# *University didn't cater to me as a Pacific person:* Building the Pacific workforce in clinical psychology programmes across Aotearoa New Zealand

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Pacific people comprise around 8% of Aotearoa NZ's population. They have higher rates of mental health distress but lower rates of mental health service use than do non-Pacific people. Having more Pacific clinical psychologists is a necessary part of addressing these disparities, yet only 1.7% of currently registered clinical psychologists are Pacific. This paper, co-authored by members of an informal pastoral and clinical support group (Pacific Clinical Talanoa), draws on experiences of clinical psychology training as Pacific people. The support group engaged in regular talanoa as part of their support for one another, which subsequently led to a multi-vocal account of training experiences and concerns. Recommendations are offered to promote and improve equity and Pacific engagement, including wider understanding amongst both non-Pacific psychologists and Pacific communities, as to how the profession can collectively enhance Pacific mental wellbeing.

**Keywords:** *Pacific mental health; clinical psychology; cultural competence; equity; health workforce diversity; talanoa*

## INTRODUCTION

### *Who we are*

A Pacific Clinical Talanoa (PCT) group was set up at the beginning of 2021 as an attempt by the first author to bring together current Pacific students in clinical psychology across universities. It is an informal group providing pastoral and clinical support to one another where experiences (tears and laughter) are shared, research topics are discussed and Pacific members of the community are invited to talanoa generally about their own experiences and the role of clinical psychology among Pacific people. It is led by the only Pacific staff member in a clinical psychology programme in Aotearoa NZ and it is intended to be a safe space where we are seen for who we are – Pacific people.

It was during one of these talanoa nights that the idea for this article arose. Whilst we all dream of becoming clinical psychologists, ultimately to serve our Pacific communities, the experience remains challenging to our cultural and spiritual selves. This needs to be addressed in order to meet the over-representation and growing needs of our Pacific people in mental health.

First, we briefly outline the state of Pacific health and mental health in Aotearoa NZ, before focusing on clinical psychology in particular. We give a multi-vocal account of our experiences within clinical psychology training, under a methodological framework of Pacific talanoa. Our experiences bring to life our questions and concerns. Then, recommendations are offered for vital discussion and debate, so we can see them enacted.

Just as 'western' medicine used to be seen as separate from Pacific ways, but has increasingly been woven into our collective wisdom, so our vision is that clinical psychology can be a relevant and culturally appropriate response to Pacific mental health concerns, alongside other tools.

### *Pacific people*

Pacific people in Aotearoa New Zealand (NZ) are a heterogenous group who have either migrated or are descended from the Pacific Islands, Oceania.1 Currently, they make up 8.1% of the population and consist of more than 23 communities, the most populous of which include Sāmoa, Tonga and Cook Islands (Ministry for Pacific Peoples, 2016). It is estimated that, in 20 years, one in eight workers and one in five children will be Pacific (Pasefika Proud, 2016). At the same time, it is well known that Pacific people continue to face the worst inequities across health, employment and home ownership (Health Quality & Safety Commission, 2021; Ministry of

[1] Whilst this article focuses on Pacific people in Aotearoa NZ, we wish to acknowledge our tuakana-teina relationship with tangata whenua, our Polynesian family members with whom we share ancestry, the indigenous Māori people. This article prioritises the Pacific perspective(s), though we are explicitly aware of our place in te Tiriti o Waitangi and the significant inequities faced by tangata whenua that must always be prioritised in Aotearoa NZ.

Business, Innovation & Employment, 2021; Ministry for Pacific Peoples, 2021).

Health, in particular, is a priority need. A recent study found that 7% of Pacific children, between the ages of 12 and 24 months, experienced barriers to seeing a local doctor, compared to just 2.8% of NZ European children. Furthermore, 9.1% of Pacific children aged 3½ to 4½ years experienced barriers, compared to 3.2% of NZ European children. This can be expected to have major health, social and economic implications, as limited access to primary health care leads to poor health outcomes now and in the future for these communities (Irurzun-Lopez et al., 2021). Research by Southwick et al. (2012) found that barriers for Pasifika people accessing primary healthcare included inadequate cultural competence in the workforce and poor training of health professionals in family-based approaches. Building capacity and capability of a Pacific workforce in health remains an immediate and future priority (Ministry of Health, 2014; 2020).

### *Pacific mental health*

Mental health is no exception, with Pacific people experiencing higher rates of psychological distress and suicidal behaviour compared to non-Pacific People (Ataera-Minster & Trowland, 2018). This is compounded by the low proportion of mental health service-users that are Pacific, relative to Māori and NZ Europeans (Ataera-Minster & Trowland, 2018; Ministry of Health, 2021). Barriers that exist to service use for Pacific People include the stigma about mental health within their community, a lack of trust in services or access to information about them, and lack of familial involvement (Fa'alogo-Lilo & Cartwright, 2021). In interviews with Pacific people who had used mental health services, and service providers, Fa'alogo-Lilo & Cartwright (2021) found that Pacific people preferred to locate solutions within the family, had a mistrust of services, had limited knowledge of where to seek help, and found that services lacked understanding of their cultural values and practices. For those who had accessed mental health services, they reported preferring contact with Pacific health and mental health providers (where available), working with Pacific clinicians and treatment grounded in Pacific cultural understandings of health and wellbeing. This included cultural interpretations of mental health and illness, and recognising the important role and involvement of family within a person's recovery.

This presents an opportunity for Pacific service-providers to intervene to ensure the removal of these and other present barriers for service-users and their families. Addressing the mental health needs of Pacific people, both current and future, is critical to their overall health. This was recognised in the NZ Government's 2018 inquiry into mental health, He Ara Oranga, which emphasised that the mental health system requires a transformation where, "at every corner of the system, [there is] … a strong Pacific presence" (New Zealand Government, 2018, p. 41). The inquiry reported that the mental health sector has a need for more culturally competent mental health practitioners, including Pacific clinicians (New Zealand Government, 2018). The recommendation for more culturally diverse clinicians was made after mental health research has consistently reported increases in the rates of Pacific people experiencing psychological distress over decades (e.g., Ministry of Health, 2008). Despite higher incidence, research also indicates that, relative to all NZ populations, Pacific people are less likely to access mental health services (Ministry of Health, 2008).

Tiatia-Seath (2014) also researched Pacific people's engagement with mental health services, finding that offering treatment that recognised and valued a Pacific worldview was desired by Pacific people and their families. According to Tiatia-Seath (2014), however, there are not enough Pacific clinicians available to work with the number of Pacific people needing to access mental health support. She called for a focus on matching Pacific clients with culturally competent clinicians. While moves have been made toward improving non-Pacific clinicians' cultural knowledge and skills (New Zealand Government, 2018), it is vital that we continue building a larger workforce of Pacific mental health clinicians (Fa'alogo-Lilo & Cartwright, 2021). This includes Pacific providers from the organisational level through to the professional workforce and informal caregivers. The latter includes family and Church members and friends, who are vital alongside the formal roles of social workers, cultural support workers, peer support workers, nurses, clinical psychologists, doctors and psychiatrists. For the purposes of this article, we focus on clinical psychologists, but we also invite those from other disciplines to consider issues of training, recruitment and retention, as there will be similarities.

### *Pacific programmes in health*

In other areas of health, such as medicine, there have been successful programmes targeted at recruiting and supporting Pacific students. For example, the University of Otago Pacific Opportunities Programme (POPO) programme for Health Science first-year students showed better retention of Pacific students than previously (Sopoaga & van der Meer, 2012). In addition, there have been calls for targeted pipeline approaches across secondary, tertiary, community and workforce development so that students from minority communities are well supported as they train into and across health professional programmes (Curtis et al., 2014). Such examples include the Waipapa Taumata Rau University of Auckland's Māori and Pacific Admission Scheme (MAPAS) programme for medical students, which showed increased retention and completion, alongside a sense of belonging, for the Māori and Pacific students who participated (Curtis et al., 2015).

The Aniva Programme funded by Manatu Hauora (Ministry of Health) and Te Whatu Ora (Health NZ) provides support to build the Pacific health workforce through leadership and networking opportunities. Evidence has shown that Pacific Aniva students had higher retention rates, and faster and higher completion rates in the Whitireia Aniva Master of Professional Practice degree than did other Pacific Master's learners, from 2012-2019 (Pacific Perspectives, 2020). The Auckland University of Technology's Pacific Learning Village, in the Faculty of Health and Environment Sciences, was credited with raising success rates of

Pacific students from 65% to 72% over five years (Nanai et al., 2011).

Common to many of these programmes is that they are led by Pasifika and teaching and tutoring is carried out in a collectively shared environment, where relationships are prioritised and individual support is provided in a community space. Given this evidence across other areas of health, we believe that a local and national targeted approach is needed to increase Pacific representation in clinical psychology curriculum and practice.

### *(Clinical) Psychology in Aotearoa NZ*

There are 3791 psychologists holding a current practising certificate (email communication, New Zealand Psychology Board NZPB, 23/08/23).

There are currently 84 registered psychologists who identify themselves as Pacific (Samoan, Fijian, Niuean, Tongan, Other Pacific Peoples, Pacific Peoples NFD and Cook Islands Māori). Of these, 37 Pacific psychologists (44%) are practising in the scope of clinical psychology (email communication, NZPB, 23/08/23). Overall, as of June 2022, just 2% of currently registered psychologists in Aotearoa NZ are Pacific, yet Pacific people are known to have disproportionately higher rates of mental health distress than do non-Pacific. This highlights a significant gap in the Pacific psychology workforce.

The higher rates of Pacific mental health distress may be due to barriers relating to accessing mental health services, economic inequality and issues with mental health literacy, which has been described as being lower for Pacific people than for non-Pacific people in Aotearoa NZ (Kapeli et al., 2020). The over-representation of Pacific people in mental health statistics means that, although we need to build the Pacific workforce in psychology, we also need to build Pacific competence amongst all psychologists, because of the time needed for recruiting and training a Pacific workforce to meet the demand for services by Pacific communities.

At present, there are six, university-based, professional clinical psychology programmes across NZ (University of Auckland, University of Waikato, Massey University, Victoria University of Wellington, University of Canterbury, and University of Otago). What do we need to consider in terms of ensuring these programmes build responsiveness to Pacific mental health service-users amongst all graduates, attract and retain Pacific clinical psychologists, and also build Pacific clinical psychology leadership in academia and services?

A review of the research looking at student experiences in clinical psychology training in the UK and US acknowledged that the programmes needed a cultural shift, from what British psychologist James Randall (2019) described as breeding a culture that encouraged elitism, individualism, and isolation:

This is a profession whose history is rooted in disconnecting individuals from their social context. A profession that has secured status and a powerful standing within the professional market, through predominantly placing the impetus for change on the individual. (Randall, 2019, p. 7)

Notably, Pacific students in doctoral clinical psychology programmes in the US had lower rates of representation and higher rates of attrition than did other ethnicities (Callahan et al., 2018).

Pacific students' experiences of psychology/health professional programmes in NZ have been little explored. Waiari et al. (2021) noted that the success of Pacific and Māori students in psychology was dependent on whether the learning environment upheld a student's cultural identity and beliefs. The authentic involvement of students was dependent on how their learning connected to lived experiences, where Pacific knowledge and engagement needed to be seen in the curriculum and in practice settings. Interestingly, Tapu Tu'itahi (2018) noted her experiences in a psychotherapy programme was having to leave her cultural and spiritual self at the door in order to survive the training programme. She went further to describe the isolation, lack of cultural safety and the cultural incompetence of academic staff during her training. This is consistent with earlier studies with Pacific students in clinical training who described feelings of loneliness (Berking et al., 2007), having to leave spirituality outside (Makasiale, 2007) and psychology training that was not welcoming nor supportive of Pacific values and beliefs (Coombes & Alefaio-Tugia, 2013). McRobie and Agee (2017) described their training as a struggle to maintain their Pacific sense of self while engaged in a NZ European/Pākehā mainstream counselling programme.

As part of increasing psychology services for Pacific communities, 'Pasifikology' was formed in 2005, to provide a network of support for the few Pacific psychologists practising in Aotearoa NZ, and for graduates and students of psychology in general (https://www.pasifikology.co.nz/). Our talanoa focuses on clinical psychology, specifically, now, not the broader grouping of Pasifikology over time (though there will be some commonality).

### *This research*

The purpose of this paper is to provide you with our own real-life experiences, frustrations and recommendations. Eight authors are listed; there were other clinical psychology students moving in and out of the Pacific Clinical Talanoa support group over time whose experiences are echoed here; plus we know other Pacific students in psychology, including Pacific practitioners and lecturers, have felt troubled. We want this to be the beginning of a vital conversation leading to action, not a fixed summary purporting to have all the answers.

## METHOD

To authentically honour the 'method' we used, we drew on our deep and lived understandings of talanoa, where conversations move across initial meetings, discovering each other's identity and origins, to relationship-building and trust, to also supporting formal debates and self-reflexive learning (Rumsey et al., 2022; Tecun et al., 2018; Vaioleti, 2013). We did not purposely attempt to select and choose a formal research method for our talanoa to begin. Rather, it was through the natural flow of building a relationship of trust and respect where talanoa was generated. As the talanoa was held each month, experiences were shared and common themes emerged as we acknowledged the similarities and (sometimes painful)

journeys that some of us were on, or had been on. Preparation of the results included a talanoa where draft themes were discussed to seek collective agreement from all as to what were the key points we wished to raise in our article.

Vaioleti (2006) highlights the way that the talanoa method provides a particular engagement, where the knowledge, experiences, spirits and emotions of those involved intermingle in conversation that may lead to critical discussions or knowledge creation, such as our talanoa have. Rumsey et al.'s (2022) paper focused on cross-cultural issues, such as 'confidentiality' that is expected in research, as opposed to reality, which is that:

> "The concept of confidentiality in the Pacific, in small island states, is extremely hard to maintain. If you start talking about someone on the island you can bet your bottom dollar they know who it is." (Rumsey et al., 2022, p. 1307)

In our desire to enhance clinical psychology, we must engage with both Pacific and non-Pacific viewpoints to move forward; reporting on our talanoa as 'findings' for this journal is a beginning of that, echoing Vaka et al.'s (2016) call for cross-cultural, mental-health care advancement:

> "We suggest that talanoa is able to open up the dialogue to construct quality research evidence to ultimately support the development of practice, which will be culturally relevant and appropriate and can lead to improved health-related experiences for all people in society." (Vaka et al., 2016, p. 543)

As part of a talanoa support group, the more we shared our experiences, the more we began to realise common themes and experiences and ways in which we responded to them successfully and ways that were not successful. This formed a frame of analysis that has simply developed in ongoing talanoa (over videoconferencing), acknowledging key themes that were emerging and recognising that we were not alone in our experiences. It led to discussions on how we could prevent this from continuing for future Pasifika students in clinical psychology. We decided to communicate more widely to the psychology profession via The New Zealand Journal of Psychology. Those who had time and interest then wrote sections of this paper, including some history, literature review, and understanding what others had experienced in trying to build the Pacific health workforce, especially in psychology. One of us sent out email communication to the group to seek out key points of experiences to be synthesised for further discussion. Drafts were refined and revised, and populated with illustrative quotes, then with recommendations as to what we want to see the wider profession engage with and act on.

Given the small number of Pasifika clinical psychology students (one has now joined the even smaller ranks of practising Pasifika clinical psychologists), we decided to provide shared quotes that are representative of our general views, rather than named quotations. Formal ethics approval was not sought nor required for this talanoa, commentary and expression of our perspectives on diverse university clinical psychology programmes.

## FINDINGS

Findings are presented as key points derived from our talanoa, with illustrative quotes.

### *Clinical psychology training is a lonely place, expecting us to park our culture at the door*

As we reflected on our journey through our clinical programmes, this comment was typical:

> *Indeed, at times I've felt like I've had to park my culture at the door. I've also felt incredibly lonely in the Clinical Psychology programme, feeling like I wish I just had someone else like me to go through the programme with. As I went through the programme, I felt more and more removed from my culture and my spirituality; which was ironic given a mantra of the programme is encourage your cultural background. At times, I felt the mantra had great intentions but no substance.*

### *The myths that put you off even applying for training: Is it impossible to get in or will you be 'the brown vote'?*

It is well known that places in a clinical psychology programme are strictly limited. However, circulation of discouraging myths have established themselves as common beliefs amongst psychology undergraduates and essentially dampen hopes of potential applicants.

Drawing upon anecdotal evidence from psychology students at different academic stages, the majority of myths construe programme admission as 'impossible'. One of the authors recalled not being aware of the competitiveness of the programme and, had she known, she would not have applied. Fears of the application process were based on perceived entry preferences for students with previous counselling experience and high GPAs.

We also acknowledge the limitations of being able to compete fairly, due to family (nuclear and extended), cultural and church responsibilities that require prioritisation and are an innate part of our lives. Those of us who have been successful were initially hesitant to apply, due to concerns about financial pressures and anecdotal stories of having to leave your culture behind. Our own experiences are also highlighted in the following:

> *The selection process was difficult. I remember getting a call the evening before the interview to attend. And when I arrived, another Pasifika person had the same experience so I couldn't help but feel we were both "brown votes". We later sat and had a long talanoa and found we were asked concerning questions that we were unsure others were asked too, such as ..... We also felt that they couldn't let both of us in, which ended up being the case.*

Following further discussion among students, it became aware that the concerning questions related primarily to financial and motivational concerns including their knowledge of the Pasifika culture, despite there being no Pasifika representation on the panel.

### *Shouldn't Pacific mental health service-user experience be of value to clinical psychology training?*

One Pacific candidate, who also had mental health service-user experience, felt there are covert selection criteria differences between universities that disadvantage certain groups. They shared their journey of the application process:

> *Of the three clinical programmes allowing entry after Bachelor's, two programmes required explicit disclosure of mental health history – I wasn't short-listed for either. The remaining university, I applied under their advanced entry pathway as they require an honours degree or higher. It was with the third programme I was accepted and felt culturally safe and seen throughout the interview process. The difference in results makes me feel varying prejudices exist in some programmes.*

### *Pacific worldviews are poorly incorporated*

The struggle to have Pacific worldviews recognised within psychology academia and training was clear. Many Pacific clinical psychologists felt their cultural worldview was incorporated "*poorly*". Low Pacific staff representation and overall handling by institutions led to students feeling, "*University didn't cater to me as a Pacific person."* Academically, the worldview was merely "*theorised*", no tangible proactivity was seen to "*tackle the systemic prejudice*" that we feel hinders Pacific students and potential programme applicants.

### *Where does private clinical psychology practice fit within Pasifika communities?*

We note a growing concern about clinical psychologists moving into private practice (that is, relatively soon after qualifying), whereas there used to be much more of an expectation that clinical practice would start in the 'public mental health system', with multi-disciplinary teams working with different ages and issues, to become an experienced and ethical practitioner, before 'going it alone' in private practice.

As Pasifika people, we see the growing inequity that private practice brings. Pasifika people continue to earn below the living wage and yet remain over-represented in seeking health services (Ataera-Minster & Trowland, 2018; Ministry for Pacific Peoples, 2021). Pasifika people, in general, can in no way, shape or form, afford private practice psychology services; therefore, the disparity between Pasifika people and others who can afford private psychology will continue to increase.

This is not to discredit counselling services available through Work and Income NZ (where a person accessing WINZ benefits may apply for some subsidised sessions with a private counsellor/therapist); public health organisations (PHOs, where a GP might refer someone to in-house counselling for a few 'free' sessions); employee assistance programmes (EAP, where an employer may provide access to a few free sessions of counselling to an employee to manage issues that are affecting their productivity at work, such as grief, behavioural issues, substance abuse, financial concerns etc); or churches (providing that the person is involved with a church community and is comfortable seeking counselling support from church leaders). All these services may be of benefit, but note that all have barriers – you must be receiving a benefit (WINZ), or be able to pay to see a GP (PHOs), or working in a job where EAP is available (EAP), or engaged with a church. The lack of publicly funded availability and access to clinical psychologists will continue to increase the disparity and inequity of psychological services to our underserved communities, that include Pacific.

The fear we have, as Pasifika people, is that psychology becomes a service that only 'those who have' can access. We are aware of how alluring the 'money train' is that private practice provides, where hourly rates surpass what is currently being paid in health, education and forensic settings. We also understand that the clinical psychology training programme does take a significant financial sacrifice and the need to pay back debt following graduation. However, we question the values that we as a profession have. As far as we know, there is no monitoring or accountability requirements for a clinician to engage in private practice, other than to be a registered clinical psychologist. How do clinical psychologists keep themselves safe in private practice - particularly when they could easily be only 1-2 years after graduation? How do their clients know that they are sufficiently skilled to work independently, without audited requirements for clinical or cultural oversight?

As a point of comparison, it may be helpful to review the process by which lawyers commence their practice as barristers (New Zealand Law Society, 2020). Requirements include that a lawyer must have 3 years' full-time experience within the last 5 years and they are required to undertake a further course, and be assessed as being adequately skilled, in order to practice on their own.

Also, who are we serving as a profession when we engage in private practice? The health system in Aotearoa NZ continues to burst at its seams with waiting lists across our mental health services. If we as a profession are promoting private practice as an opportunity to avoid the high caseloads and limited resources within the public mental health system, what happens to those on these waiting lists?

Where does clinical psychology see itself in terms of improving equity amongst Pasifika communities? We leave this question for you to reflect upon and we challenge those in the learning institutions and on the New Zealand Psychology Board to see this as a priority for further exploration.

## RECOMMENDATIONS

The following recommendations are offered for discussion, debate – and ultimately – implementation. We would also welcome other ethnic minorities to consider their applicability to building a truly representative profession in clinical psychology.

*1. Early intervention – Given the small number of Pasifika applicants to clinical psychology programmes in the first place, a review of undergraduate psychology courses is recommended to explore the pipeline of Pasifika students from undergraduate to doctoral clinical psychology programmes.*

A clear progression pathway from first-year undergraduate to doctoral-level clinical psychology programmes needs to be developed for Pasifika students. A review of the relationship between undergraduate psychology courses and clinical psychology programmes

is needed to ensure Pacific students are given optimal opportunity from the outset to 'have what it takes' to apply for the doctoral programme. Therefore, clinical psychology programmes will need to be visible and accessible from first-year undergraduate courses and participate in the student mentoring programmes that are generally available for undergraduate psychology students. Early visibility of clinical psychology at undergraduate level will provide a practical opportunity for students to seek information about clinical psychology programmes. There are likely to be support groups for Pasifika psychology students and that may be a viable option for clinical psychology programmes to connect and engage with.

*2. Have a collective vision and strategy across all clinical psychology programmes to promote and improve equity for Pasifika students*

We believe that for any initiative to work effectively, and be sustainable over time, a nationwide approach across all clinical psychology programmes to a) promote Pasifika worldviews in psychology training, and b) target representation of Pasifika students in a training programme, will begin to authentically meet the needs of Pasifika people in Aotearoa NZ. As a starting point, a national Pacific advisory group made up of key Pasifika leaders across the sectors and in the local community would be worthy of consideration to promote the role of clinical psychology among Pacific communities.

*3. Targeted approach with Pasifika students and their families, from high school, to promote the relevance of psychology within a collective worldview*

Engagement with Pasifika students and their families is imperative to ensure a holistic worldview is undertaken at the outset of any interest in psychology. This would essentially require a relationship with secondary schools and, equally importantly, with the Pasifika community, that begins at high school and continues throughout undergraduate psychology courses.

Each learning environment will require a different response. For example, Pasifika high school students and their families will need to know what psychology is, what it offers to the Pasifika community, what the requirements are for studying psychology and, of equal importance, how much it pays. The transparency of the psychology profession is pivotal to ensure that there is active and sustainable engagement from Pasifika families to support their family member, should they wish to embark on this journey.

At undergraduate level, a specific support programme is needed from Year One. One example is the Tuākana programme at The University of Auckland for Māori and Pacific students. The Tuākana programme for psychology has been a positive experience for some of the authors as it provided collective support for Pacific people.

*[The Tuākana programme for psychology] was also a safe space to talk about worldviews, perspectives, experiences, to be heard, learn and grow together.*

*4. Specific scholarships for Pacific students in clinical psychology*

Pacific people overall continue to face social and economic hardship and most of the authors in this article are no different. From an individual perspective, Western academic and career aspirations take priority. However, from a Pasifika perspective, family (and church) obligations and aspirations are just as important. It is not uncommon for Pasifika students to engage in short courses only, as the need to financially provide for families remains paramount. Therefore, we believe that if there were specific scholarships available for Pasifika students, this is likely to remove the economic barriers for Pasifika to engage in such training programmes.

*5. Nothing about us, without us*

We believe that if therapeutic services are authentically meant to be accessible for all, start with the communities that continue to be under-served by the practice of clinical psychology. Promote and actively target Pasifika representation across all levels of clinical psychology - from leadership to practice, from theory to frameworks.

We challenge the institutions to provide direct opportunity for Pasifika worldviews to be authentically incorporated in the curriculum. We do not mean having guest lecturers where one or two lectures incorporate the Pasifika worldview, we suggest that Pasifika is embedded throughout the training. For example, provide an opportunity for a Pasifika clinical formulation model to be developed or to include Pasifika case examples in assessments or create opportunities for placements and internships with Pasifika agencies/organisations. Opportunities to engage with Pasifika in clinical psychology are endless.

*6. Pasifika people do not understand clinical psychology as a career choice*

Pacific cultures are collective, and according to the 2018 census, the majority of Pacific peoples in Aotearoa NZ are religious and identify as Christian (7 out of 10). Furthermore, most Pacific people continue to seek support when worried from family and friends (Ataera-Minster & Trowland, 2018). This experience is typical, from among our group:

*Dad could not understand why there was a need for a psychologist. His view was that if people needed help, they should either talk to their family or talk to God. Why would they want to talk to a stranger?*

More education is needed amongst our Pacific communities about the role of clinical psychology. It is another approach that can work alongside support that Pacific peoples have, such as family, church and social support. It can also help provide more effective coping strategies to support one's own health and wellbeing.

As a comparison, there was a time when western medicine was frowned upon, and Pacific people in the islands continued to prioritise traditional medicine. Now, both traditional and western medicine work side by side, in both Aotearoa NZ and in the Pacific Islands. We believe that clinical psychology, overall, could have a place in holistic approaches to the health and wellbeing of Pacific people.

*7. Build Pacific resources in clinical psychology programmes*

Research tells us that when students can see themselves in their teachers, their student journey is likely to improve

(Nanai et al., 2017). We encourage targeted approaches to mentoring Pasifika clinical psychologists or early-career doctoral graduates to consider a part-time role with universities. Newly registered clinical psychologists are more than likely going to enter the field to practice, but could also be encouraged to remain engaged with training in manageable ways. We believe that, in order to increase Pasifika visibility in clinical psychology, influencing the curriculum as a teacher will allow students of all backgrounds to experience the reality of the cultures in Aotearoa NZ that will be needing their service.

Whilst we recommend the inclusion of Pasifika in teaching staff, we do so with caution. For example, research has shown the challenges faced by Pacific women in New Zealand universities, including experiences of being devalued and their Pasifika knowledge ignored, alongside many examples of exclusion (Naepi et al., 2020). We challenge universities that, in order to build Pasifika staff in clinical psychology programmes, the system needs to deconstruct its institutional and systemic biases and make space for indigenous and ethnic minority experience, knowledge and practice.

### *Future research*

More work is needed to authentically include Pacific worldviews in our clinical psychology curriculum and practice. One place to start is to review our clinical psychology programmes to establish: a) To what extent are Pacific worldviews, theories, models and practices included in clinical psychology programmes to inform assessments and examinations? b) What placements or internships are supported to actively include Pasifika agencies and organisations? c) What targets are in place to achieve Pasifika representation in the recruitment of clinical psychology students and staff? d) Is there a collective vision of clinical psychology programmes throughout Aotearoa NZ to improve equity and increase accessibility of the practice to underserved communities in Aotearoa NZ? If the answers to these questions are hard to find, then simply put, we are not doing enough.

### *Strengths and limitations*

We hope this paper is enlightening and inspiring to both Pacific and non-Pacific people associated with clinical psychology. We are keen to explore the experiences of others who may feel the 'mainstream' of clinical psychology cannot truly and safely meet their identities, even though there are good intentions. There are limitations to our expression, observed in pulling a formal 'paper' together, including about using our names in a profession where reputation matters, and where we were unsure as to how we might be seen following this publication, though recognising that the need for our voice to be heard was stronger than a fear of repercussions as students or staff in clinical psychology.

### *Conclusion*

Whilst we have highlighted the challenges faced by our own Pacific lived experiences in clinical psychology, we are acutely aware of the need for us to work alongside our non-Polynesian family in psychology to serve our Pacific communities. We believe that growing a Pasifika workforce does not necessarily mean that the answer lies solely in increasing the number of Pasifika students and practitioners in clinical psychology. Whilst that may be a formidable solution, the reality is that this solution is decades from being realised, nor do we believe that only Pacific psychologists should work with Pacific communities. We must all be responsible in serving all of our communities in Aotearoa NZ (Ioane, 2023). There are things that we can do now to cater for Pacific students in clinical psychology training, and in the practice. There is room for all of us to share in the decision-making for clinical psychology – if we are truly authentic in creating a practice that is accessible and equitable for all our communities in Aotearoa NZ.

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