their internal states and needs when using the caregiver as a secure base for exploration and as a haven of safety; (d) increase caregiver empathy by supporting reflection about both the caregiver's and the child's behaviours, thoughts, and feelings regarding attachment-oriented interactions; and (e) increase caregiver reflection about how his or her own developmental history affects current caregiving behaviour.

There are no formal qualifications required for the facilitators apart from the requirement to complete the train the trainer workshops and supervision, over a one year period.

3.3.2 COS systematic reviews/meta-analysis.

Only one meta-analysis, by Yahoholski and colleagues (2006), could be located for the COS intervention (see Table 1). COS uses a small-group treatment modality to provide parent education and psychotherapy that is based on attachment theory (Marvin, Cooper, Hoffman, & Powell, 2002). The meta-analysis reported an encouraging medium effect size for improving child attachment security (* $g = 0.65$, $p = .003$, $k=4$), for quality of caregiving (* $g=0.60$, $p=.012$, $k=4$) and reduction of caregiver depression (* $g=0.53$, $p<.001$, $k=3$) and a reported large effect size for improved caregiver self-efficacy (* $g=0.98$, $p<.001$, $k=2$). However, the fact that there were small studies with very small sample sizes means these results need to be reported cautiously, because of the risk of bias and an increased opportunity for type 1 errors.

The meta-analysis only included 10 studies, of which five were results from unpublished dissertations, meaning they were not peer reviewed. There were two randomised control studies were included (Cassidy studies et al., 2011 and Dehghani et al., 2014). The Dehghani et al., (2011) study included just 12 families and the Cassidy study had 169 subjects. The study conducted by the designer of COS, and so we need to consider the objectivity of the

study. In addition, there were no methods for testing publication bias in the study, such as the use of funnel plots or ratings of sensitivity.

The majority of the studies (7/10) included small sample sizes (8, 9, 10, 12, 20, 24, 37) is a concern because smaller sample sizes are associated with low statistical power, inflated effect size estimations and low reproducibility (Hackshaw, 2008). In terms of the utility for clinical problems, there are also concerns given that there were only three studies (Cassidy et al., 2011; Hoffman et al., 2006; and Page & Cain, 2010) which looked at children who would be considered to have clinical difficulties e.g. disorganised attachment.

Given all the studies were conducted in the US, their utility with our New Zealand population and with Māori in particular also needs to be considered

The Incredible Years Parenting Programme

3.3.3 Incredible Years Parenting Programme

Incredible Years Parenting Programme (IYPP) was developed by Carolyn Webster-Stratton initially as a treatment for children (aged 3 to 8) with conduct problems, then later it was developed more as a prevention programme (Webster-Stratton & Reid, 2003). IYPP is delivered in a group-based format that meets for two hours weekly over a course of 10-14 weeks. The group leaders facilitate parent discussion and role-plays based on instructional videos, which demonstrate the weekly skills session and provide the structure for the homework assignments. The IYPP has a manual to help ensure treatment fidelity. There are no formal qualifications required for IYPP facilitators but there are recommendations suggesting at least one of the two facilitators should hold some form of higher qualification including a master's degree. The programme uses a train the trainer approach which includes supervision and additional training.

IYPP intervention is based on social learning theory for reducing children's conduct problems. IYPP applies principles of modelling and reinforcement to support parents in improving their relationships with their children. In the IYPP, parents view videotapes depicting parent models interacting with their children in different scenarios. The group leaders facilitate parent discussions using the videos and put learned techniques into practice through parent-to-parent role-plays. In addition, homework is assigned, and parents are encouraged to practice these parenting skills at home to encourage prosocial behaviour. This alongside limit setting is discussed and role played in groups.

The IYPP has been a programme that the New Zealand government has imported into New Zealand and for which there are now programmes in almost every large town in New Zealand. So, it is now well-embedded into the New Zealand system of parenting support. Importantly there have also been some cultural adaptations to IYPP, including translations of and adaptations to make it more culturally responsive to Māori (Lakhotia, 2019). This included the use of Te Reo Māori, values, principles and ways of working and importantly delivered by and for Māori.

3.3.4 IYPP systematic reviews/meta-analysis.

There were four systematic reviews which looked exclusively at IYPP after 2010 (Menting et al., 2013; Leijten et al., 2018; 2019 and Gardner et al., 2019). The 2013 Menting study examined the effectiveness of the Incredible Years Parenting Programme (IYPP) regarding disruptive and prosocial child behaviour. There were 50 studies included in the analysis (17 of which had been conducted by the developer of IYPP) and there were 2,472 subjects in the treatment group with 2,273 control subjects. They found that there was a small but significant mean effect size $d = .27$ (CI = .21–.34, $p < .001$) for child disruptive behaviour across all 50 studies. There was a similar weighted effect size for prosocial behaviour $d = .23$ (CI = .15–.31, $p < .001$) across the 26 studies included. There were a variety of programmes

included in the analysis. Most of the studies were prevention studies (23 studies, 46 percent) while 22 studies (44 percent) were treatment studies. The last five studies could not be classified. The Menting and colleagues (2013) analysis identified seven potential moderators of effect size: two intervention characteristics (training components and number of sessions attended), two child characteristics (gender and initial severity of child behaviour), and three methodological features (ECBI, assignment, and nature of the comparison group).

Menting and colleagues (2013) reported a mean percentage of 44.7 percent of subjects from minority groups, but no other information (such as status or how the groups were organised or analysed) was included. They did report that family characteristics such as single parenthood, ethnic minority status, mother's level of education, and at-risk populations may be associated with less positive intervention outcomes, however, the analysis reported that this was not the case in some of the studies they analysed. They failed to report the number of studies which included these more at risk families and how their data was analysed.

The three studies from Gardner and Leijten their colleagues (2018, 2019) were unique in that these studies were able to get individual participant data and use them in their meta-analysis. In the Leijten (2018) study there were 14 RCTs (1,799 subjects) reported on IYPP in Europe. Their study reported that the IYPP was effective in reducing parent reported child conduct problems ($\beta = -.35.$) and in reducing ADHD symptoms ($\beta = -.30$). In addition, the parents reported that they were using more positive parenting behaviour. However, it was noted that there were no improvements in parental depressive symptoms, self-efficacy, and stress. The second study conducted by Leijten and colleagues (2019) used the same studies but looked at whether improvement in conduct problems also leads to improvements in maternal depressive symptoms. Again, although conduct problems improved, there was no improvement in maternal depressive symptoms for most families. However, they did report that those mothers with severe depression and their children with severe conduct problems did improve.

This suggests that it may be even more important that those families who are struggling with the most difficulties need to be engaged in evidence-based parenting programmes. Although both the Leijten studies involved studies across six different countries, there was very little data about culture or ethnicity reported, and no data on indigenous communities. The use of individual data is interesting and allows for a larger range of potential issues to be investigated.

Overall, it is clear that IYPP is helpful for improvement of behaviour problems and positive parenting. The analyses also suggest in some studies that IYPP may be more helpful for maternal depression when the symptoms are very severe and when child behaviour problems are very severe. However, what is still unclear is what the cultural implications might be and how this information and data should be being reported. In addition, there were no studies that looked at indigenous information and data.

3.3.5 Triple P – positive parenting programme

The Triple P Positive Parenting Program, was developed by Matt Sanders to provide parents with skills that would prevent and reduce child behaviour problems. The Triple P Positive Parenting Program is based on social learning theory. There are a series of programmes aimed at preventing emotional and behavioural problems in children aged 0-16. The programmes are designed to build parents' knowledge, skills, and confidence through a series of structured multi-levelled interventions. There are five levels, which correspond to the intensities of the programs.

At a low intensity, parents attend group seminars, while higher intensity formats typically include more individual support for at-risk parents or those with specific concerns. At high intensity, parents attend more individualised home-based interventions. Triple P is a well-established, evidence-based programme associated with increases in positive parenting behaviour, decreases in negative parenting practices, and improved child functioning for

school-age children but with limited effects on parent-child outcomes for young children (Ryan, O'Farrelly, & Ramchandani, 2017).

Keown and colleagues (2018) conducted a randomised control trial of Te Whānau Pou Toru – a cultural adaptation of Triple P for Māori whānau in New Zealand. In this study there were cultural adaptations including use of Te Reo Māori, the inclusion of cultural values and delivery by Māori facilitators. In this study Māori parents reported statistically significant improvements in child behaviour and high levels of satisfaction with the brief, low intensity variant of Triple P (Keown et al., 2018) but no changes on parenting wellbeing, confidence and dysfunctional parenting skills.

3.3.6 Triple P systematic reviews/meta-analysis.

There were four systematic reviews which looked exclusively at Triple-P, published after 2010 (Fletcher et al., 2011; Wilson et al., 2012; 2019; Tellegen et al., 2013; Sanders et al., 2014). The 2011 Fletcher study examined the effectiveness of the Triple-P Programme on mothers and fathers parenting practices. There were 28 studies involving almost 5,000 subjects (4959) with 20 percent reported to be fathers (983). The analysis showed a large positive effect size on mothers' parenting practices ($d=0.77$, CI 0.65-0.87, $p < 0.05$) and a moderate positive effect size on fathers' parenting practices ($d=0.51$, CI 0.37- 0.63, $p < 0.05$). It was also reported that the more clinically oriented/specialised formats of Triple P (Stepping Stones for developmental disorders and Enhance Triple P) were reported to have larger effect sizes than the lower level Triple-P programmes.

A major limitation of the Fletcher (2011) study was the fact that ethnicity and culture was not considered and was not collated. It may well be that this is a sign of the types of research that were conducted 10 years ago when researchers were less aware of the need to provide good cultural analysis and information regarding parenting programmes – especially

as there was a large importation of programmes into countries where they had not been designed. In addition, the fact that there was no follow-up data means it reviews only post intervention effects and can't be used to consider longer term effects of the programme.

The Wilson study (2012) looked at 23 English-language studies which measured a child-based outcome and which compared Triple P interventions with a comparison condition. The outcomes in terms of effect size for maternal reported ECBI scores showed a moderate effect size $d=0.61$

However, the comparison condition was mostly a waitlist control group, there were only two trials which used an active comparison group and neither of those studies showed any advantage of Triple-P. It also did not allow for between group comparisons.

Most of the studies involved families who responded to media advertisements, so they weren't clinically referred families, and are likely to be parents who were motivated to change because they were literate and confident to present for treatment as volunteers. Secondly only three of the included studies were independent of the Triple-P designer and so objectivity may be an issue. Thirdly, there was no follow-up data, only post intervention data gathered. So, no longer term outcomes can be inferred from the analysis. Finally, there was no data which looked at ethnicity or variables associated with culture, which calls into question the ability of the intervention to be used with other cultural groups.

There is substantial risk of outcome reporting bias in the study, with inconsistent use of measures, lack of reporting of randomisation processes, and the fact that all of the studies had Triple-P affiliated authors or co-authors.

The Tellegen study (2013) looked specifically at a specialist Stepping Stones Triple P (STTP) intervention, which was developed as a behavioural family intervention for parents of

children with disabilities. Twelve studies were included with a total of 659 families. There were ten studies conducted in Australia and one each in Canada and Germany. The majority of the studies (seven out of 12) were co-authored by the designer of Triple P and (four out of five) independent studies were unpublished theses.

The results indicated that across all the levels of the SSTP, a medium effect size was found for reducing child problems $d = 0.537$, 95% CI [0.372, 0.702], $p < .001$. In addition, a significant medium-to-large effect size was found for parenting style across all levels of SSTP combined, $d = 0.725$, 95% CI [0.553, 0.896], $p < .001$. So, this is a clear suggestion that SSTP has good outcomes for this specialist group of families.

However, there were limitations of many of the studies. There was reported again to be a high risk of bias in the nine RCTs, because many of the studies did not include blinding procedures or randomisation sequencing. It was also reported that because there were a number of smaller studies that there may not have been sufficient power to determine effect sizes. In addition, like the previous studies there was no inclusion of culture or ethnicity data.

The final meta-analysis was conducted by the designer of Triple-P Sanders and colleagues (2014). A total of 101 studies were included, 62 studies were RCTs. The analysis reported 16,099 families from 13 different countries although the vast majority 62/101 were conducted in Australia. The results reported a small-medium effect size for child problems (social, emotional, behavioural) $d = 0.473$, $k = 106$, 95% CI [0.404, 0.543], $p < .001$. There was also a reported medium effect size for parenting practices, $d = 0.578$, $k = 100$, 95% CI [0.490, 0.666], $p < .001$. However, the analysis included a diverse range of Triple P variants and therefore there were significant amounts of heterogeneity across all of the outcomes. There were significant risks for bias given there was no blinding or randomisation strategies in the

RCTs. There was also reported concern regarding selection bias operating in 60 percent of cases. There was no ethnicity or cultural data and analysis.

3.3.7 PCIT

PCIT was developed by Sheila Eyberg as an intervention for families with young children (ages two to seven) with severe externalising behaviours (Eyberg, 1988). PCIT is based on attachment, behavioural, and social learning theories. PCIT uses attachment theory to highlight both the importance of the parent-child relationship and the impact of sensitive, responsive, and repetitive interactive experiences between the parent and child. These repetitive experiences with the parent help the child to develop an internal working model of relationships, which becomes the template upon which children then go on to build their relationships with others. PCIT supports building a stronger parent-child relationship through parents interacting with their children in more responsive and consistent ways. The therapy uses concrete activities in the context of in-vivo play therapy sessions to help parents learn how to reinforce their child's adaptive behaviours and extinguish maladaptive behaviours (behavioural theory) through their relationship and are encouraged to practice these behaviours in their own social context (social learning theory).

In PCIT the parent and child are seen together and therapy uses live play therapy sessions, which are conducted using a transmitting and receiving device (worn by the parent), allowing the therapist to coach the parent through this device as the parent and child play together in another room. In this way, the therapist can intervene early before challenging behaviour happens, which helps parents become aware of their potency as a parent (i.e. increase their confidence in their parenting). It also provides the parent an opportunity to practice the use of the PRIDE (praise, reflect, imitate, describe, and enjoy) skills with their children. The PRIDE skills are the five positive parenting skills which form the cornerstone of the first phase of treatment Child Directed Interaction (CDI) in PCIT. In order to move from phase one to

phase two, both the parent and child must meet criteria set out in the PCIT protocol, to show that they have both mastered the skills required for a closer and warmer relationship.

In the second phase of treatment Parent-Directed Interaction (PDI), parents learn and practice how to set appropriate limits and boundaries for their children through the use of a sensitive discipline programme. There are set criteria parents have to attain. Together, both of these phases of treatment help to promote sensitivity, responsiveness, and safety within the parent-child relationship. Therapy does not end until all criteria have been achieved and the parent reports feeling ready and confident in their ability as a parent.

PCIT uses a protocol to ensure fidelity to the treatment which includes a thorough assessment process, including both observation and self-report data. In addition, parents are expected to fill in Eyberg Child Behavior Inventory (ECBI) weekly, and the reported score and the observation data from the Dyadic Parent-Child Interaction Coding System (DPICS), as well as parental reports of the child's behaviour during the week are used to set individual goals for the session, which the therapists supports with their coaching.

There is no set timeframe for therapy and length of treatment depends on parental achievement of the criteria and improvement of the child on psychometric data. PCIT is an intensive programme with parents expected to conduct play therapy (special playtime) with all of their children who are aged between two and six.

To become a PCIT practitioner you must have at least a masters level degree (or higher) in mental health, be licensed as a mental health provider, have completed the 40-hour face-to-face training with a PCIT Level II or Master Trainer, and have conducted two PCIT cases to graduation criteria whilst having had 12 months supervised practice.

3.3.8 PCIT systematic reviews/meta-analysis.

There were four systematic reviews which looked exclusively at PCIT published after 2010 (Cooley et al., 2014; Kennedy et al., 2016; Ward et al., 2016; and Thomas et al., 2017). The Cooley study (2014) examined the effectiveness of PCIT on child behaviour and on parental stress. There were 11 studies involving 496 subjects. The effect sizes for externalising child behaviour (using the CBCL) showed a large mean effect size $d=-1.06$ CI [-1.93, -.19]. Negative effect sizes indicate the treatment group (i.e., those that received PCIT) scored lower on measures of child behaviour problems and parent stress than the control group, indicating that PCIT was an effective treatment.

There were only four studies which reported using the CBCL. The ECBI is the standard measure used by PCIT and the mean effect size was again large $d= -1.06$ CI [-1.51, -.61], showing a significant decrease in scores between the treatment and control group for the intensity of the child's behaviour problems. Half of the studies (five out of ten) showed a significant decrease in scores between the treatment and control group. Of interest is the fact that there were a range of different cultural groups reported and included in the studies (Puerto Rican, Chinese, Australian, and Mexican-Americans). This means that there was a lot more heterogeneity than would normally occur when only PCIT studies from the US are included. The fact that there were small sample sizes and so it can be difficult to make comparisons.

The Kennedy study (2016) included six studies with 571 families and the focus was looking at how effective PCIT was at reducing future physical abuse among physically abusive families. The majority of the parents involved were female (85.3 percent) with a mean age of 32.1 years. Children were majority male (66.8 percent) with a mean age of 5.3 years. Most of the parents (60 percent) were referred from child protective, legal, or social service providers. Results regarding physical abuse recurrence were taken from only two studies (Chaffin et al., 2004; 2011) with 186 parent-child dyads. The results indicated a fixed-effects weighted mean

effect size estimate of $d=0.52$, [0.14, 0.90], $p < .01$ suggesting a medium effect size for parents in the PCIT groups compared to those in the TAU comparison group. Five studies (Chaffin et al., 2004; Foley, 2010; Terao, 1999; Thomas & Zimmer-Gembeck, 2011, 2012) examined child abuse potential using the standardised measure Child Abuse Potential Inventory (CAPI). They reported a weighted mean effect size estimate of 0.31, [-0.002, 0.620], $p=0.53$ which is not considered significant.

Limitations exist in this review that warrant caution in the interpretation of the results. First, this meta-analysis synthesises results from a small number of studies on three outcome constructs. Secondly, given there are only published studies, there may be some risk of bias of the trend to publish only positive result studies. Finally, the fact that several adaptations were included did increase the heterogeneity of the sample and may make wider application of these findings difficult.

Although the current analysis synthesised results from only six primary studies, the trend towards being able to use PCIT not just for changing challenging child behaviour, but also to be able to reduce the incidence of abuse, child abuse potential, and parenting stress is exciting and may change the lives of already extremely vulnerable families. In addition, the inclusion of culturally diverse studies is important if we are to support a range of culturally diverse communities.

The Ward Study (2016) included 12 studies, 254 families (254 treated and 118 control) looking at the efficacy of PCIT. The results showed a large effect on improving externalising behaviour problems in children with Disruptive Behaviour Disorder (DBD) based on the effect size derived from pre- and post-treatment behavioural outcomes ($d = 1.65$, 95 % CI [1.41, 1.90], $p < .001$) and treatment and control group data ($d = 1.39$, 95 % CI [1.05, 1.73], $p < .001$). Neither gender nor diagnosis was found to significantly moderate the effectiveness.

However as with the previous PCIT, a major limitation is the limited number of studies eligible for inclusion. Another is the fact that although there was homogeneity between the samples, there was only one study that included culturally diverse families, which makes the applicability of PCIT to other communities challenging.

Thomas and colleagues (2017) conducted a systematic review and meta-analysis of the effects of PCIT on child externalising behaviours. They included 23 studies (1144 participants) that met their inclusion criteria which were RCTs or quasi-experimental PCIT Studies (with children under the age of 18) with pre- and post-data on child externalising behaviour. They found various positive effects for children in the PCIT group when compared to the control group.

PCIT was superior to control for reducing child externalising behaviour (SMD = -0.87, 95% CI = -1.17, -0.58) and for increasing child compliance to parental requests (SMD = 0.89, 95% CI = 0.50, 1.28). In addition, parents in the PCIT group experienced significantly reduced parent-related stress (MD = -6.98, 95% CI = -11.69, -2.27) and child-related stress (M = -9.87, 95% CI = 13.64, -6.09).

Of interest were two further findings. Firstly, that the PCIT studies that required skill mastery had significantly greater reductions in externalising behaviour (SMD = -1.09, 95% CI = -1.44, -0.73) compared to those studies that did not require any mastery criteria (SMD = -0.51, 95% CI = -0.85, -0.17, $p = .02$). Overall, Thomas and colleagues concluded that PCIT continues to be an effective treatment for reducing child externalising behaviour and parents' stress.

Table 1 *Overview of Parenting Reviews*

| Review | Systematic review | Meta-analysis | PPP | IYPP | COS | PCIT | K (N) | Ethnicity data | Independent studies |
|--------------------------|-------------------|---------------|-----|------|-----|------|--------------|----------------|---------------------|
| Yaholkoski et al. (2016) | | X | | | X | | 10 (428) | | 7 |
| Menting et al. (2013) | | X | | X | | | 50 (4745) | | |
| Leijten et al. (2018) | | X | | X | | | 14 (1,799) | | 14 |
| Leijten et al. (2019) | | X | | X | | | 10 (1280) | | 10 |
| Gardner et al. (2019) | | X | | X | | | 13 (1696) | | 13 |
| Fletcher et al. (2011) | | X | X | | | | 28 (5299) | No | 4 |
| Wilson et al. (2012) | | X | X | | | | 23 (648) | | 20 |
| Tellegen et al. (2013) | X | X | X | | | | 12 (659) | | 5 |
| Sanders et al. (2014) | | X | X | | | | 101 (16,099) | | 31 |
| Cooley et al., (2014) | | X | | | | X | 11 (496) | | 10 |
| Kennedy et al. (2016) | | | | | | X | 6 (571) | | |
| Ward et al. (2016) | | | | | | X | 12 (254) | | |
| Thomas et al. (2017) | X | X | | | | X | 23 (1144) | | |

Table 2 *Meta-Analysis of Circle of Security (COS) Incredible Years Parenting Programme (IYPP) or Triple P*

| Study | Focus | <i>k</i> | <i>N</i> | <i>d</i> [CI] | Results | Discussion | Limitations |
|--------------------------|--|----------|----------|--|--|--|--|
| Yaholkoski et al. (2016) | Efficacy of COS | 10 | 428 | * <i>g</i> = 0.65, <i>p</i> = .003 | Improved attachment security Non-significant for disorganisation | Improved quality of caregiving and self-efficacy | Small studies Only 2 RCTs Lack of independence Culture not reported |
| Menting, et al. (2013) | Effectiveness IYPP on DBD | 50 | 2,472 | <i>d</i> =0.27 [.21, -.34] | Positive effect sizes Treatment studies most improvement | IYPT successful in improving child behaviour in a diverse range of families | Leader credentials unreported Missing data Culture not reported |
| Leijten et al. (2018) | Individual data in meta-analysis of IYP | 14 | 1,799 | ² Reduced conduct problems $\beta = -.35$. ADHD symptoms $\beta = -.30$ | Reduced conduct Reduced ADHD Improved parenting No improvement in - emotional health - parent mental health | Improved parenting and child conduct problems Wider benefits limited | Culture not reported Relied on parental report Examined immediate program effects only |
| Gardner et al. (2019) | Meta-analysis of IY | 13 | 1,696 | <i>d</i> = 0.43 [0.55, -0.40] | Reduced conduct No support for the early intervention hypothesis. | Reported 24% of the sample were ethnic minority | Limited studies 24% ethnic data No indigenous data |
| Leijten et al. (2019) | Co-occurring Conduct and maternal depression | 10 | 1,280 | Conduct $\beta = -.35$, <i>p</i> < .001 | Reduced conduct No improvement in depression | Families with severe depression and severe conduct problems did report changes | 20% ethnic data No indigenous data |

² β intervention effects (shown in units of baseline std deviations). A negative β reflects benefit, a positive effect β reflects harm.

| Study | Focus | <i>k</i> | <i>N</i> | <i>d</i> [CI] | Results | Discussion | Limitations |
|------------------------|---------------------------------|----------|----------|---|---|--|---|
| Fletcher et al. (2011) | Triple P parenting practices | 28 | 4959 | Mother <i>d</i> = 0.77 [0.71-0.84] Father <i>d</i> = 0.51 [0.37, 0.63] | Large improvement mothers parenting Smaller improvement on fathers parenting | Effective at improving parenting practices as measured by the self-report Suggestions of how to get more fathers involved | Culture not reported Lack of independence Different types of intervention included |
| Wilson et al. (2012) | Triple P parenting program | 23 | 648 | Maternal <i>d</i> =0.61 [0.42, 0.79] Paternal <i>d</i> =0.42 [-0.02, 0.87] | Triple P with a comparison condition Most of the studies involved families recruited via media | Mothers report that Triple P group interventions are better than no intervention No evidence of universality No long-term evidence 79% used wait list control. | Selective reporting bias Lack of independence Small studies Culture not reported |
| Tellegen et al. (2013) | Efficacy of Stepping Stones | 12 | 659 | Child behaviour <i>d</i> = 0.537 [0.372, 0.702] Parenting <i>d</i> = 0.725, [0.553, 0.896] | Effective for children with disabilities | Significant effects found for improving parenting No significant effects on parent observation data | Culture not reported Lack of independence |
| Sanders et al. (2014) | Efficacy of multilevel Triple P | 101 | 16,099 | Child behaviour <i>d</i> = 0.473 [0.404, 0.543] Parenting <i>d</i> = 0.578 [0.490, 0.666] | Triple P improved child social, emotional and behaviour Improved parenting | Effective for child and parenting outcomes | Parent self-report. Culture not reported Lack of independence |
| Cooley et al. (2014) | Effectiveness of PCIT | 11 | 496 | CBCL <i>d</i> = -1.06 [-1.93, -.19] ECBI <i>d</i> = -1.06 [-1.51, -.61] PSI Distress <i>d</i> = -.73 [-.97, -.48] | Improved child externalizing behaviours Improved parenting stress | PCIT was effective in reducing child externalising behaviours. | Importance of culture not reported |

| Study | Focus | <i>k</i> | <i>N</i> | <i>d</i> [CI] | Results | Discussion | Limitations |
|-----------------------|---|----------|----------|---|--|--|--|
| Ward et al. (2016) | To examine the efficacy of PCIT | 12 | 254 | <i>d</i> = 1.65, [1.41, 1.90], | Large improvement on child externalizing problems | Efficacious intervention for child DBD, Lack of diversity Excluded populations who were victims of abuse | Culture not reported Lack of independence |
| Kennedy et al. (2016) | Effectiveness of PCIT at reducing physical abuse | 6 | 571 | Physical abuse recurrence (* <i>g</i> = 0.52) | Significantly fewer physical abuse recurrences Improvement on parenting stress | Effective at reducing physical abuse recurrence and parenting stress for physically abusive families. | Culture not included Small studies |
| Thomas et al. (2017) | Effects of PCIT on child externalizing behaviours | 23 | 1144 | SMD -0.87, 95% CI -1.17—0.58 | PCIT was superior to control for reducing child externalizing problems Children more compliant PCIT effectiveness did not differ on intervention | PCIT has robust positive outcomes across multiple parent-reported and observed parent-child interaction measures | No cultural data |

Note. *Hedges' *g* effect sizes are reported such that positive estimates indicate results favouring the intervention group and negative effect sizes indicate results favouring the comparison or control group

3.4 Summary

Parenting is an important determinant of child wellbeing for the very young child and we now have substantial, high-quality evidence from meta-analysis that there are several evidence-based parenting programmes (EBPP) that work well and are a good return on the investment by the New Zealand government. As demonstrated by the review of the meta-analyses above, improving parenting skills can reduce child behaviour problems and reduce parental stress. The four programmes available in New Zealand (COS, IYPP, Triple P and PCIT) have at least one meta-analysis conducted.

The COS review had very limited evidence, and no cultural adaptations or studies which were included in the review. Therefore, it has limited applicability for whānau Māori.

Both the IY and Triple P did have some generic, good outcomes reported for improved child behaviour and parenting practices. Both of these interventions had included cultural adaptation and at one study conducted in New Zealand and with Māori families. The inclusion of culturally adapted programmes is important for Māori who are in the unique position of being the indigenous people of New Zealand. With this comes some additionally important issues, that is, that the studies must be conducted and analysed by Māori in order for them to align with kaupapa Māori research values (Cram, 1997, 2001).

PCIT, which is the newest of the parenting programmes to be introduced to New Zealand. It also shows good results for being able to improve disruptive behavioural disorders and improve parenting practices. It is important that Māori research is conducted to look at how PCIT may be enhanced and tailored so that it is more reflective of Māori practices and values. Given the active method of delivery and the fact that it has been shown to be able to reduce physical abuse, PCIT appears to be an important intervention for Māori to consider given the over-representation of Māori whānau. It may be that PCIT can offer support and help

to whānau Māori who are struggling to support their tamariki to flourish, or who have been abusive in the past. We require evidence to be able to see whether investing in PCIT will be helpful for whānau Māori, given our need to invest in supporting indigenous parenting frameworks too. There is a known tension for programme designers who do not want to lose intervention fidelity but also known as Baumann (2015) reminds us, that “culture counts” in mental health care. Culture is powerful because it shapes how people seek help and engage in health behaviours. In addition, it also shapes how providers communicate with clients and deliver services to our communities.

However, as indigenous people, who are politically astute Māori, also understand that they have a right to demand services that support a Māori worldview where Māori children are viewed as belonging to a whānau, hapū, and iwi and as such, the responsibility for raising children is shared beyond the immediate family (Cram, 2012). Accordingly, familial therapies need to be supported which are adaptive enough to be able to incorporate Māori parenting values.

Chapter 4: Literature review, PCIT in Indigenous communities

“Hapaitia te ara tika, pumau āi te rangatiratanga mo ngā uri whakatīpu.”

“Foster the pathway of knowledge, To strength, independence and growth for future generations.”

(Brougham et al., 1987)

4.1 Introduction

Like other governments in the world, New Zealand has promoted the widespread importation of foreign parenting programmes in order to deal with growing rates of child behaviour problems. However, the effectiveness of imported programmes across countries have had mixed results; some studies have indicated successful implementation (Gardner, Burton, & Klimes, 2006) while others have reported less successful outcomes (Malti, Ribeaud, & Eisner, 2011). More recently, Gardner and colleagues (2016) conducted a meta-analysis of 17 trials of transported parenting programmes into 10 countries (n=1,558). The vast majority of these trials (14/17) included mainly indigenous or “ethnically native” families. The results indicated that basic cultural adaptations such as translating training materials from English (the language of the country where the programme was developed) into the language of the trial country and using local native practitioners rather than foreign experts achieved a larger effect size ($d=0.96$) of improving child behaviour than trials conducted in English speaking countries ($d=.44$) (Gardner, Montgomery, & Knerr, 2016).

Culture matching of client and practitioner is well supported in New Zealand (Cargo, 2008a; Lapsley, Nikora, & Black, 2003; Maniapoto & Gribben, 2003) because indigenous practitioners add the cultural appropriateness to the programme or context. The ability to make subtle cultural adaptations, use their own language, and cultural examples, increases the suitability of the programme for Māori whānau (Cargo, 2008a; Herewini, 2014; Keown et al., 2018).

One of the programmes the New Zealand government has imported into New Zealand is Parent-Child Interaction Therapy (PCIT). PCIT is an effective evidence-based family psychotherapy for reducing behavioural problems in young children (2-7 years of age), designed in the US for the mainly white population and normed on white European-American ideologies. White Euro-American ideologies have dominated the parenting literature and culture has largely been ignored, meaning that the view of parenting is likely to be skewed (Patel & Sumathipala, 2001; Feldman and Masalha, 2007), and that culturally responsive interventions are likely to be limited (Patel & Sumathipala, 2001; Feldman and Masalha, 2007). Further, a failure to create a culturally responsive intervention may create a social injustice by limiting access to evidence-based interventions (Cram, Gulliver, Ota, & Wilson, 2015b).

The developers of PCIT have become more aware of the importance of becoming more culturally responsive. Given the cultural make-up of America (Butler & Eyberg, 2006; Fernandez, Butler, & Eyberg, 2011; Querido, Warner, & Eyberg, 2002), the fact that PCIT is being imported into other countries (Calzada & Eyberg, 2002), and that it is being used with indigenous populations (McNeil, 2010), it is important to fully understand the unique needs of indigenous communities.

This chapter first discusses appropriate definitions of indigenous people to set the context for the remainder of this chapter, and highlights some of the unique challenges of implementing PCIT in indigenous communities. This set the context for the remainder of the chapter which reviews the qualitative and quantitative cultural adaptation literature that exists for PCIT. The focus is on examining the commonly reported adaptations made across cultures and for indigenous communities so that those findings can be used to make PCIT in New Zealand more culturally responsive for *whānau* Māori.

4.2 Indigenous Peoples definition

Considering the diversity of indigenous peoples, an official definition of “indigenous peoples” has not been adopted by the United Nations (UN), instead they report that indigenous peoples is a term based on the following:

- Self- identification as indigenous peoples at the individual level and accepted by the community as their member.
- Historical continuity with pre-colonial and/or pre-settler societies
- Strong link to territories and surrounding natural resources
- Distinct social, economic, or political systems
- Distinct language, culture, and beliefs
- Form non-dominant groups of society
- Resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities (UN General Assembly, 2007).

The World Health Organisation (WHO, 2019) defines Indigenous populations a little differently, putting the focus more on the land area they were descended from and remain attached to, regardless of any modern definitions of territorial boundaries. However, like the UN the definition includes the importance of self-identification and the ability to maintain cultural and political aspirations that are separate from the mainstream, colonised, or dominant society (World Health Organisation, 2019).

Finally, the New Zealand Human Rights Commission (2012) reinforced the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) definition of Indigenous Peoples and also explained how the Treaty of Waitangi applied to Māori and the New Zealand situation. The Commission stated that the Treaty of Waitangi is strongly aligned and mutually consistent with UNDRIP and that the Treaty of Waitangi principles of partnership (good faith, cooperation, and shared decision making), participation (in society, on an equal basis and free

from discrimination), and protection (of self-determination, language, customs, knowledge, land and resources) help to provide practical applications of UNDRIP (NZ Human Rights Commission, 2012).

Perhaps the final point to make is that there are reported to be only four countries that have never been colonised including Japan, Korea, Thailand and Liberia (The World Bank, 2020). Most indigenous peoples have had to survive the impact of colonisation, which has created a lasting legacy of negative health, social, economic, and political consequences for its people – especially its most vulnerable – its children (Cram, Gulliver, Ota, & Wilson, 2015a; Pihama et al., 2014; Taonui, 2010). Hence, the importance of being able to provide culturally responsive evidence-based parenting programmes.

4.3 Cultural adaptations of PCIT – review of qualitative studies

This review aimed to synthesise the qualitative data from studies which addressed the issue of the cultural adaptations of PCIT. The objective was to gather information regarding the cultural adaptations of PCIT

4.3.1 Methods

1. Data Sources

Searches were conducted in six databases: Embase, Medline, Psycinfo, Eric, Cochrane Library and Google Scholar. Additional search strategies included ancestry searching wherein I examined the reference lists of included studies. Grey literature within a search of Google Scholar or reported from other sources was also included.

2. Inclusion criteria

- Indigenous parents and/or parents from other ethnic minority/diverse cultural groups who were involved in adapting standard PCIT.
- The study should be qualitative or include qualitative aspects.

- The study should lead to some suggestions or recommendations for effective cultural adaptations.

3. Exclusion criteria

- Not indigenous
- No Ethnicity data included
- Not PCIT

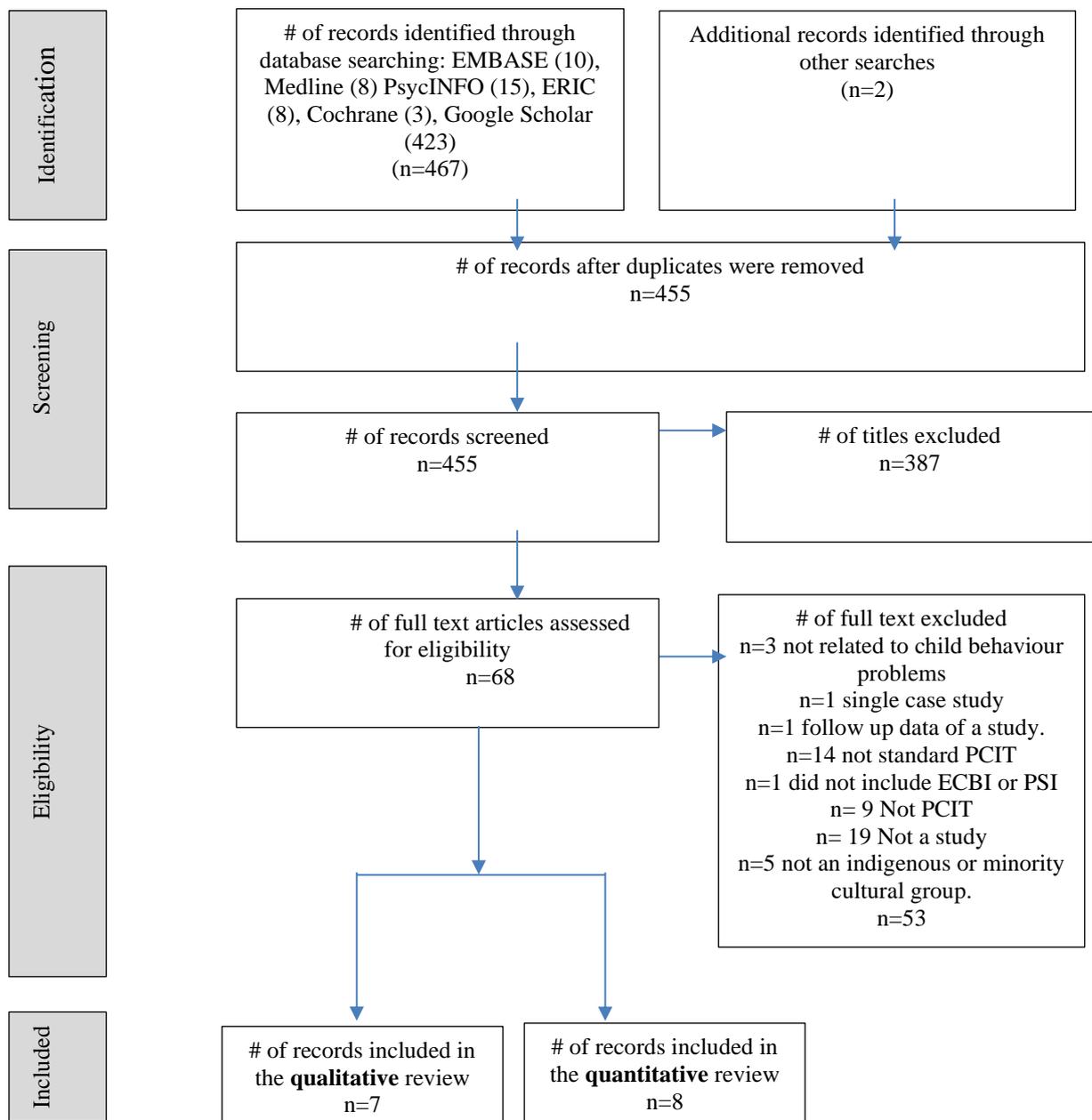
4. Screening for Inclusion and Data extraction

Initial screening was undertaken to identify potential articles meeting the inclusion criteria from the titles and abstracts. Full texts were obtained both for the relevant articles and for any study whose inclusion was unclear. All articles were examined to ensure that they met all the inclusion criteria. I screened the titles and abstracts, and then full texts of those articles deemed potentially relevant for inclusion myself, with any uncertainty resolved by discussion with another clinician. The PRISMA flow diagram procedure was used to ensure rigor in the selection process (see Figure 2).

The actual content for data extraction includes:

- Aims of the qualitative study
- Details of the PCIT adaptation
- Any related outcomes of the study

Figure 2 PRISMA Flowchart of study inclusion criteria



To facilitate a narrative synthesis of the data from the included studies, several tables were used.

- Table 3 provides general characteristics of the included PCIT studies (author, year of publication, country, and type of paper, basic demographics, measures used, and recommendations for adaptation and discussion points).
- Table 4 provides a list of the key components of the cultural adaptations identified in the studies, key therapist qualities suggested, issues related to retention and any barrier to treatment that might need to be planned for.

4.3.2 Results

1. Search outcome

The bibliographic search yielded 467 articles. After removing duplicates, a total of 455 abstracts were screened. Out of these, 68 full-text articles were assessed for eligibility. In the end, a total of seven studies met the inclusion criteria for this qualitative review. A summary of the literature identified at each stage of the search process can be found in Figure 2.

2. Qualitative studies: general characteristics

Seven studies, which included recommendation papers, PCIT cultural adaptations, and acceptability studies (see Table 3) were included. Three studies were conducted in North America (Dunlap-Ballew, 2005; McCabe, Yeh, Garland, Lau, & Chavez, 2005; Niec et al., 2014), one in the unincorporated territory of the United States (Matos, Torres, Santiago, Jurado, & Rodriguez, 2006) and one in Africa (Milz, 2015). In addition, there were two discussion pieces, which weren't studies as such, but reported on the manner in which cultural adaptations for PCIT could be conducted; one in the US, looking at Native Americans (Bigfoot & Funderburk, 2011); and the other in New Zealand, discussing how to make PCIT more appropriate for Māori (McNeil, 2010). There were two doctoral studies (Dunlap-Ballew, 2005; Milz, 2015); two discussion papers, based on expert opinion (Bigfoot & Funderburk, 2011;

McNeil, 2010; Niec et al., 2014); and three PCIT cultural adaptations, one for American Indian and Alaskan Native parents called Honouring Children – Making Relatives (Bigfoot & Funderburk, 2011), one for Mexican Americans called Guiando A Ninos Activos or GANA (McCabe et al., 2005), and one for Puerto Rican natives (Matos et al., 2006). All seven studies used focus groups and interviews as the main method for uncovering recommendations for the types of cultural adaptations that might be required to make PCIT more culturally sensitive (see table 4). The cultural groups included Native American Indians (Bigfoot & Funderburk, 2011; Dunlap-Ballew, 2005), Mexican Americans (McCabe et al., 2005), Latina/o parents in the United States, Puerto Rican natives (Matos et al., 2006), Zambian parents (Milz, 2015), and Māori parents in New Zealand (McNeil, 2010).

3. Qualitative studies: findings about required adaptations

Table 4 shows the items identified in each of the studies which were identified as key to adapting PCIT to be more culturally appropriate.

4. International studies

The Honouring Children-Making Relatives (HC-MR) is a PCIT cultural enhancement programme recommended as the key way to make PCIT more culturally responsive to the American Indian (AI) indigenous community (see Table 6). It was designed from the amalgamation of PCIT and the Parent Training Manual for American Indian Families (Bigfoot, 1990). HC-MR is based on traditional AI knowledge and “the Circle Theory” – a fundamental American Indian cultural belief and practice where the child is placed at the centre of the circle and is surrounded by supportive family members and parenting is carried out by the extended family. This is to help reinforce that the child is central and needs to be the focus of the intervention. HC-MR was further refined by AI cultural consultants to include longer introductory sessions and spending time to talk about cultural parenting practices. Currently there have not been any reported clinical trials or case studies of HC-MR.

The *Guiando A Ninos Activos* (Guiding Active Children) or GANA programme is a PCIT cultural adaptation designed to be responsive to the Mexican American (MA) community (McCabe et al., 2005). This adaptation was developed by having bilingual therapists, Mexican American (MA) therapists, and MA cultural experts discussing PCIT and then making cultural changes to the model. Then the adaptations were discussed with the developer of PCIT to ensure that GANA was able to maintain integrity to the PCIT model (see Table 6). GANA has been tested in several RCT studies (K. McCabe, Yeh, Lau, Argote, & Liang, 2010) and shown to be effective for MA children with disruptive behaviour challenges. The most recent study examined treatment effects over a six to 24-month period posttreatment for three different interventions for behavioural problems in MA children: GANA, standard PCIT, and treatment as usual (TAU). There were 58 MA families were randomly assigned to GANA, standard PCIT, or TAU. As previously reported, all three treatment approaches produced significant pre-post improvement in conduct problems across a wide variety of parent-report measures, and those effects remained significant over the follow-up period. GANA was superior to treatment as usual in six out of ten parent report measures up to two years later, and had similar effect sizes to standard PCIT .

The third study adapted PCIT for Puerto Rican (PR) families in Puerto Rico for children with hyperactivity and other behaviour problems. The process of translation and adaptation was guided by a framework of cultural sensitivity for outcome research by Bernal and colleagues in two different studies (Bernal & Sáez-Santiago, 2006; Bernal & Scharró-del-Río, 2001). There were some adaptations over and above simple translation, such as the inclusion of longer sessions (1.5 hours) and an extension of the time given to talk with parents beforehand to discuss other issues or challenges; this was seen as important for rapport building (see Table 2). This adaptation became known as the PCIT adapted treatment manual (Matos et al., 2006). The adaptation was later tested in a RCT involving 32 PR families with young children with

hyperactivity and behavioural problems. The results showed a large clinical effect size on the standard measures used and had a high (90%) completion rate (Matos, Bauermeister, & Bernal, 2009).

A doctoral thesis focused on the acceptability of PCIT for American Indian parents and children. The study recommended cultural changes required for an adapted PCIT programme for AI families. The study surveyed 51 AI parents of slightly older children (6-12 years of age) than the PCIT age range (2-7 years of age) about how acceptable key components of PCIT might be for AI families. For the most part, the families appeared to accept both the Child Directed Interaction (CDI) and the Parent Directed Interaction (PDI) components of PCIT (Dunlap-Ballew, 2005). However, this study was a cross-cultural study and it was unclear whether the author was researching from within her own cultural community. None of the parents had ever received PCIT and so they had no real experience of how and what it might feel like to participate in PCIT. In addition, the sample size for the survey was small (n=36) and there were only 15 interviews conducted.

More recently, Niec (2014) conducted six focus groups with 52 Latina/o parents living in the US about how acceptable they felt PCIT would be for Latina/o families. This included recommendations for how to make PCIT more culturally responsive for Latina/o families (see Table 4). They gained extensive feedback about how to better meet the needs of Latina/o families, which included the use of natural helpers, who were viewed within the Latina/o community as less threatening and less intimidating than therapists (Niec et al., 2014). Again, this was conducted with families who had never been engaged in PCIT and the writer was not from the same cultural background of the study participants.

The final study was based in Zambia with an indigenous population. It was a three-day workshop with 19 Child Youth Care Workers (CYCW) who were invited to a PCIT and Trauma workshop. Focus groups were conducted, questionnaires and surveys completed, and

a variety of cultural adaptations were suggested to make PCIT more culturally sensitive to Zambian parents and their children. Four key areas were identified: engagement of Ubuntu approaches to working with children, inclusion of traditional play items, advocating for wellbeing of children, and the use of other cultural practices to make PCIT more cultural responsive to the needs Zambia families (Milz, 2015). None of these professionals had ever been involved in the delivery of PCIT, although they had watched some video tapes of PCIT being conducted. Further, the writer was not an indigenous Zambian.

4.3.3 Summary

There were six different cultural groups represented across these studies and results generally supported that these groups accepted the use of PCIT in their communities. Across these studies were several key adaptations highlighted (see Table 4) about how to culturally tailor PCIT to make it more culturally responsive whilst still maintaining the fidelity to the PCIT model. Firstly, that the basic translation of PCIT materials into the communities own language is crucial because language is how culture is transmitted (Gelman & Roberts, 2017; Mazari & Derraz, 2016; Salzmann, Stanlaw, & Adachi, 2014). Secondly, the inclusion of cultural beliefs and practices in the form of appropriate play materials was also identified across the cultural groups. This appears to be important so that children can learn and play in ways that reinforce their cultural identity (Fleer, 2009; Gaskins, 2014; Goncu, Tuermer, Jain, & Johnson, 1999). Thirdly, there were qualities of openness, non-judgement, and friendliness that were reported by all seven studies. These skills are important because they help to build relationships so that the caregivers feel invested in PCIT, which is an intensive therapy, and are then more likely to complete the treatment (Matos et al., 2006). Finally, the need to address racism and socio-economic factors so that culturally diverse peoples can attend PCIT more and therefore receive a therapeutic dose of the treatment was seen as important (see Table 4).

Table 3 *Characteristics of Included PCIT Qualitative Studies*

| Study | Type | Purpose | Sample | Measures | Suggestions | Discussion |
|-----------------------|-------------------|--|---|---|--|---|
| Dunlap-Ballem (2005) | PhD | Acceptability with Native American (NA) parents in Oklahoma. | 51 Native American Indian parents of children (6-12yrs) Interviews | Demographics Acculturation Scale Parenting Stress Index Perceived Social Support Questionnaires | Individual tailoring Include cultural activities Include how to manage disrespectful behaviours Counsellor friendly NA counsellor. | Less likely to ignore misbehaviour Accepted CDI Accepted PDI Small sample No experience of PCIT |
| Matos et al. (2006) | Pilot study | Adaptation for Puerto Rican (PR) families | 24 PR families PCIT(n=9) Interviews (n=15) 5 PR psychologists | Demographics Interviews | Translation Psycho-education Extended time Use cultural metaphors Include wider family Longer sessions | 99% retention rate Accepted PCIT Time-out room not acceptable Relationship focus Therapist warmth |
| Bigfoot et al. (2011) | Discussion paper | Adaptation for American Indian (AI) and Alaskan Native (AN) parents. | Interviews AI cultural consultants Interviews with AI developers of EBTs | Qualitative interviews | Include wider family Focus on reciprocity Extend coding time Use cultural graphics Use cultural play Use cultural praise Coach as helper | Accepted PCIT Cultural enhancement supported |
| McCabe et al. (2005) | Development study | Adaptation for Mexican American (MA) | MA therapists (12), MA parents (12). | Qualitative interviews | Tailor to MA Frame as educational Therapist as teacher Align MA culture Target engagement Target rapport Translation | MA strict discipline approach MA adaptation |

| Study | Type | Purpose | Sample | Measures | Suggestions | Discussion |
|--------------------|------------------|--|--|---|--|---|
| McNeil (2010) | PCIT Pilot | Therapist satisfaction and cultural appropriateness | 25 NZ PCIT therapists including Māori | Focus group interviews | Māori include whānau Align Maori culture Translation Code in the room Use cultural play Use touch as praise Time-out room concerns | PCIT Promising Māori therapist provide the cultural context. More time to discuss By for Māori |
| Milz (2015) | PhD | Cultural implications for PCIT in Zambia | 19 English speaking workers in Zambia | Demographics Focus groups Questionnaires Surveys | Strengthen Zambia culture Community promotion Include colonisation. Include Zambian values Use culture play Child focused | Zambian values. Collectivist culture. Zambian adaptation |
| Niec et al. (2014) | Prevention study | Latina/o (LO) parent's opinions about parenting and PCIT | 52 LO parents Interviews with 8 community representatives | Focus group interviews | Home visits Include wider family Use LO teachers to promote and teach Time-out concerns Punishment issues. | Adaptation of PCIT as a prevention treatment for LO families with conduct problems |

Table 4 *Components of PCIT adaptations*

| | Dunlap-Ballew (2005) Native American Indian (USA) | Matos et al. (2006) Puerto Rican Families (A territory of the US) | Bigfoot et al. (2011) Native American Indian (USA) | McCabe, et al. (2005) Mexican American (USA) | McNeil (2010) (New Zealand) | Milz (2015) Zambia, (Africa) | Niec et al. (2014) Latina/o (USA) |
|------------------------------|--|--|---|---|--------------------------------|---------------------------------|--------------------------------------|
| PCIT acceptable | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| PCIT requires tailoring | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Concerns | | | | | | | |
| Ignoring | ✓ | ✓ | ✓ | | ✓ | | ✓ |
| Praise | | | ✓ | | ✓ | ✓ | ✓ |
| Play | | ✓ | ✓ | | ✓ | | ✓ |
| Time-out | | ✓ | ✓ | | ✓ | | ✓ |
| Live coaching | | | | | ✓ | | ✓ |
| Cultural Items | | | | | | | |
| Translation | ✓ | ✓ | ✓ | ✓ | | | |
| Cultural activities | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Cultural beliefs/values | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Extended family | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Native language | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Positive approach | | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Group/community approach | | | | | ✓ | ✓ | ✓ |
| Family approach | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Colonisation acknowledgement | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Acculturation stress | | | | | | | |

| | Dunlap-Ballem (2005) Native American Indian (USA) | Matos et al. (2006) Puerto Rican Families (A territory of the US) | Bigfoot et al. (2011) Native American Indian (USA) | McCabe, et al. (2005) Mexican American (USA) | McNeil (2010) (New Zealand) | Milz (2015) Zambia, (Africa) | Niec et al. (2014) Latina/o (USA) |
|-----------------------------|--|--|---|---|--------------------------------|---------------------------------|--------------------------------------|
| Therapist | | | | | | | |
| Friendly, open, non-judging | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Cultural matched | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Reciprocity in coaching | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Teacher role | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Jargon free | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Retention | | | | | | | |
| Active engagement | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Address barriers | ✓ | | | | | ✓ | ✓ |
| Outreach | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Barriers | | | | | | | |
| Racism | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Poverty | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Extended family | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Stigma | ✓ | | | ✓ | | ✓ | ✓ |
| Language barriers | ✓ | | | ✓ | | | |
| Transport | ✓ | | | ✓ | ✓ | | |

4.3.4 New Zealand studies

Since PCIT was introduced into New Zealand there have been increasing numbers of Māori practitioners who have been trained in the model. McNeil (2010) interviewed three Māori practitioners who had been trained in PCIT and emphasised the importance of viewing the child in the context of the extended whānau. Therefore, PCIT needed to be able to be responsive to a collective parenting approach if it was going to be more culturally responsive to Māori families. In addition, McNeil (2010) reported that the use of *tuakana/teina* [processes means that Māori older children may be expected to look after and care for younger children], which is strongly reinforced in Māori culture, where the older child learns about parenting through the actual experience of caring for a younger sibling. The Māori practitioners stated that Māori families tend to value a “learn by doing” approach of self-reflection and self-discipline through observation of elders, rather than by being “told” what to do.

Some important cultural responsiveness suggestions were made, such as beginning the session with *karakia*, practice *mihi*, and *powhiri*. They also stated that cultural sensitivity lies in the therapist as well as the programme and felt that it was up to the therapist to translate the PCIT principles into language and concepts that fit with the family’s cultural identity. In particular, McNeil (2010) reported that Maori therapists discussed that the use of coding may have negative connotations for some Māori whānau because of the history of colonisation and institutionalised racism that exist in New Zealand.

There were also concerns regarding the discipline programme in PCIT. Because in Māori communities the elders are nurturers and shower their grandchildren with love and positive attention, the use of timeout was not seen as appealing. The final aspect was the idea that verbal praise is less likely to be used in Maori homes, where the value is mostly one of physical contact through touch, such as hugs, kisses, and gestures. This is because cultural values believe that praise should be seen rather than talked about and that to talk about oneself

in a positive regard is not valued, shown in the *whakatauki* “*Kāore te kumara mō tōna ake reka*” (the kumara doesn’t speak of its own sweetness). The meaning is one that encourages people to be modest, humble, and practice humility, and discourages people from being arrogant and pompous.

4.4 Cultural adaptations of PCIT – quantitative studies

This systematic literature review aimed to synthesise the evidence and effectiveness of PCIT with Indigenous Peoples (or other term such as Native, Aborigine, First Nations etc.), and/or Peoples of ethnic minority or other cultural diverse communities. The objective was to analyse the available quantitative evidence regarding the efficacy of PCIT delivered to Indigenous parents (or other term such as Native, Aborigine, First Nations etc.) and/or Peoples of ethnic minority or other culturally diverse communities.

4.4.1 Methods

1. Data Sources

Searches were conducted in six databases: Embase, Medline, Psycinfo, Eric, Cochrane Library, and Google Scholar. Additional search strategies included ancestry searching wherein we examined the reference lists of included studies and included any grey literature within a search of Google Scholar. The titles, abstracts, and index terms were searched using combinations of relevant keywords related to parent-child interaction therapy, behaviour/behaviour parent training, indigenous populations, indigenous peoples, native people, first nation’s people, aboriginal, ethnic minority, ethnic self-definition, cultural minorities, diverse communities, and diversity. All terms were combined with the Boolean operators AND OR. The year limits were established as between January 2000- October 2019. Only those articles available in English were reviewed.

2. Inclusion criteria

- Indigenous parents (or other term such as Native, Aborigine, First Nations etc.), and/or Peoples of ethnic minority or other culturally diverse communities, whose children are aged between two and seven years old and have behavioural problems
- The intervention should only be Parent-Child Interaction Therapy.
- The study should, at minimum, have 50% of the sample that self-identified as Indigenous or ethnically/culturally diverse parents.
- The study should be an RCT, or if there were no RCT's, then Pre-Post experimental designs will be considered.
- The study should assess child behaviour problems through the use of the ECBI and improvement in parenting stress using the PSI.

3. Exclusion criteria

- Not Indigenous or from other ethnic minority/diverse cultural groups
- Not PCIT
- No Eyberg Child Behavior Inventory (ECBI) or Dyadic Parent-Child Interaction Coding System (DPICS).
- Children not aged two to seven.

4. Screening for inclusion and data extraction

Initial screening was undertaken to identify potential articles meeting the inclusion criteria from the titles and abstracts. Full texts were obtained both for the relevant articles and for any study whose inclusion was unclear. All articles were examined to ensure that they met all the inclusion criteria. Any uncertainties were resolved by discussion between writer and another senior clinician. The PRISMA flow diagram procedure was used to ensure rigor in the selection process (see figure 1).

The actual content for data extraction includes:

- Demographic and cultural composition of the sample and therapist

- Details of the PCIT intervention (including any adaptations);
- The primary outcome is child problem behaviour measured by Eyberg Child Behaviour Inventory (ECBI), and secondary outcome is parenting stress measured by Parenting Stress Index (PSI)
- Risk of bias was assessed using CASPe guide.

To analyse and synthesise the data from included studies, several tables were used. Table 3 provides general information of the studies (author, year of publication, country, design, sample, setting, measurement tools, and main results). For methodological quality assessment, an adaptation of the CASPe guide developed by Ruiz-Zaldibar, Serrano-Monzo and Mujika (2017) was used (Table 5).

Table 4 *Study Quality Based on the CASPe Guide for Controlled Trials.*

| Study | Questions | | | | | Quality |
|-------------------|--|--|--|---|---------------------------------|---------|
| | Was the study aimed at a clearly defined question? | Was the assignment of participants random? | Were all participants adequately considered until the end of the study | Were the groups similar at the start of the trial | Were the groups treated equally | |
| Chen (2015) | ✓ | x | ✓ | x | x | Low |
| Danko (2016) | ✓ | x | ✓ | x | x | Low |
| Fernandez (2011) | ✓ | x | ✓ | x | x | Low |
| Leung (2008) | ✓ | x | x | ✓ | x | Low |
| Leung (2014) | ✓ | ✓ | ✓ | ✓ | ✓ | High |
| McCabe (2009) | ✓ | ✓ | ✓ | ✓ | ✓ | High |
| Matos (2009) | ✓ | ✓ | ✓ | ✓ | ✓ | High |
| Self-Brown (2012) | ✓ | x | X | x | x | Low |

4.4.2 Results

1. Search outcome

The bibliographic search yielded 467 articles. After removing duplicates, a total of 455 abstracts were screened. Out of these, 68 full-text articles were assessed for eligibility. In the end, a total of eight studies met the inclusion criteria for this review. A summary of the literature identified at each stage of the search process can be found in Figure 2

2. Study design

Study designs included three randomized controlled trials (Leung, Tsang, Sin, & Choi, 2014; Matos et al., 2009; McCabe & Yeh, 2009), one controlled trial (Leung, 2008) and four quasi-experimental 'pre-post' studies (Chen, 2015; Danko, 2016; Fernandez, 2011; Self-Brown, 2012).

3. Location of Studies

Five studies were conducted in North America (Danko, Garbacz, & Budd, 2016; Fernandez et al., 2011; Matos et al., 2009; McCabe & Yeh, 2009; Self-Brown et al., 2012), three in China, (Leung et al., 2008; Leung, Tsang, Sin, & Choi, 2014).

4. Therapist Qualities

Four studies reported that they used bilingual or native speaking therapists, so that there was therapist and parent culture-matching (Matos et al., 2009; McCabe & Yeh, 2009). One study reported that the therapists and parents were not culture-matched (Fernandez et al., 2011) another study reported that the therapists were from diverse racial and ethnic backgrounds (Danko et al., 2016). One study the other four studies either did not report any information regarding therapist characteristics other than their academic qualifications (Danko et al., 2016; Fernandez et al., 2011; Leung et al., 2014; Self-Brown et al., 2012).

5. Setting

Three of the studies were conducted in community clinics (Danko et al., 2016; Fernandez et al., 2011; Self-Brown et al., 2012) and two were in university clinics (Chen & Fortson, 2015; Leung et al., 2008) and two did not report the setting (Matos et al., 2009; McCabe & Yeh, 2009).

6. Indigenous population/ethnicity

Chen & Forston (2015) reported the parents' race as predominantly Taiwanese while Leung and colleagues (2008) reported only that the sample was Chinese (Leung et al., 2008). There were two studies that included African American (AA) families, one study only described that 23.1% of their sample was AA (Danko et al., 2016) while the other study reported that 100% of the families were AA (Fernandez et al., 2011). Lantia/o families were included in two studies, representing 55.4% of the sample (Self-Brown et al., 2012), and 36.5% of the sample (Danko et al., 2016). The final two studies reported 100% MA families (McCabe & Yeh, 2009) and 100% Puerto Rican families in Puerto Rico (part of the Caribbean Islands, but considered part of North America).

7. Target of PCIT

The two studies with Chinese families targeted different things. The first study by Leung and colleagues (2008) targeted both child behavioural problems and parenting stress, whereas the Chen and Fortson (2015) study focused on parents and trying to identify the qualities of Chinese parents in PCIT that predict treatment attrition and treatment length. Two studies looked at low income African American families and children with behavioural problems (Danko et al., 2016; Fernandez et al., 2011). McCabe and Yeh (2009) targeted child behaviour problems but were interested in whether GANA was as effective as standard PCIT

and Treatment as Usual (TAU) for low income MA families. Matos and colleagues (2009) were interested in ADHD in young children and used PCIT to help improve ADHD behaviours.

8. Characteristics of parents

In four of the five US studies the focus was on vulnerable populations: low-income families, disadvantaged families, or mothers at psychosocial risk. Participants were mostly women (80-95%) who attended the therapy, while the children were mostly boys (60%). However in the Puerto Rican study, the families were high achieving with no identifiable risk factors (Matos et al., 2009). In six studies boys made up over 65% of the sample (Danko et al., 2016; Fernandez et al., 2011; Leung et al., 2008; Matos et al., 2009; McCabe & Yeh, 2009), while the final study involved parents and so no child data was presented (Self-Brown et al., 2012).

There was a wide variance in terms of parental education and family income across the studies, which tend to be positively related to each other, meaning higher education indicated higher income (see Table 3). In three studies (Danko, Matos, Chen) over 65% of the parents were described as highly educated e.g. having had a college or higher degree and a significantly higher mean income than parents in the other studies. In four studies (Fernandez et al., 2011; Leung et al., 2008; McCabe & Yeh, 2009) the household income was below \$US 20,000 for 70% of the families.

9. Details of intervention/adaptation

The two Chinese studies translated the PCIT manual and used Chinese languages in sessions, but there were no other adaptations made to PCIT (Leung et al., 2008). The other US studies used either English or Translation for Latina/o and Mexican American families only, but no other adaptations were made (Danko et al., 2016; Fernandez et al., 2011; Self-Brown et al., 2012). Both the McCabe and Yeh study (2009) and the Matos and colleagues study (2009)

made significant adaptations and used their own treatment manuals, see the above qualitative study review for more information (Table 4).

10. Retention in training

The ability to retain parents in training, so that they received a minimum therapeutic dose, was a significant issue with a wide variation of retention rates in the studies from 44%, for over half the studies in the Self-Brown study (Self-Brown et al., 2012), to 77%, in the Leung and colleagues study (Leung et al., 2008). Interestingly those programmes which were conducted in their own countries with their own culture-matched therapists had significantly higher retention rates (73% and 77% respectively) than the other studies (Chen & Fortson, 2015; Leung et al., 2008), while one study, with mostly white therapists working cross-culturally, had the lowest rate of 44% (Fernandez, 2011).

4.4.3 Outcomes

Child assessment methods varied across studies; however, all six studies included the ECBI which enabled good comparison between studies. Parental stress was assessed in five studies (Chen & Fortson, 2015; Danko et al., 2016; Fernandez et al., 2011; Leung et al., 2008; McCabe & Yeh, 2009) using a well-validated measure – the Parenting Stress Index (PSI). Self-Brown and colleagues (2012) used benchmarking as a way to look at programme evaluation to see if the outcomes of the parents/children, who participate in PCIT, approximate the outcomes found in randomised trials.

Table 5 *Characteristics of Included PCIT Studies*

| Study Country | Design | Ethnicity of Parents (%) | Parent education level | Family Income Mean \$000 | PCIT Fidelity | Intervention Focus | Outcome | Attrition (%) |
|---------------------------------|----------|---|--|--------------------------|---------------|--|---|---------------|
| Chen et al. (2015) China | Pre-post | Min Nan Taiwanese (88.6%) | < 12 th Grade (34.1%) College plus (65.9%) | X | Yes | Treatment attrition | Attrition: Personality Single parent Child removal Low parent education | 27 |
| Danko et al. (2016) USA | Pre-post | Black/African American (23.1%) Hispanic/Latino/a (36.5%) White (28.5%) Asian/Asian Am (1.9%) | <12 th Grade (7.7%) High school (23.1%) Graduated college (34.6%) | 45.1 | Yes | Oppositional children from low-income ethnically diverse families completion rates | Higher levels of education Two parent homes White families | 52 |
| Fernandez, et al. (2011) USA | Pre-post | African Am (100%) | X | X | Yes | DBD children from low-income African American families | Significant improvement in child behaviour improvement in parental depression | 56 |
| Leung et al. (2008) China | RCT | Female parents | < 9yrs education 40% | < 20 | Yes | Children with significant behaviour problems Parenting stress | Effective in reducing behaviour Decrease parenting stress | 23 |

| Study Country | Design | Ethnicity of Parents (%) | Parent education level | Family Income Mean \$000 | PCIT Fidelity | Intervention Focus | Outcome | Attrition (%) |
|------------------------------------|-----------------|--|------------------------|--------------------------|---------------|--|---|---------------------------------|
| Leung et al. (2014) HongKong | RCT | Comparison Male 78% | | < 20 | Yes | Children with significant behaviour problems Parenting stress | Effective in reducing child behaviour problems Decrease parenting stress | 22 |
| Matos et al. (2009) Puerto Rico | Pre-post | Puerto Rican (100%) | Bachelor's Degree | X | Yes | Culturally adapted PCIT focus on ADHD | 75% no longer in the clinical range for ECBI-I. | 10 |
| McCabe & Yeh. (2009) USA | RCT | Mexican American (100%) | X | 23 | Yes | Compared culturally modified GANA, to standard PCIT and TAU for Mexican Am | Improvement in all Parents more satisfied with GANA. | Gana 43% PCIT 32% TAU 56% |
| Self-Brown et al. (2012) USA | Bench - marking | Latina/o (55.4%) African Am (37.3%) Caucasian (7.2%) | X | X | Yes | Case illustration of benchmarking of PCIT. | Completers Latino/a, Spanish speaking | 35% |

4.4.4 Quality assessment

Quality assessment of the studies was based on the methodological approach of the study, given that PCIT is already an evidence-based intervention. Six of the studies had documented strategies to ensure that PCIT was being delivered with fidelity, such as completing written session fidelity checklists (Chen & Fortson, 2015; Danko et al., 2016; Fernandez et al., 2011; Matos et al., 2009); and receiving supervision by highly experienced PCIT clinicians (Chen & Fortson, 2015; Danko et al., 2016; Matos et al., 2009) three studies involved the review of a percentage of tapes (10-25%) of sessions to check for session content according to the fidelity checklist (Danko, 2016; (Danko et al., 2016; Matos et al., 2009; McCabe & Yeh, 2009; Self-Brown et al., 2012). One study (Leung, 2009) did not report any treatment integrity items.

In terms of methodological quality (Table 5), only two studies (Matos et al., 2009; McCabe & Yeh, 2009) was regarded as having high quality, while the other five were considered low quality because they lacked a comparison group and or had no randomisation.

4.4.5 Efficacy results

The focus for the interventions was described predominantly as efficacy or effectiveness trials for PCIT with minority populations (Table 3). The primary endpoint for most of the studies was child behaviour and parental stress. All seven studies showed clinically significant improvement in child behaviour using the ECBI to indicate this change (Table 4). There were large effect sizes ($d=.97$ to $d=3.38$) observed across the studies. In the five studies that used the PSI as the measure for parenting stress one study showed no change (Fernandez, 2011), while the other four studies showed moderate to large effect sizes ($d=.64$ to $d=1.99$).

Table 6 Results of the Intervention Studies: Means, Standard Deviations and Effect Sizes for Parent-Child Report Measures

| | Pre-treatment | | Post-treatment | | Follow up | | Main Effect | |
|---|---|--|---|---|--------------------------------------|-------------------------------------|---|---|
| | ECBI Intensity M (SD) | PSI Total Stress Score M (SD) | ECBI Intensity M (SD) | PSI Total Stress Score M (SD) | ECBI Intensity M (SD) | PSI Total Stress Score M (SD) | ECBI | PSI |
| Chen (2015) <i>n</i> =44 | 139.03 (34.62) | 57.75 (9.54) | 97.34 (27.47) | 48.97 (7.00) | 102.50 (31.06) | 48.03 (8.36) | d=1.20 | d=0.92 |
| Danko (2016) <i>n</i> =13 | 150.44 (33.40) | 93.92 (20.85) | 80.92 (26.28) | 80.44 (21.45) | | | t(24) = 10.13** d = 2.30 | t(24) = 3.43* d = 0.64 |
| Fernandez (2011) <i>n</i> =18 | 171.81 (4.80) | 98.38 (19.52) | 125.25 (45.55) | 94.25 (22.13) | | | t(7)=3.14* d=.97 | t(7)=.92, d=.14 |
| Leung (2008) <i>n</i> =48 PCIT <i>n</i> =62 Control | PCIT Control 164.65 146.10 (22.78) (17.65) | PCIT Control 121.60 112.87 (17.16) (14.35) | PCIT Control 102.21 140.19 (26.00) (22.17) | PCIT Control 85.27 109.08 (19.91) (14.98) | PCIT Control 96.41 (19.90) | PCIT Control 80.91 (12.42) | Significance F(2,66) 218.67*** d=1.59 | Significance F(2,66) 155.50 *** d=1.38 |
| Leung (2014) <i>n</i> =54 PCIT <i>n</i> =57 Control | PCIT Control 167.80 16084 (24.34) (17.76) | PCIT Control 123.80 122.72 (16.28) (15.60)) | PCIT Control 111.63 152.99 (26.37) (32.26) | PCIT Control 101.99 115.46 (18.69) (18.22) | PCIT Control 107.42 (26.08) | PCIT Control 97.78 (17.34) | Significance F(3,102) 66.93 *** d=1.40 | Significance F(3, 102) 42.04, *** d=0.78 |
| McCabe (2009) <i>n</i> =58 | Not listed in the study | Not listed in the study | 84.30 (34.40) | | | | d=3.38 | d=1.99 |

| | Pre-treatment | | Post-treatment | | Follow up | | Main Effect | |
|---|---|-------------------------------------|--|-------------------------------------|------------------------------------|-------------------------------------|-------------|-----|
| | ECBI Intensity M (SD) | PSI Total Stress Score M (SD) | ECBI Intensity M (SD) | PSI Total Stress Score M (SD) | ECBI Intensity M (SD) | PSI Total Stress Score M (SD) | ECBI | PSI |
| Matos (2009) <i>n</i> =20 PCIT <i>n</i> =12 Control | PCIT Control 68.86 71.93 (8.46) (9.79) | Not used in the study | PCIT Control 51.52 68.36 (10.05) (9.74) | | PCIT Control 58.42 (8.83) | - | | |
| Self-Brown (2012) <i>n</i> =83 | 134.3 | Not used in the study | 94.08 | | | | d=1.13 | |

Note. M = Mean; SD = Standard Deviation; ECBI = Eyberg Child Behavior Inventory; PSI = Parenting Stress Index; $d = (M_{\text{post}} - M_{\text{pre}}) / SD_{\text{pre}}$, where M_{post} was the mean value at post-treatment or at follow-up, M_{pre} was the mean value at pre-treatment, and SD_{pre} was the standard deviation at pre-treatment*** $p < .001$. ** $P < .005$; * $p < .05$

4.5 Discussion

These reviews highlight important cultural adaptations required to PCIT and illustrate the efficacy of such adapted PCIT programs for Indigenous or ethnically/culturally diverse communities. This highlights the amenability of the PCIT model for alterations, tailoring, or adaptations to better meet the needs of culturally diverse families and their children, both in the United States (American Indian, Alaskan Natives, Mexican Americans), and outside of the United States (Puerto Ricans, Chinese, Taiwanese, Zambian and Māori). The cultural adaptations showed that when cultural experts and family members are included in the adaptations, similar positive results from western studies were also found in these cultural adaptation studies.

The six quantitative results showed that PCIT with Indigenous or ethnically/culturally diverse parents achieves similar results as US populations. This is consistent with findings of a large meta-analysis conducted by Gardner and colleagues (Gardner et al., 2016), where providing slight changes such as translation can have positive results when the therapist is also Indigenous or ethnically/culturally diverse.

There was general agreement that the main concepts of PCIT were acceptable to the indigenous and minority families who participated in the qualitative studies. However, most of the acceptability was based on people who had never completed PCIT before and so they were only able to give minimal feedback. The quantitative studies were of moderate quality, although the themes recorded across the groups were fairly consistent, regardless of cultural background.

Clearly, translation and the inclusion of cultural activities and practices made PCIT more culturally responsive (see Table 6). Including extended family members was also reported across cultural groups as an important factor as many cultures have a collectivist approach to parenting, where the child belongs to the wider family, not just to the biological parents (Cram,

2011; Cram et al., 2015a; Gibson, 2005). In addition, respondents in the Milz (2015) and Niec (2014) studies suggested the need for a positive and group/community approach to PCIT with their Zambia and Latina/o families.

All seven studies in the qualitative review found that there was a need to have friendly, open, and non-judgemental therapists who were culturally matched to the group delivering the training. Four of the five studies also noted that there needed to be reciprocity in the coaching role (REFS) and three highlighted that the coach needed to be considered a teacher or educator, rather than a counsellor (REFS), because this was seen to have less stigma attached to the role.

Retention issues were addressed by all six qualitative studies and included a focus on ensuring that the leaders used active engagement strategies to ensure their families stayed in treatment, and a belief that there needed to be some kind of outreach or community connection for the families.

Finally, the barriers identified across all six qualitative studies were the belief that there may be some racist practices involved in the parenting programme and that financial hardships or low socio-economic positions of families may be barriers to attending PCIT. In three studies (McCabe, 2005; Milz, 2015; Niec, 2014), it was found that ensuring the extended family believed in the programme was considered important. If there was no support for these ideas in the extended family environment, then participants were less likely to complete treatment.

4.6 Limitations

The main limitation is that there are very few studies that could be included in the reviews. The sample sizes were small, so these results need to be considered cautiously. Therefore, there is a real need to have more Indigenous or ethnically/culturally diverse researchers involved in their own PCIT communities.

4.7 Summary

To the best of my knowledge, this is the first review to examine indigenous and ethnic minority cultures' experiences of PCIT and to try to analyse the qualitative aspects of PCIT according to indigenous and ethnic minority practices. This systematic review provides some evidence that in minority cultural groups, PCIT works at least as effectively as PCIT delivered to the US white population for whom it was originally designed. There is also some evidence from the intervention studies that it significantly improves parental stress levels via an improved relationship with their child.

Nonetheless, there are a number of issues that merit attention. There were very few studies conducted with ethnic minority groups, and only two intervention studies conducted by and for indigenous peoples in China. While the majority (5/6) of the intervention studies were considered methodologically low quality, the statistically significant differences between the PCIT and control groups used well-validated measures. These findings are positive and highlight the need for further high quality studies of culturally responsive PCIT in Indigenous or ethnically/culturally diverse communities around the world.

In order to advance research in this area, a number of issues originating from this review need to be considered in future research. More rigorous studies involving indigenous populations are needed to contribute to the development of more culturally responsive PCIT interventions which will not only be able to promote improved child behaviour, but will also

be able to create improved family caregiving practices. This may well include designing more culturally responsive evaluation methods, which can gather the types of information indigenous and ethnic minority cultures consider important for their own communities. These should encompass an objective dimension, as well as focus on the use of validated scales which can be used for the subjective dimension.

Therefore, it makes sense to see if an indigenous programme, delivered by indigenous therapists in New Zealand, would generate similar results to those documented in these systematic literature reviews. The aim of this research will be to examine whether the same results are able to be achieved for Māori children and their parents if the only thing that is tailored to them is the fact that the clinicians are Māori and experienced in PCIT.

The following chapter will provide the data gathered from a pre-post study of Māori families who engaged in PCIT with Māori practitioners, some basic adaptations that were included, and qualitative interviews following completion of the programme.

Chapter 5: A Māori PCIT: pre-post trial in South Auckland.

“Poipoiā te kakano, kia puawai.”

“Nurture the seed and it will blossom.”

(Brougham et al., 1987)

5.1 Introduction

Supporting parenting early in the life cycle has been shown to be cost-effective (Edwards et al., 2007), beneficial to the establishment of a healthy parent-child relationship, and effective in the treatment of conduct problems (Hutchings et al., 2007). The quality of this relationship is associated with the infant’s subsequent physical (Felitti et al., 1998; Lundberg, 1993) and psychosocial health (Feldman, 2007b; Jee et al., 2010), and cognitive development (Ramey & Ramey, 1998). As discussed in chapter three parenting programmes have been shown to be effective (Law et al., 2009) and to ameliorate child behaviour problems (R. Thomas & Zimmer-Gembeck, 2007). They have showed improvements in the mental health of parent and child (J. Patterson et al., 2002; Sanders, 2002; S. Scott, 2012; Stewart-Brown & Schrader-McMillan, 2011) and, in the prevention of child abuse (Love, Sanders, Metzler, Prinz, & Kast, 2013).

In this chapter the results from a pre-post trial of Māori adapted and delivered Parent-Child Interaction Therapy (PCIT-Māori) with Māori whānau and their tamariki are presented after completing (PCIT) and at four-month follow-up.

5.2 Background

Implementing evidence-based parenting programmes into those communities who could most benefit from them has been reported to be challenging (Olds, Sadler, & Kitzman, 2007) and to require clear policies and government approaches (Law et al., 2009; Lucas, 2011) in order for them to be implemented and utilised efficiently (Gardner et al., 2016).

This was important for me, because I am a Māori clinical psychologist working with Māori whānau with mental health challenges and tamariki with conduct problems, and I saw the positive impact PCIT had on whānau. However, I seldom had the opportunity to follow up with whānau after treatment. I wanted to see how acceptable PCIT was to whānau and their recommendations regarding adaptations.

PCIT was first developed as an intervention for families with children, ages 2–7, with severe behaviour problems (Eyberg, 1988). PCIT was upon both attachment theory and social learning theory, although marketed as a family behavioural parent management training programme (Eyberg et al., 1995). Attachment theory aspects can be seen PCIT by the focus on one-to-one, parent–child relationship, which is the main focus of the intervention and that it is the repetitive experiences of these interactions that serve as a powerful force in achieving more warmth and responsiveness in the parenting behaviour. The social-learning aspects can be seen in the manner the therapist is able to coach the parent to help shape the thoughts, feelings, and behaviours of their child (Foote, Schuhmann, Jones, & Eyber, 1998)

Additionally, PCIT focuses on the concrete activities that occur between parent and child that helps parents learn to reinforce adaptive behaviours and extinguish maladaptive behaviours in their child. Ultimately, PCIT seeks to strengthen the parent–child emotional bond which attachment theory describes as the fundamental developmental need that must be met in order for children to mature into healthy, functional adults (Bowlby, 1969).

The pre-post trial was conducted at community Infant Mental Health Service (IMHS) which provides free tertiary mental health assessment and treatment to families living in the Counties Manukau District Health Board (CMDHB) area. Families must have a parent or infant with a diagnosable (e.g. DSM-V) mental health disorder. Clients from a second service, a non-government Residential Parenting Service (RPS) who met criteria for entry into the IMHS were

also included in this study. The RPS provides a range of parenting and psycho-social support programmes to women (and their children) who have survived domestic violence, trauma and addiction issues. The clients are referred via the family court system or the care and protection service (Child Youth and Family Services). The assessment and intervention were conducted both at the IMHS and RPS for convenience of the whānau involved.

PCIT helps parents recognise the impact that positive interactions with their children can have on child behaviour. In addition, PCIT helps parents gain new positive parenting skills thereby increasing parenting confidence. PCIT was developed to meet the needs of American families but has increasingly been imported into countries and cultures outside of the US. The literature review in chapter four showed that PCIT with families from minority cultures is effective for improving child behaviour problems and for improving parental stress levels, although there are limited studies to date.

It was particularly important to see whether PCIT would work for Māori when it was delivered by and for us. I had two concerns regarding PCIT (as discussed in the chapter one). Firstly, were the parenting and family values expressed in PCIT, specifically those which saw the PRIDE (praise, reflect, imitate, describe and enjoy) skills as the mechanism for assessing whether a parent had mastered the skills required to move onto the next level in the programme were culturally aligned with Māori parenting skills and values. This is a concern because the value is placed solely on verbal language skills of parents. While oratory is highly valued in Māori society, I was concerned that in parenting Māori parents tended to use more physical and spiritual strategies to change tamariki behaviour.

Secondly, I was concerned that the focus on only one parent and child at a time would not reflect the fact that Māori whānau often had multiple children. Given that overcrowding and larger family groups were common challenges in Māori whānau, living in low decile areas.

I was concerned that whānau would not have the time and space to do the special play (daily therapy) where parents practice the PRIDE skills, and where join play is used to strengthen the parent-child relationship.

However, given the international literature which showed that PCIT had been successful for both conduct problems and maltreatment histories within low-income communities. The growing cross-culture evidence of successful PCIT outcomes and previous anecdotal evidence that it could work with Māori, I was willing to trial this, as there were currently no Kaupapa Māori interventions which had been shown to be effective with both children with severe behavioural problems within families with maltreatment histories.

The PCIT literature also highlighted the need to address retention issues with reports of attrition rates of between 30% (Bagner & Eyberg, 2003, 2007) and over 60% (Kohlhoff, Morgan, Briggs, Egan, & Niec, 2020; Werba, Eyberg, Boggs, & Algina, 2006). The addition of motivational sessions prior to commencing PCIT was found to significantly increase retention among parents from a high-risk child neglect population (Chaffin et al., 2009). So, this may be an important adaptation worth considering.

The international PCIT studies with ethnically diverse populations have found more favourable completion rates ranging from 72.7% for Taiwanese families (Chen & Fortson, 2015) up to 90% for Puerto Rican families (Matos et al., 2009). Explanations suggested for the good retention rate reported were the small sample sizes in the studies, the good rapport established by the PCIT team, high satisfaction with PCIT, and families noticing changes in their children's behaviour which motivated them to continue (Matos et al., 2009). A clear cultural factor was the respect for authority in the Chinese culture (Liu, Li, & Yue, 2010; Wong & Piran, 1995), where the PCIT therapist was an authority figure .

Working in tertiary services, I had the opportunity to explore how multi-challenged or vulnerable, whānau responded to PCIT, whether it was acceptable to them, culturally relevant for them, and whether they experience similar positive outcomes reported in the culturally diverse PCIT literature.

5.3 The Study

5.3.1 Aims

1. To carry out a pre-post trial to ascertain acceptability, including completion rates, satisfaction, and cultural acceptability, of PCIT for Māori who have young *tamariki* with severe behaviour problems.
2. To determine whether PCIT improves tamariki behaviour (disruptive behaviour and compliance), and hauora [cultural wellbeing]
3. To determine whether PCIT improves parenting
 - a) motivation to improve parenting and
 - b) positive parenting behaviour
4. To determine whether PCIT improves parental wellbeing (stress, psychological distress, and hauora)
5. To gather further information about the feasibility of PCIT via therapist fidelity to PCIT with this population.

5.3.2 Hypotheses

5.3.3 Primary hypotheses

1. That the primary parent attending PCIT will have good programme completion rates.

2. Tamariki who complete PCIT will demonstrate an improvement in parent-rated disruptive behaviour measured on Eyberg Child Behaviour Inventory , from pre- to post-intervention.

5.3.4 Secondary hypotheses.

1. Primary parent attending PCIT will have good levels of satisfaction with PCIT, measured with the Therapy Attitudes Inventory .
2. Primary parent attending PCIT will endorse high levels of cultural acceptability of PCIT measured by the Supplemental Therapeutic Attitude Inventory (STAI) adapted by UC Davis Children’s Hospital PCIT Training Centre.
3. Tamariki who complete PCIT will demonstrate an improvement in observer-rated compliance (DPICS-IV) from pre- to post-intervention and this will be maintained at four months post-intervention.
4. Tamariki who complete PCIT will demonstrate an improvement in hauora measured by the primary parent’s reports on the Hua Oranga.
5. Primary parents will demonstrate improvements in their motivation to improve their parenting (Readiness, Efficacy, Attributions, Defensiveness, and Importance Scale, READI) and positive parenting behaviour (Dyadic Parent-Child Interaction Coding System, DPICS-IV).
6. Primary parents will demonstrate improved levels of stress (using the Parenting Stress Index, PSI), psychological distress (using the General Health Questionnaire, GHQ), and hauora (Hua Oranga).
7. These improvements in parental wellbeing (hypothesis 6) will be maintained at four-month follow-up.
8. It will be feasible to deliver PCIT to Māori whānau as measured by therapist adherence measured using the PCIT Integrity Checklist

5.3.5 Methods

5.3.6 Ethics Approval

This trial was approved by the Central Health and Disability Ethics Committee (13/CENT/68) Appendix 1 the Counties Manukau District Health Board Research Committee Appendix 2, the Counties Manukau District Health Board Māori Research Review Committee Appendix 3. It was registered with the Australian New Zealand Clinical Trials Registry (ACTRN12613000798763) see Appendix 4.

5.3.7 Trial Design

A pre-post trial was implemented to determine the acceptability, initial outcome, and feasibility of PCIT Māori for primary parents and their tamariki with behavioural problems.

Participants were informed about the study process by an independent triage clinician who explained the study to the participants, gave out additional study pamphlets and obtained written informed consent (Appendix 5). Eligibility for the trial included being over the age of 16 and living with their child (ren) who had severe behavioural problems (indicated by an ECBI intensity score of 131 which is the clinical cut point). A primary parent could be any whānau member or carer in that role at the time of presentation. Only those who had a current episode of a serious psychiatric illness (e.g., psychosis or schizophrenia) were excluded from the trial.

All whānau participated in a pre-treatment assessment that took place during a two-week period prior to beginning PCIT treatment which included important demographic information (Appendix 6). Following the pre-treatment assessment, the primary parent participated in the intervention for 12 sessions. Additional whānau members were also allowed to participate in the PCIT sessions, but only data from the primary parent was collated.

Participants

A clinical sample of 24 Māori primary parents (of children from two to six years), took part in the trial. The participants were recruited sequentially at each site. Every participant who was approached agreed to participate in the trial.

5.3.8 Intervention

Eligible Māori primary parents received PCIT-Māori (standard PCIT with cultural tailoring processes).

PCIT-Māori included the use of tikanga Māori practices which included (a *mihi whakataua* [official Māori welcoming speeches] in a group at RPS, and with individual whānau at IMHS; karakia, kai). Te Reo Māori was also used throughout the coaching sessions when it was appropriate for the whānau. Māori values of manaaki, whanaungatanga and aroha were also demonstrated through the therapists and whānau relationship. The use of tuakana-teina relationship in the coaching aspects of PCIT were also demonstrated through a Māori video which had been made of other whānau talking about their experiences of going through the PCIT programme. This video was shown to whānau at the mihi whakataua service, and helped to facilitate an environment where whānau could openly discuss any issues they had about beginning PCIT.

PCIT uses a two-phase, mastery-based approach aimed at relationship enhancement and the use of positive parenting skills (Child Directed Interaction; CDI), and child behaviour management skills (Parent Directed Interaction; PDI). The parent's use of positive parenting skills (**P**raises, **R**eflections of appropriate child verbalisations, **I**mitation of appropriate child behaviours, **D**escriptions of the child's play, **E**njoyment of the interaction; represented with the acronym "PRIDE") and decrease in negative parenting behaviours (criticisms, questions, and commands). At the start of every therapy session, in five-minute "special playtime" coding sessions. The therapist codes the parent according to how many PRIDE skills the parent uses

in a five-minute special play session. Parents are expected to practice the PRIDE skills during daily five-minute special playtime sessions at home.

PCIT uses a protocol to ensure treatment fidelity; every session is structured, and the PCIT therapist uses observational (Dyadic Parent-Child Interaction Coding System, DPICS) and psychometric data (Eyberg Child Behaviour Inventory, ECBI) gathered before each session to inform the live coaching of the parent with their child. PCIT has a pre-treatment assessment session (see PCIT protocol 2011 p. 9) during which initial baseline measurement is collected. Weekly sessions are 45-60 minutes in length and each session has clearly defined goals, session outlines, and accompanying handouts.

The parent-child interaction addressed in PCIT is measured by means of the Dyadic Parent-Child Interaction Coding System (Robinson & Eyberg, 1981). Therapy continues until a specific criterion on the DPICS is reached. Thus, the therapy rests upon the proposition that there is a strong relation between parent-child interaction as measured by the DPICS and behavioural disorders—i.e., Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). Recent studies by Bjorseth and colleagues found that some DPICS categories (negative talk and commands) was able to effectively discriminate between children with CO or ODD from children with no diagnosis (Bjørseth, McNeil, Wichstrøm, & Therapy, 2015; Cotter, Brestan-Knight, & Studies, 2020). Suggesting some categories may be more important for clinical diagnosis than others.

The DPICS is an observational tool that is part of the standard PCIT protocol. In order to be able to use this measure, the clinician must have completed all requirements for certification as a PCIT Therapist, which involves ensuring they are able to achieve 80% coding compliance with a master trainer. PCIT therapists must have: a) a graduate education (masters degree or higher) and be registered as a mental health service provider b) basic PCIT training

(40 hour face to face training with a regional or global trainer), c) completed 12 months of consultation training (regular twice monthly contact with their regional trainer until 2 PCIT cases have met graduation criteria) and d). skill review measures (where their treatment sessions are reviewed by a certified PCIT trainer). All these requirements are part of the protocol as documented by PCIT International (PCIT International Training Task Force, 2020)

PCIT was conducted by the writer (the PCIT regional trainer for New Zealand) and one other Māori PCIT clinician (with 2 years post PCIT registration experience). Both were registered as PCIT International clinicians. PCIT started with each clinician conducting a 5 minute live coding (play session) of the parent-child together using the DPICS measure, this is standard PCIT protocol. The marks from the DPICS are used both to coach parenting behaviour and to assess parenting behaviour achievement for criteria in order to show skill attainment.

The primary parent (and any additional whānau members) were able to enrol all of their tamariki into the study, provided they were within the age range (i.e., two to six years of age). This was done intentionally to include all whānau members because whakawhanaungatanga [family relationship] is an important cultural value within Māori society. However, only the data on the primary parent and the primary tamariki was analysed in the study.

As per standard PCIT protocol, throughout treatment, the therapist reviewed progress on specific positive parenting skills (PRIDE) that were coded by the Dyadic Parent-Child Interaction Coding System- IV (DPICS-IV). The primary parent was assigned homework activities (five minutes of special playtime) congruent with the PCIT protocol as opportunities for independent problem solving and skills generalisation. Homework was reviewed at the onset of each subsequent session along with other PRIDE skills.

5.3.9 Measures

A number of measures were used in the study and across time points (see Table 8 below for a description of the measures included). Several of these measures are used as part of the PCIT standard treatment protocol as described above and are highlighted in Table 8.

5.3.10 Primary outcome 1 – completion rates of PCIT

1. For completion of PCIT, 100% attendance of the 12 PCIT sessions is regarded as completion for the purposes of this trial

5.3.11 Primary outcome 2 – ECBI

2. *Eyberg Child Behavior Inventory, ECBI* (Eyberg & Pincus, 1999). The ECBI is a 36-item parent-report, which measures the degree of behavioural problems of children between the ages of two to 16. The ECBI assesses ratings of behaviour on two different scales: the Intensity Scale and the Problem Scale. The ECBI Intensity Scale measures the frequency of disruptive behaviour along a 7-point scale (1 = never to 7 = always). The clinical cut score for the ECBI Intensity Scale is 131. ECBI Problem Scale measures whether or not the primary parent views those behaviours as problematic (1 = yes, 0 = no). The clinical cut score for the ECBI Problem Scale is 15. The ECBI was standardised with a sample of 512 of children aged two to 12 (Robinson et al., 1980). A T-score of greater than or equal to 60 on the ECBI is indicative of a total score falling in the clinical range. Test-retest reliability has been estimated at $r = 0.80$ for the Intensity Scale, $r = 0.85$ for the Problem Scale over 12 weeks, and $r = 0.75$ for both scales over 10 months (Funderburk et al., 2003).

5.3.12 Secondary outcome measures

1. *Therapy Attitude Inventory* (Eyberg, 1992). The TAI is a ten-item parent-report scale of satisfaction with the process and outcome of treatment. These ten items address several areas: (1) the method of PCIT delivery, (2) parenting confidence, (3) discipline skills, (4) quality of the parent-child interaction, and (5) overall family adjustment. Each of the ten items is rated on a one to five scale, where a 'one' indicates strong dissatisfaction and a 'five' indicates strong satisfaction. Cronbach's alphas for the TAI have been reported as high (0.91). The stability coefficient across a fourth-month period has also been shown to be high (0.85). External validity has been demonstrated with moderate correlations of 0.36 to 0.49 (Brestan et al., 1999). For this study, the TAI was administered at post-treatment and at follow-up.
2. *Supplemental Therapeutic Attitude Inventory Items, STAI* (UC Davis, 2019). The STAI includes five items that address the cultural acceptability of PCIT. The five questions address several areas: (1) the level of comfort with the ethnicity of the therapist, (2) the level of comfort with the ethnicity of the assessors, (3) the degree of acceptability of the skills learnt in PCIT within the family, (4) the degree of acceptability of the skills learnt in PCIT within the community, and (5) the degree of acceptability of the skills learnt in PCIT within the parents' spiritual values. Each of the five items is rated on a one to five scale, where a 'one' indicates strong dissatisfaction and a 'five' indicates strong satisfaction. For this study, the STAI was administered at post-treatment and at follow-up. I have been unable to locate any psychometrics for the STAI in any published literature, although the Cronbach's

alphas for the main items on the TAI have been reported as very high (Brestan, Jacobs, Rayfield, & Eyberg, 1999).

3. *Dyadic Parent-Child Interaction Coding System -IV* (Eyberg et al., 2004). The DPICS is a behavioural observation Measure used for assessing the quality of parent-child interactions as well as for capturing child prosocial and externalizing behaviours. In this system, both parent and child verbalizations, vocalizations, and behaviours are coded.

The DPICS is used at the start of every PCIT session. It is conducted during live sessions (as per PCIT protocol). Only the “pre, post and follow-up” DPICS scores were analysed during this study. The initial sessions were videotaped and coding by opposite intervention clinician. This means that if clinician 1 did the assessment then clinician 2 did the therapy. This was to add some objectivity to the process, but also make it a real life study, that might be able to be replicated by other treatment settings.

In this study, child non-compliance was defined according to the PCIT Protocol (Eyberg & Funderburk, 2011) as a “child response following a direct or indirect command given by the parent wherein the child does not perform, does not attempt to perform, or stops attempting to perform the requested behaviour within the 5-second interval following the command”. Compliance was calculated as the number of times they complied over the number of times a parent gave a direct command.

4. *Hua Oranga* (Durie & Kingi, 1999) is a Māori measure of mental health outcome that uses a holistic view of Māori health, where cultural determinants of hauora are

collated, including physical, mental, spiritual, and family domains of health. It is designed to give three scores (a self-report from the patient, a report from the patient's whānau, and a clinician's report about the patient). The three scores are combined to give a single score of hauora. McClintoch et al., (2011) developed an alternative version of the Hua Oranga, which is used in this study because it was reported to be much easier to understand. This version was slightly adapted and has two subscores (1. the primary parent self-report, 2. the primary parent report on the health of their tamariki). The scores use a 5-point Likert scale (1 extremely bad, 2 not good, 3 okay, 4 good, 5 extremely good). Total scores range from 5 to 20. Thus, a higher score indicates better *hauora*. For this hypothesis, the child rated score will be used.

5. *Readiness, Efficacy, Attributions, Defensiveness and Importance Scale, READI* (Chaffin et al., 2009) is a self-rated measure of motivation to change parenting behaviour. It is a 23-item scale with five subscales: (1) Readiness to Change (e.g., "I'm ready to change the way I discipline my child"; "I don't really need to change my parenting, I'm only here because I'm forced to be here"), (2) Problem Recognition (e.g., "The way I'm disciplining my child now is not working"; "If I don't change soon, my child's future could be hurt"), (3) Belief in Harsh Discipline (e.g., "Physical punishment is the only thing that will work for my child"), (4) Attitude Toward the Program (e.g., "It feels like an insult to be sent to a program like this"; "I am committed to completing this program, whatever it takes"), and (5) Self-Efficacy (e.g., "This program is asking for more than I can do"; "I'm sure I can do positive things to help my child and myself"). Responses ranged from 1 (strongly disagree) to 5 (strongly agree), and composite scores were formed by averaging the

items. The alpha for the overall 23-item scale was 0.84 (Chaffin et al., 2009). Higher scores signal a greater willingness to change their parenting behaviour.

6. *Parenting Stress Index – Short Form* (Abidin, 1995) is a 36- item self-report measure of parental stressors and stress level. It provides summary scales of Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. The PSI was originally standardised in 1995 with a sample of 534 of children ranging from one month to 12 years. A percentile ranking of 85% or higher indicates a significant level of parental stress and represents the clinical cut score ranking. Percentiles between 15% and 80% were considered to be within the normal range. A subsample of 530 subjects from the normative sample revealed correlations of 0.94 between the PSI/SF and PSI Total Stress scores. A correlation of 0.92 was found between the PSI-SF Parental Distress Scale and the PSI Parent Domain and a correlation of 0.87 was found between the PSI-SF Difficult Child Scale and the PSI Child Domain (Abidin, 1995). In this study, the total score was used to measure parental stress.
7. *General Health Questionnaire-28* (Goldberg & Hiller, 1979) is a 28 item self-rated measure of psychological distress, designed for screening use in the general population. It is well validated and addresses how the person has been feeling over the past two weeks, with emphasis put on the person's ability to function. It has four subscales (each with seven items) that are used to help identify somatic symptoms, anxiety/insomnia symptoms, social dysfunction concerns, and severe depression symptoms. For this study, only the total score was used. It is suitable for use with 16-year-olds and above. It assesses both the current state and the usual state. Test-retest reliability coefficients range from 0.75 to 0.90 (Goldberg & Williams, 1988). The GHQ-28 total score was utilised as a measure of psychological distress. Total

scores on the GHQ-28 range from 0 to 84, with higher scores indicating higher levels of psychological distress. A total of 13 or greater represented a clinical level of distress.

8. *PCIT Integrity Checklist* (Eyberg & Funderburk, 2011). Each PCIT session has an integrity checklist of items that the PCIT therapist must complete at the end of each session. These are structured checklists to ensure that clinicians maintain high fidelity to the treatment protocol. The PCIT Integrity Checklist was completed at every PCIT session by the therapist. The Integrity checklist is expected to be completed by the therapist to ensure all items are covered. A compliance rate of 85% and above is the reported rate standard PCIT protocol.

Table 7 Data Collection Timeframe

| Measure (completed by) | Cronbach's Alpha for the study | Pre-Treatment | Weekly | Post Treatment | Follow Up |
|---|--------------------------------|---------------|--------|----------------|-----------|
| Demographics | | X | | | |
| ECBI (primary parent)* | .93 | X | X | X | X |
| TAI (primary parent) | .91 | | | X | |
| DPICS-IV (therapist)* | | X | X | X | X |
| Hua Oranga (primary parent and therapist) | .85 | X | | X | X |
| READI (primary parent) | .92 | X | | X | |
| PSI (primary parent) | .93 | X | | X | X |
| GHQ (primary parent) | .93 | X | | X | X |
| Hua Oranga (primary parent) | .85 | X | | X | X |
| PCIT Integrity Checklist (therapist)* | | X | X | X | X |

Note. * are required PCIT as documented by the PCIT (2011) treatment protocol

5.3.13 Assessment process and timing.

After consent was obtained, the pre-treatment assessment followed, which was conducted by the writer (therapist 1) and another Māori PCIT clinician (therapist 2).

The pre-treatment assessment involved several measures. A semi-structured demographic questionnaire for the primary caregiver was designed to capture important information including referral, educational, cultural, and socio-economic data. The assessment schedule for the remainder of the assessments conducted is described in Table 8.

5.3.14 Statistical Analysis

All data for parents who consented to participate in the study were included in the analyses. For pairwise analyses, only parents who had data at all three time points concerned were included in the analysis.

5.3.15 Study power and Sample Size.

As the comparison of outcome measures is made “within subjects” this sample size provided at least 80% power to show an effect size of -0.4 or more as significant (2-tailed $\alpha = 0.05$). Data from a previous meta-analysis of PCIT reported an effect size of $d = -1.06$ (Cooley et al., 2014) on the ECBI. A sample size of fifteen would be required to achieve a power of 80% and a level of significance of 5% (paired t-test) for detecting an effect size of 1.06 between subjects. PCIT has already been shown to be an effective intervention overseas, but there have been no New Zealand data and no Māori data on which to base the sample size calculation. Other PCIT trials have found 'drop out' rates of between 50-75%, in 'high risk' populations, it was anticipated conservatively that approximately 25% of those enrolled would not complete the programme and would not complete post-and follow-up programme assessments. Twenty-six participants were enrolled in the study, anticipating that approximately 20 would complete post and follow-up assessments for the primary outcome measures.

5.3.16 Statistical analysis.

An experienced statistician provided oversight of the statistical analysis of this study. Baseline demographics and clinical data were summarised for the entire cohort. Continuous measures were summarised as means, medians, confidence intervals and ranges. For all pairwise comparison analyses, data were compared between start of group and completion of group, and completion and 4-month follow-up. All data analyses were performed using a series of statistical analyses using SPSS (v25.0) where the significant level was set at 0.05.

5.3.17 One-way repeated measures ANOVA.

One-way repeated ANOVA tests were conducted on measures to detect changes in outcome measures across data which had data collected across three time points (pre-treatment, post-treatment and 4-month follow-up). Effect sizes are reported for each analysis, in order to interpret whether significant findings are meaningful within the study. The effect measure reports is partial eta-squared (η^2) which is one of the most common effect indices, probably because it is reported by SPSS. According to Cohen (1988), partial eta-squared and eta-squared are the same if you only have one predictor. Therefore a η^2 value of 0.01 can be interpreted as indicating a small effect size, 0.06 as indicating a medium effect size and 0.14 or greater as indicating a large effect.

5.3.18 Pairwise comparison analysis.

If a significant main effect for time was found, Bonferroni pairwise comparisons were used to examine change from pre- to post-intervention, and pre- and post-intervention to 4-month follow-up. Pre- to post-intervention effect sizes were calculated to examine the change over time for each outcome measure. For this effect size, the following formula was used for each condition separately: the difference in mean pre to post-intervention scores divided by the pooled pre- and post-intervention standard deviation (Cohen, 1992). The results of these analyses are reported in table 12.

5.3.19 Missing Data

Three families dropped out of treatment and did not have Time 2 data available. Missing data were, in the first instance, managed with a last observation carried forward (LOCF) approach with additional sensitivity analyses undertaken using multiple imputation (MI) methods as generated by SPSS version 24. MI has been shown to be robust, support

more valid statistical inferences (King, 2003), and has more recently been used in PCIT studies (French, Yates, & Fowles, 2018).

5.3.20 Safety and risk monitoring

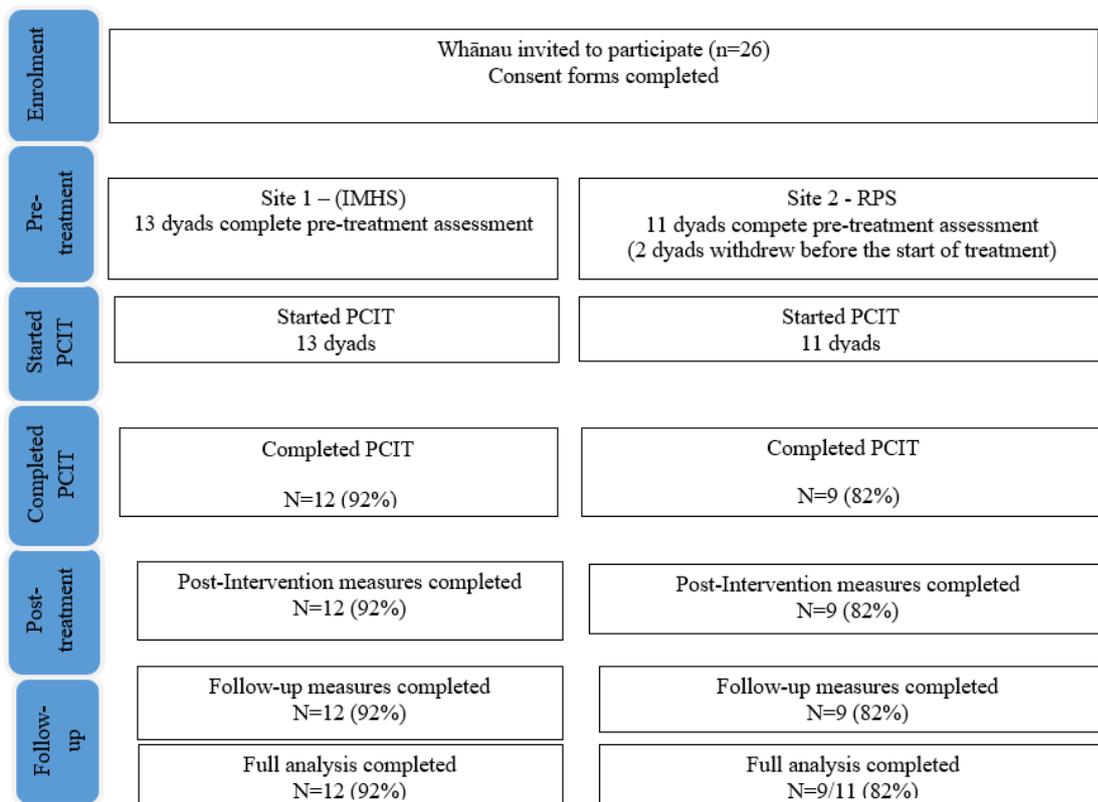
The writer (therapist 1), a therapist 2 are both registered mental health professionals and fully trained PCIT therapists (eight and two years of PCIT experience, respectively). Safety monitoring included weekly clinical team meetings, weekly group PCIT supervision (where all PCIT cases were discussed), and monthly one to one supervision with the clinic lead (an infant and child psychiatrist) which ensured every case and all risks were reviewed on a regular basis.

5.4 Results

5.4.1 Study population

Twenty-four Māori primary parents (and their first child) had pre-treatment data analysed. There were complete data collected for 21/24 (88%) of families at post-treatment and at four-month follow-up. Imputation using last observation carried forward was used for $n = 4$ at post-treatment and four-month follow-up. A two-tailed $\alpha = 0.05$ was used for all statistical testing and results are summarised using 95% confidence intervals. Cohen's d was calculated to show the size of the treatment effect.

The mean ECBI Intensity score for the tamariki at the start of treatment was 166, which is above the clinical cut score (131), and the mean ECBI Problem score for tamariki at the start of treatment was 21.29, which is above the clinical cut score (15). Twenty-one (88%) of the whānau successfully completed PCIT. Three whānau withdraw from the study (one for breaching a non-association order and one for physically assaulting an older child., and one who moved out of the area). A total of 21 dyads completed the post- and four-month follow-up assessments (Figure 3)

Figure 3 *Flowchart of Participants*

5.4.2 Demographics.

These demographics were collected by a demographic questionnaire that was discussed and noted by the writer (see Appendix 6). There was one father while the other 23 primary parents (95.2%) were women (22 mothers, two maternal grandmothers, and one foster mother). The average age of the primary parent was 32.23 years (SD 6.82). The mean age for parents having their first child was 20.73 years of age.. The whānau had an average of 3.65 tamariki, although there was a large range of between one and eight tamariki. Most parents (14 or 58.3 %) described themselves as not being in a relationship. The majority of the parents (22/24, 92%) indicated on the General Health Questionnaire that they had difficulties in at least one mental health area, with 11 (46 %) reporting a history of trauma or abuse, four (17%) a history of alcohol or drug abuse, and five (21%) a mood disorder (depression or anxiety).

Over half of the parents (14/24, 58%) did not complete secondary school education while only three (13%) reported a bachelor or higher academic degree. The majority of parent participants (23/24, 96%) had very low incomes and were reliant on state-benefits as their only source of income, with a mean net family income of \$30,769, which ranged from \$26,000 to \$42,000 a year depending on the types of benefits and other entitlements they received.

The tamariki were split equally in gender (12 boys and 12 girls) and ranged from two to six years of age with a mean age of 3.9 (SD 0.70). The majority of referrals (80.8%) came from the child protection service and the other referrals came from GPs and adult mental health services (Table 9). Almost all the tamariki (23/24, 96%) attended kindy or school. Apart from one child, all the others (23/24, 88%) had been exposed to at least one form of abuse (physical 88%, emotional 65%, neglect 15%) and 74% had been exposed to multiple forms of abuse (Table 9). All of the tamariki (100%) from the RPS had suffered physical and emotional abuse, and witnessed familial violence (this is one of the conditions that is required to be admitted

into the RPS programme). In terms of a mental health challenges, five (21%) had a PTSD diagnosis, 17 (71%) had a behavioural disorder diagnosis (conduct disorder, oppositional defiant disorder), and four (17%) had an ADHD diagnosis (DSM-5; American Psychiatric Association, 2014).

Household Composition. Only one whānau (4%) lived in their own home; the remainder were renting properties or living with other whānau members (16/24, 67%), and the majority were living in high poverty areas (deprivation index of 9 or 10, 89 %), with their tamariki attending low decile rated schools (decile 1-2 rated schools). Most households were female-headed households (19/24, 79 %), in which tamariki shared beds and bedrooms and where there was no access to the internet (Table 10).

Table 8 Primary Caregiver Baseline Demographics (n=24)

| | Site 1: Residential n=11 | Site 2: Infant n=13 | Total Sample n=24 |
|--------------------|-----------------------------|------------------------|----------------------|
| Age | | | |
| Mean age (SD) | 29.08 (4.9) | 35.38 (7.1) | 32.23 (6.82) |
| Median age | 28 | 33 | 32 |
| Age range | 22 - 37 | 27 - 50 | 22-50 |
| Sex | | | |
| Female (%) | 11 (100) | 12 (92.30) | 24 (96.15) |
| Number of Children | | | |
| Mean (SD) | 3.85 (1.9) | 3.46 (1.7) | 3.65 (1.81) |
| Median | 3 | 3 | 3 |
| (Range) | 2 – 8 | 1 - 7 | 1-8 |
| Age 1stPregnancy | | | |
| Mean (SD) | 18 (2) | 23 (4) | 20.73 (3.75) |
| Median | 20 | 22 | 23 |
| Range | 16-25 | 17-29 | 16-29 |

| | Site 1: Residential <i>n</i> =11 | Site 2: Infant <i>n</i> =13 | Total Sample <i>n</i> =24 |
|-----------------------------|-------------------------------------|--------------------------------|------------------------------|
| Ethnicity of Parents | | | |
| Māori only | 11 (84.6) | 9 (69.2) | 20 (83.3) |
| (%) | 0 | 1 (7.7) | 3 (12.5) |
| Māori/Pacific | 0 | 2 (15.4) | 1 (4.2) |
| (%) | | | |
| Relationship Status | | | |
| Married/Defacto | 1 (9.1) | 9 (69.2) | 10 (41.7) |
| Single | 10 (90.9) | 4 (30.8) | 14 (58.3) |
| Education Status | | | |
| No NCEA | 9 (81.8) | 5 (38.5) | 14 (58.3) |
| NCEA2 | 1 (9.1) | 1 (7.7) | 2 (8.3) |
| (yr11/12) | 1 (9.1) | 4 (30.7) | 5 (20.8) |
| NCEA3(yr13) | 0 | 3 (23.1) | 3 (12.6) |
| Bachelors Degree | | | |
| Mental Health | | | |
| Mood Disorder | 0 | 5 | 5 |
| Trauma/Abuse | 8 | 3 | 11 |
| Substance Use | 3 | 1 | 4 |
| Financial Income \$ | | | |
| Mean (SD) | 27,769 (2,682) | 33,769 (5,510) | 30,769 (5,233) |
| Median | 28,000 | 34,000 | 32,000 |
| (Range) | 26,000 – 34,000 | 26,000 – 42,000 | 26,000 – 42,000 |
| State benefit (%) | 11 (100) | 10 (77) | 21 (88) |

Note Data are mean (SD), median (range), number (%)

Table 9 *Tamariki Baseline Demographics (n=24)*

| | Site 1: Residential Service <i>n</i> =11 | Site 2: Infant Service <i>n</i> =13 | Total Sample <i>n</i> =24 |
|------------------------------|---|---|------------------------------|
| Age | | | |
| Mean age (SD) | 3.77 | 4.12 | 3.99 |
| Median (range) | 3.4 | 4.0 | 3.9 |
| Sex | | | |
| Female (%) | 8 | 5 | 13 |
| Ethnicity | | | |
| Māori/Māori (%) | 10 (90.90) | 5 (38.46) | 15 (62.50) |
| Māori/Pacific(%) | 1 (9.10) | 2 (15.39) | 3 (12.50) |
| Māori/Pākehā(%) | 0 | 6 (46.15) | 6 (25.00) |
| Pre-school Attendance | | | |
| Kindy (%) | | 10 (76.92) | 21 (87.50) |
| Kohanga(%) | 11 (100%) | 1 (7.69) | 1 (4.17) |
| No Pre-school (%) | | 2 (15.39) | 2 (8.33) |

| | Site 1: Residential Service <i>n</i> =11 | Site 2: Infant Service <i>n</i> =13 | Total Sample <i>n</i> =24 |
|----------------------|---|---|------------------------------|
| Trauma History | 11 | 4 | 15 |
| Neglect | 11 | 5 | 16 |
| Emotional | 11 | 10 | 21 |
| Physical | 1 | 1 | 2 |
| Sexual | 11 | 10 | 21 |
| Family violence | | | |
| Trauma History (%) | | | |
| One form | | 4 (30.76) | 4 (16.7) |
| Multiple forms | 11 (100) | 9 (69.23) | 20 (83.33) |
| Diagnosis (%) | | | |
| Conduct/ODD | 9 (81.8) | 7 (52.84) | 16 (66.7) |
| ADHD | 1 (4.1) | 3 (23.07) | 4 (16.7) |
| PTSD | 1 (4.1) | 3 (23.07) | 4 (16.7) |
| Referral Pathway | | | |
| Care & Protection | 11 (100%) | 7 (52.84) | 18 (75.0) |
| Mental Health | | 4 (30.76) | 4 (16.7) |
| General Practitioner | | 2 (15.39) | 2 (8.3) |

Table 10 *Participant Home and Community Information*

| | Site 1: Residential Service <i>n</i> =11 | Site 2: Infant Service <i>n</i> =13 | Total Sample <i>N</i> =24 |
|----------------------|--|---|------------------------------|
| Social dep. index | | | |
| 7 (%) | 1 (9.1) | 1 (7.7) | 2 (8.3) |
| 8 (%) | 0 | 0 | |
| 9 (%) | 0 | 2 (15.4) | 2 (8.3) |
| 10 (%) | 10 (90.9) | 10 (76.9) | 20 (83.4) |
| School decile rating | | | |
| 1 (%) | 11 (100) | 11 (84.6) | 22 (91.6) |
| 2 (%) | | 2 (15.4) | 2 (8.40) |
| Home ownership (%) | | 1 (7.7) | 1 (4.17) |
| Female home (%) | 11 (100) | 7 (53.8) | 18 (75.0) |
| House Composition | | | |
| Parent/child only | 2 (18.1) | 6 (42.6) | 8 (33.3) |
| Multiple whānau | 9 (81.9) | 7 (57.4) | 16 (66.67) |
| Own Bedroom | 2 (15.4) | 5 (38.5) | 7 (29.17) |
| Own Bed | 5 (38.5) | 9 (69.2) | 14 (58.33) |
| Internet (%) | 0 | 7 (57.4) | 7 (29.17) |

5.4.3 Primary outcome 1: Acceptability

5.4.4 Treatment completion rates.

There were very high completion rates with 21/24 whānau (88%) successfully completing PCIT-Māori.

5.4.5 Length of treatment.

It took an average of 17.4 weeks (± 8.7) to complete all 12 sessions of PCIT treatment (Table 12). RPS parents took an average of 15.2 weeks (± 9.6) to complete PCIT, while whānau in the IMHS took 19.7 weeks (± 7.4). The reasons for this are unclear, although the more severe mental health issues experienced by the primary parents in the IMHS may explain some of the difference.

5.4.6 Daily special playtime.

Parents are expected to complete five minutes of special playtime with their children every night, as PCIT homework. This is so that the parent can practise positive parenting skills with their child (ren) every day. The primary parents' mean score for weekly special playtime sessions was 4.77 sessions a week (Table 12). So, almost five out of seven days, parents were reporting that they were practising their PCIT positive parenting skills with their children.

Table 11 *PCIT Completion Rates Across Treatment Settings*

| | Residential N=12 | IMHS N=12 | Combined N=24 |
|------------------------|---------------------|--------------|------------------|
| Completed (%) | 9 (81.80) | 12 (92.30) | 21 (88.00) |
| Weeks to complete (SD) | 15.20 (9.60) | 19.70 (7.40) | 17.4 (8.70) |
| Homework (SD) | 5.23 (1.36) | 4.31 (1.49) | 4.77 (1.48) |

5.4.7 Primary outcome 2- ECBI

To begin, the first analysis that occurred was to determine whether there were significant differences between treatment settings at pre-treatment on the dependent variable.

An independent t-test indicated no significant differences in ECBI Intensity scores between treatment conditions (Figure 3) at pre-treatment, $t(22) = -1.02$, $p = 0.32$. In addition, there were no significant differences in ECBI Problem scores between treatment conditions at pre-treatment, $t(22) = -.63$, $p = 0.58$. Therefore, the data from both treatment settings were combined and analysed as one cohort (Table 12).

The primary outcome variable was change in ECBI Intensity overtime. The results (Table 12) revealed a statistically significant reduction in the frequency of disruptive behaviour reported by parents. A one-way repeated ANOVA indicated that the ECBI scores were significantly different at least one of the time points $F(2,46) = 171.24$, $p < .001$, partial $\eta^2 = .88$. The partial eta-squared (η^2) value of 0.88 indicates a large effect.

The post-hoc test revealed that parents reported their child's behaviour had significantly changed from the start of PCIT ($M=166.00$ compared to the end of treatment $M=98.62$). Scores also significantly changed from the start to the follow up ($M=95.67$). As expected there was no significant difference between end of treatment and four-month follow-up (see Figure 4). Suggesting that the decrease in child behaviour problems was maintained four months after treatment had ended.

Figure 4: *Child Behaviour Outcomes - ECBI.*

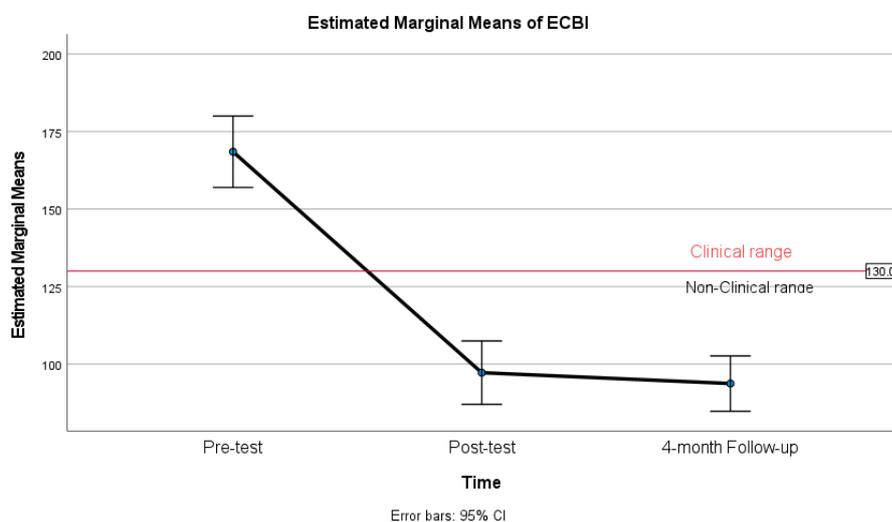


Table 12 Descriptive Statistics and Effect Sizes for One-way Repeated measures ANOVAs..

| | | Combined settings <i>n</i> =24 | | | | | |
|------------------------|-------------------|-----------------------------------|------------------------------|----|--------------------|----------|----------|
| <i>Parent measures</i> | Pre M (SD) | Post M (SD) | <i>F Up</i> <i>M (SD)</i> | df | F | <i>p</i> | η^2 |
| PSI | 109.58 (22.68) | 89.79 (19.10) | 87.04 (11.00) | 2 | 39.77 | .000 | 0.63 |
| HO-P | 9.63 (1.81) | 13.96 (1.88) | 13.88 (1.70) | 2 | 71.02 | .000 | 0.76 |
| GHQ-28 | 12.79 (5.70) | 5.04 (4.69) | 4.17 (3.80) | 2 | 17.84 | .000 | 0.44 |
| DPICS-IV PPB | 2.54 (1.25) | 30.50 (3.09) | 29.08 (2.74) | 2 | 660.23 | .000 | 0.97 |
| <i>Child measures</i> | Pre M (SD) | Post M (SD) | <i>F Up</i> <i>M (SD)</i> | | <i>F statistic</i> | <i>p</i> | η^2 |
| ECBI-I | 166.00 (33.30) | 98.62 (23.15) | 95.67 (27.95) | 2 | 171.24 | .001 | .88 |
| DPICS-IV Compliance | 16.99 (9.03) | 96.80 (8.45) | 87.09 (17.13) | 2 | 388.11 | .001 | .94 |
| HO -C | 7.79 (1.32) | 13.67 (1.94) | 14.00 (1.67) | 2 | 97.13 | .000 | 0.81 |

Note. READI = Readiness, Efficacy, Attributions, Defensiveness and Importance Scale, PSI = Parenting Stress Index, HO -P = Hua Oranga Parent, GHQ = General Health Questionnaire-28, DPICS-IV PPB = Dyadic Parent-Child Interaction Coding System-IV Positive Parenting Behaviour, TAI = Therapy Attitude Inventory, ECBI -I = Eyberg Child Behavior Inventory(Intensity), ECBI -P = Eyberg Child Behavior Inventory(Problem), , DPICS-IV CCom = Dyadic Parent-Child Interaction Coding System-IV Child Compliance, HO-C = Hua Oranga Child.

5.4.8 Clinical significance.

Using the PCIT Protocol (Eyberg & Funderbunk, 2011), the definition of clinical cut scores for the ECBI Intensity score is 131 and for the ECBI Problem score is 15, so scores above these cut scores indicate a clinically significant score. At pre-treatment, 22/24 (91.67%) of the tamariki had ECBI Intensity and Problem scores in the clinical range. At the end of treatment, only two tamariki (8.3%) were still rated in the clinical range. These changes were maintained at the four-month follow-up (Figure 4).

5.5 Secondary outcomes

5.5.1 Parent satisfaction with PCIT.

Parent satisfaction was assessed by calculating mean responses to the standard Therapy Attitude Inventory (TAI) across parents and each question. Parents who completed PCIT reported very high satisfaction with PCIT. Specifically, post-intervention, they reported a mean satisfaction rating across the ten standard questions of 49.05 (SD=2.16, range 48-50) out of a potential score of 50. At the four-month follow-up, the participants continued to rate PCIT highly across all the items.

5.5.2 Cultural acceptability of PCIT.

The Supplemental Therapeutic Attitude Inventory (STAI) has five questions which directly address the level of comfort parents feel with the ethnicity of the therapist assessors. It asks them to rate how acceptable the PCIT parenting skills are for their family and community, and how the values align with their spiritual beliefs. The fact that the therapist and assessor were Māori received a 5/5 score from all 21 primary parents. With regard to the total score for all five items, primary parent mean total score was 24.95 out of 25, showing the PCIT was acceptable to the Māori whānau involved (see Table 13). This high level of acceptance actually

improved at four month follow-up with a total mean score of 25/25 from all of the primary parents.

Table 13 Supplementary Therapy Attitude Items - Cultural Acceptability of PCIT

| Question | Site 1: Residential Parenting Service (n=9) Mean score (SD) | Site 2: Infant Mental Health Service (n=12) | Combined N=21 |
|--|--|---|---------------|
| Level of comfort with the ethnicity of the therapist | 5(0) | 5(0) | 5(0) |
| Level of comfort with the ethnicity of the assessors | 5(0) | 5(0) | 5(0) |
| PCIT Skills accepted by whānau | 5(0) | 4.92 | 4.95(.22) |
| PCIT Skills accepted by community | 5(0) | 5(0) | 5(0) |
| PCIT programme values aligns with spiritual values | 5(0) | 4.92 | 4.95(.22) |

5.5.3 DPCIS-IV Compliance rate

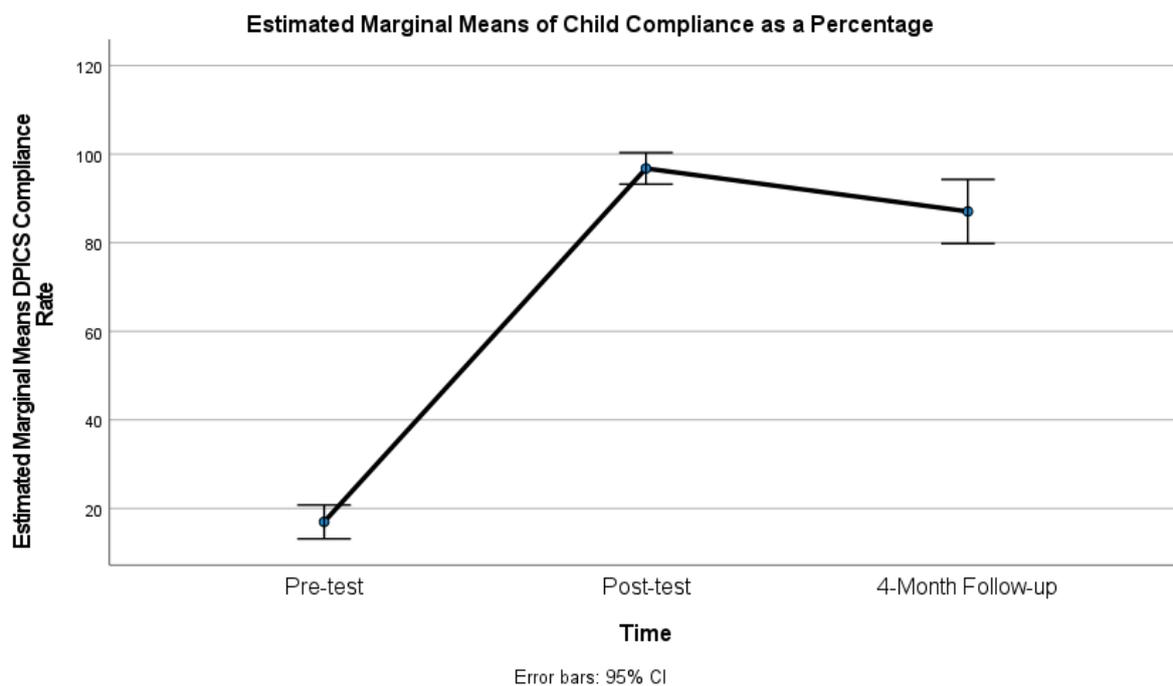
To begin, the first analysis that occurred was to determine whether there were significant differences between treatment settings at pre-treatment on the dependent variable. An independent t-test indicated no significant differences in DPICS- child compliance using the DPICS-IV compliance skills. Scores between treatment conditions at pre-treatment, $t(22) = -.58$, $p = 0.57$. Therefore, the data from both treatment settings were combined and analysed as one cohort (Table 12).

The primary outcome variable was change in DPICS-IV compliance score overtime. The results (Table 12) revealed a statistically improvement in child compliance. A one-way repeated ANOVA indicated that the scores were significantly different at least one of the time

points $F(2,46) = 388.12$ $p < .001$, partial $\eta^2 = .94$. The partial eta-squared (η^2) value of 0.94 indicates a large effect.

The post-hoc test revealed that children's compliance skills significantly changed from the start of PCIT when the children were only complying to ($M=16.99$ percent of parental commands compared to the end of treatment when they were complying to $M=96.79$ percent of parental commands) see Figure 5.

Figure 5. *Compliance as a Percentage Using DPICS*



5.5.4 DPICS-IV Positive parenting behaviour

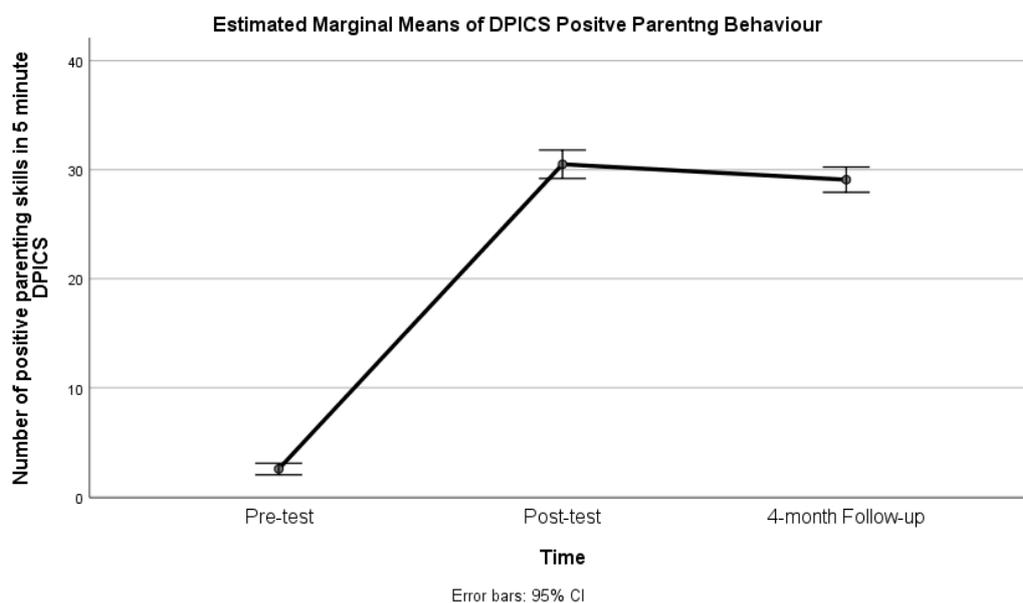
To begin, the first analysis that occurred was to determine whether there were significant differences between treatment settings at pre-treatment on the dependent variable. An independent t-test indicated no significant differences in DPICS-Positive Parenting Behaviour using the DPICS-IV “Do” skills. Scores between treatment conditions at pre-

treatment, $t(22) = -1.66$, $p = 0.06$. Therefore, the data from both treatment settings were combined and analysed as one cohort (Table 12).

The primary outcome variable was change in DPICS-IV total score overtime. The results (Table 12) revealed a statistically improvement in positive parenting skills. A one-way repeated ANOVA indicated that the scores were significantly different at least one of the time points $F(2,46) = 660.23$, $p < .001$, partial $\eta^2 = .97$. The partial eta-squared (η^2) value of 0.97 indicates a large effect.

The post-hoc test revealed that parents positive parenting skills significantly changed from the start of PCIT ($M=2.63$ compared to the end of treatment $M=30.17$). Scores also significantly changed from the start to the follow up ($M=28.29$) see Figure 5.

Figure 6. *Positive Parenting Behaviour DPICS*



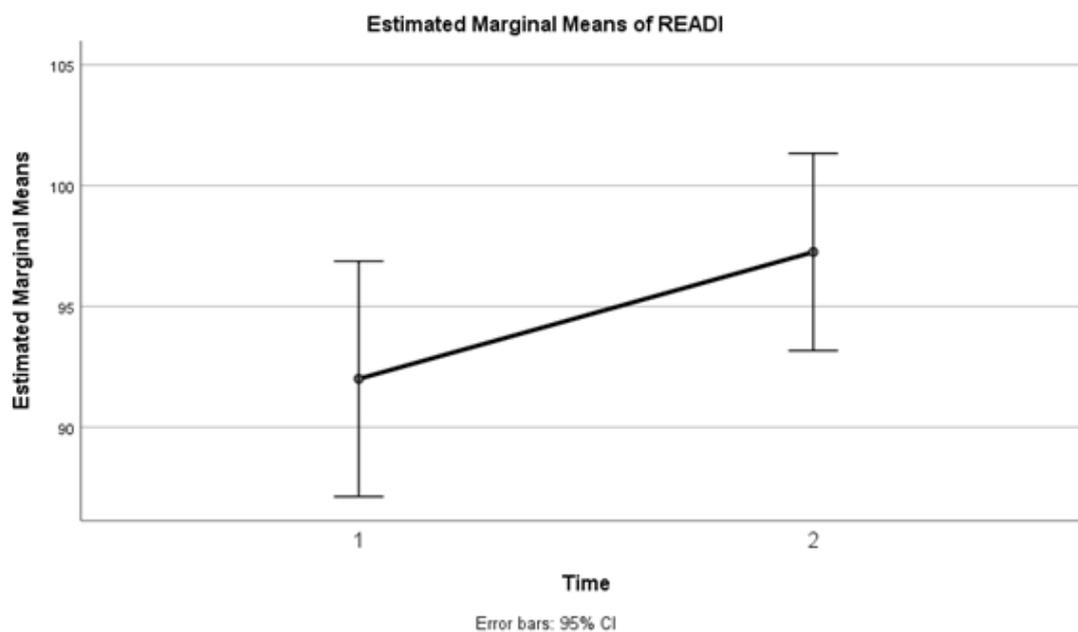
5.5.5 READI Changes in parent motivation

To begin, the first analysis that occurred was to determine whether there were significant differences between treatment settings at pre-treatment on the dependent variable. An independent t-test indicated no significant differences in READI compliance scores

between treatment settings at pre-treatment, $t(22) = -1.14$, $p = 0.27$. Therefore, the data from both treatment settings were combined (Table 12).

The mean READI score at pre-treatment was 92.71 (SD = 12.14, range 80-105) and post-treatment, 98.04 (SD=9.89, range 90-110). There was not a statistically significant difference between pre-test and post-test scores $t(23) = 5.17$, $p = .12$ see Figure 6.

Figure 7. *Motivation to Change Parenting Behaviour READI*



5.5.6 PSI - Changes in parental stress.

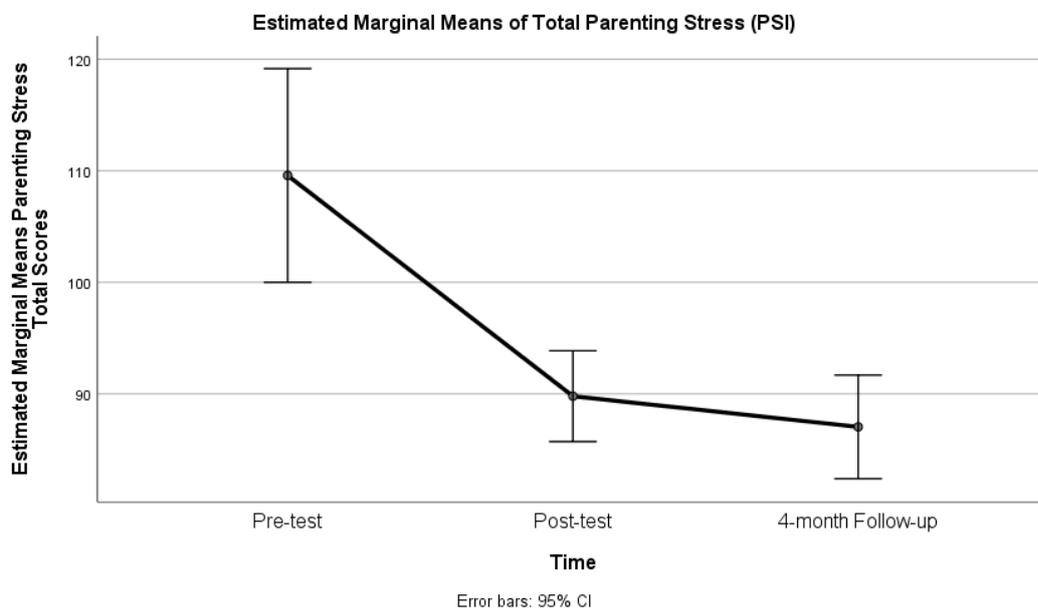
To begin, the first analysis that occurred was to determine whether there were significant differences between treatment settings at pre-treatment on the dependent variable. An independent t-test indicated no significant differences in PSI Intensity scores between treatment conditions at pre-treatment, $t(22) = -2.072$, $p = 0.60$. Therefore, the data from both treatment settings were combined and analysed as one cohort (Table 12).

The primary outcome variable was change in PSI total score overtime. The results (Table 12) revealed a statistically significant reduction in the level of stress reported by parents. A one-way repeated ANOVA indicated that the PSI scores were significantly different at least

one of the time points $F(2,46) = 39.77$, $p < .001$, partial $\eta^2 .63$. The partial eta-squared (η^2) value of 0.64 indicates a large effect.

The post-hoc test revealed that parents reported their stress level significantly changed from the start of PCIT ($M=110.92$ compared to the end of treatment $M=84.67$). Scores also significantly changed from the start to the follow up ($M=82.11$) see figure 7.

Figure 8. *Changes in Parenting Stress, PSI.*



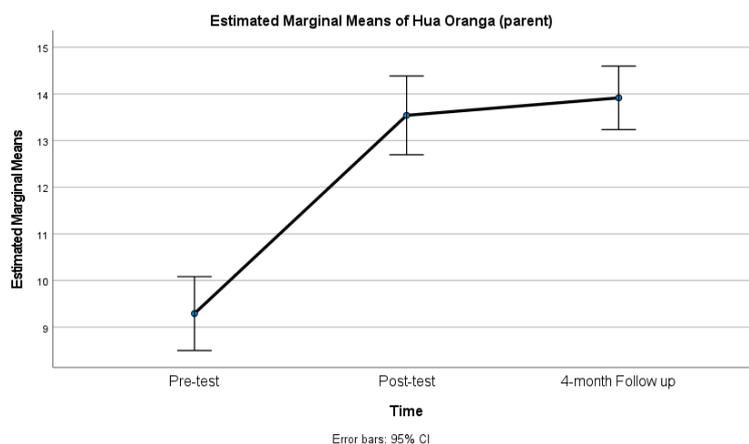
5.5.7 Changes in parents cultural wellbeing

To begin, the first analysis that occurred was to determine whether there were significant differences between treatment settings at pre-treatment on the dependent variable. An independent t-test indicated no significant differences in Cultural Wellbeing scores on the Hua Oranga for parents across treatment conditions at pre-treatment, $t(22) = -.69$ $p = 0.50$. Therefore, the data from both treatment settings were combined and analysed as one cohort (Table 12).

The primary outcome variable was change in the Hua Oranga total score overtime. The results (Table 12) revealed a statistically significant improvement in parental cultural wellbeing. A one-way repeated ANOVA indicated that the Hua Oranga scores were significantly different at least one of the time points $F(2,46) = 71.02$, $p < .001$, partial $\eta^2 .76$. The partial eta-squared (η^2) value of 0.76 indicates a large effect size.

The post-hoc test revealed that parents reported their cultural health significantly changed from the start of PCIT ($M=9.29$ compared to the end of treatment $M=13.54$). Scores also significantly changed from the start to the follow up ($M=13.92$) see Figure 8.

Figure 9. *Changes in Parental Cultural Wellbeing, Hua Oranga.*



5.5.8 GHQ-28 Changes in parents health

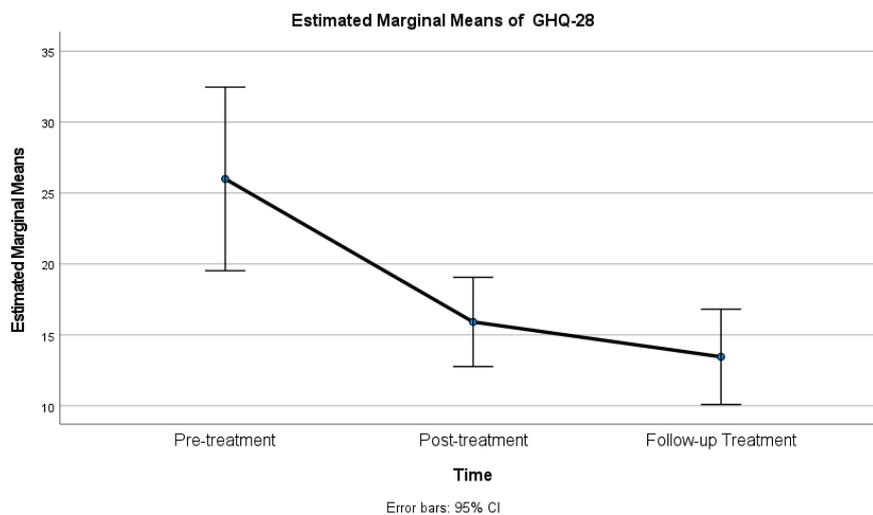
To begin, the first analysis that occurred was to determine whether there were significant differences between treatment settings at pre-treatment on the dependent variable. An independent t-test indicated no significant differences in GHQ-28 scores across treatment conditions at pre-treatment, $t(22) = -.76$ $p = 0.45$. Therefore, the data from both treatment settings were combined and analysed as one cohort (Table 12).

The primary outcome variable was change in GHQ-28 total score overtime. The results (Table 12) revealed a statistically significant improvement in parental health. A one-way

repeated ANOVA indicated that the GHQ-28 scores were significantly different at least one of the time points $F(2,46) = 17.84, p < .001$, partial $\eta^2 = .44$. The partial eta-squared (η^2) value of 0.44 indicates a large effect size.

The post-hoc test revealed that parents reported their health significantly level significantly changed from the start of PCIT ($M=26$ compared to the end of treatment $M=15.91$). Scores also significantly changed from the start to the follow up ($M=13.46$) see Figure 9.

Figure 10. *Change in Parental Health, GHQ-28.*



5.5.9 Changes in children's cultural wellbeing

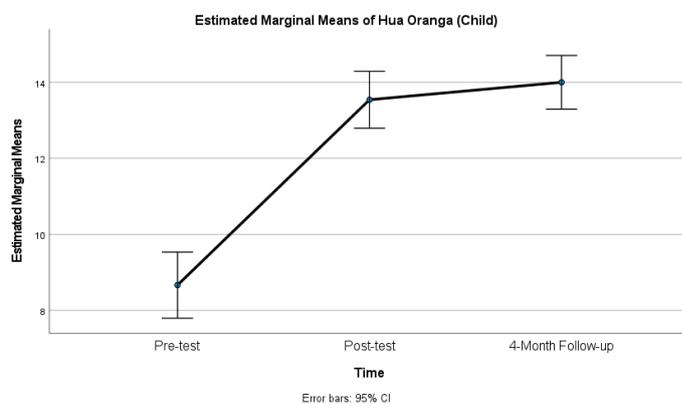
To begin, the first analysis that occurred was to determine whether there were significant differences between treatment settings at pre-treatment on the dependent variable. An independent t-test indicated no significant differences in Cultural Wellbeing scores on the Hua Oranga for parents across treatment conditions at pre-treatment, $t(22) = -.33, p = 0.75$. Therefore, the data from both treatment settings were combined and analysed as one cohort (Table 12).

The primary outcome variable was change in the Hua Oranga total score overtime. The results (Table 12) revealed a statistically significant improvement in child cultural wellbeing.

A one-way repeated ANOVA indicated that the Hua Oranga scores were significantly different at least one of the time points $F(2,46) = 97.13, p < .001$, partial $\eta^2 = .80$. The partial eta-squared (η^2) value of 0.80 indicates a large effect size.

The post-hoc test revealed that parents reported their cultural health significantly changed from the start of PCIT ($M=8.67$ compared to the end of treatment $M=13.54$). Scores also significantly changed from the start to the follow up ($M=14.00$) see Figure 10.

Figure 11. *Changes in Child Cultural Wellbeing, Hua Oranga -child.*



5.5.10 PCIT feasibility

Therapist adherence (PCIT Integrity Checklist). There were two fully certified Māori PCIT clinicians. Both therapists maintained a high degree of PCIT treatment adherence as rated by the treatment integrity checklist across 12 sessions for each primary parent. The mean score reported by the therapists was 94.62 ($SD=4.02$, range (87-100)), which is within the guidelines for standard PCIT (Eyberg & Funderburk, 2011).

5.6 Summary of Main Findings.

The first primary hypothesis that the primary parent attending PCIT will have good programme completion rates was supported. The high completion rate of 88% demonstrated that these Māori whānau, with multiple challenges (including low incomes, low educational

achievement, and living in crowded homes in high deprivation areas), and their tamariki (with histories of trauma and severe behavioural problems), were able to complete PCIT. While there were very good completion rates overall, it is worth noting that two families had their children uplifted while participating in the research. These multi-challenged whānau are precisely those who could most benefit from PCIT, so ensuring that they are all able to participate in PCIT with their tamariki is important.

The second primary hypothesis that tamariki who complete PCIT will demonstrate an improvement in parent-rated disruptive behaviour measured on Eyberg Child Behaviour Inventory (Eyberg & Pincus, 1999), from pre- to post-intervention was also supported. In addition, these positive results were maintained at a four-month follow-up with 90% of the tamariki behaviour being within the non-clinical range of the ECBI Intensity scale.

The improvement in child behaviour was further supported by the secondary hypotheses findings that child compliance was significantly improved and directly related to parental positive behaviour improving and that child cultural wellbeing was improved significantly according to the reports from the primary parent. It was interesting that there was no significant improvement in parents' reported motivation to change their parenting behaviour as measured by the READI.

Parental wellbeing was also shown to improve as measured by western measures (e.g., GHQ-28 and PSI) and on cultural measures of wellbeing (e.g., Hua Oranga). However, what the results from scores on the PSI also showed was that these primary parents still reported significant levels of stress at the conclusion of PCIT; the four-month follow-up results suggested that there were further improvements in parental wellbeing.

Finally of particular interest is the fact that these Māori parents were highly satisfied with PCIT-Māori and felt that it was culturally acceptable when delivered by Māori therapists,

and this intensive intervention was feasible and could be delivered in tertiary services in New Zealand.

5.6.1 Strengths and limitations

This is the only study to date, examining the acceptability and efficacy of PCIT with Māori whānau living with multiple psychological, social, and economic challenges (often referred to as vulnerable families). There have been few published studies of PCIT outside the US and only a handful with indigenous populations (China, Japan, and Puerto Rico).

This study showed that PCIT can be delivered by and for Māori in real-world clinical environments with positive results when cultural adaptations are made and when it is delivered by and for Māori.

The limitations of this study include that it was a small, uncontrolled pre- post-trial, with 24 whānau and their tamariki, delivered by two Māori PCIT therapists in their usual clinical services. The small numbers and lack of a control group means that improvements reported here may be due to other factors. However, the literature shows that disruptive behaviour problems of young children have a high degree of stability over time if not treated (Fergusson, 2014).

Second, due to the real-life setting of the study, the study assessors were also the study therapists, there was no blinding. Therapist 1 assessed therapist 2 client and vice-versa. So while the therapist did not do the assessments for their the whānau they did the interventions for, in an attempt to introduce some objectivity.

5.6.2 Implications for practice and research

Despite its limitations, this study has provided evidence that PCIT is acceptable to Māori whānau when culturally adapted (PCIT-Māori) and delivered by and for Māori. It

improved parenting practices and tamariki behaviour, and parents learnt a safe and effective approach to setting limits and boundaries. Nonetheless, future research is required to address the shortcomings of the present study. A randomised controlled trial with a culturally adapted version of PCIT could compare the results with a Māori clinical control group and investigate long-term effectiveness.

5.7 Conclusions

This was the first study, internationally, of PCIT by and for an indigenous population and in that respect, it contributes to what is known about cross-cultural adaptations of evidence-based interventions for families and children. In addition, it provides evidence of statistically significant and clinically meaningful, short-term effectiveness of PCIT in New Zealand when delivered by Māori therapists to Māori whānau living in multi-challenged environments.

Chapter 6: A kaupapa Māori qualitative study

“Ma whero ma pango ka oti it e mahi.”
 “With red and black the work will be complete.”

(Brougham et al., 1987)

6.1 Introduction

This qualitative study was based on kaupapa *Māori*, philosophies (Cram, 2001) outlined below (Table 14). Māori researchers have found that qualitative methods are more well suited to our unique indigenous needs. Moekawa-Barnes (2000) stated that qualitative methods enabled “a more equal conversation to take place where power can be negotiated in ways that are not generally considered or thought possible in more quantitative approaches” (p.6, Barnes, 2000).

Kaupapa Māori theory prioritises Māori experiences and aims to give voice to Māori stories in a manner that is culturally respectful and culturally safe. Hearing Māori voices is important so that practitioners, programme developers, funders, government agencies, and other indigenous communities can learn from and develop a greater appreciation of these experiences. The learning is not only about developing more culturally responsive and culturally safe parenting programmes but also about trying to understand the user experience from a Māori worldview. *Kaupapa Māori* takes for granted the validity and legitimacy of Māori culture, language, philosophy, and principles while supporting research that will benefit the Māori community (L. Smith, 1999).

Bishop (1999) suggested that Kaupapa Māori also acknowledges a participatory role for the researcher where in a qualitative piece of research Māori are able to utilise important principles of whanaungatanga so that our Māori participants may feel and recognise the deeper relational connection. This ability to establish and maintain our relationships between ourselves and the whānau we are researching is seen as an important element of Kaupapa Māori research. In this way the research is participatory for the participants and the “ Māori researcher who

becomes part of the process” (p.4, Bishop, 1999). It is because of this closeness and connection between researcher and the researched that Western Science often struggles to understand Kaupapa Māori research or try to assert that it is bias and therefore flawed (Walker, Eketone, & Gibbs, 2006). Such a lack of cultural understanding is exactly why Kaupapa Māori methods are crucial for the development of methods that support the development of Māori processes.

While there are links to participatory action research (PAR) methods and Kaupapa Māori research (Eruera, 2010; Walker et al., 2006) within clinical research the utilisation of *manaaki* and *awhi* are additional values which need to be demonstrated as the clinician is also responsible for ensuring that the safety of the participants are maintained.

This chapter covers *kaupapa* Māori principles, describes qualitative methodology, uncovers the stories and experiences of 18 primary parents, and discusses the implications of this new knowledge for the future benefit of *whānau* Māori and other mental health communities.

6.2 Kaupapa Māori Principles

A major feature of Kaupapa Māori methodology is that a Māori world view is both valid and legitimate. Kaupapa Māori is “by, for and with Māori” and is inherently about cultural survival and *tinō rangatiratanga* [self-determination] (Cram, Smith, & Johnstone, 2003; L. T. Smith, 2013). Kaupapa Māori research asserts Māori participants as partners with the Māori research team and aims to protect Māori interests while preventing information from being used to undermine Māori in a social, economic, spiritual, or cultural sense (Edwards, et al., 2005).

Kaupapa Māori research approach emphasises the use of *kanohi ki te kanohi* (face to face interviews) (Carpenter & McMurchy-Pilkington, 2008; Cram, et al., 2006). Interviews are conducted using Māori protocol and competencies which ensure *Tikanga Māori* (correct

procedure, method, practice, custom) are upheld and include whakawhanaungatanga , karakia, mihi, and kai (Carpenter & McMurchy-Pilkington, 2008). These practices also ensure that due respect and sensitivity are awarded to participants, but also promotes a mutual exchange (the principle of reciprocity) of knowledge given the expenditure of time and effort by participants.

There have been some criticisms of Kaupapa Māori research such as the risk of bias and subjectivity, due to the focus on the empowerment on Māori processes (Walker et al., 2006). The importance of maintaining close relationships can also lead to the potential for Māori researchers to feel conflicted over what type of data will be used, given they become guardian of the knowledge they have collated (Curtis-Clark, 2012; L. Smith, 1999). The combination of face to face interviews and the focus on Māori processes lends itself to the utilisation of thematic analysis (Braun & Clarke, 2006; Joffe, 2012).

A Kaupapa Māori approach does not exclude the use of a wide range of methods, but rather signals the interrogation of methods in relation to cultural sensitivity, cross-cultural reliability, useful outcomes for Maori, and other such measures. In this context, the use of in-depth interviews enabled us to collect people's views on Māori parenting practices at all levels, from personal experience, to community and political perspectives.

6.3 Aims

1. To explore Māori primary parents experiences of PCIT, including the benefits and challenges of engaging in PCIT.
2. To discover Māori primary parents' thoughts about the cultural acceptability of PCIT for Māori whānau.
3. To provide an open forum to talk about any other issues they wanted to discuss relating to their experiences of participating in PCIT.

6.4 Methods

6.4.1 Participants

Eighteen Māori parents participated in three hui, using tikanga Māori principles.

6.4.2 Interview Schedules

A semi-structured interview format (Appendix 7) was used to elicit qualitative information from participants because it has been noted by other Māori as a useful structure to accompany kaupapa Māori interviews (Cram & Pipi, 2000; Cram et al., 2003; Curtis-Clark, 2012)

6.4.3 Research Team

The writer and a therapist 2, taped, and analysed the hui interviews. From a kaupapa Māori framework, having and establishing a close relationship with the Māori parents helps to make whānau feel culturally safe. From a non-Māori epistemology, this is likely to be seen as a risk of bias, but from a kaupapa Māori worldview, it is seen as appropriate.

6.4.4 Study Design

This qualitative study used kaupapa Māori research values (Cram, 2001; Lawton et al., 2013) see Table 14, and an interpretative phenomenological lens (Brocki & Wearden, 2006) to uncover key themes from Māori parents stories, which offered insights into how they make sense of given phenomena . A kaupapa Māori research process was used to acknowledge and give credit to the cultural practices and *kanohi ki te kanohi* [face to face interviews] hui process as a way of supporting Māori scientific processes.

Table 14 *Mātua Whetewhete Hui Processes Aligned with Cultural Values*

| Cultural values (L. Smith, 1999) | Researcher guidelines (Cram, 2001) | <i>Mātua Whetewhete hui</i> processes |
|-------------------------------------|--|--|
| 1. Aroha ki te tangata | A respect for people—allow people to define their own space and meet on their own terms | <ul style="list-style-type: none"> • Hosting of <i>hui</i> at centres where they had received the intervention • Only Māori staff involved in the <i>hui</i> • Followed cultural protocols at <i>hui</i> |
| 2. He kanohi kitea | It is important to meet people face to face, and to also be a face that is known to and seen within a community | <ul style="list-style-type: none"> • Working history within the Māori communities where the <i>hui</i> were conducted • Acknowledged and built upon established Māori community relationships • Committed to community relationships that extended beyond the trial |
| 3. Titiro, whakarongo kōrero | Looking and listening (and then maybe speaking)—develop understanding in order to find a place from which to speak | <ul style="list-style-type: none"> • In the role of <i>hui</i> facilitator but still responsive to parent feedback during the <i>hui</i> • Inviting parents to bring with them support people to the <i>hui</i> • Discussed with Māori clinical advisors how to conduct the <i>hui</i>, and the types of questions to ask |
| 4. Manaaki ki te tangata | Sharing, hosting, being generous | <ul style="list-style-type: none"> • Supported <i>whānau</i> with transportation, child care, <i>kai</i> and a <i>koha</i>, on the days of the <i>hui</i> • Creating opportunities for parents to be part of a <i>tuakana-teina</i> mentoring system after the trial |
| 5. Kia tūpato | Be cautious—be politically astute, culturally safe, and reflective about insider/outsider status | <ul style="list-style-type: none"> • Gaining appropriate cultural permissions for the trial • Establishing Māori research advisory group • Ensuring <i>tikanga</i> Māori processes of <i>hui</i> were conducted |

| | | |
|--|---|--|
| 6. Kaua e takahia te mana o te tangata | Do not trample on the mana or dignity of a person | <ul style="list-style-type: none"> • Ensuring whānau Māori were respected and treated well according to <i>tikanga</i> Māori processes of engagement for <i>hui</i> • The inclusion of <i>whānau</i> members to support a <i>kaupapa Māori</i> way of defining family. |
| Kia māhaki | Be humble—do not flaunt your knowledge; find ways of sharing it | <ul style="list-style-type: none"> • Ongoing engagement with Māori community advisors • Acceptance of invitations to talk to with Māori stakeholder groups about the trial, research and PCIT. • Encourage Māori parents to become mentors to other parents within their own <i>whānau</i> and community. |

6.4.5 Participant Selection

All the Māori parents who had participated in the PCIT study were eligible to take part in the post-PCIT hui, including those who did not complete PCIT. Three hui were conducted: one held at the Infant Mental Health Service (IMHS) site, and two held at the Residential Parenting Service (RPS). Potential participants were recruited initially during the assessment phase of the qualitative study and then re-contacted, by the writer (TC), two weeks before each hui date to see if they were still interested in attending a hui to discuss their experiences of PCIT. The hui were held during the day, when most of the tamariki were at kura, kindy, or school; therefore, caregivers had a better opportunity to discuss issues without having to worry about their children. Across all three studies, 18 parents (70%), who had participated in the PCIT clinical trial, agreed and attended the hui. They received a small koha (\$10 petrol voucher) to help with transportation costs.

6.4.6 Setting

The *hui* were conducted in the RPS and IMHS and data was collected via videotaping the *hui*. Parents were encouraged to bring other *whānau* or support people, and three parents attended with other family members (two sisters and a grandmother).

6.4.7 Hui design

Each of the hui were conducted according to Māori kaupapa processes. The hui had the

following components

- *karakia* (prayer),
- *whakawhānaungatanga* (introductions),
- *kai* (food)
- *kanohi-ki-kanohi* (face-to-face) discussions,
- *koha* (small financial gift)

The *kawa* [protocol] for each hui, required that both interviewers introduced themselves through their own *mihi* [tribal connection] and then the purpose of the hui was restated while consent was gathered. There was also a discussion on how participants' confidentiality would be protected when collecting and analysing the data. The hui were video-recorded and transcribed by each of the Māori PCIT clinicians and compared for accuracy. Any major differences were compared with the original videotape until there was consistency in the data.

6.4.8 Data collection

The design of the semi-structured interview guide (Appendix 7) was reviewed by the Māori advisors on the study (a male kaumatua, two female PCIT clinicians, and a female Māori parenting expert). The first hui functioned as a pilot test in order to determine whether there were flaws, limitations, or other difficulties with the interview protocol (Turner, 2010). No changes were made to the initial interview guide, and the hui were conducted according to Māori *kawa*.

6.4.9 Tailoring PCIT to Māori principles

There were several Kaupapa Māori processes that were included in how PCIT was conducted. The process were all related to Māori *kawa*.

In the Residential Parenting Service (RPS), all parents were initially seen together in a group. The group was run as a *hui* would be run. This is an important cultural process of engagement.

- *Karakia* (opening prayer)
- *Himene* (Hymn)
- *Whakawhānaungatanga* (creating relationships through tribal connections)
- *Kai* (refreshments and important to lift the tapu)
- *Kawa* (agenda)
 - a. Introduction to PCIT
 - b. Video testimonial – from Māori parents who had completed PCIT
 - c. Questions and discussion time
 - d. CDI teach session
- *Karakia* (closing prayer)
- *Poroporoaki* (farewell)

2. In the Infant Mental Health Service (IMHS), all parents were seen individually. However, a similar *hui* process as above was conducted with each family. They were also encouraged to invite other family members to attend the session with them. This was an important cultural process to support cultural engagement. In addition, all sessions began with *karakia* (prayer) as a way of inviting spiritual support into each session.

6.4.10 Method of analysis.

Thematic analysis based on the general inductive approach was utilised to investigate common themes, points of agreement/disagreement, and interrelationships between the narratives from each *hui* (Thomas, 2006). All of the interviews were video-recorded using specialist equipment, and transcribed, which allowed the transcripts to be thoroughly checked against the original recordings. The writer (TC) and another Māori practitioner read the transcripts and coded them independently. Recording the interviews enabled my colleague to independently code 1/3 *hui* against key themes used in the coding strategy. Any coding discrepancies were discussed until there was coding agreement.

6.5 Results

6.5.1 Hui participants

All of the hui participants (n=18) had successfully completed PCIT with their tamariki. The hui were conducted on three separate dates (November 2014, April 2015, September 2015), and they lasted 90 minutes. In total, 18/24 caregivers (75%) participated in the hui (10 from the RPS and eight from the IMHS). The remaining six caregivers (five could not be contacted and two initially agreed to be part of the hui but then did not arrive on the day due to sickness). To ensure confidentiality any identifiable information was not used in the data, and their age was used to identify them in the data.

6.5.2 Primary Parent Interviews

A thematic analysis was conducted on the experiences of Māori parents of receiving PCIT. The women's stories are set out according to their experiences of their children's behaviour before PCIT and after PCIT and general reflections about the types of cultural adaptations required to make PCIT culturally responsive and safe for Māori whānau.

6.5.3 Parents experiences of their children's behaviour before PCIT.

Six themes were identified:

1. The trauma of having children taken from your care.
2. Experiences of racism.
3. The impact of poverty.
4. A sense of hopelessness.
5. Denial about the need to change.
6. Fearful of their own children.

6.5.4 The trauma of having children taken from your care.

In this study, the parents (15/18) who had had their children taken from their care described how traumatising it was for them and the legacy of mental health problems they felt were a direct result of having had their children taken.

I felt I had been traumatised, we as mothers had been traumatised. Because we had lost our children, our children were taken from us. We were terrified that this was going to happen again. We felt like we were being watched all the time.

(22 year old parent)

It is really traumatising, people can't understand, what it is like (having your children taken from your care). You are terrified, that you might make mistakes and then you lose your children, they're gone from you. They're taken from you by CYFS (Child Youth and Family Service), so you're just terrified that it might happen again.

(33 year old parent)

When they took my children it was horrible, the kids were screaming, police were there, my babies were ripped from my arms.

(28 year old parent)

I didn't know what to do and I was scared and so I just ignored everything. I was so terrified as a parent that I just tried to forget about my children. I dropped to my lowest point ever, I got into a really bad space, I gave up, I thought about killing myself.

(32 year old parent)

All of the parents (15/15), who had their children taken, reported feeling blamed and useless as a parent. They also felt responsible for their children's behaviour.

I felt like everyone blamed me, that it was my fault, you know that their behaviour was my fault, that I was useless as a parent.

(26 year old parent)

I felt blamed too, you know most mums who get sent to parenting courses we all feel like that, we feel bad as parents, and the social workers make us feel bad as parents.

(22 year old parent)

I was exhausted, I was really depressed, I didn't want to have to get up and face another day, I just couldn't it felt like war. I wanted to give up.

(36 year old parent)

I was so depressed, I just felt useless as a parent. I had no get up and go. I tried but it wasn't enough. It just didn't feel like I could change anything, I lost hope.

(33 year old parent)

I blamed myself because I was so sad and had no energy, I just didn't know how to be a mum. I was depressed and I couldn't do a good job as a parent.

(26 year old parent)

I think I wanted to do the right thing, but I was so focused on my own problems, I had my own trauma to deal with, from my own past. I was depressed and I couldn't focus and concentrate.

(48 year old grandparent)

I just didn't know how to be a mum. My boy had really challenging behaviour and I didn't know how to deal with it. It was my fault.

(22 year old parent)

I was to blame, if I was better as a parent I wouldn't have lost them and then maybe they would have better behaviour.

(28 year old parent)

We were really hard on ourselves, we blamed it on ourselves, so we felt we had to be better as parents.

(30 year old parent)

6.6 Experiences of racism

Almost all the parents (17/18) discussed their own experiences of racism within the state system. This was expressed by parents who saw the social workers as a reflection of a racist system.

I believe the social workers believed we were bad too. I didn't have any Māori social workers, so they didn't understand me. They were just so blaming. The way they talked to us and made us feel stink.

(28 year old parent)

I agree that the way the social workers were with us was like they believed we were bad. They were racist against us because we were Māori. My social worker kept referring me to parenting programmes and I didn't even have my children.

(33 year old parent)

The whole system is racist because it is always Māori kids taken into the system. Yet we don't have any Māori social workers.

(42 year old parent)

6.6.1 The impact of poverty

In this study, all (18/18) parents described poverty as significant stress associated with their lives and also something that impacted upon their ability to do PCIT as a family.

We wanted to do it (PCIT) together as a family, but it was so hard to try and get both of us out of work for 14 weeks you know, it just doesn't happen easily, we just can't afford to have us both off work.

(34 year old parent)

I had to make the choice to either use the gas to get to clinic or for it to go food shopping. It is such a tough choice.

(33 year old parent)

It can be hard to be on your own parenting, people don't realise how we are so hard up in this area. We can barely have enough money to feed the kids, so trying to find transport here was hard.

(28 year old parent)

If PCIT was delivered here, I wouldn't have been able to do it. I couldn't have avoided to come here every week.

(31 year old parent)

6.6.2 A sense of hopelessness

For this example, most parents (13/15) reported that they had truly lost hope that anything would work and that they had already done other parenting programmes before PCIT. They believed that nothing was going to work, which left them feeling hopeless.

I found the start of PCIT really hard because I wasn't sure that this was going to work, I suppose because nothing had worked in the past, I had done lots of other parenting things and nothing had worked. I lost hope that anything could work.

(28 year old parent)

We had all done lots of parenting programmes before and none of it worked, it was all just talk talk talk. We were pretty sure this (PCIT) wouldn't work either.

(34 year old parent)

We didn't believe this would work, I had already done heaps of parenting things, my social Worker just kept sending me to things, I felt like I had to go, but nothing worked. I just told them what they wanted to hear. I just thought this (PCIT) was going to be like all the others. I felt hopeless.

(35 year old parent)

6.6.3 Denial that change was required

A third (6/18) of the parents reported that they didn't really believe that they needed to change anything about their parenting. This was similar to what parents reported in this study because, as reported above, they had already completed a variety of other parenting programmes before they entered into PCIT.

Yeah for me, I had never had to do anything differently, I didn't really believe that there was anything wrong with my parenting. I just believed everyone was making a big deal about nothing.

(48 year old grandparent)

I didn't believe I was going to learn anything, remember I had already been to other parenting programmes. I knew more than the leader of the last programmes that I went to went. I had heard it all before.

(28 year old parent)

You don't believe that it is going to work, because nothing has worked and so you think this is just another thing to do, but you don't really believe you need to do it. So I don't think I really tried at the start of PCIT.

(33 year old parent)

It is a big change, we don't think we have to change, we think it is just others judging us. So accepting help is really hard. You have to believe that it will change, otherwise why would you do it?

(36 year old parent)

6.6.4 Fearful of their own children

The final theme showed that parents were fearful of their children because of the level of violence that their behaviour would elicit. This fear made them powerless to act. The following shows the level of fear that existed.

I was scared of putting in limits and boundaries, I knew that they were important but no one else had ever done it. I was afraid that if I tried to do it, that it would make him even more violent and I wouldn't be able to handle it.

(27 year old parent)

I was scared of my son, he would hit me and bite me, I didn't want to make him angry. So I kind of just tried to keep him happy. It was like he was in charge.

(28 year old parent)

I couldn't go out in public, I wanted to but I couldn't guarantee how he was going to be so I just use to stay home. He was so violent and he would attack me.

(33 year old parent)

We just gave in to our kids because we felt so guilty, we gave up and we gave in. I didn't want to make him angry so I just let him do what he wanted.

(34 year old parent)

6.7 Parent's Post- PCIT Stories

There were five themes identified

1. Hope returns
2. PCIT brings you closer to your child
3. Your sense of competency returns
4. *Tamariki* love PCIT
5. A support coach is important

6.7.1 Hope returns, it works

These themes were also reported in this study with indigenous parents, where all 18 participants stated that they loved the fact that PCIT worked (their children's behaviours significantly improved) and they reported that they felt much more confident as parents.

The difference is that this parenting programme really works, if you do it you get the changes. Your child improves because you improve.

(48 year old, grandparent)

It builds your confidence. You believe you can be a great parent. Your home and everyone feels so positive and your children are well behaved.

(40 year old foster parent)

I have done other parenting programmes, but this one (PCIT) is the only programme that I have done that actually works.

(32 year old mother)

The other (parenting) programmes are all talk talk talk, they don't even see you with your child. You can just say anything, no one cares whether you do it or not. In PCIT you and your child are seen together, so there is proof that you and your child are changing.

(26 year old mother)

He was awful at the start...pulling my hair, kicking, tantruming, hurting himself and hitting me. Now he is so calm and it is really amazing to see how well behaved he is after PCIT.

(34 year old mother)

His behaviour was so bad, I didn't know how to cope and now it is like night and day, his teacher has seen the change too and she asked if he was on medication because he is so good at school now.

(36 year old mother)

I liked that it gave you new skills and strategies to use and they worked. Before PCIT I had never been able to get my child to listen to me, it was embarrassing and I felt ashamed. But after learning about how to set good limits and boundaries I knew it would make a difference.

(32 year old parent)

It is so helpful when they listen, it just saved so much stress. It shows you that you can do it, when you follow through.

(27 year old parent)

6.7.2 PCIT brings you closer to your child

Indigenous parents in this study also described how PCIT enhanced the connection they felt with their child.

In this programme (PCIT), it brings you closer to your child, you feel your bond is much stronger to them.

(34 year old parent)

PCIT is focused on you and your children being in relationship together. So you find that you end up spending more time together, because you both like it and you want to be together.

(40 year old foster parent)

I just felt so much more connected to my children in this programme. You do it together so you grow together. It was beautiful to see.

(24 year old parent)

I was a terrible parent, I kept screaming and yelling at them and it never worked. They were just terrified of me and now it is so joyful and the kids are so calm and I'm calm. I realised that actually when I just talk calmly and use the PRIDE skills that things can change. I just enjoyed them more and they enjoyed me too. We kept praising each other and it made us really love each other.

(36 year old mother)

It (PCIT) was like magic, you could get them (your children) to listen without having to get angry, or screaming or using violence. For me this is the only time that my girl has

listened to me, ever. Who would have thought that just doing things and saying things consistently and the same each time, would work. Staying calm and using PRIDE was all it took.

(36 year old mother)

I felt healthier in the programme, it really helped me. It is the only parenting therapy I would recommend, because it is easy once you know about the PRIDE skills.

(43 year old father)

That the kids really appreciate their time with you, that they really love that special time with you, it is just choice to see them really wanting to be part of the play with you and wanting you to be close.

(40 year old foster parent)

6.7.3 Your sense of competency returns

Parents reported that having completed PCIT, they were much more confident as parents and they believed that they would be successful as parents. They felt that their resiliency had returned which also supported a general improvement in mood and a sense of positivity which extended to the entire family. They felt their *whānau* was becoming happy again and described it as a reparative experience.

Your children learn to behave better, they're happy, you're happy, it just makes everyone happy in your whānau. It changes your whole family.

(33 year old mother)

The programme is so positive that you feel great doing it and your whole house is positive and you are always trying to catch your kids being good. The other kids benefit too, because it's a nice place again. Even as adults we're nicer to each other.

(32 year old parent)

I use my PRIDE skills all the time. I use them when I'm at my sisters. My family questioned why I was praising my kids, then I heard my sister praising her kids like I had just done. So she wants her kids to be well behaved too.

(36 year old parent)

6.7.4 Your tamariki love PCIT

All 18 participants also liked the fact that their children all loved PCIT too, which made it much easier for them to continue on in the programme. In particular, participants emphasised that their children enjoyed the special playtime and that the treatment required only a five-minute commitment each day.

Your kids enjoy it too, they like PCIT, they're more positive and they're giving you praise as a parent.

(33 year old parent)

They loved the playtime, they looked forward to it. It took me a little while to get the hang of the skills but the kids loved it anyway, it was magical. They wanted to play with me.

(48 year old grandparent)

Just being with him in playtime he loved it, he would come running down the hall clapping his hands and singing PCIT, PCIT.

(28 year old parent)

We learnt together, it made sense for me to have my boy with me, because that is where the problem was in that relationship. It hadn't worked with other programmes when we only talked about stuff.

(22 year old parent)

It was really nice us coming together, so you could see how he was improving too, this was the first programme that ever saw us together.

(36 year old parent)

6.7.5 The importance of supportive coaching

Certainly, the majority of the participants (14/18) mentioned specifically the importance of the supportive and responsive PCIT coach was important to them and identified that it was a motivating reason to stay in the programme.

No one had ever helped me when he had one of his massive tantrums and he had one in the very first session of PCIT and you helped me to find my own skills to be able to manage it and I was like hooked on doing this programme, then.

(34 year old parent)

I loved that you were right there with me, because I was nervous and didn't know what to do when he was having his massive wobblies.

(28 year old parent)

I loved the support, I felt that I was doing things right. I had never had that before, where I was supported and told what it was I was doing.

(22 year old parent)

6.8 Cultural acceptability of PCIT

There were four main themes identified

1. Māori therapists are crucial.
2. Using *te reo* Māori.
3. Ensuring Māori *tikanga*.
4. Allowing other whānau members to attend.

6.8.1 Māori therapists are crucial

Māori parents felt that having Māori therapists delivering PCIT was the key way to ensure that the programme was culturally appropriate. All 18/18 parents felt that this was an extremely important element.

Being Māori is important to me so having a Māori therapist is really important for me. It should be just something that I should be able to expect.

(36 year old parent)

To me, you (Māori therapist) were the cultural adaptation, you were what made the programme culturally appropriate for us as Māori. I felt that I could just be myself as a Māori māmā.

(26 year old parent)

6.8.2 Use of Te Reo Māori

The importance of using te reo Māori was also identified as a reason parents reported to ensure success in the PCIT programme, reporting that it made PCIT feel much more culturally relevant and acceptable (14/18).

We used Te Reo Māori right throughout so I felt that this was how you made it culturally relevant for me. It felt tika having another Māori mum support me, I just felt safer like you could understand me and my child.

(32 year old parent)

Being able to use Māori throughout the session was important to me. I can't speak Māori but I want to be able to and I felt like that I was able to practice it.

(28 year old parent)

Having a strong Māori woman to look up to and to trust, was so empowering for me as a parent. I felt that I could use Māori and it was encouraged in the coaching too.

(34 year old parent)

You could have someone who wasn't Māori, I mean that is what we have mostly anyway, but you feel more connected to people who are of the same culture as you, it just is a comfort thing. That you know the tikanga, what to expect.

(22 year old parent)

I have had Pākehā (therapists) and they just didn't get me, they're nice and everything but they just can't really understand how it is for us. They can't understand what we have been through, you know the racism and things, where we are judged.

(26 year old parent)

No disrespect but I just feel more comfortable with Māori therapists. This is the first programme where I had Māori therapists involved.

(28 year old parent)

6.8.3 Ensuring Māori tikanga was followed

There was some minor tailoring of PCIT including common *tikanga* Māori practices of engagement, such as starting with a group whakawhānaungatanga session and the use of *mihi* to get to know each other, which the parents reported ensured that the PCIT was culturally appropriate. This group whakawhānaungatanga session was really just a general introduction to each other and to PCIT but 15/18 parents commented on its importance of setting the tone for PCIT. In addition, a videotaped testimonial from four Māori mother's was played for the group. This showed Māori mothers talking about their experiences of PCIT. It was used to help motivate the parents and to lead them into a discussion about how and what PCIT was.

It is important for us as Māori to connect as Māori, so having this whakawhānaungatanga session really set the stage for how PCIT was going to be more culturally relevant for us.

(28 year old parent)

Even though we are different as Māori mums we still know each other and that is why having mihi helps us. It sets us up to be supports for one another.

(22 year old parent)

6.8.4 Allowing other whānau members to be involved

In Māori society, parents often have other *whānau* members as support people. This study also showed that half of the Māori parents (9/18) commented that having *whānau* support was crucial. They reported that initially, *whānau* were not supportive because the types of skills the parent was using were new. However, they saw the behavioural and relational changes and then they became very supportive.

My whānau were like what are you doing, they said it looked stupid, but then they noticed the changes in the kids and that was it, they were saying gee cuz this is really working, how can we get it.

(33 year old parent)

My family they were hard initially, but then they would say things like “your kid is really good now” and they noticed that wasn’t fighting with his cousins anymore. They said it was good what I had done for them.

(26 year old parent).

It was important to have my family support, this wasn’t easy as at the start they were questioning why I would want to do it. But then they saw him and I change and we were smiling more and he was listening, they started to belief that things could get better.

(26 year old parent).

6.9 Final recommendations from parents

There were three main themes identified.

1. PCIT needs to be more readily available.
2. No changes provided the therapist is Māori.
3. Parents need to know that it is a new type of parenting programme.

6.9.1 PCIT needs to be more readily available.

The top recommendation, made by 12/19 of the parents, was that PCIT needed to be more widely available. They didn't believe that it was helpful to only be able to do it when you were already having problems, they wanted to see it used as a prevention programme.

It needs to be open to everyone, not just those of us who are in CYFs, because if we had the chance to do it earlier maybe we would have coped better and not ended up without our kids in the first place.

(26 year old parent)

I think it needs to be open to everyone who wants it, I didn't even know about it until you (therapist) told me about it. Why should it have to be in this service, before it got offered to me?

(48 year old grandparent)

I know that my sister wanted to do it too. That is why she came to support me. She told me that she wished she had done it as well.

(48 year old grandparent)

6.9.2 No changes provided the therapist is Māori.

Eleven parents didn't believe any adjustments needed to be made provided the therapist was Māori, stating that the Māori therapist made the programme culturally safe.

As long as the coach is Māori you don't need to make any changes. Because being Māori we know what we need. I just feel that the coach knows how to work with us and support us.

(33 year old parent)

I don't think anything needs to be changed. It was great the way it was, it felt like it was made for us because it felt Māori, because of you (Māori therapist).

(35 year old parent)

The final recommendation was that parents needed to be aware that this is a new type of parenting programme and so it is okay to feel “nervous” about the live coaching aspect of the PCIT programme and a little uncomfortable at the start (Kohlhoff, Cibralic, Lennie, Rabbetts, & Morgan, 2019).

I found it hard at the start because I wasn't sure what to do and I didn't know if it was going to work because nothing has in the past, so I guess I didn't really believe it would work.

(28 year old parent)

At first it was hard, to know that someone was watching you with your child, but then you get to trust them and it feels fine. You get use to each other.

(40 year old foster parent)

It is hard because you have to stay consistent, you have to do it even when you go out.

(32 year old parent)

It is sad that you can't be a loving and adoring mum because our whānau Māori and my relations didn't understand it. So I had to do it when it was just my family around.

(36 year old parent)

6.10 Summary

This chapter reported the trauma parents felt at having a child removed from their care and the mental health implications they experienced as a result. It also described how Māori mothers felt the state system was racist because there was a lack of Māori social workers, so they felt misunderstood. Finally, the parents own histories of poor parenting meant that several of the Māori parents felt that they didn't need to change their parenting believing other people were just being judgmental which made parents feel hopeless and helpless.

The following story of PCIT has been described by parents as feeling like hope had returned. It was a story where they felt closer to their children, and believing that a supportive coach alongside PCIT skills helped their parenting competency to return. They also reported their children's stories of loving PCIT and enjoying their time together.

The cultural applicability of PCIT was seen as predominantly resting with the therapist being Māori and their ability to use Te Reo Māori and *tikanga* Māori engagement processes (e.g., *mihi*, *whakawhanaungatanga*, *karakia*). The final recommendations related to a desire to have PCIT more widely available, rather than only as a specialist programme, and a need to let parents know that it is a new type of parenting that uses a transmitting device.

Overall, the important story is really one of resiliency and reparation where Māori parents were able to have a reparative therapeutic journey for themselves and their children. Where they went from being hopeless to hopeful, and where their children went from being "horrible" to "helpful".

6.11 Discussion

The findings from this small qualitative study support the findings from other researchers that the experience of having a child removed from a parents care can be so "powerfully upsetting that it can undermine the hope of parents" ultimately leading parents to feel guilty, blamed, and ashamed (Davidson-Arad, Aram-Fichman, Bashan-Paz, Gingis, &

Klein-Katz, 2013). Further stating that losing custody of a child is associated with significantly worse maternal mental health than experiencing the death of a child (Wall-Wieler et al., 2018). Being able to support parents who have suffered this loss to have a reparative experience with their children is important both for the child and the parents mental health.

Other studies have identified that parents who have had their children removed may also feel a greater sense of helplessness, more impaired self-esteem, and more criticism from family members and professionals (Buchbinder & Bareqet-Moshe, 2011; Mosek, 2004; Moss & Moss, 1984; Schofield et al., 2011). In a unique approach, Kenny and colleagues (2015) described a feminist analytical approach which uncovers deeper meaning of societal forces shaping women's access to tools and language that can explain their experiences (Kenny, Barrington, & Green, 2015; D. E. Smith, 1987) in terms of the array of social and institutional forces enacted through an individual's experience of child custody loss and its aftermath.

In this study, mothers blamed themselves, believing that they were solely responsible for their children's challenging behaviour and the situation they found their families in. Several studies (Adjei & Minka, 2018; Contenta, Monsebraaten, & Rankin, 2014; Muir & Bohr, 2014) have discussed the overrepresentation of Black children in the welfare system in Canada. They discussed how Western conceptualisation of effective parenting (e.g., authoritative practices) places Black and Indigenous parents (who may value more authoritarian styles of parenting) more at risk of a referral to Child Welfare, which may set up a stereotypical belief that Black parents are more likely to use harsher parenting methods. Keddell and colleagues (2018) also discussed racism in New Zealand – especially as it relates to the inequities that exist in the child protection rates in the New Zealand context – where in some areas, 70% of the children in state care are Māori, even though Māori are only 25% of the child population (Keddell & Davie, 2018). The caregivers in this study were very clear that they felt that racism continues to exist within the state care system.

In addition, Walsh and colleagues (2019) discussed the contribution of institutional racism to health inequities in New Zealand stating that it “not only drives ethnic inequities in poverty, but also compounds the already significant negative effects of poverty” (Walsh & Grey, 2019).

Kenny and colleagues (2015) discussed that in their sample, many of the women reported that losing one’s children was stigma producing and socially discrediting, derailing women’s sense of power and agency in moving forward with life and their ambitions. This is similar to a finding from a qualitative study by Stevens and colleagues (2018) who found that mothers often turned down offered parenting programmes because they felt that they already knew the things that were being covered in parenting programmes (Stevens, 2018).

Selma Fraiberg and colleagues (1975) coined the term “ghosts in the nursery”. This term is used to reflect how experiences (ghosts) from a mother’s past may influence her ability to form a warm and attuned relationship with her child (Fraiberg, Adelson, & Shapiro, 1973). Steele and colleagues (2018) discussed how contradictory states of mind (from attachment theory) in mothers can create contradictory behaviours in the interactions with their children. In their case study, Steele discussed a mother who was intensely fearful of her son because of her own early history of physical abuse by her father, leading this mother to be both fearful and powerless. This fearfulness was reported in 8/10 cases with parents of boy children. They reflected that at times when they feared their sons, it was either a reflection that they “saw their own fathers in their children” or that they saw their “abusive partners” in their sons.

Kohlhoff and colleagues (2019) described a small (n=10) qualitative study of Australian caregivers’ perceptions of a standard PCIT program delivered at a community-based PCIT clinic. They reported that despite caregivers initially being sceptical of the PCIT program, they all experienced a reduction in their child's challenging behaviours and felt confident to

say that PCIT was a programme that worked. In addition, they also found that participating in PCIT had given them confidence in their abilities to cope with any parenting situation (Kohlhoff et al., 2019).

Burns and colleagues (2019) reported on a qualitative study of parents' (n=15) experiences of participating in an Australian adapted trial of the Strengthening Families Program (SFP). They reported that themes relating to parent-child connectedness and communication appeared central to improved child behaviour and family functioning, further noting that it was a key familial protective factor for child psychosocial health (Burn, Knight, Taylor, & Toumbourou, 2019).

Burns and colleagues (2019) reported that parent and child communication improved after attending a parenting programme. They noted that dyads were more open and positive in the language they used. The parents in this study mentioned that the way they spoke to their children really changed, not only in their tone, but use of the PRIDE skills, which are really talking skills.

Improved parenting competence has been described in several qualitative studies associated with parenting (Furlong & McGilloway, 2015; Kohlhoff et al., 2019; Osman, Flacking, Klingberg Allvin, & Schön, 2019; Vella, Butterworth, Johnson, & Urquhart Law, 2015) Osman and colleagues (2019) also discussed, once having completed parenting completion, that the parent increased their belief in their ability to parent successfully

Barnett and colleagues (2016) explored successful therapist-parent coaching in PCIT. The study investigated how coaching influenced parent attrition and skill acquisition in PCIT. The study was conducted with 51 parent-child dyads, mainly minority parents (63% White Hispanic, 16% African American). They found that more responsive and child-centred coaching accurately predicted treatment completion for 86% of families (Barnett et al., 2017).

Cultural adaptation refers to systematic modifications of an evidence-based intervention (EBI) to improve relevance, appropriateness, and fit of the program to the way of life of the population (Bernal & Adames, 2017). Within PCIT there has only been one study which has reported clinical findings for the cultural adaptation of PCIT (K. McCabe, Yeh, Lau, & Argote, 2012). PCIT clinicians from China had translated and tailored PCIT for their own cultural needs (Chen & Fortson, 2015; Leung et al., 2014).

Having a coach who they trusted, who was non-judgement, and empathised with parents was reported by Mytoon and colleagues (2014) to be important for parents involved in parenting programmes (Mytton, Ingram, Manns, & Thomas, 2014). While others also reported that culturally sensitive programmes provide better outcomes for both parent and child (Turner, Richards, & Sanders, 2007; van Mourik, Crone, de Wolff, & Reis, 2017).

The findings that all of the parents clearly articulated that they liked PCIT because it worked, their children and *whānau* behaviour improved, their children liked PCIT, and they felt that they learnt new parenting skills. Most also found the method of delivery, with live, in-session coaching and use of a transmitting device, extremely supportive as they were learning these new PCIT skills. Additionally, most also liked the fact that they were able to do this programme with their child.

Of interest was the fact that culturally, the majority of the participants who commented on this section felt that having a Māori therapist was the thing that made PCIT culturally appropriate for them. They commented that while they had all had Pākehā therapists in other areas of their lives, they felt that having a culturally matched therapist helped them to feel comfortable and understood. They also felt that *whānau* support while they were doing PCIT was crucial. This was also an area that was most distressing for *whānau* when they did not have

their whānau support. So this needs to be considered when thinking about ways to make PCIT easier for whānau to both access and complete PCIT.

The challenges to PCIT were the fact that such an intensive programme is hard at the start when they are getting used to the skills and play therapy in PCIT. Additionally, having to be consistent was also difficult for whānau who have an array of challenges including poverty, mental health issues, and involvement with CYF.

Chapter 7: Discussion

“He purapura I ruia mai I Rangaiātea e kore e ngaro.”

“A seed sown in Rangaiātea will never be lost,”

(Brougham et al., 1987)

7.1 Summary of Research Findings

The aim of this chapter is to summarise the findings from the studies undertaken in this thesis that addressed the gaps in existing literature with regard to parenting interventions that target indigenous parents with multiple challenges, and their tamariki who have significant histories of trauma and severe behavioural problems.

From time to time, all young tamariki can struggle with behaving appropriately or doing as they're asked. Some tamariki have extremely difficult and challenging behaviour which falls outside the norm for their age and is referred to as conduct problems. These are the *tamariki* for whom the ‘terrible twos’ goes on to become the ‘terrifying threes’, ‘frightful fours’, and ‘fearful fives’. It is now clear that severe behaviour problems in early childhood do not get better on their own and if left untreated, can become enduring with long-term negative outcomes such as poor educational attainment, social isolation, familial distress, forensic incarceration, and mental health problems (Boden et al., 2010; Fergusson et al., 2011; Fergusson & Boden, 2010). Chapter 1 highlighted the importance of parenting, parent-child interaction, and the opportunity that exists for parenting interventions to address emerging conduct problems early in the life of the child. Research studies, including New Zealand studies, have shown that the best approaches to resolve conduct problems are those that engage the parent(s) in evidence-based parenting programmes early in the child's life (Bonin et al., 2011; Edwards et al., 2007; Gardner et al., 2019; Keown et al., 2018).

Chapter 2 reminded us that Māori, as the Indigenous people of Aotearoa, have a unique position in New Zealand, guaranteed under Te Tiriti o Waitangi . In spite of this, like other colonised people, Māori and tamariki in particular, carry an inequitable burden of risk with Māori tamariki significantly more likely than non-Māori tamariki to be born into poverty, have worse educational and health outcomes, to endure racism, to be in state care, and to be diagnosed with conduct disorder (Health, 2014; Ministry of Health, 2015; Ministry of social development, 2016b). However, we were also reminded that Māori are a resilient people who have been able to find creative options to supporting traditional parenting initiatives, although these remain largely untested in western science terms (K Jenkins & Harte; Rokx, 1997; Taonui, 2010; Tomlins-Jahnke, 1997). The importance of allowing space for kaupapa Māori solutions was reiterated as the ultimate goal. However, being able to culturally tailor or adapt evidence-based interventions is a worthy step until *kaupapa Māori* solutions are fully tested.

Māori have culturally tailored/adapted Triple P (Keown et al., 2018) and Incredible Years (Cope, 2018), documented in Chapter 3. Of particular focus in this thesis is PCIT. PCIT 1) has been shown to reduce physical abuse (Chaffin et al., 2011; Chaffin et al., 2004; Hakman, Chaffin, Funderburk, & Silovsky, 2009b); 2) allows for a range of whānau members to be included in the treatment, supporting a collectivist value system of Māori (Glover, Waldon, Manaena-Biddle, Holdaway, & Cunningham, 2009), and uses an active delivery method which aligns with Māori active learning styles (Macfarlane, Glynn, Cavanagh, & Bateman, 2007; Poananga, 2011; Sheehan, Jansen, Ruka, & Crengle, 2004); 3) allows for cultural tailoring (Eyberg & Funderburk, 2011); and, 4) in the New Zealand context, there were already Māori therapists trained in the model. As highlighted above, PCIT being amenable to cultural tailoring was particularly important when considering the over-representation of Māori children diagnosed with conduct disorder (Durie, 2005a; Ministry of social development, 2007).

However, like the other programmes, there has been very little indigenous research of Parent-Child Interaction Therapy (PCIT).

Chapter 4 highlighted the evidence that PCIT was generally acceptable to all of the diverse communities which were represented in the seven qualitative studies (Bigfoot, 1990; Dunlap-Ballew, 2005; Matos et al., 2006; McCabe et al., 2005; McNeil, 2010; Milz, 2015; Niec et al., 2014). Overall, all seven studies agreed on some key cultural adaptations which would make PCIT more culturally responsive (translation of materials, culturally matched therapists, the inclusion of cultural beliefs and practices, and the need to focus on active engagement). These seven studies included culturally diverse parents from Mexican American, Puerto Rican, Latino, African, American Indian, and Māori communities.

There were four pre-post studies including parents of Black and/or Hispanic (Danko et al., 2016; Fernandez et al., 2011) or Chinese parents. The Black and Hispanic parents were almost exclusively female (between 92%-100%) and they were reported to have had low educational opportunities and low incomes. The two Chinese studies included highly educated parents with medium to high incomes (Y.-C. Chen & B. L. Fortson, 2015; Leung et al., 2008). However, both groups showed statistically significant and large effect sizes for improvements in both child behaviour and positive parenting skills

There were three RCTs which also showed extremely large effect sizes for improvements in child behaviour (of between $d=.97$ and $d=3.38$) and a decrease in parenting stress (of between $d=.78$ and $d=1.99$) which were maintained at three to four-month follow-up (Leung et al., 2014; Matos et al., 2009; McCabe & Yeh, 2009). There were very good retention

rates demonstrated across all studies, when the therapist was culturally matched to the community from 78% (Leung et al., 2014) to 91% (Matos et al., 2009). However, it is still unclear the extent to which indigenous communities were included in studies as only one study included any demographic information about the indigenous status of the participants (Y.-C. Chen & B. L. Fortson, 2015).

Chapter 5 presented results from a pre-post study of a Māori delivered, culturally tailored/adapted PCIT intervention to Māori whānau. Māori whānau from an Infant Mental Health Service (IMHS) and a Residential Parenting Service (RPS). Chapter 6 presented results from three qualitative hui using kaupapa Māori principles, with whānau (18/24) who had been involved in the pre-post study. Whānau provided their own narrative about their unique experiences of PCIT that was delivered by and for Māori. Thematic analysis was used within a general inductive approach (Thomas, 2006) in order to detail the rich description of the experiences of whānau and their beliefs about PCIT in general.

Overall, results from Chapter 5 and 6 highlighted several key points. All the hypothesis were confirmed. Māori primary parents had extremely high completion rates with 21/24 whānau (88%) successfully completing treatment. Primary parents demonstrated large improvements, that were statistically significant, in positive parenting behaviour and tamariki had large and statistically significant decreases in disruptive behaviour. Wellbeing for both primary parents and tamariki also showed statistically significant large improvements. Given positive effects across all outcome measures, there was a good indication, despite limitations in study methodology, that PCIT was effective.

What is clear from the findings is that a by and for Māori approach was important for these Māori primary parents who reported in Chapter 5, via the Supplementary Therapy Attitude Inventory (STAI), that Māori primary parents were highly satisfied with the ethnicity of the therapist matching their own. In addition, in Chapter 6, the fact that the therapist was Māori was considered to be the reason that the primary parents felt PCIT was culturally appropriate and needed no further cultural adaptations. Therefore, a by and for Māori approach was a crucial reason for the success of the whānau in this PCIT study.

These findings are even more significant in the context of the stories of these Māori primary parents presented in Chapter 6. These primary parents were all wahine Māori, who came from two different, but equally challenging, tertiary services and had very similar stories. These stories tell of the trauma they have faced when they lose custody of their tamariki, and how they can spiral into a deep depression, fearing they may never regain custody of their tamariki again.

They shared a common belief that institutionalised racism within a State System was part of the reason that their tamariki were taken into state care. Racism has been reported by the mainstream media in New Zealand, who have been reported to overemphasise negative stories and statistics about Māori' this has led to a representation of Māori as inferior to Pākehā and that Māori men, in particular, are violent (Huria et al., 2014; Moewaka Barnes et al., 2005; Rankine et al., 2008; Taonui, 2010)

In additional, initially before engaging in PCIT, primary parents denied that there were any problems with their parenting but reported being fearful of their children's violent

behaviour, which left them feeling hopeless that they could change it. However, after the successful completion of PCIT, the stories from these Māori primary parents reveal the power of the reparative experiences of engaging in PCIT with their children. They report a move from feeling hopeless to feeling hopeful, from their lives being joyless to joyful with the support from their Māori therapist. The reparative healing experience they described in the qualitative findings was consistent with the quantitative measurement of improvement in child behaviour and wellbeing alongside improvement in parenting stress.

Finally, the results of Chapter 5 and the themes from the stories in Chapter 6 reveal improvements in the primary caregivers' psychological and cultural wellbeing were tied to being able to see their child's behaviour improved which was a direct result of the changes they had made.

7.2 Comparison with previous research

The reported retention rates for studies of PCIT with culturally diverse populations ranges from 77% (Leung et al., 2008) to 85% (Matos et al., 2009; Matos et al., 2006). This study had a retention rate of 88%. This retention rate of 88% can be considered exciting given the study participants in the Matos (2009) studies were far more privileged than participants in this study, being highly educated parents, with fulltime employment, and no mental health problems. This shows that indigenous Māori parents with multiple challenges can remain engaged in PCIT and gain the positive outcomes and benefits from this intervention when the therapists are Māori, are supportive, and able to provide the cultural responsiveness of the programme.

The cultural adaptations made to the PCIT programme (PCIT-Māori) were to ensure that the Māori therapists were able to facilitate cultural practices of engagement, mihi, karakia,

kai, support, and use of Te Reo Māori in sessions; allowing vidoetapes of sessions to be given to parents so they could see and reflect upon the changes they could see; inclusion of all whānau members in therapy; and to follow-up whānau using Māori hui processes. These cultural adaptations/tailoring have been reported in other studies to be useful when importing PCIT into a new country (Dunlap-Ballew, 2005; Matos et al., 2006; McCabe et al., 2005).

Future research needs to explore kaupapa Māori approaches to parenting which are based on active learning methods used in PCIT and may be more suited to a Māori learning style (Zapalska, Brozik, Dabb, & Keiha, 2002). The use of Te Reo Māori and important cultural engagement processes that reinforce tikanga Māori principles (Bevan-Brown, 2005) and support hauora Māori principles of wellbeing are key in parenting programmes (Herbert, 2001; Kuni Jenkins & Harte, 2011; Penehira & Doherty, 2013; Strickett, 2012).

7.3 Significance of Findings

These studies are the first to test PCIT that was culturally tailored by and for Māori. It fills a gap in the knowledge about the use of PCIT with Indigenous communities and within Māori whānau who have multiple challenges. It is the first to employ a pre-post test of PCIT with an Indigenous community and provides initial data to support the use of PCIT with whānau within tertiary services.

McCabe and colleagues (McCabe & Yeh, 2009) were the first to adapt and test PCIT within a culturally diverse community with Mexican Americans. The only PCIT cultural adaptation with an indigenous population included was a Chinese study, which translated materials into Chinese and had Chinese therapists but did not include any other adaptations

(Leung et al., 2014). This is the first study to provide qualitative stories of Indigenous primary parents and their journey before and after participating in PCIT. An indigenous journey is different from a culturally diverse journey in that indigenous peoples have their status acknowledged by the World Health Organisation and the United Nations policies.

Interestingly, McCabe and colleagues (McCabe & Yeh, 2009) developed a culturally adapted PCIT programme called *Guiando a Ninos Activos (GANA)*, designed for Mexican American parents living in America. They found that both GANA and standard PCIT were effective in improving parenting behaviours. However, GANA was not able to retain families better than standard PCIT, which was not expected given the extensive efforts the GANA staff made to engage with families. The writers suggest that it may be due to the fact that standard PCIT has very specific engagement techniques. However, I wonder if GANA had been delivered to Mexican parents in Mexico, using Mexican therapists, whether retention rates would have been different, that is, delivering GANA by and for Mexicans, in their own country, where they knew their own cultural practices and values which were accepted and reinforced as normal rather than as usual or different.

In addition, as an indigenous PCIT therapist, the results from this study could be interpreted by non-indigenous people as their right to use standard PCIT, rather than GANA because they both had similar positive outcomes. However, from an indigenous point of view there are several other things to consider 1) the importance of being able to use GANA and to have a by and for approach to PCIT 2) the cultural practices which are reinforced in GANA may help to strengthen families indigenous identity and 3) using GANA may help develop other indigenous content or processes.

7.4 Limitations of the Study

Several limitations of these studies need to be reported. First, with no control group, threats to validity, such as regression to the mean, cannot be completely ruled out so caution should be used in interpreting results. Although randomised control trials (RCTs) have increasingly become the “gold standard” of western intervention research, especially when establishing the efficacy and effectiveness of a particular treatment (e.g., Chambless & Ollendick, 2001), Māori have suggested that these western approaches have only served to silence indigenous voices (Cram, 2001; L. T. Smith, 2013). Cram and colleagues have supported the need to hear Māori voices and the use of qualitative methodology (Cram & Kennedy, 2010; Cram et al., 2003) when working with whānau Māori.

Second, while the small sample size in the pre-post study is a limitation, our findings were statistically significant across a large range of outcomes, with large effect sizes that are comparable to larger trials of standard PCIT.

7.5 Future Research

There are several possible direct extension of these studies. The key recommendation for future research is that an RCT should be undertaken that would ideally test the efficacy of a Kaupapa Māori parenting programme, culturally adapted PCIT (as tested in Chapter 5), and a Waitlist or other appropriate control group.

The importance of a longer term follow-up, which would be able to track these young tamariki through to their later schooling, would provide some longitudinal data and help to

show how early parenting interventions may be protective against future other challenges that Māori face.

A final area would be to look at the experience and outcomes of whānau who were not able to stay in the programme because they lost custody of their tamariki and how they could be supported to complete PCIT, because they will always be whānau to these tamariki.

7.6 Practical Implications of the Research

The New Zealand Government has invested a lot of money and resources into the importation of parenting programmes to deal with severe behavioural problems. Expert panels have stated that investing in our tamariki requires an all of whānau approach. However, the treaty partnership documented in Te Tiriti O Waitangi must allow a by and for Māori approach.

As a community, we have to do better for Māori, and we have to provide options for our most challenged whānau, which may include, at the least, a by and for cultural tailoring of imported programmes and more funding to ensure that Māori are encouraged to be trained in these programmes. In addition, the government needs to be courageous enough to look beyond the aspirational approach of kaupapa Māori-designed interventions, which have been given the appropriate funding and investment, to do more than a pilot study and have the types of funding that would enable at least a ten-year development and trial period, like other western programmes have had.

7.7 Conclusion

While PCIT has sound evidence, including that it can be transported into other countries outside of the US, little evidence suggests that it can be effective for Indigenous peoples. This

thesis was the first to examine the acceptability, feasibility, and efficacy of standard PCIT delivered by Māori therapists to a sample of Māori whānau with tamariki with both severe histories of trauma and current severe behavioural problems. It is the first study that demonstrates the importance of cultural tailoring for an indigenous people, while highlighting the role of this in the efficacy of the programme. Whilst the quantitative study was an uncontrolled pre-post study, it showed consistent results across a range of parenting, child behaviour, and child and parent wellbeing outcomes, and the primary parents described the reparative healing that took place during the intervention, which was tailored by for and with Māori.

Appendices

Appendix 1: Central Health and Disability Ethics Committee Approval



Health and Disability Ethics Committees
1 The Terrace
PO Box 5013
Wellington
6011
0800 4 ETHICS
hdec@moh.govt.nz

04 June 2013

Mrs Tania Anne Cargo
51 Bay St
Red Beach
Orewa
HBC, Hibiscus Coast 0932

Dear Mrs Cargo

| | |
|------------------------|---|
| Re: Ethics ref: | 13/CEN/68 |
| Study title: | Parent whispering - the art of empowering parents to change so they can improve their child's behaviour. PCIT in New Zealand. |

I am pleased to advise that this application has been approved by the Central Health and Disability Ethics Committee. This decision was made through the HDEC-Full Review pathway.

The main issues considered by the HDEC in giving approval were as follows.

- This is a very worthwhile study and the Committee commended Mrs Cargo on such a well written application.
- Please note that health data derived from the study must be stored for a minimum of 10 years according to the Health (Retention of Health Information) Regulations 1996.

Conditions of HDEC approval

HDEC approval for this study is subject to the following conditions being met prior to the commencement of the study in New Zealand. It is your responsibility, and that of the study's sponsor, to ensure that these conditions are met. No further review by the Central Health and Disability Ethics Committee is required.

Standard conditions:

1. Before the study commences at *any* locality in New Zealand, all relevant regulatory approvals must be obtained.
2. Before the study commences at *any* locality in New Zealand, it must be registered in a WHO-approved clinical trials registry (such as the Australia New Zealand Clinical Trials Registry, www.anzctr.org.au).
3. Before the study commences at a *given* locality in New Zealand, it must be authorised by that locality in Online Forms. Locality authorisation confirms that the locality is suitable for the safe and effective conduct of the study, and that local research governance issues have been addressed.

After HDEC review

Please refer to the *Standard Operating Procedures for Health and Disability Ethics Committees* (available on www.ethics.health.govt.nz) for HDEC requirements relating to amendments and other post-approval processes.

Participant access to ACC

The Central Health and Disability Ethics Committee is satisfied that your study is not a clinical trial that is to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled. Participants injured as a result of treatment received as part of your study may therefore be eligible for publicly-funded compensation through the Accident Compensation Corporation (ACC).

Please don't hesitate to contact the HDEC secretariat for further information. We wish you all the best for your study.

Yours sincerely,



Mrs Helen Walker
Chairperson
Central Health and Disability Ethics Committee

Encl: appendix A: documents submitted
appendix B: statement of compliance and list of members

Appendix 2: Counties Manukau DHB Māori Research Review Committee

05/08/2013

Ref: June_app_02

Tania Cargo (Ngāti Manu, Ngapuhi, Ngāti Maru)
Clinical Psychologist, CMDHB
51 Bay St, Red Beach, Orewa

t.cargo@auckland.ac.nz

Teena koe Tania

Ngaa mihi rangatira mo ouu whakaaro ki teenei kaupapa rangahau hauora

Re: *Parent Whispering - The art of empowering parents to change, to improve their child's behaviour. A study looking at the feasibility and utility of delivering PCIT to vulnerable New Zealand families in two real-world settings (community and residential).*

The Counties Manukau Maaori Research Review Committee reviewed your research application at its meeting on 4 June 2013.

The committee is satisfied with the responses received to our feedback. The committee is able to approve your research project to be conducted in the auspices of CMH.

We wish you every success in your research and the Committee would appreciate a copy of any research publications produced as an outcome of this research.

Kia piki te ora,



Karla Rika-Heke
Chair
Maaori Research Review Committee
CMDHB

Appendix 3: Australian NZ Clinical Trials Registry



Updated Successfully

Dear: Tania Cargo,

Re: Parent Whispering - the art of empowering parents to change, to improve their child's behaviour. A study looking at the feasibility and utility of delivering Parent-Child Interaction Therapy (PCIT) to vulnerable New Zealand families in two real world settings (community and residential).

Thank you for updating the trial information of the above trial registered with the Australian New Zealand Clinical Trials Registry (ANZCTR): 12613000798763

All your updated trial information has now been approved and successfully updated on the website.

Please be reminded that the quality and accuracy of the trial information submitted for registration is the responsibility of the trial's Primary Sponsor or their representative (the Registrant). The ANZCTR allows you to update trial data, but please note that the original data lodged at the time of trial registration and the tracked history of any changes made will remain publicly available.

The ANZCTR is recognised as an ICMJE acceptable registry (<http://www.icmje.org/about-icmje/faqs/clinical-trials-registration/>) and a Primary Registry in the WHO registry network (<http://www.who.int/ictpr/network/primary/en/index.html>).

If you have any enquiries or have received this email by mistake please contact the ANZCTR Admin.

Thank you,
ANZCTR Staff



Appendix 4: Participant Information Sheet and Informed Consent

| | | |
|---|---|---|
|  | <p>THE UNIVERSITY OF AUCKLAND FACULTY OF MEDICAL AND HEALTH SCIENCES</p> |  |
| <p align="center">Consent For Parent and Child To Participate In This Study Parent Whispering: The art of empowering parents to improve their young child's behaviour.</p> | | |
| <p>Kia ora, my name is Tania Cargo, I am a clinical psychologist working for Counties Manukau District Health Board. I am conducting a study as part of my PhD research, and I would like to invite you and your young child to participate in this exciting piece of research.</p> | | |
| <p>The study? Child behaviour problems are difficult and stressful for parents. Research tells us, that if parents get help early, when their children are very young, they are more likely to be successful. This study is interested in whether Parent-Child Interaction Therapy (PCIT), a family-behavioural therapy, is acceptable and works for New Zealand families/whānau. In PCIT parents learn play therapy and behavioural management skills which they practice while being coached by a PCIT therapist. You learn by "doing" not just talking.</p> | | |
| <p>Who? We are inviting all clients of Whakatapu Ora and Merivale, who are parents (18 years and over) and their toddlers (2-4 years of age with behavioural or relational problems), to participate. This study involves you and your child together.</p> | | |
| <p>Choice? Whether you choose to participate or not, is up to you. If you do choose to participate your experience will help gather important information about whether PCIT should be made more available to other families/whānau like yours. If you decide not to be involved you will still receive our support. If you change your mind mid-way through we would like your permission to use the valuable information you gave, up to the time you left the research.</p> | | |
| <p>What's Involved?</p> <ol style="list-style-type: none"> 1. You will complete an assessment over two sessions (120mins). The assessment involves questionnaires, clinical discussions and a "before therapy" video. 2. Participate in weekly PCIT sessions, over 12 weeks. 3. At the end of therapy, the assessment measures will be repeated and you will meet other families to talk about your experience. 4. A 3 month follow-up – to see how things are going. | | |
| <p>What's the benefit? If you complete PCIT, your child's behaviour will improve, they will feel better about themselves and learn how to listen. You will have more confidence as parent and have a warmer relationship with your child. Plus, you will be helping other families, like yours, by providing crucial information about whether PCIT should be more freely available in New Zealand.</p> | | |
| <p>Confidentiality? All information will be stored, for 10 years, under lock and key (University of Auckland) and I will remove any information that might identify you, protecting your confidentiality.</p> | | |
| <p>Sharing the Results? Once the study is complete, I want to share it with you, so you will be invited to a lunch, to celebrate the study findings. We will also publish the results, so that other interested people may learn from your study.</p> | | |
| <p>Want to know more? Tell your therapist and they can contact me directly, or you can ring or text me on the numbers below and I can arrange to meet you.</p> | | |
| <p>Thanks so much for your support. Tania Cargo 09 2595099 or 0211430399</p> | | |
| <p align="center">Approved by the Health and Disabilities Ethics Committee on 4/5/13 for a period of three years, from July 2013 to July 2016 Reference 13/CEN/68.</p> | | |

Appendix 5: Semi-structured interview guide



Maori Follow-up PCIT Discussion Group Questions

1. How far through PCIT did you get? Why/why Not?
2. What aspects of PCIT did you like? Not like? Why?
3. What about the homework aspect of PCIT? What did you like? Not like? Why?
4. What was it like being coached?
5. What was it like coming to sessions with your child?
6. What about the Time Out sequence, what did you like? Not like? Why?
7. What changes would you like to make? Why?
8. What do you think the key differences were between PCIT and other programmes you have heard, used?
9. How do you think other kiwi families would react to PCIT?
10. Would you recommend PCIT to other New Zealand families? Why? Why not?
11. What do you think your children thought about PCIT?
12. What do you think other family members thought about PCIT?
13. How did PCIT fit for you culturally?
14. What would have made PCIT more culturally acceptable to you?
15. Do you think having Māori therapist would have added anything additionally to your experience of PCIT?
16. What was the most/least culturally appropriate part of your PCIT experience
17. Would you recommend PCIT to other Māori whānau? Why? Why not
18. Any other comments you would like to make about PCIT and or your experience with it?

9. Secondary School Achievement

- i. Completed Intermediate school (Year 8)
- ii. Completed Year 9
- iii. Completed Year 10
- iv. Completed Year 11
- v. Completed Year 12
- vi. Completed Year 13

Highest secondary school attainment

- a. Level 1 NCEA
- b. Level 2 NCEA
- c. Level 3 NCEA

10. Tertiary School Achievement

- i. NZQA Level course at a tertiary institute
- ii. A Bachelors Degree at a university
- iii. A Masters Degree at a university
- iv. A Doctoral Degree at a university
- v. OTHER? Please name

11. Your own family history of parenting

12. Your own experiences of being a parent

13. Your own experience of abuse

14. Your own experience of mental health issues

15. Your own experience of AoD issues

16. Your own experiences of CYF

17. Anything else you would like to add that may have impacted upon you as a parent

Appendix 7: Glossary

Aotearoa lit. Land of the Long White Cloud (Māori name for New Zealand)

Ahau I me

Ariki god

Atawhai adopted child

Atua spiritual being/God

Hapū sub-tribe, collective group; pregnancy

Haka dance/war dance or chant

Hapū group of extended families with a common ancestor (subtribe)

Hauora wellbeing

He Paiaka Tōtara Māori Psychologist Association

Hui meeting, gathering

Iwi tribe descended from our common ancestor

Kaikaranga a woman (or women) who calls visitors onto a marae, and a woman (or women) who responds to the hosts, during the welcoming ceremony.

Kaimahi worker

Kaitiakitanga guardianship

Kanohi kitea literally „the seen face“, refers to the principle of being physically present for matters of spiritual or tribal importance

Kanohi ki te kanohi literally translates to “face-to-face”.

Karakia incantation/prayer

Kaumatua elder

Kaupapa topic/plan/principle

Kaupapa Māori a Māori philosophy

Kawa protocol and customs of marae

Koha gift/offering/contribution/donation

Kōrero talk/speak

Korowai cloak

Kūare ignorant, of low social standing

Kura school

Mahi work

Mamae pain

Mana authority, prestige, power accorded to a person/whānau/hapu/iwi

Manaakitanga to show hospitality/to help/care for

Mana wahine power /prestige/authority accorded specifically to women

Manaakitanga principle of hospitality, of caring and kindness to others

Māori Indigenous New Zealander

Māoritanga Māori culture/ Māori way of life

Marae the open area in front of the Meeting House (often also used to include the buildings around the marae)

Mātauranga knowledge

Mātauranga-a-iwi specific tribal knowledge

Matua father/uncle/parent

Mātua whāngai adoptive parents

Mihi/Mihi whakatau speech of greeting/official welcome speech

Mokopuna grandchild/grandchildren

Mōteatea Traditional and ancient song/chant

Muru revenge

Ngāpuhi northern tribal group

Ngāti Kahungunu central tribal group

Ngāti Porou East coast tribal group

Noa free from tapu, free from spiritual restriction

Ora wellbeing wellness health

Oranga to be well

Oriori song/chant usually composed for children to convey important tribal knowledges and whakapapa, sung to children from a young age.

Pākehā New Zealander of European/British descent

Pakiwaitara legend, story

Papakāinga original home/home base

Pepeha tribal saying.

Pīkau to carry on the back

Pipi a type of shellfish

Powhiri - welcome

Pūaoteatātū day break

Rangahau to seek or search knowledge/research

Raranga to weave, process of weaving.

Rohe tribal area or region

Rito small shoot, reference to infant small child

Ruāhine women of non-childbearing age with the ability and authority to lift and place tapu.

Tainui descendants from the Tainui canoe whose territories include the Waikato, Hauraki, Tauranga, and King Country areas

Tamanuitērā personification of the sun

Tamariki children

Tangata person/people

Tangi/tangihanga to cry/Māori funeral ceremony

Taonga treasure, anything prized

Tapu under spiritual restriction/prohibition. Key regulatory aspect of the Maori legal system

Taiwi foreigner, person from afar, non-Māori

Taurima adopted child

Te ao Māori the Māori world

Tēnā koe hello, welcome to one person

Te reo Māori the Māori language

Te reo Māori me ona tikanga Māori language and culture

Tikanga customs/protocols

Tino rangatiratanga - sovereignty

Tipuna/tīpuna ancestor/ancestors

Titiro - look

Tohunga expert/traditional healer

Tuakana-teina older sibling – younger sibling gendered relationship

Tupuna/tūpuna ancestor/ancestors

Tūpato careful

Tūrangawaewae standing/ place where one has the right to stand/place where one has the rights of residence and belonging through kinship and whakapapa

Waiata song/sing

Waikato collective name of the tribes living in the Waikato Basin. Also the river from which they take their name

Whānau (1) familial grouping, (2) relating to birth (whakawhānau, whānautanga)

Whakaaro thought/idea

Whakarāpōpoto summary

Whakarongo - listen

Whakatauki proverbial saying

Whakawhitiwhiti whakaaro to debate, moot, discuss

Whakapapa genealogical and familial connections and also

Whakatauaki saying proverb

Whakatupu Ora grow up well, name of Infant Mental Health service, CMDHB

Whānaungatanga maintenance/acknowledgement of relations/relationships between people.

Whare house/building

Wharepuni traditional communal building

Whenua (1) land (2) placenta

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