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## A Qualitative Investigation of the Application of Behaviour Modification to Group-Quitting for Maori and Pacific Smokers



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### Abstract

*Hauora Pacific (HP), a research group for Maori and Pacific nursing students, explored the adaptation of a behaviour modification programme as a health promotion strategy and smoking cessation resource for Maori and Pacific people. Each of seven HP members, supported by a mentor from their family or church, conducted a focus group with about six participants of their own ethnicity. The focus groups met twice. Data were collected on smoking beliefs, and what might aid smoking cessation. In the second meeting, themes common to the seven focus groups from the first meetings were validated, and a draft behaviour modification workbook for “quitting in groups” was discussed and edited. The initial surprise for HP members was that their participants did not share the dominant discourse on health risks from smoking; nor did they want to be told they should quit. Participants framed smoking as a positive activity. Discussion highlighted the common belief that “quitting in groups” would not be a preferred way to stop smoking, linked to personal shame from an inability to stop smoking; and the potential for a group to be too judgmental or pressuring. Although some work on the adaptation of a behaviour modification resource for “quitting in groups” did occur, participants felt that much more Maori or Pacific input would be required to shift an essentially western approach to behaviour change, into something another culture could feel ownership of. Addiction was seen as the issue that had been least well addressed in the past, and participants believed that having more trained-and-available people would be their preferred health resource.*

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Psychological principles of behaviour have been taught in the Bachelor of Nursing (BN) Programme at Wellington Polytechnic, now Massey University’s Wellington Campus, as they have been historically developed: from Americans J.B. Watson and B.F. Skinner (Caltabriano & Sarafino, 2002; Sarafino, 1996; Weiten, 2001). This paper reports a research project, where Hauora Pacific (HP), a research group for Maori and Pacific third year Bachelor of Nursing students, took the basic concept of a behaviour modification programme and explored ways it

might be modified for health promotion with Maori or Pacific people: the people they perceived were not always interested in existing resources, and specifically resources to assist people to quit smoking. The proposed adaptation was to extend a behaviour modification programme for group use: an approach that had not been explored in literature, but which had face validity for workplace, church, club, whanau, or marae settings.

Chamberlain and O'Neill (1998) have explored socio-economic status (SES) differences in smoking and found the health beliefs between high and low SES groups are different. They found that lower SES people were more likely to focus on health as the ability to complete daily tasks, while being fatalistic about the long-term health outcomes of smoking. Their findings suggest that low SES people are not motivated to quit smoking for the good of their future health, only for short-term benefits. HP members generalised from this, to the assumption that a behaviour modification programme should therefore be useful in providing valued rewards in the short-term, for behaviour that begins to approximate a smoke-free outcome, in lieu of any intrinsic motivation.

However, it is not enough to simply take the health promotion tools developed in a western cultural context and apply them to people from another culture, even a colonised one. This project took the approach discussed by Raeburn and Rootman, (1998) where taking a people-centred health promotion approach permits participants to be empowered to inform the direction of the project. This is to recognise the importance of the location and the community that any participant group belongs to.

Further, HP members recognised that there were contestable assumptions on how nurses, who as students learned a process like behaviour modification, could use it to promote health with people whose traditional ways of transmitting health knowledge had not included a "nurse-client" partnership.

The project also adopted the cooperative inquiry approach that Reason, (1994) maintains is the most appropriate method when undertaking exploratory research in an area that is not clearly described in existing literature. In this paradigm, the people who will benefit from the research shape the direction of the inquiry.

McKegg has written that the "hope for improving Maori health" comes from involving Maori health providers in "community health education projects" (1998, p.14). He goes on to suggest that the best chance for improving Maori health is when "... it is recognised that knowledge does not easily cross cultural boundaries, and cultural differences that impact on healthcare are identified and addressed by all health professionals" (1998, p.15).

In exploring appropriate methodology, HP members were concerned about the risk of privileging their voice and objective position above the subjective experience of the participants. As Heron (1994) suggested, this could close potential avenues of meaningful data. The choice of focus groups for the project was seen to have the added advantages of not relying on the knowledge of the HP facilitator, nor using the language of the scientific literature. The reality of stopping smoking for the participants would be experiential, not theoretical.

The focus group research method is a standard exploratory, qualitative research tool (Stewart & Shamdasani, 1990). The 1990's saw a shift in social exploratory research to a greater use of focus groups, when the aim was "not to generalise... to a broad population or universe, but to maximise discovery of the heterogeneous patterns and problems that occur in the particular context under study." (Erlandson, Harris, Skipper & Allen, 1993, p.83).

In this case the aim was the discovery of the kind of support Maori or Pacific people may require for stopping smoking.

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In considering group interaction, focus groups were not seen as a forum for socially desirable answers, nor scripted responses but an opportunity for participants to actively create a discussion “product”. Potter & Wetherall, (1994) suggested that a group will construct a version of their experience to accommodate a variety of conceptualisations of key ideas and issues. Kreuger, (1994) suggested that this occurs when the discourse arises from a group with the specific focus of exploring phenomena. As the experience of stopping smoking, and the development of a “quitting in groups” smoking cessation resource, are such phenomena, there was confidence that important components of the experience would be raised and debated.

At a more critical level, having people talk about their experiences in a normal social context, would construct the power relationship between the researcher and the researched, so that participants were less likely to feel constrained if wishing to express non-mainstream views (Denzin, & Lincoln, 1994). For all these reasons, the focus group method of inquiry appeared to be the method of choice for the HP project. To that end, a qualitative study was designed, in which Maori and Pacific participants could express their health beliefs and suggest culturally appropriate ideas and directions for a behaviour modification project in focus group discussions.

The aim was to undertake an exploratory study to generate ideas about making a behaviour modification, group smoking cessation programme accessible to Maori and Pacific people. It was an attempt to both learn from smokers, and contribute to the promotion of a smoke-free lifestyle, while being aware of the need for culturally compatible basic research. The specific objectives were:

1. to approach groups of smokers to explore health beliefs and what they think would help them consider becoming non-smokers;
2. to explore the need for a group-quitting resource;
3. to explore ways of applying psychological theory in settings where it has not traditionally been used for promoting health; and
4. to explore a behaviour modification resource book as being a useful educational tool in culturally diverse communities.

## Method

### *Participants*

A quota, criteria-based, snowball sampling method was used to identify volunteers for each focus group discussion. The first step involved each HP member approaching a person from their target community (hapu, church, etc.) to advise, support and mentor them in the research process. Secondly, the identification of potential volunteers was discussed and overseen by the kaumatua, matai, mata pule, pastor, or mentor. Individual people were then approached with information for the volunteers and consent forms.

The quota was the number of participants that each HP member needed to recruit to make a viable focus group. The minimum was to be four participants, and the maximum was eight. A snowball technique was used to reach the quota, where one person who is willing to participate, suggested the names of other people whom they think might participate (Backstrom & Hursh-Cesar, 1981). In this project, introductions may have been to either the HP member or their mentor.

The participants also had to meet the following selection criteria:

1. belong to a specific, targeted group;
2. self-identify as Maori, Samoan, or Tongan; and
3. be smokers.

The targeted groups that were selected by the HP member with their mentor included family groupings, a church, a workplace and a close neighbourhood. Demographic data on the participants was not collected on the advice of several mentors. Possible implications of this are

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raised in the discussion.

In all, seven groups ranging in size between five and eight participants (Mean group size was six people) were arranged, centred on the ethnicity of the HP members as facilitators. One group comprised Tongan participants, one group comprised Western Samoan participants, and there were five groups with Maori participants.

*Focus group preparation and organisation.*

HP members had training for the study in addition to their coursework, including: familiarisation with existing smoking cessation resources; proposal writing; obtaining Human Ethics Committee approval; focus group facilitation techniques; budgeting; validating themes and patterns; and pre-testing draft ideas for the behaviour modification group-quitting workbook.

For the first round of meetings the facilitators all used four predetermined discussion triggers (multi-faceted questions), and allowed the discussion to flow in any direction, and in any language, after the trigger was read to the group in English. Each discussion trigger related to one of the objectives. They were:

1. (The warm-up trigger.) “This is a general question - or one with several parts. Comment on any part. Does the group think smoking and illness are linked – or how does smoking affect your health, and is health ever a reason to make you wish you could give up?”
2. “Do you think it would help someone quit if they were part of a group who were all trying to, and supporting each other?” Probe for why, and include “Does culture have anything to do with why a group approach to quitting would be better than leaving it up to individuals?”
3. “What are the most important things that health promoters like *Smokefree* and nurses can do to help our people give up smoking if they want to? What do we (nurses) need to understand?”
4. Finally, “How can we as nurses, take some of our knowledge from our university or tech training to our people, when there are traditional and different ways of teaching about health and values?”

HP members were provided with colour-coded, formatted response sheets for note taking. For the second round of meetings they had the combined-groups’ thematic summaries from the first meetings to trigger discussion; and packs of pens and a copy for each participant of the draft group-quitting workbook based on the behaviour modification programme.

***Procedure***

Each HP member organised and facilitated a focus group that met on two occasions (a total of 14 meetings). Discussion lasted a minimum of two hours and the groups were often together for three hours or more, including time sharing kai (food).

Between the first and second focus group meetings, HP members met to discuss, identify and summarise collected common themes, to familiarise themselves with the progress of the draft group-quitting workbook, and to edit it.

At the second focus group meetings participants were asked to validate and comment on the collective themes from round one. Then participants explored the design, content and presentation of the proposed behaviour modification programme – the group-quitting workbook resource.

## **Results and Discussion**

While HP members began their focus group by asking the same four discussion triggers, there were not four distinct sets of answers. This was principally because the triggers were multi-

faceted questions. In analysing the discussion, seven themes emerged, and these were validated in the second meetings, as being common to all groups. Examples given may have come from any group. Table 1 shows the themes generated by the discussion “triggers” with the theme label summarising the content from the analysis, not the participants.

*Theme 1: Smoking and health beliefs*

Table 1  
*Objectives, triggers and themes*

| Objectives   | Discussion Trigger   | Emerging Themes   |
|--|--|---|
| To explore what smokers think would help them consider quitting through understanding health beliefs | “Does the group think smoking and illness are linked – or how does smoking affect <u>your</u> health, and is health ever a reason to make you wish you could give up?”   | 1. “Smoking and Health Beliefs” <ul style="list-style-type: none"> <li>• personal experience</li> <li>• the official line</li> <li>• health not being a reason to quit</li> </ul> 2. “Smoking does not affect your health”<br>3. “Smoking can affect your life” |
| To explore the need for a group resource   | “Do you think it would help someone quit if they were part of a group who were all trying to, and supporting each other?”<br><br>“Does culture have anything to do with why a group approach to quitting would be better than leaving it up to individuals?” | 4. Pitfalls of the “quitting in groups” concept.<br><br>5. Issues for “quitting in groups” and culture.   |
| To apply psychological theory in non-traditional settings  | “What are the most important things that health promoters like <i>Smokefree</i> and nurses can do to help our people give up smoking if they want to? What do we (nurses) need to understand?”   | 6. What (future) nurses can do.   |
|  | “How can we as nurses, take some of our knowledge from our university or tech training to our people, when there are traditional and different ways of teaching about health and values?”  | 7. What (future) nurses need to understand.   |

Participants did not generally think about health as related to smoking, nor was smoking a particular concern if they thought about health. This was consistent with the Chamberlain and O’Neil (1998) research. Smoking was seen as a personal choice and participants wished to convey the message to funders of anti-smoking campaigns that they should be aware that there are different opinions about smoking and its link with illness. There were three aspects to this discussion: the participants’ personal experience; what they knew to be and talked of as “an official line”; and the emphasis on health *not* being a reason to give up.

1. Personal experience – here the findings indicated that a link had been made between smoking and health, but not to the extent that it would change cognitions about an immediate danger. Common examples were that smoking

- causes cancer and makes asthma worse; it stunts growth; and people feel worse when they take it up (e.g. they get breathless).
2. The official line – participants said they are told there is a link but, “It’s only someone’s opinion, and not *our* personal experience.” The participants talked about the sources of knowledge showing health and smoking are linked, and they expressed some scepticism about the authority of the message.
  3. Health is not a reason to give up – participants discussed the ways they think about smoking that makes it possible to have knowledge of health related illness from smoking but not to let it influence their habit. This was a well-developed theme. Common examples were:
    - “You can make rules to see it doesn’t affect others, like smoking away from children”
    - “Smoking is an important part of daily (social) life”
    - “It gives you power and control over part of your life”
    - “While you still have lots of energy it’s (smoking) OK, and it doesn’t stop you playing sport”
    - “If you can afford it and you can enjoy it”
    - “Legislation is what makes you feel like a social reject and angry, not being a smoker” (on office workers having to smoke out on the street).

With the theme of smoking and health, the participants were generally saying that although they have been told that years of smoking would take its toll of their health, this message could be easily countered by self talk that focused on the immediate and positive, personal aspects of being a smoker.

The message from the participants to HP members developing the group-quitting resource was not to focus on health benefits of quitting. The potential problems may be real but they are too distant to have any real impact on thoughts of smoking or not smoking. On the other hand there were perceived “real benefits” to being a smoker.

#### *Theme 2: Smoking does not affect your health*

There was no common agreement within or across groups that smoking *adversely* affects health. There were personal observations, and comments on what smoking did to others. Personally smoking was not seen in a causal relationship with symptoms of ill health. Despite this, examples of how a smoker knew smoking was affecting health were later generated. This apparent contradiction was explained as “other people” not being able to see most of the personal signs.

Only four ways of realising that smoking was having a health effect on others were mentioned by more than one person from across any of the groups. These were: “asthma in tamariki”, “cancer in Kuia”, “death at an early age”, and “smokers give birth to small babies”.

In the second round feedback this was modified to say, “Cancer in anyone,” and “everyone stinks after being subjected to smokers.” One participant wrote, “(It) looks like individuals trivialise effects on self...”

The message here for HP members, read with the message of the perceived benefits of being a smoker, and recognising a general inability to see health related problems except in others, was the importance of taking a holistic approach to smoke-free education and approaches to smoking cessation.

#### *Theme 3: Smoking can affect your life*

The last theme to emerge from the opening trigger question addressed the wider issues of smoking. A few participants across the groups thought health should be mentioned here, but most

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thought that exploring wider issues would further the non-smoking cause, and provide support in what might be more fundamental reasons for smoking. The need to have smokers understand addiction from physiological and psychological perspectives was seen as very important. The non-health effects of smoking were seen as being two sides of a coin. Benefits and problems of smoking were suggested, and the groups were in high agreement on the following issues:

Control: "This is still an area of our lives where we can make our own choices"

Finance: "It costs heaps to smoke". "Money is an issue".

Sense of belonging: "Work groups and social groups smoke together". "I might have to mix with others if I quit now".

Social well-being: "We enjoy smoking and it reduces stress".

Role Models: "Don't really want children smoking but they see you do it".

Smell: "You smell but you loose your sense of smell!"

Fitness: "I would feel fitter if I stopped". "I can still play sport".

Addiction: "Stinks to know you're addicted and can't stop".

The message here to HP members was to be aware that a health promoter is taking an ideological stance that says a non-smoker's life is better than a smoker's life. There was a clear message from all the groups that a smoke-free educator can be seen as interfering in a situation in which the smoker is aware of the consequences of their choice, and still choose it. This was particularly clear because all the participants were smokers. Although most had considered stopping at different times, they claimed they did not want to be given messages that there was anything wrong with the choices they were making in their lives.

*Theme 4: Pitfalls of the "quitting in groups" concept*

When considering the concept of having a group of people quitting together, the predominant response was that participants did not like this idea. The Pacific groups particularly thought that there would be a sense of shame involved in having to talk about how they could not manage stopping smoking individually. They reported that it would be shameful for an aunt for example to have to tell younger relatives or neighbours that they did not have the will power to just stop if they wanted to. Again from the Pacific peoples' comments was a strong sense of individual responsibility for personal choices.

The same message came from the Maori groups. In their cases it was more linked to the notion that they are a communal people and so should want to do something like a quit programme in a group setting. However, the participants commented that the flaw in this thinking relates to an over-generalisation of what it means to be Maori. They suggested that older people or rural people may like a group quitting programme, but that younger people and urban Maori often share the same individual responsibility for their behaviour or urban lifestyle that anyone of the same age, occupational status, or interest group might. They reported the "cultural message" was unnecessary and overplayed in their case.

Discussion did include some common acknowledgement of the place of family and peer support in times of stress, such as generated by quitting smoking and in favour of involving others in any lifestyle change. However this was outweighed by comments against the individual being involved with a quit-smoking group. The dominant responses focussed on a person not wanting others to know and share their problems; and issues of embarrassment, criticism, pressure, letting others down, and the additional costs that group meetings meant (e.g., kai - food).

Pacific groups were generally more against the "quitting in groups" idea. There was a suggestion that because of "cultural dynamics" group quitting might work better in the next generation (e.g. New Zealand born Samoans). For Maori there was a more mixed reaction. The support would have to be flexible to allow for individual differences and personalities.

The message to HP members here was the group-quitting programme does not have the support

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originally suggested by the “face validity”. This was an important point when analysing the feedback on the draft resource book that the groups went on to critique, irrespective of their opinion of the concept.

*Theme 5: Issues for “quitting in groups” and culture*

There was some pattern to the discussion that followed the rejection of the group-quitting concept. Generally culture was not seen as important except for older persons. The social context of the group was emphasised as being more important. Like the concept of health, there was a problem defining culture. The participants discussed culture as not just being related to ethnicity. “Organisations” was given as an example of something else having a culture. Smoking was seen to affect everyone regardless of cultural background. The discussion could be summarised by the following summary comment from one group.

“Maori historically are communal people and function better as a group, but it is not the same for all Maori. Many are urbanised and do not associate with traditional Maori customs, so any Maori individual may work just as well on an individual programme.”

The message to HP members here was not to think there is a separate solution for every ethnic group. While epidemiological data may be presented as rates across ethnic groups, the participants would argue that personally, other considerations are more important when considering whether to quit or not to quit, like where they work or where they socialise.

*Theme 6: What (future) nurses can do*

Participants discussed what might get them to think about quitting smoking. They generated ideas that generally involved them being reached by people. The Tongan group were quite specific about wanting people to be trained as educators who could provide information, tips to apply to an individual’s specific problems, and someone who had themselves been a smoker who could point out the benefits of a smoke-free life. Across the groups the request was for more use of role models, promotion through sports and music stars, a focus on the home and (again) using people who have quit as educators. Other common ideas included providing material a variety of languages; sending messages through the appropriate media e.g. in an oral culture use radio messages; target children first, get them before they start smoking; and take services to the people (e.g., the provision of “patches” from sports clubrooms).

Future nurses were advised to be a role model by not smoking, to understand addictions and to be non-judgmental – not to lecture but provide alternatives. The message here was that the participants might have been receptive to quitting messages if they thought the message and help was for them individually. There was a cry to be understood as a person with an addiction, and to be helped by people with their individual best interests at heart.

By this point in the group discussions, the message of “my right to smoke if I choose, and I don’t want you to preach to me that it’s wrong’ was partially replaced with the message that “I might quit if I thought you understood me.”

Considering *Smokefree New Zealand* has a 0800 quit line that fulfils many of the criteria stated above, it was put to their groups by some facilitators that resources were already there to help them. The one group that explored this idea, clarified its position to state that it was not culturally appropriate to talk to a stranger about personal issues, and particularly by phone. The help needed to come at a personal level and it must highlight the benefits.

*Theme 7: What (future) nurses need to understand*

The last aspect of the discussion involved the participants in summarising their discussion by focusing on what nurses or health educators needed to understand about smokers. The strongest message was that health educators must not forget that smoking is enjoyable and people do like it.

Second most common comment related to addiction and how hard it is to quit. Third was the emphasis on the right to choose to smoke to relieve stress, boredom, or peer pressure. Finally there were various comments from Maori groups that could be summarised as a call for tinorangatiratanga – returning ownership of health to Maori. In this discussion wider social issues surfaced including the exploration of the fundamental ownership of health, knowledge and resources.

The message here for HP members was for health educators not to produce a resource that appeared to preach but with the benefits clearly laid out. As the proposed workbook that the participants had not yet seen, had pages on issues like addressing your addiction, and identifying the benefits, this theme seemed to support pursuing the development of the behaviour modification workbook.

#### *Age and mana*

A key variable in social research is “age” and participants’ ages were not recorded. Aspects of the latter themes seemed to suggest age differences in the opinions expressed in health beliefs, smoking experience, and the relevance of culture in health promotion. However, the intention to not gather information about age was strong and deliberate. Whereas age may be important in western research, *mana* was seen to be the overarching, non-quantifiable variable in Maori and Pacific research. Several HP members’ mentors advised against collecting age data.

Following this line, it may be argued that in each group, only the people with the mana will express opinions for the group, and HP members therefore could have found themes by using key-informant interviews. However this is to ignore other non-western processes at work when specific groups are involved in cooperative inquiry.

Relevant examples of other processes that occurred because the people who may benefit from the research were helping shape it were atawhai (or awhina) and taonga. With the former, HP members’ experienced the nurturing and protective help from their kuia, kaumatua, matai pule or matai who understood that the research had its own aim, but that the process supported the development and future of a protégé, so the methodology needed to be followed carefully. With the latter, the stories, opinions and experiences of the participants were presented to Hauora Pacific as a gift: the focus group product is a taonga. Ensuring the special nature of the gift relationship was acknowledged from the outset, and written into the ethics application.

To this extent then, the western reader should accept that age may not be as relevant in a Maori and Pacific people-centred approach to research as in western traditions, and that the discussion product was not generated by dominant voices alone.

#### *The second round of focus groups*

In addition to validating the reported findings, participants worked through a draft workbook for quitting in groups. The details are not reported here, as this was a commissioned resource, but there were lessons for inter-cultural interaction from the task.

Perceptions and meanings for symbols, colours, and diagrams may be provided from the world of the researcher, or health educator, but they must always be aware of the lack of universal interpretation. Participant driven research and development was very useful in uncovering problems in this area, as participants suggested what was relevant and appropriate in particular circumstances.

One ethics lesson for HP members when designing behaviour modification plans was that if you design a poor plan, you might well be setting your client(s) up for failure. A safeguard against this is to evaluate the plan while it is in progress and to change it or stop it, if it is not working. This might occur when the rewards are not valued enough or they are too hard to earn. Similarly, if the plan has not worked to the extent that the new behaviour does not continue without the need for

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continued external rewards after a period like three to four weeks, then again it should be stopped and the problems reviewed. For this reason an avenue to evaluate and stop the programme must be built in. Participants liked the idea of seeing the job finished with some form of group celebration.

Participants pointed out that to develop a group quitting resource for Maori and Pacific people was to privilege ethnicity over other cultural and sub-cultural groups they identified with. Culture, as in traditional cultural practices, was seen as something “older” people or other people had. To that end, a workbook for group quitting was seen as having more disadvantages than advantages, especially for young urban adults. However, group activity was said to be strong in rural Maori communities and in urban whanau where kuia and kaumatua were present.

Finally, it was concluded by HP members that the behaviour modification workbook was still largely mono-cultural and without a lot more “customising” participants felt they had no sense of ownership of programme.

The HP members reported that they had found the project especially rewarding in terms of their knowledge of health promotion, smoke-free issues, and where they are in their own journeys to find a place for themselves as Maori and Pacific nurses in Aotearoa/New Zealand.

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