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Kia ora and welcome to Psychology Aotearoa the official twice yearly publication of the New Zealand Psychological Society. Psychology Aotearoa aims to inform members about current practice issues, discuss social and political issues of importance to psychologists, celebrate the achievements of members, provide a forum for bicultural issues and highlight research and new ideas relevant to psychology. It also aims to encourage contributions from students, hear the views of members and connect members with their peers.

Being part of Psychology Aotearoa

We welcome your contributions to Psychology Aotearoa. We are looking for submissions related to psychology which readers will find stimulating and can engage with. This can include items on practice and education issues, social and political issues impacting on psychology, bicultural issues, research in psychology, historical perspectives, theoretical and philosophical issues, kaupapa Māori and Pasifika psychology, book reviews, ethical issues and student issues.

For more information on making submissions to “Psychology Aotearoa” – go to www.psychology.org.nz/Psychology_Aotearoa

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The New Zealand Psychological Society is the premier professional association for psychologists in Aotearoa New Zealand. Established as a stand-alone incorporated society in 1947, it now has over 1000 members and subscribers. The Society provides representation, services and support for its New Zealand and overseas members. Psychology Aotearoa is the Society’s member-only periodical published twice a year. It contains articles and feature sections on topics of general interest to psychologists including the teaching, training and practice of psychology in Aotearoa New Zealand, research and new developments in psychology, application of psychology to current and social and political issues.

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President’s Korero

President Peter Coleman suggests that psychologists - particularly those employed in the public sector - actively reclaim their professional identity and autonomy and warmly thanks and farewells co-editor Mike O’Driscoll and Student Forum editor Ros Case who are stepping down from their editor roles.

Editorial

Mike O’Driscoll previews the contents of this edition in his final editorial for Psychology Aotearoa.

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President’s Korero—Peter Coleman

The November 2012 Korero argued that the strength of professional psychology was its research methodology and the steady accumulation of ‘evidence-based’ or research based findings. Some of these findings are represented in the formal submissions which the Society has made to Government Ministries and Parliament in recent years, including the contribution of childhood poverty to many existing social problems. The May 2013 Korero similarly noted that the scientist-practitioner model is at the heart of professional psychology, that formative research by field-workers has an important part to play in the development of the science and that there is a need to empirically validate and if necessary adapt assessment procedures and interventions in the New Zealand context. There is a particular need for the replication of overseas generated ‘best evidence’ practices for Māori and Pacific Island peoples whose needs and world views may be different from the original research populations. Promoting and facilitating original Māori-focused research is hugely important to New Zealand but it is very difficult to do this outside of university sponsorship for reasons that will be apparent.

The current Korero extends on these themes and suggests that psychologists – particularly those employed in the public sector – need to actively reclaim their professional identity and autonomy. As an aside, the theme of the 2007 National Māori and Pacific Psychologies Symposium was “Claiming Spaces”; recent developments suggest that other branches of psychology may also need to reclaim lost territory. Some of the threats to psychologists’ professionalism were identified in the June 2013 Psychologists Board Newsletter and some ways of overcoming these were identified. Another way of doing this is to actively engage in for example formative research activities but this is not possible for many psychologists (e.g. educational psychologists, counselling psychologists, industrial/organisational psychologists, community psychologists) because of a structural impediment to gaining ethical approval. Gaining access to an accredited research ethics committee remains a priority for the Society (see paper in this issue) and I can only hope that this doesn’t involve another decade of lost opportunities.

We are all aware of the gap between ‘evidence-based’ and ‘effective’ interventions, in particular with manualised intervention processes and procedures. Many of us are also aware that very often such processes and procedures are ‘rolled out’ as a result of governmental, ministry and department decisions without much reference to the professionals who are expected to implement them. This is frequently accompanied by a statement about the need for a ‘flexible workforce’ which is expected to implement the mandated initiative. An earlier paper in this publication (Brown, 2011) warned about the problems of ‘scaling up’ imported interventions and the last Kororo warned about the related problem of our psychological scopes being increasingly usurped by paraprofessionals.

A starting point for turning the situation around can be found in the writing of Richard Elmore, a very influential researcher in the school-improvement movement. His concept of ‘backward mapping’ has particular appeal and starts with the premise that policy should be developed from a clear understanding of the results that it is hoped to achieve in the smallest unit (Elmore 2005). He argues that those closest to the problem are most often best able to develop a solution to it and that structural, organisational and policy decisions should be informed by the demands of the work at that level. The intended outcome of policy decisions should therefore be checked level by level at each intended implementation step, firstly as to whether the innovation is feasible and secondly whether it is needed. He writes:

"Solving organisational problems and challenges requires systems of accountability and capacity-building that are responsive to the features of the problem itself, not to the problems as it has been constructed by policy makers. Backward mapping helps ensure that innovations grow out of local needs (presumably that is why it was initially done) and encourages the acceptance of policy. Successful reforms most often start with the existing practices and it is our job to improve these and for policy makers to modify the structures to accommodate them. There is a need for organisations to invest in capacity building activities to enhance the professional knowledge, skills and resources available to its employees. This has been described as ‘reciprocity of responsibility’ for outcomes in that an individual improvement that is required should be matched with an improvement in organisation capacity to produce that performance at all levels of the system”.

Organisational reform (connecting good practice with policy and with what actually happens and replicating this) therefore has to happen from the inside out. Action research (the collaborative planning of research, development, implementation and dissemination activities) is the educational practice that helps ensure alignment of policy and innovative practice in that one influences the other. This is what in our modest ways we should all be trying to do.

Last but not least a very warm thank you to Mike O’Driscoll who has co-edited Psychology Aotearoa for the past two years. A big thanks also to Rosalind Case who has been the Student Forum editor during this period also. The excellent work of Mike and Rosalind on behalf of us all is very much appreciated.


Editorial

Tēnā koutou colleagues,

This is my final introduction as co-editor of Psychology Aotearoa, a role I was invited to take up in 2010. I would like to take this opportunity to especially thank my co-editor, Pam Hyde, Executive Director of the NZPsS, who has worked tirelessly on behalf of Psychology Aotearoa and has literally kept the ship afloat. Without her considerable efforts, Psychology Aotearoa would not get to print each time. Thank you very much, Pam, for being a wonderful colleague to work with, as well as for all the invaluable advice you have given me along the way. I would also like to thank Heike Albrecht at the NZPsS, who formats and compiles each issue ensuring that it is both engaging and attractive in its presentation. Thank you, Heike, for this very important work.

This final issue for 2013 contains an array of interesting papers on several topics. It is very pleasing to obtain the diversity of papers which are submitted to Psychology
Aotearoa, illustrating an interest in the development of our profession and showcasing our work to the world at large. Over the three years that I have been co-editor, we have received numerous comments on papers and issues which are published in Psychology Aotearoa, and these comments have been overwhelmingly favourable and encouraging. I attribute this positive feedback to Pam’s hard work in securing valuable contributions from academics, students and practitioners in various areas of psychology.

I would like to briefly mention a few of the (many) topics that are covered in this issue. There include a summary of the New Zealand Psychological Society AGM held at the recent conference in Auckland, along with the Executive for 2013/14 Peter Coleman continues his sterling work as president of the NZPsS. Many congratulations to Bev Burns, John Fitzgerald, Averil Herbert and Judith McDougall, who have been elected Fellows of the Society, and to Linda Waimarie Nikora, elected as Honorary Fellow. These awards reflect the significant contributions of you all, not just to the NZPsS but also to the profession and the wider community.

Among the papers presented in this issue, I would highlight the article on using communications technology (or ICT) for educational and therapeutic functions, by Barry Parsonon and Trevor Stokes, who point out some major pros and cons of this technology for practicing psychologists. Another article of considerable interest is Nancy Pachana’s paper based on her keynote address at the conference on psychology and ageing, a topic of growing importance as the population ages and we confront the challenges of an ‘ageing’ population. In the section on international perspectives, Karen Cohen (CEO of the Canadian Psychological Association), reflects on the provision of psychological services in Canada. Despite geographic, cultural and demographic differences between our societies, many of the issues discussed by Karen are very pertinent to our own psychological services. We thank her for providing us with these valuable reflections on the Canadian situation.

A regular feature is the book review section, edited by John Fitzgerald, (thanks for your excellent contribution, John). In this November issue three books are reviewed. Once again the Student Forum has been (very ably) compiled by Rosalind Case, who is also stepping down from this role after this issue. We extend our sincere thanks to Ros for her considerable efforts in obtaining student material for several issues, including in this issue reports from four students on their research work. The incorporation of these summaries is an important mechanism for promoting the research of students at our universities. Many thanks, Ros.

Finally, thank you to everyone who has contributed to Psychology Aotearoa over the period when I have been co-editor. Without your contributions we would not have this publication. We are now searching for a new co-editor to join Pam in the production of Psychology Aotearoa and I wish my successor all the very best in continuing the important role which the journal plays in our profession.

Nga mihi nui,
Michael O’Driscoll
Co-Editor (m.odriscoll@waikato.ac.nz)

The following is a brief summary of the AGM held on 8 September at the Owen G. Glen building at the The University of Auckland in conjunction with the NZPsS annual conference Thirty-one members and two students attended the meeting.

Minutes and Reports
The 2012 minutes and reports were accepted. President Peter Coleman and Executive Director Pamela Hyde spoke to a power point outlining the activities of the Society over the past year. Peter and Pamela thanked members for their excellent contributions throughout the year to the Society and to their colleagues in a wide range of areas. (The power point is available for viewing on the Members Only section of the website). Peter Coleman spoke to the issue of developing a category of “retired member” noting that the Executive considered this issue and found that current policy covered those members who might need to access a reduced fee.

Elected Fellows
Elected Fellows Bev Burns, Dr John Fitzgerald, Dr Averil Herbert and Judith McDougall were congratulated by the meeting and thanked for their contribution to psychology and to the Society. The AGM unanimously elected Associate Professor Linda Waimarie Nikora as an Honorary Fellow of the Society (see September/Mahuru Connections for more about Linda’s honorary fellowship).

Election of Officers
Dr Rose Black was elected as Director of Professional Affairs on the NZPsS Executive.

Discussion items
There was a discussion about the funding of branches to enable them to become more active on behalf of members. This issue will be discussed at a scheduled meeting of Branch chairs, National Office staff and Executive in October and a remit put forward as necessary. There were also concerns expressed about the DSM-5 and an appropriate NZPsS response to it. Finally, there was a discussion on the Psychologists Board complaint procedures and member experiences of these. There was agreement that these procedures needed to be looked at from the perspective of members’ who had been through the complaint procedures. The Society will also look at the ways in which it currently supports members who are going through the Board’s complaint procedures to see if there are additional ways in which the Society can assist.

A vote of thanks
A vote of thanks was passed to the Executive and National Office for their hard work on behalf of the Society.

Who is who
NZPsS Executive
President - Peter Coleman
President-Elect - Dr Kerry Gibson
Directors of Bicultural Issues - Dr Waikaremoana Waitoki & Dr Erana Cooper
Director of Professional Affairs - Dr Rose Black
Director of Professional Development and Training - Iris Fontanilla
Director of Scientific Affairs - Dr Jackie Feather
Director of Social Issues - Quentin Abraham
Kaihautū- Professor Angus Macfarlane
National Office Staff
Executive Director - Dr Pamela Hyde
Executive Officer- Debta Rodway
Professional Development Coordinator - Heike Albrecht
Membership Administrator - Donna Macdonald
Branch Chairs
Auckland - Alison Kirby
Waikato - Dr Marianne Lammers
Bay of Plenty - Dr Peter Stanley
Central Districts - Dr Barbara Kennedy
Wellington - Wellington Branch is currently being revitalised
Otago/Southland - Brian Dixon
Institutes/ Divisions
Institute of Health Psychology (IHP) - Iris Fontanilla
Institute of Community Psychology Aotearoa (ICompA) - Dr Rose Black
Institute of Clinical Psychology (ICP)- Chris Dyson
Institute of Criminal Justice and Forensic Psychology (ICJP) - Rajan Gupta
Institute of Counselling Psychology (ICounsPsy)- Dr Bill Farell
Industrial and Organisational Division (I/O Division)- Frank O’Connor
Institute of Educational and Developmental Psychology (IEDP) - Fiona Ayers
Children passports for children

Psychologists at the Royal Hospital for Sick Children in Glasgow have piloted an innovative scheme to help children feel more involved in their treatment and care and to combat fear of being in hospital. This involves the use of passports that can be used by children to collect a variety of stickers and stamps as they go through treatments and “travel” to various departments of the hospital. The scheme has had positive feedback from children, their parents and staff with 100% of children surveyed saying they would recommend the passport to their friends and 90% of parents saying they would recommend the tool. “The main benefits of the scheme appear to be in helping children and parents talk more about what is wrong and why they came to hospital and for children to talk to staff about procedures.

Source: The Psychologist vol 26 (6) 2013, p390

Child poverty is about adult poverty

NZPsPS Public Interest Award winner 2009 Sue Bradford believes that child poverty is about adult poverty and systematic change rather than “hand-wringing charity”. Speaking at the New Zealand Nurses Organisation, Wellington Regional Convention, Bradford called on the unions to work with groups like Auckland Action Against Poverty to bridge the growing gap between those in work and those who do not have work. She noted that people needed to talk about and work towards “systemic, structural solutions to poverty and unemployment, going beyond the surface of things to what really needs to happen – like lifting wages, rebuilding the public sector, forcing a government commitment to decent job creation and in engaging in major progressive reforms to our welfare system”. Bradford criticises current Government policies which she says will not alleviate poverty but will drive down wages and conditions and increase division and prejudice between employed workers and those who are out of work and/or on benefits.


Mental health promotion for gay, lesbian, bisexual, transgender and intersex New Zealanders

Writing in the New Zealand Family Physician Adams et al report that there is compelling evidence that gay, lesbian, bisexual, transgender and intersex (GLBTI) people experience poorer mental health when compared with the general population with higher rates of depression, anxiety and substance abuse. Research was commissioned as part of the Ministry of Health’s implementation of the New Zealand Suicide Prevention Action Plan 2008-2012. The aims of the research were to identify the mental health promotion activities focussing on GLBTI populations, mental health services specifically available for these populations and initiatives and key issues facing the sector.

Surveys and interviews were carried out of service providers, key informants and GLBTI individuals. Findings of this study included:

- Very limited leadership in relation to mental health issues for GLBTI people from government agencies and GLBTI communities
- Reducing GLBTI people’s exposure to prejudice, stigma, rejection and violence and heterosexism is important in supporting their mental health
- Ensuring young people’s safety particularly in school was identified as a priority. This would include training of teachers in suicide prevention, mental health promotion, preventing bullying and challenging homophobia/transphobia.

Other issues raised related to the need for more funding, resources and research into mental health services and information related to GLBTI people. This included ensuring the competency of practitioners, councillors and psychologists etc.

Source: K. Tiaki Nursing New Zealand. Vol 19 (5) June, 2013 pp 105-113

Motivational Interviewing for Diabetes Care – Is it Effective?

A study by R. Jansink et al published in the Scandinavian Journal of Primary Health Care 2013;31(2):119-27 investigated the effectiveness of a comprehensive programme in general practice that integrates patient-centred lifestyle counselling into structured care for diabetes patients. The programme conducted by nurses consisted of a protocol, record keeping, reminders and feedback, plus training in motivational interviewing and agenda setting. At follow-up after 14 months, analyses that adjusted for baseline outcomes showed that the intervention was no more effective than usual care – there were no significant improvements in the diabetes outcome measures (HbA1c levels, blood pressure, cholesterol, BMI), the reported consumption of alcohol, fat, vegetables and fruit, or physical activity, or any of the other measures of clinical parameters, patient’s readiness to change, or quality of life.

Commenting on this study Christopher Triefield noted that a similar study in New Zealand some years ago demonstrated similar outcomes to this study and was the basis of removal of funding for the “get checked” diabetes programme. He notes that the authors go so far as to question the impact and value of motivational interviewing in general practice.

The abstract of this article can be accessed on http://tinyurl.com/ku47yy

Source: GP Research Review, Issue 74, 2013, p4

Insight into bullying in New Zealand

In the first New Zealand study of its kind, a Victoria University researcher Dr Vanessa Green has found that 94 per cent of the school staff she surveyed had seen bullying in their school.

Dr Green, Head of Victoria’s School of Educational Psychology and Pedagogy, surveyed 860 teachers and senior staff from primary, intermediate and secondary schools around New Zealand about their experiences with, perceptions of, and attitudes towards bullying. She found that the majority of teacher and senior school management were concerned about bullying with almost half of respondents reporting that instances of verbal bullying were brought to their attention weekly.

“The majority of teachers and senior school management personnel are concerned, and there is a general feeling that we need to do something about it,” says Dr Green.

Nearly half of those who took part in the survey said instances of verbal bullying were being brought to their attention weekly.

Other findings were that 68 per cent of respondents believe bullying begins between the preschool years and the ages of seven or eight, while just under half the respondents reported that cyberbullying is mainly conducted by 11 to 14 year olds. Over half of the respondents considered that girls were responsible for most of the cyberbullying.

Respondents considered that anti-bullying strategies needed to involve entire schools, the community, parents and whanau. A theme that emerged from respondents was that they felt there was a disconnect between schools and families on how bullying is being dealt with. She noted that although programmes to deal with bullying are widely available, they are being used at less than a third of the schools represented in the survey. Dr Green believes that a good place for schools to start is to put a greater emphasis on professional development for staff in the area of bullying prevention.

Questioning Identity: A critique of arguments for prescribing rights for psychologists in New Zealand

Nigel George and David Semp

Miraculously the new DSM-V has omitted a significant disorder of identity affecting many psychologists. Please ask yourself the following questions to see if you may have or be developing this condition.

1. Do you find yourself fantasising about prescribing psychotropic medications to your clients?
2. Do you think that perhaps you could do a better job of prescribing than medically trained doctors and psychiatrists?
3. Do you imagine yourself and the psychology profession gaining more systemic respect for being able to prescribe?
4. Do you tell yourself that the ability for psychologists to prescribe would benefit society?
5. Do you tell yourself that the ability for psychologists to prescribe would benefit society?
6. Do you think that your colleagues who do not share your desire are ‘narrow minded’ and failing to ‘step up’ to the challenges facing the profession of psychology?
7. Do you believe that prescribing will make you be more holistic in your treatment, as you are able to add the ‘bio’ to your psychosocial approach?

If you answer ‘yes’ to 3 or more of these questions, and if you’re a psychologist, you could well be suffering from ‘Psychological Identity Disorder’. This condition has been identified in the United States for nearly two decades but has only recently appeared in New Zealand.

Nigel George works as a senior clinical psychologist in Older Adult Mental Health Services and is Director of the Psychology Clinic at the University of Auckland. He qualified and worked as both a registered general and psychiatric nurse prior to training as a clinical psychologist.

David Semp is a clinical psychologist working primarily in public mental health services (PMHS). His areas of expertise include individual therapy, groups, supervision, team consultations, psychoanalytic informed therapy, mindfulness based therapies and DBT. David’s PhD explored issues regarding sexual orientation and PMHS. David also has a small private practice.

We are mindful of the problematic nature of creating new disorders, especially without rigorous scientific research to support them. However, this phenomenon could have significant detrimental effects on the discipline of clinical psychology in New Zealand and ultimately on clinical practice. Accordingly we apply a psychological approach to try and understand this development. We explore the aetiology of this condition, we consider its implications for the profession and practice of psychology in New Zealand; and finally, we suggest potential avenues for responding to this development in ways which strengthen psychological practice.

Turning first to aetiology, why has this phenomenon arisen in New Zealand now? Several factors, socio-political, discipline based, and individual, seem to have coalesced to account for this.

The current socio-economic and political climate in New Zealand is one where the quickest and cheapest interventions are strongly preferred for an under-resourced public mental health system. Medication fits well within this environment as it is readily available, quick to prescribe and is supported by the dominant medical discourse of mental health. Correspondingly, in this desire for ‘quicker and cheaper’, the more complex and intensive of psychological treatments seem vulnerable. They require increasing justification for their use within a largely medically focused system.

A double standard operates in regard to how medical and psychological treatments for mental health issues are funded and valued. For example, when psychiatrists diagnose a person with schizophrenia the system does not question the prescribing of expensive mind-altering medications, for decades. Yet despite evidence showing its efficacy, psychologists offering one or two years of therapy for a variety of complex psychological presentations are often considered a ‘luxury’. In this context psychologists are increasingly pressured to offer ‘brief interventions’ for complex psychological conditions where there is little evidence of their long term efficacy in this short interventionist form.

Paradoxically, at the same time as provision of complex psychological treatments is under duress, there is an increasing public demand for psychology. This has led to national mental health policies for improving access to ‘talking therapies’. To try and achieve this ‘quicker and cheaper’, other professions such as nursing are being invited to practice within clinical psychologists’ ‘traditional turf’ e.g. to offer CBT and other psychological interventions.

These clinicians are often being engaged within a ‘stepped care’ model, which, while opening talking therapies up to more people, undoubtedly a progressive move, makes us as a profession feel nervous that others see our skills as easily transferable and can be supplied cheaper.

There are however opportunities here for psychology. We could celebrate this increasing valuing of psychological treatments and focus our attention on treating those we are trained to work with; those people with more complex presentations. Further, we could have a role in ensuring that psychological treatments are utilised and offered in ways that fit the extensive evidence base. Our training is aimed at developing clinicians who can work with and advocate for people struggling with complex psychological difficulties. These are often the most psychologically troubled people in our communities. These people require clinicians who can work beyond manualised therapies for depression and anxiety; who can understand complex presentations, formulate complex histories and provide complex individualised psychological therapies and interventions based on these formulations. Yet instead of embracing and advocating for these treatments within the systems in which we can have influence, many psychologists are calling for the right to prescribe psychotropic medications as a new direction for our profession. Why might this be?

In New Zealand, clinical psychology is a relatively marginalised profession within the increasingly stretched public health system. In the current socio-political context many of us as individuals and collectively as a profession feel anxious and perhaps are searching for ways to make ourselves feel more secure. The current context operates to undermine our sense of ourselves as valid mental health professionals with unique skills and treatments to offer our clients. Instead we are described by those who do not understand or support our evidence based treatments, as an ‘expensive luxury’, or the ‘cream on the cake’. This climate can create an anxious thinking lens focused on what we are not doing as clinical psychologists. For example, waiting lists for psychological treatment are often seen as failures of psychology and psychologists rather than the result of choices to invest in medical treatments over psychological ones. In contrast, waiting lists for surgery are seen as a resource issue, not a failure of medicine or doctors. Further, little attention is given to the evidence from research about the efficacy of therapy for complex psychological issues. Instead many of us feel that we must join with, and augment the ‘quicker and cheaper’ paradigm to rescue ourselves from institutional and cultural marginalisation and perhaps also our resultant lack of self-belief. But to do this is to conform to a system focused on biology and medication, with brief therapy as a side order. In this context, prescribing medication aligns us with medical psychiatry and the apparent security and validity that come with this paradigm.

We ask psychologists to question if apprehension about our place in the health system is informing our calls for prescribing rights.

We suggest that it is the socio-political climate combined with the continued dominance of the medical model and a lack of security in our identity as a discipline which informs this increasing call for prescribing rights. We believe the arguments used to support this are rather justifications for our own need to bolster our professional identity and power. Alternatively we contend that we can collectively support our professional identity, in the areas we specialise in. The issue of psychology’s focus has been recently debated in the UK following the release of DSM-V and criticism of its medical and ‘disease’ focussed model. The British Psychological Society’s Division of Clinical Psychology (DCP) has advocated for a paradigm shift in psychiatry “away from an outdated disease model, towards one which gives much more weight to service user experience and psychosocial approaches”. 
If the call for prescribing rights is a response to psychologists’ fears of marginalisation let us consider what we would advise a client that came to us with an anxiety problem? Would we invite them to change their behaviour, to not be true to their values, in order to avoid their anxious feelings? No, we would help our client understand their anxiety and strategise how to respond to the anxiety in ways which supports their long term goals. Similarly we ask psychologists to question if apprehension about our place in the health system is informing our calls for prescribing rights. If it is, we encourage you to find other ways to promote and enact the practice of psychology, not to change the essence of who we are by joining and acquiescing to the dominant medical paradigm. Through this challenging time we can work to strengthen our collective identity, we can take pride in what we have trained so hard in to offer to our clients, colleagues, and teams; to ultimately, believe in ourselves!

If we fail to strengthen our psychological identity we risk weakening the profession and ultimately weakening our practice. There is little enough funding available for psychological professional development. Overseas experience shows that considerable time and money is required to train psychologists to safely perform even basic prescribing. This would further reduce the little spent on psychological professional development. Prescribing also risks splitting the profession by creating a two-tier model whereby psychologists who can prescribe are seen as preferable in a mental health system socio-historically biased towards biology.

This is not about being anti-psychiatry or anti-medication, but rather, a call to be pro-talking therapies, pro-clinical psychology; to offer as unique and essential to comprehensive health services in New Zealand. We encourage psychologists to promote what we have to offer as valuable; and through this visible pride, we invite others to value what we have to offer as valuable; and through this visible pride, we invite others to value what we have to offer as valuable; and through this visible pride, we invite others to value what we have to offer as valuable; and through this visible pride, we invite others to value what we have to offer as valuable; and through this visible pride, we invite others to value what we have to offer as valuable; and through this visible pride, we invite others to value what we have to offer as valuable; and through this visible pride, we invite others to value what we have to offer as valuable; and through this visible pride, we invite others to value what we have to offer as valuable.

In 2006 our Ministry of Health was in the process of reviewing the Medicines Act alongside grappling with the reality of a national shortage of psychiatrists, increasing pressure to move more mental health care from the secondary to the primary healthcare sector, an aging and numerically declining population of general practitioners, and increasing rates of mental health diagnosing. At the time the Ministry produced a consultation document entitled ‘Enabling the Therapeutic Products and Medicines Bill to Allow for the Development of Collaborative Prescribing’. This paper invited consideration of the need for collaborative prescribing and what skills practitioners might require if prescribing authorities were extended beyond medical doctors, some nurses and those allied health professionals who already have limited authorities in this area.

Psychologist Prescribing in New Zealand: Is it Worth Considering?

John Fitzgerald

John has been the director of The Psychology Centre in Hamilton since 2001. He was born and raised in England, completed his clinical psychology training at the University of Birmingham in 1988 and moved to New Zealand in 1992. He has worked in community adult mental health and A&D services, but has spent most time working in the area of child, youth and family mental health. He has additional training in family therapy, and still has an interest in working with family systems.

John has been chair on the NZPsS Institute of Clinical Psychology and contributes to the life of the Society in a number of other ways. He was recently made a Fellow of the Society. John is currently a member of the Health Practitioners Disciplinary Tribunal and has previously undertaken tasks for the Psychologists Board.

He has a clinical service and research role at The Psychology Centre, supervises clinical students and a range of other healthcare staff, and is regularly engaged to provide training on a diverse range of clinical and professional topics.

In response to the Ministry’s initiative Fitzgerald & Galyer (2008) undertook a survey of New Zealand psychologists via the NZPsS and NZCCP. The survey format and questions they used were largely a replication of a similar survey completed in 2007 by the Australian Psychological Society. A total of 571 psychologists completed the survey. In response to the question ‘In your opinion, is it desirable to enable the Therapeutic Products and Medicines Bill to allow for the Development of Collaborative Prescribing?,’ half the respondents indicated support for psychologist prescribing, although only a minority of these (18%) had no reservations. Conversely, only 8% of all respondents were absolutely opposed to psychologists gaining prescribing authority. The vast majority of survey participants responded with reservations (56%), or indicated that they could not answer the question without further information (18%).

More recently the NZPsS has conducted its own survey of the views of its members on a prescribing role for psychologists in New Zealand. While there was a general spread of agreement/disagreement in response to most of the 13 questions the survey respondents expressed greater agreement on some items; that psychologists generally have more time to assist clients with medication adherence (74%), that with prescribing client perceptions of psychologists could change (64%), medication would be further reinforced as the dominant mode of intervention (62%), prescribing could create a two-tier split within the profession (60%), and indemnity insurance costs would likely increase (63%).

With two surveys of psychologists completed are we any clearer about the views of the profession, and the needs of the New Zealand population on this issue?

It is common knowledge from research conducted both in New Zealand and elsewhere that a majority of mental health presentations are ‘missed’ by primary care practitioners….

Is there a case to be made for psychologist prescribing in NZ?

Without any clear ethical reasons for not exploring this domain of practice further, at this stage I don’t think we concern ourselves with the details of why or how, but limit our consideration to why. That is, is there a case for walking further down this road… or should we just sit by the side of the highway and watch the traffic pass by?

Robert Sternberg (2003), in one of his columns as president of the American Psychological Association, wrote a piece entitled, ‘Is time for prescription privileges.’ He briefly identified some of the key arguments which had persuaded him that this was indeed the case. It seems worthwhile to explore and expand on the points raised by Sternberg.

1. The opportunity to ‘intervene’ with the whole person. There is a long tradition in applied psychology for the rational consideration and integration of biological, social and psychological aspects of human behaviour and experience. These must be honestly and judiciously applied to psychological treatments if we are to truly realise a bio-psycho-social approach to healthcare, even if our medical colleagues are still struggling with this commitment. Where medical doctors have laughed openly at the term bio-psycho-social. If we fail to do this then there is a risk of the pot calling the kettle black, and we remain in the ‘dark ages’.

2. The opportunity to provide “full service.” Psychologists are generally motivated to provide as broad a range of supports to their clients as possible, responding to expressed and assessed need without compromising their commitment to an overarching psychological perspective. In pursuit of this New Zealand practitioners are often quick to embrace new therapeutic ideas. This willingness to develop practice and harness opportunities for the benefit of our clients, when managed with care, is commendable and reflects the New Zealand penchant for recognizing...
opportunities and adapting them to fit local conditions. Psychologist prescribing certainly presents this type of opportunity for practitioners concerned to offer the most convenient and integrated services to their clients.

3. Reduction of dependence on medical practitioners.

The diffused approach to delivery of mental health care creates problems of coordination, information transfer, and treatment consistency, leading to risk and sometimes inadequate care. Psychological treatments can be compromised by uninformed changes to medication regimens. Service users are often required by default to coordinate multiple practitioners, and bear multiple costs associated with the separation of service types. In this regard there may be some benefits from having a ‘one stop shop’, which is focused on practitioners rather than buildings.


The development of prescribing psychologists in America has been a slow and cautious process. For a decade the pursuit of prescribing authority for psychologists has been the policy of the American Psychological Association. Despite the concerns expressed at its inception adverse events and errors have not been commonplace, indeed, they have been far less frequent than the rates amongst medically trained staff. Also, there has not been a movement away from delivery of psychological therapy in favour of ‘pill pushing’ amongst prescribing psychologists.

5. Political timing and responding to sector needs.

In America the initial impetus for prescribing privilege was the military, followed by a small number of States. In New Zealand the debate has, to a great extent, been initiated and developed by our Ministry of Health. This is because our service structures, resources and needs are different from America. While we can look at the American experience and learn from it, we also have to be able to step aside and consider the challenges that face us in Aotearoa New Zealand, and consider how the development of prescribing psychologists (and other professions such as nurses), are likely to impact on local healthcare provision.

There appear to be political support for this development, it is proactive with respect to anticipated need, rather than reactive, giving time for debate and consideration of the implications. However, there will come a point at which a commitment needs to be made to move to the next planning step. The New Zealand College of Clinical Psychologists is leading the way with this via its ongoing dialogue with Health Workforce New Zealand and the Ministry of Health.

6. Availability of psychology practitioners.

Within the American states which have allowed psychologists prescribing authority one key driver has been the sharp and rapid decline of psychiatry staff numbers, and the increase in the number of psychologists. It is not clear that this trend is so marked in New Zealand as we have had a shortage of psychiatrists for a long time. In 2009, the last year for which we have figures, the availability of psychologists of any specialization was approximately 3,500:1, whereas the availability of psychiatrists was about 6,500:1. However, a vast majority of mental health prescribing in New Zealand is within primary care settings, by general practitioners who have very limited training in mental health care. It is common knowledge from research conducted both in New Zealand and elsewhere that a majority of mental health presentations are ‘missed’ by primary care practitioners, and that there is growing evidence of a prescriber first diagnosis second approach being adopted. Given this we should dismiss out-of-hand any idea of placing some prescribing authority within the purview of a group of practitioners who are better trained to recognise the problems, monitor change, and respond to risk?

7. Medication management, not just prescription.

Prescriptive authority may actually support psychologists taking clients off prescribed medications. This is an argument that I particularly like, although the numbers concerned are likely to be small. Just think of the times that you have spoken to a client about reducing medication, knowing that to do this safely the client will have to incur the cost and inconvenience of another visit to their GP who may well be relying on your advice in the first instance. Also, one of the arguments often raised against allowing psychologists prescribing authority is the difficulties they may experience in managing side-effects of medication. Well, the news is that a client would have side effects no matter who prescribes the medication. Most psychologists have more regular contact with their clients than the involved medical practitioner does, and the monitoring of medication efficacy, adherence, and side-effects would likely be more timely and consistent.

8. Professional standards and practice.

“...whatever problems there may be with prescriptive authority, we need to have faith in ourselves- that when we are granted prescriptive authority, we will use it in a caring and responsible way.” (Sternberg, 2003). Is Sternberg being a little naive here? I think not. I have faith in my fellow psychologists to engage responsibly with their clients. Our profession has the tradition of a much more robust supervision and consultation system than the often non-existent systems employed by most other health practitioners. An expectation of professionally open and transparent practice, a strong registration and continuing competence process, and an emphasis of building and maintaining collaborative working relationships with our clients all work in favour of us being able to do this job well.

9. Psychologists don't need to duplicate the prescribing practices of medical doctors.

The goal of training for prescribing psychologists would not be to create a physician, but rather to tailor the training to provide sufficient training in medicine and pharmacology so that already registered and (presumably) experienced psychologists can prescribe safely and effectively. The assumption often made is that prescribing psychologists would practice in a similar way to prescribing physicians or nurses. Of course, this is not necessarily the case. The medical model is disease-based, allopathic, focused on ‘curing’ symptoms, and basically biological in its model of causation. This leads necessarily to a search for internal causes of illness by a specialist/ expert, and a highly instrumental and prescriptive treatment paradigm. Psychological models are bio-psycho-social in orientation, attuned to interpersonal and contextual causal factors, and have a non-symptom focused focus. These lead to collaborative treatment paradigms where medication is adjunctive (this is an important point) in favour of treatment across a spectrum. Medically and psychologically trained practitioners are ‘different animals’.

The debate over prescribing in psychology is often framed as a dichotomous struggle between pharmaceutical (biological) and cognition/emotion (psychological) within the domain of mental health. Doctors, nurses, and other allied health practitioners who hand our medication represent the ‘dark side’ of a biological-based understanding of pathology and ‘cure’, whereas more enlightened psychosocial approaches represent a more caring, empowering, contextually-based approach to formulating and responding to the difficulties that people face. Of course, this dichotomy is a false and divisive representation of healthcare generally promulgated by those who have too much time on their hands, and little real contact with the day-to-day struggles of the contemporary healthcare environment. The reality is that a vast majority of health care providers are trying to assist the client in the best way they know how, using the best resources that they have available to them.

We would also do well to remember that psychologists working within the mental health field generally only see those clients who do not respond to medication, cannot tolerate medication, or do not want to use medication. We have to accept that many clients use medication, choose to use medication, and benefit from medication … even if it is just a placebo. These latter groups are likely to have restricted access to their treatment of choice in the future if a solution is not found to address the shortage of those skilled in the selection and management of appropriate pharmacological treatments.

A final consideration – maybe we also need to be honest with ourselves about our own perceptions/prejudices about medication, and to what extent these views and values may be impacting on our positioning. Is it okay for us to take medication, alcohol, nicotine when we are feeling low, worried, stressed, but not for our clients? If our clients choose to take medication to assist them should we not try to ensure that this is provided in a timely, careful, well monitored, knowledgeable, supportive manner? And if this is the case and a well trained and experienced clinical psychologist is the best person to provide such care, then isn’t this something we should at least be considering? Times are changing, we do not take on major new responsibilities and risks, opportunities without due consideration, but we must also accept that we are now in the 21st century, and that practice, knowledge, and societal needs and wishes may be changing.

References


Prescribing rights for psychologists – some thoughts on purpose and training

Jeanette Shennan, HNC MSc DipPsych(Clin) MNZPAS MICP

Jeanette Shennan is consultant clinical psychologist at the Pain Service, Waikato Hospital. Her first working life was in biochemistry laboratories in Dunedin, Palmerston North, Canberra and Glasgow. After completing her clinical psychology training at the University of Waikato, Jeanette worked in adult mental health and as Child Youth and Family before returning to the interface between physical and mental well-being by joining the Pain Service in 1997. Since 2000, Jeanette has been increasingly committed, as a practitioner, researcher, teacher and therapist, to the potential of mindfulness meditation and mindfulness-based therapies. With two psychologist colleagues, as “Mindfulness Waikato”, she regularly facilitates mindfulness-based group programmes as part of her private practice.

Is taking a pill a good companion to doing your homework? Administering medication to patients who need their physiology modified to cure their disease or to remEDIATE their symptoms in order to be healthy is a substantial distance away from teaching skills, informing and counselling clients who need to think, feel or behave differently in order to be healthy. So what are the reasons behind seeking prescribing rights for psychologists? And how might we be equipped to do this new job competently? Why?

In the United States two states, New Mexico in 2002 and Louisiana in 2004, already have prescribing rights for psychologists who have undertaken additional relevant post-doctoral training. Missouri was hoping to become the third state and another four states were also investigating the process, but as far as I have been able to ascertain, this has not eventuated. (The US Department of Defence had much earlier granted prescribing rights to psychology practitioners in some of its facilities, beginning in Guam).

In my view, a collegial relationship is likely to be easier to sustain when the GP retains the prescribing, and the psychologist provides the mental health formulation and therapy expertise.

Persuading the arguments from the US, a major driver appears to have been relative numbers of practitioners and associated access to services. For example in Missouri there is a four and a half-fold difference in numbers of psychiatrists (400) and numbers of psychologists (1800). In that state’s rural areas psychologists are more accessible than psychiatrists.

Is this a relevant argument in New Zealand? Hardly; there are more clinical psychologists (1300) than psychiatrists (550) but the ratio is under 2.5:1, and this includes all those clinical psychologists practicing outside mental health. There are few areas where access to a psychologist is quicker or easier than to a psychiatrist. Furthermore, the role of the general practitioner is much more significant in NZ, much anti-depressant prescribing occurs in primary care, and there are few if any places where access to a psychologist is easier than access to a GP.

Prescribing by psychologists is limited to “mental health” drugs and would be mainly anti-depressants, as well as the adjunct medications to offset side-effects of the primary drug(s). The anti-depressants are in two clusters, those able to be prescribed by GPs, and those requiring specialist prescription. Would prescribing psychologists be placed alongside GPs, able to prescribe the first line drugs fluoxetine, citalopram etc., or would they be with the psychiatrists, prescribing second- and third-rank anti-depressants such as the SNRIs, mood stabilizers including lithium and anti-epileptics, anti-epilepsy and major tranquilizers? If we are assuming that we are in the first group, relative numbers of psychologists and psychiatrists becomes irrelevant, and the relevant comparison is with GPs.

Many psychotropic medications, including some of the common first line anti-depressants, require monitoring in some situations or some individuals, with blood tests measuring drug levels and/or liver or kidney function, or physiological measures such as blood pressure. Will prescribing psychologists also be expected and able to request and interpret blood tests? And what about blood pressure or other physiological monitoring, and interactions with other medications? Perhaps prescribing psychologists will have collegial relationships with their clients’ GPs, whereby the GP does the monitoring and oversight while the psychologist does the prescribing?

In my view, a collegial relationship is likely to be easier to sustain when the GP retains the prescribing, and the psychologist provides the mental health formulation and therapy expertise. Establishing collegial relationships with one’s clients’ GPs is highly desirable and possible. Many – most – GPs value communication from a psychologist who is also seeing their patient. Some GPs are open and responsive to suggestions, requests and discussion around medication options for their clients. A typical scenario is the patient on fluoxetine for depressed mood who the psychologist assesses as also experiencing significant anxiety; most GPs will be appreciative of this informed opinion and the associated suggestion of a more anxiolytic option such as citalopram or paroxitine.

Clinical psychologists, however, may complete their professional training, even to doctoral level, devoid of basic chemistry and biology.

The Louisiana law relating to psychologist prescribing rights mandates a close collegial relationship between the ‘medical psychologist’ and a physician: the medical psychologist may prescribe medication “only in consultation and collaboration with the primary or attending physician and with the concurrence of that physician.” Any medication changes – dose, starting or stopping a drug – may only be done in consultation with the primary doctor. If there is no primary doctor, the psychologist may not prescribe. This is incompatible with the view of those psychologists who express the value in being able to prescribe independently.

Another supporting argument in favour of psychologists prescribing relates to cost. It is stated to be cost-effective to have a single clinician prescribing and undertaking psychotherapy. This is in fact overridden by the access and numbers situation; if psycholgist time is harder to access than psychiatrist time, as is true in most DHB services, then using psychologist time for prescribing is not cost-effective at all.

So we have an argument about access to psychiatry which doesn’t add up here, and the laudable goal of a partnership with primary care, which seems less sustainable with psychologists prescribing than when the drugs are left in the responsible hands of the GPs.

How?

In the survey of NZ psychologists’ views on prescribing rights conducted by Fitzgerald and Galway in 2008, a majority of respondents who considered the questions relating to training for prescribing indicated that they would consider undertaking such training. Pre-requisite professional streams likely to be considered appropriate included clinical, neuro- and health psychology. Neuropsychology and health psychology practitioners are likely to have some basic physiology and anatomy included in their training. Clinical psychologists, however, may complete their professional training, even to doctoral level, devoid of basic chemistry and biology. Attempting to tack on knowledge of physiology, basic pharmacology, biochemistry and anatomy, let alone advanced concepts such as drug-drug interactions, and drug metabolics, without a background of basic science is hazardous.

The US training requirements are interesting to consider. In Louisiana, a post-doctoral Master’s degree in clinical psychopharmacology is required, a two year university programme, followed by a national proficiency exam. The curriculum must include anatomy and physiology, biochemistry, neurosciences, clinical medicine, pathophysiology and health assessment in addition to pharmacology and psychopharmacology. In New Mexico the curriculum and time requirements are similar but may be studied as continuing education rather than as a formal university masters programme. However, the psychologist must then complete a 400 hour 100 patient practicum under psychiatrist or physician supervision before being licensed to prescribe.

In Louisiana, a post-doctoral Master’s degree in clinical psychopharmacology is required, a two year university programme, followed by a national proficiency exam.

The Louisiana requirements seem appropriate for our situation, providing that the psychologist has the basic science – chemistry and biology – foundation. One might assume that psychologists without such a foundation would not consider undertaking the study, but there is a clear risk that lack of awareness of one’s ignorance facilitates unwarranted confidence. Perhaps a familiar psychological atonology is worth pondering: the health practitioner from another discipline who undertakes a course in CBT – substance and thorough as it may be – and then implements this learning without the solid background of learning theory, psychological assessment and formulation and
A comparison among US prescriber training programmes concluded that the psychologist training in pharmacology compared favourably with nurse practitioners and physicians (Muse & McGrath 2010). This study was robustly criticized (Heiby 2010) for disregarding prerequisites, apprenticeships, internships and supervised practice as well as peripheral subject areas undertaken by trainee physicians and nurse practitioners. In NZ there are now a small number of nurse practitioners who have undertaken the extensive training required for them to attain prescribing status. This curriculum is similar to that described above for the Louisiana psychologists, and similarly typically occurs over two or more years. Nurse practitioners, like psychologists, are permitted to prescribe a limited and specified domain of drugs relating to the specialist area only. Training for prescribing psychologists here will need to be at least as comprehensive as that for nurse practitioners.

As a lighter-hearted look at the training issue, I invite readers to undertake a self-test of background knowledge see below. This was included in a brief look at prescribing an ethics workshop offered by the Fitzgerald and Galyer (2008) survey that many NZ psychologists are already concerned about this aspect.

A personal perspective

In an earlier life I spent years in biochemistry laboratories, and have tertiary qualifications in biochemistry, physiology, microbiology and genetics. My psychology major undergraduate degree included biology as the first minor. I have spent 16 years in a tertiary pain service and am knowledgeable and competent to advise on pain medications and on anti-depressants used in the pain context. I do not support psychologists’ prescribing, and I believe those psychologists who do so lack an awareness of the breadth of knowledge needed for safe and ethical prescribing practice.

Quick quiz for aspiring prescribers

1. What does CO2 mean?
2. What does H2O mean?
3. What substance has the formula C6H12O6?
4. What substance has the formula CH3CH2OH?
5. What is an important difference in composition between carbohydrates and proteins?
6. What are the catalysts called which control all chemical reactions within cells and tissues? What are these catalysts made of?
7. What are some factors which affect the rate at which biochemical reactions occur?
8. When a substance, for example alcohol, is metabolized by an inducible enzyme, what significance does that have?
9. What is cytochrome P450? What is its connection with taking medication?
10. If you have deranged alkaline phosphatase, what isn’t working as well as it should? What is the connection with taking medication?
11. How many neurotransmitter substances are there? What controls their levels at a synapse?

References


Psychology as the behaviorist views it – A centenary appreciation.

Neville M Blampied

Neville has been a member of the academic staff of the University of Canterbury for more than 40 years, teaching learning and behaviour change processes and researching behavioural interventions, primarily for children and families. He is a Fellow of the NZPsS, served from 2006 – 2010 as NZPsS Director of Scientific Affairs, and is an Associate Editor of The New Zealand Journal of Psychology.

The year 2013 marks the centenary of an event that at least some psychologists might feel was worthy of recognition and even of celebration, for it made the century of John B. Watson’s famous (or notorious, depending on your feelings about behaviourism) article, Psychology as the behaviorist views it (Watson, 1913). At the time he wrote this Watson was 35 years old and in the middle of his 12 year tenure as professor of psychology at Johns Hopkins University in Baltimore, Maryland. His was a quintessential American success story. Born into a poor white family in rural South Carolina, abandoned by his father from age 13, Watson managed to get a degree from an undistinguished local college and worked for a time as a school teacher. Somewhat fortuitously, he then was accepted as a student by the University of Chicago and completed his PhD in 1903, having shifted from philosophy to psychology, because, as he claimed later in life, he couldn’t understand anything that Dewey [the eminent

1. John Dewey, somewhat ironically, was one of those who responded favourably to Watson’s (1913) position, although with some reservations. He described himself as a “well-wisher” of behaviourism but was worried that it was completely asocial (Buckley, 1989, p.78).

The opening paragraph is stunning in the boldness and clarity of his vision for psychology. Psychology was to be objective and experimental, a branch of natural science, and would study the behaviour of both humans and non-human animals. Rather than being concerned with consciousness as its primary focus and introspection as its primary method, its theoretical goal was the prediction and control of behaviour (Watson, 1915). The rest of the article is largely an expansion and defense of these propositions.

Psychology was to be objective and experimental, a branch of natural science, and would study the behaviour of both humans and non-human animals.

Viewed as a call for methodological reform in psychology, Watson’s speech and article might well be the most successful such appeal ever uttered. Psychological theories and methods did not become behavioural overnight, but by the 1930s the article was being referred to as the behaviorist manifesto (Samelson, 1994), and 100 years later, Tonneau (2015) could write

Although scientific psychologists differ widely in terms of their ontological views and proposed subject matter, one methodological principle has commanded broad agreement: Psychological explanations are to be

pseudology which would have been included in the undergraduate and graduate course of study of a psychologist practitioner.

A comparison among US prescriber training programmes concluded that the psychologist training in pharmacology compared favourably with nurse practitioners and physicians (Muse & McGrath 2010). This study was robustly criticized (Heiby 2010) for disregarding prerequisites, apprenticeships, internships and supervised practice as well as peripheral subject areas undertaken by trainee physicians and nurse practitioners. In NZ there are now a small number of nurse practitioners who have undertaken the extensive training required for them to attain prescribing status. This curriculum is similar to that described above for the Louisiana psychologists, and similarly typically occurs over two or more years. Nurse practitioners, like psychologists, are permitted to prescribe a limited and specified domain of drugs relating to the specialist area only. Training for prescribing psychologists here will need to be at least as comprehensive as that for nurse practitioners.

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References

The heirs of Witmer and Watson today are the great company of behavioural and cognitive-behavioural therapists (McKenzie, 1997) at work in the world, as well as the many other applied psychologists our discipline sustains.

The year 1913 was not only a watershed year for psychology; it was a watershed year for Watson. From that time on the nature of his research changed, and was no longer largely concerned with (non-human) animal behaviour. Instead, his interests turned to humans (Cohen, 1979).

Buckley, 1989). The arc of Watson’s academic and research career was to be badly disrupted in the next years, first by World War 1 and then by the scandal that led, in 1920, to his leaving academic life for the business of advertising (Boakes, 1984; Buckley, 1994). However the work he did in this time, first in the notorious “Little Albert” studies of emotion and conditioning in children (Watson & Rayner, 1920, see also Beck, Levinson, & Iorns, 2009; & Harris, 2011), and then in the research with “Little Peter” (Jones, 1924, 1974) where he and Jones anticipated a number of the techniques for the treatment of phobic anxiety developed twenty-five and more years later by Wolpe (desensitization) and Bandura (vicarious learning) went some small way to demonstrating the promise of behaviour to deliver such an applied science.

Footnote to Title: This is an amended version of an article prepared for publication in the January 2014 issue of the IAAP Bulletin (IAAP being the International Association of Applied Psychology). It is reprinted with the permission of the Editor, Dr V. Hearne.

References
Buckley, K.W. (1989). The arc of Watson’s revolution was that Watson himself ultimately became a most effective promoter and popularizer of his ideas, notably in a series of books and popular-press articles he published in the 1920s and 1930s, after his forced departure from academia (Logue, 1994). Logue (1994) proposes that a successful scientific revolution needs an agent ... who is lead and extreme. ... Watson certainly supplied those characteristics (p121). Unfortunately, as time wore on, Watson’s rhetoric became more extreme and his claims less and less well-founded on research. Nevertheless, Watson’s ardent promotion of behaviourism had an impact on intellectuals generally, who came to see behaviourism as identified with being scientific, and it was this acceptance of behaviourism more widely in intellectual life, especially in North America, that forced psychologists to take it seriously (Burnham, 1994).

The aspect of Watson’s 1913 article that most struck me when I first read it, and strikes me again now, is the optimism that Watson displayed about the potential for an applied psychology to develop if psychology would only become behavioural. While this prospect pleased some of his contemporaries, it displeased others. Tichener, for example, the most senior criterion of introspection in America, was outraged at the prospect of giving psychology the stamp of technology (quoted in Buckley, 1989, p 80). But Watson was perfectly clear – he wanted a psychology which concerns itself with human life (Watson, 1913, p170), and he was confident that behaviouralism would deliver:

If psychology would follow the plan I suggest, the educator, the physician, the jurist, and the business man (sic) could utilize our data in a practical way, as soon as we are able, experimentally, to obtain them (Watson, 1913, p 168).

This aspiration addressed the third of the challenges that O’Donnell (1985) saw psychology facing in the period up to World War 1, namely, demonstrating that psychology was sufficiently useful to warrant institutional, social, and economic support for its teachers, researchers, and graduates. Others had seen the need for applied psychology and advocated for it, but the zeitgeist was not necessarily favorable. Lighten Wirtem’s attempt a decade or more previously to inspire APA to an effective promoter and popularizer of his ideas, notably in a series of books and popular-press articles he published in the 1920s and 1930s, after his forced departure from academia (Logue, 1994). Logue (1994) proposes that a successful scientific revolution needs an agent ... who is lead and extreme. ... Watson certainly supplied those characteristics (p121). Unfortunately, as time wore on, Watson’s rhetoric became more extreme and his claims less and less well-founded on research. Nevertheless, Watson’s ardent promotion of behaviourism had an impact on intellectuals generally, who came to see behaviourism as identified with being scientific, and it was this acceptance of behaviourism more widely in intellectual life, especially in North America, that forced psychologists to take it seriously (Burnham, 1994).

The aspect of Watson’s 1913 article that most struck me when I first read it, and strikes me again now, is the optimism that Watson displayed about the potential for an applied psychology to develop if psychology would only become behavioural. While this prospect pleased some of his contemporaries, it displeased others. Tichener, for example, the most senior champion of introspection in America, was outraged at the prospect of giving psychology the stamp of technology (quoted in Buckley, 1989, p 80). But Watson was perfectly clear – he wanted a psychology which concerns itself with human life (Watson, 1913, p170), and he was confident that behaviouralism would deliver:

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Pending ethics conversations: A New Zealand ethics review system inclusive of psychologists

Martin Tolich and Peter Coleman

Martin Tolich is an Associate Professor of Sociology at the University of Otago. His recent book co-authored with Professor Joan Sibert Planning Ethically Responsible Research (2013) was published by Sage. He has a three-year Marsden Grant to study tensions with the ethics review system and is the founder and convenor of the not-for-profit New Zealand Ethics Committee http://www.nzethics.com/. He was the inaugural chair of the Multi-region Health and Disability Ethics Committee.

Peter worked as an educational psychologist within the Department of Education and now Ministry of Education from the early 1970s until 2009, the last 15 years part time. He then moved into full-time private practice specializing in Family Court and child protection work and recently began working part time for Child Youth and Family in the cross-agency South Auckland Specialist Services. Peter was formerly Director of Social Issues for the NZPsS and helped prepare a number of recent parliamentary and Government Ministry submissions on behalf of the Society. His professional interests include special education, curriculum design, the functional analysis of challenging behaviour, youth offending, family violence, parenting, and the effective implementation of social policy. He is currently President of the NZPsS.

On February 10th 2010, the New Zealand Health Committee initiated an ‘Inquiry into improving New Zealand’s environment to support innovation through clinical trials’. An analysis of the submissions made to this select committee inquiry (Report of the Health Committee 2011) elucidates a number of themes around the administration of the HDEC system.

The most important change in these recent reforms was the restructured in six ways (New Zealand Ministry of Health, 2012b) (2012) main concerns pertained to the protection of participants, and they stated that the proposed changes were a ‘significant departure from the current standards’ developed since the Cartwright Inquiry, and from international instruments for the protection of human participants in research. The Law Society went on to question the legal status of the draft, and what legal effect they would have on the framework for ethical review of research in New Zealand. They also accurately predicted the problems that HDECs would have with the peer review process as the SOPs gave no clear definition of what constituted peer review.

The New Zealand Law Society’s (2012) main concerns pertained to the protection of participants, and they stated that the proposed changes were a ‘significant departure from the current standards’ developed since the Cartwright Inquiry, and from international instruments for the protection of human participants in research. The Law Society went on to question the legal status of the draft, and what legal effect they would have on the framework for ethical review of research in New Zealand. They also accurately predicted the problems that HDECs would have with the peer review process as the SOPs gave no clear definition of what constituted peer review.

HDECs are not themselves directly responsible for assessing the scientific validity of proposed studies. Researchers and sponsors must ensure that the scientific validity of proposed research has been peer-reviewed before an application is made to an HDEC. While HDECs are responsible for checking that appropriate peer review has been carried out, they do not conduct it themselves.

A summary of submissions to these standard operating procedures (SOPs) was compiled (New Zealand Ministry of Health, 2012a) and made available publicly, however only two of the fifty-one written submissions were publicly available in their entirety. One was from the New Zealand Law Society, and the other from the Women’s Health Action Committee; both expressed dire warnings about the new HDEC system.

Besides multiple legal and human rights issues regarding the draft proposals, the Law Society expressed concern that the Ministry of Health had not sought advice from the National Ethics Advisory Committee on Health and Disability Support Services Ethics (NEAC).

The Women’s Health Action Committee (2012) expressed similar concerns in their submission regarding the draft SOPs for HDECs focusing on the short 35 day ‘review clock’, the reduction of membership and the absence of any evidence that the current system needed change.

Like the New Zealand Law Society, Gillett and Douglas (2012) were concerned that the new ethics committees are not themselves directly responsible for assessing the scientific validity of proposed ethics; this deviates from the World Health Organisation standard. Paul (2011) was particularly critical of the fact that the Minister of Health, Tony Ryall, did not seek advice from the NEAC prior to formulating the Government response to the Health Select Committee report, which runs counter to NEAC’s previous advice. Like Gillett and Douglas (2012), Paul also questions the ‘odd’ Government decision to not require ‘scientific or clinical expertise’ on ethics committees, as without such expertise, it is impossible to accurately weigh up the harms versus benefits for the research participants and general public. In many ways these dire warnings are prescient and are borne out in what happened.

Additionally, a problem related to the new configuration of the post-2012 HDECs is their ability to review the adequacy of consultation with Māori about research which might affect them and specifically consultation with whanau, hapu and iwi where the research subjects are Māori. The HRC “Guidelines on Ethics Research” prescribes methods of ensuring adequate input by Māori communities in any Māori health research proposal. However a paper (Smith 2013) at the recent symposium at the University of Otago suggests that this obligation might not now have a proper predominance.

How the post-2012 HDECs responded

Analysis of the HDEC minutes July 2012-April 2013 reveal one in five applications (Tolich 2013) received by the HDECs did not contain what the committee considered adequate peer review. Compounding this problem was the deliberate exclusion of key committee personal such as biostatisticians, a feature of previous HDECs. One HDEC committee person interviewed (Tolich 2013) said at times she was blind when reviewing applications under the new system.

So we are missing a significant part of the committee’s faction, we are actually blind at the moment. To figure out what is going on, because we are not required to critique it.

The minutes of the Northern A HDEC meeting on March 2013 record the following outcome that suggests under the new system committee members at times do not have sufficient information to make sound recommendations.

(A Northern A HDEC Committee member) signalled dissatisfaction with information, study purpose and design provided in some application forms, noting that it is frequently difficult to tell what a study is about. He suggested the committee take a stronger line with this in future and expect more clarity. This also applied to the explanations given of the scientific design of studies, which were frequently too brief and failed to justify the choice of design. (He) suggested changing the test of questions, i.e. what is the justification for performing this study?; what is the state of the knowledge?; how will knowledge increase as a result of the study?; can this knowledge be translated into change and outcomes?; what is the primary question?; and what’s the method by which it will be answered? (Northern A Health and Disability Ethics Committee Minutes, March, 2013).

In a paper given at the 25th anniversary of the Cartwright Commission Tolich (2013) presented these and other responses to the post-2012 prohibition of scientific validity. He made a number of recommendations inclusive of the HDEC secretariat not passing on any application to the HDECs that did not have evidence of adequate favourable...
peer review. Associate Professor Tim Dare (2013) Chairperson of the Health Research Council’s Ethics Committee in the following panel discussion made an additional recommendation, calling for an inquiry to evaluate the HDECs. In matters unrelated to these recommendations the NEAC is currently producing a discussion document (personal communication) seeking to enhance cross-sectoral ethics arrangements in New Zealand. NEAC is producing a discussion document that will summarise current ethics arrangements, and outline possible ideas to enhance the current arrangements. NEAC seeks information on any gaps, inconsistencies with the current arrangements and possible ideas to address identified issues or enhance current arrangements.

What are the current ethics arrangements? Independent ethics review in NZ stemmed from the Cartwright Inquiry’s recommendation to end in-house hospital ethics review (Cartwright 1988) and the creation of fifteen health and disability ethics committees (HDECs), established in 1989 (Moore 2011). Most tertiary institutions followed suit. From the outset ethics review excluded professional researchers outside either health research or the tertiary sector. Overlays by outsiders to establish ethics committees, including those from members of the New Zealand Psychological Society and researchers from local and central government, NGOs or community researchers, fell on deaf ears. In the past twenty five years tertiary sector ethics committees have remained within their silos, their composition virtually unchanged, never combining to create a unified pan-university code of ethics, nor have they sought peer review from each other. Social scientists have languished under this biomedically dominated ethics review system.

Research conducted by health practitioners that is considered to be education research would not generally be considered by HDECs.

In that time period the HDECs have undergone two complete restructures. The first followed the 1999 Botrell cervical smear debacle in Gisborne (Moore 2011). A notable change under this regime was the appointment of all ethics committee members by the Minister of Health increasing the accountability of members with the potential to curtail a committee’s independence. The number of ethics committees reduced from 15 to 7 and only one committee reviewed each ethics application (Moore 2011). The second restructure in 2012 reducing the committee number from seven to four followed New Zealand Health Committees ‘inquiry into improving New Zealand’s environment to support innovation through clinical trials’. The New Zealand Psychological Society took no part in the conversation about this post-Botrell restructure. Nor did they take part in the 2011 health select committee inquiry when the number of HDECs was reduced from seven to four.

Why is this restructuring relevant to the New Zealand Psychological Society? The second author of this paper has long advocated for psychologists researching outside the academy to be able to have their research evaluated by an independent ethics committee. His advocacy dates from problems in gaining access to the Health Research Council ‘Auckland Ethics Committee Y’ to review a Ministry of Education-funded research proposal. The committee in declining to review the proposal (Letter from Chairperson, HDEC Committee Y, 18 March, 2003) recommended “I suggest that you approach the Ministry of Education and the psychologists Board for advice on this matter.” Letters were subsequently written to the Secretary of Education and the Director General of Health (4 May, 2006), the Ministers of Health and Education (23 May, 2006) and the Chairperson of the New Zealand Psychologists Board (28 June, 2006) expressing concern that psychologists whose work was outside of the ambit of ‘health and disability’ did not have access to an accredited ethics committee. Although most respondents recognised that there was a problem, none offered a solution and one (Ministry of Education) indicated that although they were setting up a ‘Research Advisory Committee’ (Letters from Team Leader: Research, Professional Practice, Group Special Education 23 May 2006 and 7, August 2006), it wasn’t envisaged that this would offer ethical review and approvals. The Manager Strategic Policy on Ethics and Innovation, Ministry of Health also clarified (14 May, 2007) that research conducted by health practitioners that is considered to be education research would not generally be considered by HDECs.

Informed approaches were also made to the Chairs of the Universities of Auckland, Otago and Massey Ethics Committees, seeking access to a research ethics committee but clearly they were not able to provide ‘grace and favour’ ethical reviews. The conundrum for psychologists who don’t practice in the health and disability sectors (approximately 50% of the Society’s members) was expressed most succinctly in the letter of the then President of the New Zealand Psychological Society, Dr Raymond Nairn, to the Ministers of Education, Health, Justice and Social Development (24 May, 2007). This letter concluded:

I trust you can see the problems this impasse creates. For those receiving psychological services, there can be a constraint on available interventions and it is less likely that interventions developed overseas can be safely tested and adapted for local clients. It also reduces the opportunities for clients to affect wider psychological practice. For practitioners it creates a double jeopardy; they could face a complaint for practitioners without or beyond a relevant evidence base and, were they to attempt to address that evidential lack, could face a complaint for undertaking research that had not received ethical approval. We consider this is intolerable and request your urgent intervention.

This issue has continued to be pursued with the Ministry of Health and Education and more recently in the Society’s 26 October, 2012 submission to the review of the Health Practitioners Competency and Assurance Act. This in part noted that psychologists who are not registered within the clinical scope (or work as health psychologists, neuropsychologists or in the disability sector) do not have access to the Ministry of Health Ethics Committees is creating an anomaly for a significant number of practicing psychologists, who by virtue of their registration are deemed to be health practitioners.

In addition a brief position paper was also tabled by our representative on the Social Sciences Advisory Committee of the Royal Society of New Zealand for discussion at their meeting of 2 December, 2011. The paper noted:

Like other social scientists, our psychologists members see research as a central part of their professional identity and activity. Following standard practices, they require their research projects to be subject to ethical review. The New Zealand Psychological Society is concerned about the absence of a structured process that enables individual researchers to submit their research plans to a suitable ethics body for scrutiny, advice and approval.

Some of our members work in university contexts and are able to make use of the ethics committees associated with these. Others are attached to health services and can make use of the Health and Disabilities Ethics Committee which is funded by the Ministry of Health. But a number of our members who work in other settings (e.g. NGOs, Ministry of Education, as private consultants) are not able to access either of these options and if they wish to conduct research, may find themselves in breach of standard ethical practices.

Psychological Society is concerned about the absence of a suitable organisation to provide advice on this matter. Panel members were invited to consult with their constituent organisation to determine if their members were facing similar difficulties to that of the psychologists. Possible steps by the Panel to address the issue in the coming year could include a position statement or workshop on the subject, and highlighting the issue to research bodies such as Government Departments and the RSNZ Academy.

The logical body to administer this [ethics] committee should be a non-health focused entity: the Royal Society of New Zealand would be an ideal body to serve this purpose.

If a revised ethics review system was established in response to these brooding tensions the New Zealand Psychological Society could take part in a conversation which would include whether the Ministry of Health is a suitable organisation to provide the type of pastoral care required to administer ethics review in New Zealand. What follows prepares and justifies the groundwork for this intervention.

The logical body to administer this committee should be a non-health focused entity: the Royal Society of New Zealand would be an ideal body to serve this purpose. Since 1867 the Royal Society’s mission statement has claimed to “advance and promote science, technology, and the humanities in New Zealand” this may be true, but until recently the Royal Society has taken no part in advancing or providing ethics oversight. Research ethics in New Zealand would be healthier and more inclusive if the RSNZ saw to it that ethics review served the interests of all scientists, not just health researchers.
A second step would have the Royal Society commission establishing a set of ethics guidelines sufficiently broad to encompass both health and non-health research and accredit ethics committees which conform to these guidelines. Canada and Australia both have a national statement, revised periodically and signed off by bodies beyond the narrow health sector. A feature of these national guidelines is an awareness that research methodologies used by social scientists have distinct epistemological assumptions (i.e. hypothesis driven deductive research versus inductive, participant lead emergent research questions) requiring ethics committees to enrol committee members who have expertise in social science methodologies. This is not always the case under the HRC EC accreditation process.

Gluckman also noted that there is not always the culture and capability within the public service to seek out appropriate evidence and to critically appraise and apply it to a policy question. He suggests (p7) a need for “concerted efforts to lift capabilities within public service communities of practice so that there is capacity to evaluate such evidence without bias and with rigour”, and that this might require a shift in culture within these organisations. In our opinion these problems could be partially addressed by encouraging professionals employed within the public sector to undertake some of this research and thus provide a feedback loop between the development of policy and its implementation. Psychologists whose professional description is as a scientist-practitioner are well placed to accept this role. This of course would require that they have access to an accredited ethics committee.

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The New Zealand Ethics Committee

The recent establishment of the New Zealand Ethics Committee demonstrates the absurdity of ethics review in New Zealand. NZEC, an independent not for profit group funded by the Ministry of Social Development serves a broad constituency of researchers excluded from formal ethics review. These researchers are housed in local and central government, NGOs, independent research companies, and community groups. NZEC recently sought accreditation form the Health Research Council Ethics Committee, the only body able to accredit ethics committees and were told that NZEC did not review health research, the HRC EC did not have jurisdiction to accredit it which is why we have suggested that the Royal Society have this function.

The New Zealand Psychological Society recognises the NZEC as a bona fide ethics committee with sufficient expertise to review its members’ research and a Past-president, Jack Austin, is on this Committee. However, the Society (and probably their regulating authority the New Zealand Psychologists Board), would strongly prefer that NZEC is formally accredited as suggested.

The Next Stage

The next conversation about ethics review in New Zealand will occur and the Psychological Society must claim a seat at the table to be part of the conversation. The Psychological Society must insist that funding of ethics administration leave the Ministry of Health and be housed within the Royal Society who should have the authority to administer and accredit ethics review committees and create a system where ethics review is inclusive, not exclusive. A spirit of that inclusiveness would be the development of a national statement along the lines developed in Canada and Australia.

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What Higher Education Should Be For

Barry Schwartz

I have been teaching at Swarthmore College, one of the most distinguished liberal arts colleges in the world, for 42 years. Throughout that time, Swarthmore has attracted the very best (brightest, most committed) students that high schools have to offer. Though it has provided significant specialized training in the various scholarly disciplines, it has also insisted that such training be embedded in a broad general education. This is, after all, what ‘liberal arts education’ is about.

Now, this model of liberal arts education is under threat. Students come to college hell-bent on learning something that will make them employable. At a place like Swarthmore, which doesn’t offer any professional degrees, this mostly means training in natural science, math, computer science, and economics (which is the closest we come to “business.”) This is an understandable response to the economic uncertainties of our age, and to the extraordinary cost of an education at a place like Swarthmore (the “sticker price” for a four-year degree is over $200,000). Whether eighteen-year-olds are experiencing this economic anxiety themselves, or whether it is being hammered into them by their parents, I don’t know. What I do know is that the humanities are struggling for students while classes in all the sciences are bursting at the seams. And President Obama’s recent announcement that he wants colleges and universities to be “accountable,” by making public such statistics as graduation rate, student debt, and post-graduate employment results, only enhances the growing perception that you go to college to learn a trade, and that the safest trades to learn involve training in math and science.

If this trend continues, the future of higher education—at least in the U.S.—is clear. It will be training in various disciplines that lead to a professional credential and a secure job. If this happens, higher education in the U.S. will come to look like higher education in the rest of the world already looks. The world somehow expects that by age eighteen, people will know enough about their talents and interests to walk confidently into the right silo and come out the other end to occupy a place in the professional class.

Though the impetus for this change in American education is clear enough,
I regard it as a tragedy. In my view, higher education should be equipping students to answer these four questions:

1. What is worth knowing?
2. What is worth doing?
3. What makes for a good human life?
4. What are my responsibilities to other people?

College is not the only place in which answers to these questions can develop, but it is an important place. And silked, specialized training in a discipline—any discipline—will answer none of them.

_Students come to college hell-bent on learning something that will make them employable._

You often hear defenders of liberal arts education offer a platitude like “We’re not here just to teach the current understanding in physics, biology, psychology, or philosophy. We’re here to teach students how to think.” Almost everyone knows what it means to know how to think. Hiring masters of a discipline—any discipline—will teach students how to think. Almost everyone also knows how important it is to them to have a flexible and innovative workforce.

Frequently intone about how fast the technological world is changing and how important it is to them to have the many different forms that good thinking takes, that truth takes, and that evidence takes. It nurtures a kind of wise appreciation of the complexity of the world and its problems. It makes clear to students that not everything is a nail, awaiting their hammer. If you get specialized training, in anything, you will likely be good at solving the small problems that other people hand you. In the world of practical affairs, those “other people” will be bosses and supervisors. In the world of scholarly research, they will be senior scientists in your discipline. What you will not be able to do very well is decide for yourself what is a problem worth solving. You will not be very good at even recognizing the big problems, let alone solving them. Yes, we need people who are capable of having small ideas and developing them meticulously. Specialized training can teach that. But we also need people capable of recognizing big problems and articulating them in a way that can move scholarly disciplines and professional practices in a whole new direction. I’m pretty sure that specialized training will not teach that.

I can see the “fruits” of specialization in my own discipline of psychology. I have made a vow to stop attending professional meetings because my experience at them in the last few years has been so disappointing. As I listened to one technically proficient paper after another, I found myself asking, again and again, “why would anyone care about this?” I think that my question could be answered, at least most of the time, but none of the people giving the papers provided the answers. Perhaps this was because they thought the answers were self-evident, but I don’t think so. More likely, it was because this was a question these very smart and ambitious young psychologists had never asked themselves. They were simply doing the next small thing that research in their fields required.

It was an axiom of the upheavals of the 1960s and 1970s that “you can’t take down the master’s house with the master’s tools.” What this means to me in the context of higher education is that you can’t discover the deep limitations of economics by only studying economics. You can’t uncover the deep limitations of genetics or evolutionary biology by only studying genetics and evolutionary biology. To see the limitations of a discipline—any discipline—requires a perspective developed at least partly outside that discipline.

To see the limitations of a discipline—any discipline—requires a perspective developed at least partly outside that discipline.

Learn how to think. But nobody really knows what it means to know how to think.

_Liberal arts training, done well, appreciates and exposes students to the many different forms that good thinking takes, that truth takes, and that evidence takes._

Liberals who do well at liberal arts training, done well, appreciate and expose their students to the many different forms that good thinking takes, that truth takes, and that evidence takes. It nurtures a kind of wise appreciation of the complexity of the world and its problems. It makes clear to students that not everything is a nail, awaiting their hammer. If you get specialized training, in anything, you will likely be good at solving the small problems that other people hand you. In the world of practical affairs, those “other people” will be bosses and supervisors. In the world of scholarly research, they will be senior scientists in your discipline. What you will not be able to do very well is decide for yourself what is a problem worth solving. You will not be very good at even recognizing the big problems, let alone solving them. Yes, we need people who are capable of having small ideas and developing them meticulously. Specialized training can teach that. But we also need people capable of recognizing big problems and articulating them in a way that can move scholarly disciplines and professional practices in a whole new direction. I’m pretty sure that specialized training will not teach that.

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It was an axiom of the upheavals of the 1960s and 1970s that “you can’t take down the master’s house with the master’s tools.” What this means to me in the context of higher education is that you can’t discover the deep limitations of economics by only studying economics. You can’t uncover the deep limitations of genetics or evolutionary biology by only studying genetics and evolutionary biology. To see the limitations of a discipline—any discipline—requires a perspective developed at least partly outside that discipline. General education is not a substitute or disciplinarian expertise. What it is, however, is an essential ingredient to keep the disciplines from running around in circles, and swallowing their own tails.

So, do I think higher education will enable students to answer the four questions I listed at the beginning of this piece? I’m not optimistic. The more costly higher education becomes—the more that colleges and universities see themselves as having to be summer camps with a library—the greater the pressure on them will be to make sure that their graduates get good jobs. And the more that people who run workplace organizations feel pressure to produce high returns on a quarter-by-quarter basis, to satisfy shareholders, the greater the pressure on them will be to hire people who can solve today’s problems and pass up people who might anticipate tomorrow’s. I don’t think that colleges and universities have done a very good job of defending themselves from assault and resisting the pressure to produce “practical” results, understood as high-paying jobs.

Do I think higher education will enable students to answer the four questions I listed at the beginning of this piece? I’m not optimistic. The more costly higher education becomes—the more that colleges and universities see themselves as having to be summer camps with a library—the greater the pressure on them will be to hire people who can solve today’s problems and pass up people who might anticipate tomorrow’s. I don’t think that colleges and universities have done a very good job of defending themselves from assault and resisting the pressure to produce “practical” results, understood as high-paying jobs. If they don’t do a better job, higher education in the U.S. as we have known it will disappear. And the world will become a much less imaginative, more impoverished place.
The Complexity of Developing a Global Definition of Competency

**Dr Waikaremoana Waitoki**, **Dr Rosanne Black**, and **Bridgette Masters-Awarete**

**Abstract**

In July, 2013, representatives of professional psychology organisations attended the International Congress on Licensure, Certification and Credentialing in Psychology in Stockholm, Sweden. The goal of the Congress was to work together to develop “a global agreement on identifying the benchmark competencies that define professional psychology”(1). The National Standing Committee on Bicultural Issues (NSCBI) sent two representatives to ensure that the voices and experiences of indigenous peoples were included in the process of developing benchmark competencies. In keeping with the principles of the United Nations Declaration on the Rights of Indigenous Peoples, NSCBI considered it important to contribute to the benchmark competencies and definition of competence as the outcomes of the Congress will have ramifications for minority groups and indigenous peoples. This paper will describe the outcome of the Congress and the feedback by participants at the annual New Zealand Psychological Society conference held in September 2013. A common theme from the Congress was that standards of competency were variously defined and considerably more work was needed particularly in relation to the importance of culture and research. Back in Aotearoa, attendees at the psychology conference, unanimously endorsed the importance of the need to be explicit about culture in relation to the self and to the other.

Introduction

The intention of this paper is to promote the importance of including indigenous peoples in discussions nationally and internationally about how psychology is regulated, accredited and practiced. Indigenous peoples throughout the world recognise that there are many different systems of knowledge and patterns of learning and behaviour that are not generally incorporated in or valued by some of the more recent development of Western psychology. Mason Durie (2001), for example, advocated for the need for inclusion of both te Ao Māori and Western world views of human behaviour and understanding if health services, including psychology, in New Zealand was going to provide effective service to Māori clients.

The experience of NSCBI is that despite the intention to incorporate meaningful indigenous, Māori world views and perspectives into psychology, the profession is deeply attached to Western models of education, research and practice. A prevalent feature of psychology is to present Western science and knowledge in detail, as the ex-nominated or un-named normal cultural position, while consigning ‘other’ cultural scientific knowledge to the add-on position (Black & Huygen, 2007; McCreon, 2005). Positioning cultural knowledge as an add-on preserves the view that Western psychological competence is more important than cultural competence, and that discussion about culture only occurs when the non-dominant culture is present. Western cultural underpinnings of psychology are usually left as invisible, normal and taken for granted.

The theme developed by the Congress organising committee as they prepared for the 5th ICLCCP was competence as a common language for professional identity and international recognition. Earlier congress had fostered an appreciation of the global diversity in the ways that psychologists are educated and trained, and the impact of local and political contexts in which professional regulatory structures currently exist (5th ICLCCP Organising Committee, 2012).

The local and political context in Aotearoa

Aotearoa/New Zealand has a unique and increasingly diverse cultural and ethnic population mix, that includes a resilient Māori (indigenous) presence in the face of nearly two centuries of Western cultural underpinnings of psychology are usually left as invisible, normal and taken for granted.

Notes

1 All quoted sections directly referring to the Congress have taken from the following website and associated links: http://www.wpbl.net/604/pages/index.cfm?pageID=3602

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Bicultural Issues

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Ngāti Hako, Ngati Mahanga (Hamilton)

Waikaremoana has been an NSCBI member since 1998. She is the co-convenor of NSCBI and the Bicultural Director on the NZPsS Executive. She is a psychologist with work and research interests in adult mental health, child and adolescent mental health, and addictions. Waikaremoana is on the Reconciliation Action Plan working party with members of the Australian Indigenous Psychologists Association and the Australian Psychological Society. Waikaremoana previously lectured at Waikato University in the clinical training programmes, and was a board member of Waikato University’s psychology program.

Bridgette Masters-Awarete (BSocSc, MSoSc, PGDipPsych(Clin)) Waikato, MNZPs, Registered Psychologist, PhD candidate. Te Rangi, Ngāi Te Rangi, Whakarewarewa ki Kewerau (Hamilton).

Bridgette is a lecturer in Kaupapa Māori and Community Psychology within the Psychology Department at the University of Waikato and a one of a small, but growing, number of Māori registered psychologists. Being registered with the New Zealand Psychologists Board, with a current Annual Practising Certificate (APC) in combination with her current role means she has been able to, over the past 6 years, contribute in a significant way to the supervision of interns within the Community Psychology programme. With an open commitment to Māori students and the development of a Māori psychological workforce her research interests include using applied research methods towards developing culturally appropriate programmes and education processes for Māori. Over the past 6 years Bridgette has been involved with the bicultural development of psychology through her work on the National Standing Committee on Bicultural Issues (NSCBI) and for 3 years served as Bicultural Director on the Executive of the New Zealand Psychological Society.

Rosanne Black BSc (Massey); MSoSc; PGDipPsych(Clin); PhD (Waikato) MNZPs.

Rosanne (Rose) is a Pākehā New Zealander of Irish and Scots descent. Her family settled in rural Southland, where she grew up alongside the Oreti River and in view of the Tākitimu Mountains. She is a registered psychologist with a Post Graduate Diploma in Community Psychology and has been a member of the NSCBI since 1994. She served as a Bicultural Director on the NZPsS Executive for four years. Her PhD research focused on ways in which Pākehā culture is recognised and marked by people involved in Te Tiriti o Waitangi networks (Treaty People) in Aotearoa. Rosanne is currently the chair of the Institute of Community Psychology Aotearoa, an Associate of the Community Psychology programme at Waikato University and has supervised a number of interns through the community psychology programme. She is the lead researcher for a community based research and advocacy project ‘Poverty Action Waikato’ and has written reports and presented at conferences about local issues of poverty with colleague Anna Cox.

*The authors would like to thank Hera White, Director Māori at Winter, Hamilton for reviewing this paper. Affiliation: "Māori and Psychology Research Unit (MPR/U), University of Waikato; "Poverty Action Waikato

Bicultural Issues

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Culturally competent psychologists are needed to ensure the best outcomes for service users who are predominantly Māori.

The imposition of a body of Western cultural practices, as professional psychology, as mentioned above, means that the imposition of culture is ultimately destructive and genocidal in its effect on indigenous peoples (Love, 2002, p. 15).

The processes of legitimising and validating psychological practice, in this instance to produce a global framework to enhance psychological practice as it applies to all peoples, runs the very serious risk of perpetuating the current status of psychology for Māori in Aotearoa/New Zealand; which is to say "the profession of psychology as it currently stands has not managed to garner the trust or respect of many Māori" (Milne, 2005, p. 31). It is the view of NSCBI that the definition of competence and the criteria for assessing competent practice needs to incorporate multiple indigenous realities.

Culturally competent psychologists are needed to ensure the best outcomes for service users who are predominantly Māori. A particular concern is the low number of Māori psychologists compared to non-Māori. In the most recent 2009-10 workforce survey, of the 1225 registered psychologists who indicated active practice, only 65 were Māori; a figure that is in sharp contrast to the overrepresentation of Māori as service users (Cooper, Rickard, & Waitoki, 2011; New Zealand Health Information Service, 2009). Until the mechanisms for improving those figures are implemented (Levy, 2002) Māori as individuals and whānau are more likely to be assessed and treated by psychologists who have varied understandings of competence.

The Code of Ethics (New Zealand Psychological Society, 2002) sets out a universal framework for minimum standards for the survival, dignity, well-being and rights of the world's indigenous peoples. The Declaration promotes the full and effective participation of indigenous peoples in all matters that concern them. It also affirms their right to remain distinct and to pursue their priorities in economic, social and cultural development.

The description of the Declaration provided by the Human Rights Commission complements our position that it is essential to include indigenous perspectives in all aspects of psychology. In 1986, the Special Rapporteur in his report on discrimination against indigenous peoples stated:

"...the Declaration exists because Indigenous peoples have been denied equality, self-determination and related human rights. It does not create for them new substantive rights that others don't enjoy. Rather, it recognises for them rights that they should have enjoyed all along as part of the human family, contextualises those rights in light of their particular characteristics and circumstances and promotes measures to remedy the rights' historical and systemic violation (2009, p. 65)."

From NSCBI's perspective, the status of Māori as an indigenous, colonised people meant that we could not afford to pass up the opportunity to offer our contributions.

On the basis of this definition Māori would be considered a dispossessed people in their own country who are subject to the laws, policies and perspectives of the dominant culture. Our view relates to the inequities Māori experience as indigenous people and the need to address those differences through culturally-informed standards of psychological practice and training and regulation. Discussion of a formal global competency framework without the involvement of indigenous peoples contravenes the Declaration and creates additional privileges for dominant groups. James Anaya, the Special Rapporteur, argued that,

"...the Declaration exists because Indigenous peoples have been denied equality, self-determination and related human rights. It does not create for them new substantive rights that others don't enjoy. Rather, it recognises for them rights that they should have enjoyed all along as part of the human family, contextualises those rights in light of their particular circumstances and promotes measures to remedy the rights' historical and systemic violation (2009, p. 65)."

From NSCBI's perspective the status of Māori as an indigenous, colonised people meant that we could not afford to pass up the opportunity to offer our contributions. We were also interested to know whether other indigenous groups would be represented at the Congress, in particular, the Sami from Norway, Finland, Denmark and Northern Russia. NSCBI was concerned that if the indigenous population of the host country was absent, what impact might that have for the development of global competencies. The Congress is charged with working together to investigate the utility of identifying a globally common set of professional competencies that could inform the basis for: promoting consistency in the quality of psychological services, promoting professional cohesion, promoting the profession to the public, facilitating mobility across borders, and for promoting psychology's role in advancing, wellbeing and productivity

A long-term goal is to establish common and consistent criteria for the accreditation, registration and regulation of psychology. NSCBI comprise indigenous Māori and Pacific and Pakeha (non-indigenous) members who are experienced in psychology education, research, practice and regulation. Our practice experience covers clinical, critical psychology, indigenous psychology, community, health, organisational, education, forensic and neuropsychology. NSCBI has been involved in the development and implementation of key Acts, policies and Codes that have had a direct bearing on psychology in Aotearoa. The key focus areas for NSCBI are to:

- Increase and support Māori participation and development in all areas of psychology
- Support the recognition and development of psychologists relevant and applicable to Aotearoa
- Promote bicultural accountability and responsibility within psychology

Including culture on the agenda

Prior to attending the Congress and after several emails, it became apparent that notions of culture had various understandings. Our pre-Congress readings revealed that culture was relegated to ‘the margins’. The placing of culture in the margins, appendix or its own box, typically means that culture is an afterthought; important enough to be on the page, but not as important as the ability to conduct psychometric tests, develop rapport, or devise amusing, evidence-based interventions. The ability to do these things without recognising culture is one of the marvels of Western psychology.

A particular theme at the congress meeting was the way culture was viewed as a competency. Some attendees felt that it was unnecessary to use the term culture in definitions of competency as it was already implied in the term competency. For example, a tentative definition of competency was developed by one of the working groups:

A psychologist observes, measures and understands the many factors that influence how people believe, think, feel and behave in their ‘cultural contexts’. We facilitate change by engaging with and responding to the needs of individuals, groups, organizations and communities. We evaluate and...

2 All quoted sections directly referring to the Congress have been taken from the following website and associated links: http://www.asppb.net/ site/page/index.cfm?pageID=3602

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The goals of the Congress were discussed with the approximately 20 attendees of the bicultural symposium group. The participants were from New Zealand Psychological Society Annual conference. Participants were encouraged to discuss their thoughts about the International Project. Their responses showed that more work is needed to actively incorporate understandings of cultural competency as a core component of accreditation, registration and ongoing professional development. While the intention for this to happen is stated in the Board's documentation (New Zealand Psychologists Board, 2011), participants felt that cultural competency is viewed as an optional extra that university programmes and practitioners can choose to include in teaching, research and practice. These concerns echo internationally as there is some concern amongst educators that the national guidelines and standards are being implemented to satisfy accreditation requirements with little real attention given to satisfying standards of ethical best practice (Smith, Constantine, Dunn, Disehart & Montoya, 2006).

...participants felt that cultural competence is viewed as an optional extra that university programmes and practitioners can choose to include in teaching, research and practice.

Trainee psychologists in the discussion group commented that in their institution (they asked for anonymity) when they asked for cultural competency as part of their learning experience they were advised to go to the University of Waikato where there are a number of Māori staff and an active Māori research unit (Māori and Psychology Research Unit). A focus on the excellent work carried out by MPRU is well deserved; however this does not necessarily mean that cultural

initiatives are infused throughout the entire school of psychology. These comments highlight that despite the requirement to offer cultural programmes and to prepare students to work with diversity, a quick glance at the paper-offerings and the cultural/ethnic composition of academic staff and students across New Zealand psychology training programmes indicates that there is still room for improvement. There is also wide variability with regard to the quality and content of bicultural programmes in psychology (Barnett, 2004; Evans, & Fitzgerald, 2007; Skogstad, & Skogstad, & Britt, 2005).

With assistance from the related professional organisations and NSCBI, the New Zealand Psychologists Board has created registration, accreditation and regulation procedures that require culturally competent standards of teaching and practice (New Zealand Psychologists Board, 2006a; New Zealand Psychologists Board, 2006b) update). These procedures could be used to inform the international project. Over the last 30 plus years of cultural competency and cultural safety discourse a considerable body of research has been developed that could be used to inform standards of competency (Abbot & Durie, 1987; Bishop & Glynn, 1999; Campbell, 2005; Herbert, 2002; Huynghens, 2007; McHoul & Rapley, 2001; Nairn & National Standing Committee on Bicultural Issues, 1997; Nairn, Black, Pehi & Waitoki, 2012; New Zealand Psychologists Board, 2011b; Nikora, 1993, 2012; Rasmussen, 1998, Ritchie, 1992). The question really comes down to "why aren't they being used?"

The participants in the group discussed that it was vitally important for psychologists to recognise that competence (including cultural competence) is a life-long process requiring constant attention. The need to strengthen cultural competency training remains a serious and significant concern to indigenous peoples, nationally and internationally (Cooper, Rickard & Waitoki, 2012; Gillies, 2013; Herbert & Morrison, 2007; Levy, 2007; Lowe & Waitoki, 2007; Nairn, Black, Pehi & Waitoki, 2012; Nikora, 2007; Smith, 1990, 1999). In conversations and research with NSCBI members over the last two decades, it is clear that cultural competency needs to be regarded as an on-going developmental process rather than a target credential with an endpoint.

Conclusion
The NSCBI supports national and international guidelines that advocate for culturally competent practice (see also, American Psychological Association, 2003). The importance of a culturally-inclusive definition of competency is vital for psychologists to attempt to come to a global agreement on the benchmark competencies that define professional psychology. The Congress committee recognised the multiple dimensions that exist across our cultures and that it is no easy task to develop an international standard of competent practice, or definition of competency. The view of NSCBI is that the mobile psychologist needs to have a firm understanding of the bicultural understandings of practice in their own country before they embark on an international sojourn. How might this translate to cultural competency in another setting? Until we are certain that an international qualification contains contextual understandings of culture from a myriad of views, extra training will be required so that mobile psychologists become familiar with the cultural contexts of the host country.

NSCBI recommends that all professional bodies involved in the registration, accreditation, and

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professional practice and training of psychologists as the Psychologists Board, the New Zealand Psychological Society, the College of Clinical Psychologists and Heads of Schools of psychology and professional training programmes support indigenous perspectives. That we encourage our global psychology colleagues to show their commitment to improving the health and wellbeing of indigenous peoples and promote social justice by embedding cultural reality in core competency conversations for psychologists.

At the time of writing this paper, the report from the Congress has been released. There is a follow-up meeting in Kampa, Uganda this November and in Paris in 2014. This project has been three years in the making and may take many more. The Declaration for Indigenous Peoples took 25 years of intense and heated discussion to come to an agreement that, even now, is still contentious. Through working collaboratively and sharing our expertise we will generate a more culturally and critically aware discipline of psychology.

References


NZPsS Conference 2013

The 2013 conference was held in Auckland and had over 350 attendees. The conference venue the Owen G. Glenn building was an excellent venue for the conference and delegates indicated that they felt well catered for in terms of both conference presentations and wonderful food. A big thank you to the Department of Psychology and academic convenors Fred Seymour and Kerry Gibson for their work in support of the conference. A big thank you also to keynote and invited speakers and to all presenters who shared their learning and expertise with us all. We would also like to thank our sponsors for their support and presence at the conference. We feature below a paper from Nancy Pachana based on her keynote address at the conference.

Psychology and Ageing: A decade of turning points

Nancy Pachana

Dr. Nancy Pachana is a clinical psychologist and neuropsychologist who has received extensive specialist training assessing and treating older adults. She is currently professor in the School of Psychology at UQ. Her main research interests include anxiety in later life, early assessment of dementia and driving safety and dementia. She also conducts research into improving training in geriatric mental health service provision.

After graduating with honours from Princeton University, Professor Pachana went on to receive a Ph.D. in Clinical Psychology from Case Western Reserve University, Cleveland, Ohio, in 1992. She received specialist training in neuropsychological assessment and clinical treatment of older adults during three years of post-doctoral training at the University of California at Los Angeles – Neuropsychiatric Institute and at the Palo Alto Veterans Hospital System. She is the National Convener of the Australian Psychological Society's Psychology and Ageing Interest Group, dedicated to furthering research and public policy relating to older adults in Australia. She is Fellow of the Society as well as on the Board of Directors of the International Psychogeriatric Association, and is a faculty affiliate of the Royal Australian & New Zealand College of Psychiatrists - Faculty of Psychiatry of Old Age. She has published over 100 peer-reviewed articles and book chapters on various topics in the field of ageing. She is currently the editor-in-chief of the Australian Psychologist, and Deputy Editor of International Psychogeriatrics.

Ageing is a universal, and yet deeply personal, experience for individuals. It is an experience that is often regarded with some trepidation: will I grow old and infirm, unable to remember those I love and cherish? Will I be left alone in my old age? And yet this picture of ageing, perhaps better thought of as a stereotype, is not inevitable, and has indeed never been inevitable – throughout both ancient and modern times, some people have aged successfully, and others have not. The question for psychologists, in the face of increasing lifespans and interest in maintaining good mental and physical functioning for as long as possible, is how can we serve both those who age well and those who experience more of the burdens of later life?

Demographics

Internationally, the proportion of persons over the age of 65 is increasing dramatically. Statistics available from the World Health Organization (WHO) and the United Nations (UN) are illuminating in their depiction of how the world is changing in the face of changing demographics. For example, for the first time in history, the number of persons under age 5 will be outstripped by the number of persons aged 65 and over (UN, 2011). Indeed, the number of older adults is rising exponentially, with a projected 1.5 billion people over age 65 expected by 2050, with much of this growth in an ageing population experienced by developing countries (WHO, 2011). Some parts of the world are also ageing much faster than others. For example, it took over 100 years for the proportion of individuals over age 65 in France to rise from 7% to 14% of the population, which occurred over the years 1860-1970. In contrast, this same rise in the older population in South Korea, the fastest growing country in the world, will take place in less than 20 years, from roughly 2000-2018 (Kinsella & He, 2009).

Illnesses associated with ageing often come with great economic and human costs; this is especially true of Alzheimer’s disease. The total estimated worldwide costs of dementia were US $604 billion in 2010; if dementia were a country, it would be the world’s 18th largest economy (Alzheimer’s Disease International, 2009).

Improvements in living standards, health care, reduced infant mortality, and medical advances both in decreasing mortality by acute illnesses and greater symptom control and reduced mortality from chronic diseases, has led to increased longevity worldwide. Globally, individuals over age 85 are projected to increase by 351% between 2010 and 2050, compared to a 188% increase for those 65 or older and a 22% increase for those under age 65 (WHO, 2011). And between 2010 and 2050
Clinical geropsychology as a discipline has relatively recent beginnings, and in some countries remains relatively under-represented both in terms of clinical psychology training and presence in the workforce. In the face of changing demographic realities, interest in clinical geropsychology as a discipline, as an area of research, as well as a profession, is increasing internationally.

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Absolute increases in the numbers of people of advanced age have a number of implications for geropsychology, including the responsibility of ensuring that our diagnostic, assessment and intervention strategies have relevance and empirical support for this age group. The development of age-appropriate assessment tools is particularly important for the field. In the last decades many innovative new instruments for older adults have been developed or adapted, including development of age-specific instruments. Examples of the latter include the Geriatric Depression Scale (Yesavage, Brink, Rose, Lum, Huang, Adey, & Leiter, 1983), the Geriatric Anxiety Inventory (Pachana, Byrne, Siddle, Koloski, Harley, & Arnold, 2007), and the California Older Adult Stress Test (Pachana, Thompson, Marotzou, & Vlah Gantz, 2004). Age-specific screening tools of note include the MAST-G (Blow, 1998) and the Suicidal Older Adult Protocol (SOAP; Fremouw et al., 2009). Tests, and particularly cognitive screens, which take account of culture more broadly (e.g. the Rowland Universal Dementia Assessment Scale (RUDAS); Story, Rowland, Basic, Conforti, & Dickson, 2004) or specific cultural contexts, such as the Kimberly Indigenous Cognitive Assessment tool (KICA; LoGiudice, Smith, Thomas, Lautenschlager, Almeida, Atkinson, & Fleck, 2006) developed for Indigenous populations in Australia. In the course of therapy, one may wish to assess progress with age-specific instruments such as the California Older Adult’s Pleasant Events Schedule (COPPES; Rider, Gallagher-Thompson, & Thompson, 2004; website: http://oafc.stanford.edu/cppes.html). It is also important to understand the effective application of assessment strategies to older populations, particularly those living in specific settings such as nursing homes (Pachana, Emery, Konnert, Woodhead, & Edelstein, 2010).

It is imperative that psychologists with an interest in aging and in serving older adult populations in research and practice settings have a good grasp of lifespan psychology, particularly normal developmental trajectories in the latter stages of life. This is because it is very difficult to understand pathology without an appreciation for normal developmental trajectories. Unfortunately, close attention has not been paid to such later life developmental stages. Gene Cohen was one geropsychologist who was quite interested in later stages of human development. In his seminal book, The Creative Age (2001), he identified four developmental phases encountered in mid- and later life — mid-life re-evaluation (involving exploration and transition), liberation (involving experimentation and innovation), summing-up (involving resolution and contribution), and encore (involving reflection and celebration). All of these phases, argues Cohen, provide opportunities for creativity and generativity to blossom in later life. An understanding of the experience of how healthy older adults move through life, using such frameworks as well as direct experience of older people outside of the clinical context, is essential for psychologists working with older persons, particularly trainees.

The clinical interview itself deserves special consideration and adaptation when applied to older persons (Mohlman, Sirota, Papp, Staples, King, & Goreenstein, 2012). Building rapport is important with older clients, as many will not have experience of mental health professionals and may feel stigma for visiting a psychologist. It is an idea to not be the only one asking questions; allowing clients to ask questions before the interview starts demonstrates collaboration. If the interviewer can establish points of commonality (e.g. a shared common interest) with clients, so much the better. It is important during the interview and in any assessment that the language, duration, and response formats of tests be carefully considered for their age-appropriateness. The therapist may wish to facilitate an older adult’s ability to hold response formats in mind when answering questions; using cards which display response choices is an option here. The interviewer should endeavor to ask about medical problems older adults sometimes neglect to report (e.g. musculoskeletal problems), and inquire about the relationship of medical symptoms to psychological symptoms, even if this may not be clear to the older person themselves. Probing for older abuse is important if any suspicions exist. Finally, the psychologist may wish to consider the value of collecting additional information through an informant, especially if capacity questions arise (e.g. Pimler, Pachana, Wilson, Tile, & Byrne, 2010).

If older adults are not visible in research and in applied work throughout the undergraduate and postgraduate psychology curricula, how will students know there are great opportunities in this field?

With regard to diagnoses, awareness of age-associated factors and correlates is important. A meta-analysis of 20 studies by Cole and Dengdurni (2003) identified disorders, new medical illness, poor health status, prior depression, poor self-perceived health, and bereavement as risk factors for depression in old age. With respect to anxiety, poor self-rated health and physical or sexual abuse in childhood are risk-factors for later development of an anxiety disorder, whereas high perceived social support and regular exercise are protective (Almeida, Draper, Pirski, Snowdon, Lautenschlager, Byrne, et al., 2012).

Moving through therapy with an older client requires a conceptual framework suited to this population. Knight’s Contextual Adult Life Span Theory for Adapting Psychotherapy (CALTAP; Knight & Poon, 2008) is an important framework for effective therapy with older persons. It systematically sets out how to incorporate the older individual’s contextual, cohort and cultural setting, along with their experience of positive and negative aspects of maturation, into a framework for both the client and therapist to better understand the impact of age on current cognitive and emotional health, as well as the therapeutic relationship itself. Other considerations in therapy include effective rationale and use of homework with older patients (Seecker, Kazantzis & Pachana, 2004).

With respect to the efficacy of psychotherapy with older persons, the empirical literature has been increasing in this regard. Research points to four evidence-based psychotherapeutic interventions for anxiety in older adults: cognitive behavior therapy, cognitive therapy, relaxation training, and supportive therapy (Ayers, Sorrell, Thorp, & Werrell, 2007). Several psychotherapies also are effective with older adults with depression: cognitive behavior therapy, interpersonal psychotherapy, problem-solving therapy, and brief psychodynamic psychotherapy (Ellison, Kyomen, & Harper, 2012). Finally, interdisciplinary treatment models are highly effective with older persons (Zeiss & Gallagher-Thompson, 2003).

The settings in which older adults receive psychological care are evolving. One new setting in which increasing numbers of older adults are seen is primary practice, with research focusing both on diagnosis and treatment in these settings (e.g. Serflay, Haworth, Blanchard, Buzowicz, Murad, & King, 2009; Stanley, Diefenback, Hopko, Noyv, Kunik, Wilson, et al. 2003; Stanley, Wilson, Noyv, Rhodes, Wagner, Greisinger et al., 2009). Unfortunately, more work needs to be done to ensure mental health needs of older persons are addressed effectively in primary care settings. Only a minority of older patients with anxiety or depression (15-56%) are recognized in this setting; most of these patients go untreated (Kroenke, Spitzer, Williams, Monohan & Lowe, 2007).

Primary care settings are particularly suited to an interdisciplinary approach to treating older persons (Sper & Schneider, 2003). The IMPACT (Unützer et al. 2002) trials have investigated use of integrated mental health care models using a depression clinical specialist, and the interventions have been found superior to treatment as usual for older adults (http://impact-uw.org).

Residential aged care is another key setting which will require increased input from psychologists in the future (Pachana, 2008). There are many excellent models of mental health care provision in nursing home settings (e.g. Barrels, Moak & Dums, 2002); psychologists need to be more active in providing care to older adults residing in such settings.

Geropsychology and Future Training

The projected estimated needs and short-fall for mental health specialists in general and geropsychologists in particular has been a concern for many years (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009; Karel, Gatz, & Smyer, 2012). This has been in a global concern (e.g. Finequest, 2007), and has resulted in renewed interest in improving training opportunities in geropsychology (Qualls, Segal, Norman, Niederhe & Gallagher-Thompson, 2002). To some extent the numbers of geriatric specialists is reflective of training opportunities. In a cross-national study of clinical geropsychology content across three countries (USA, Australia, Canada), a minority of programs were shown to provide strong leadership in the ageing area (Pachana, Emery, Konnert, Woodhead, & Edelstein, 2010). A U.S. National Conference on Training in Professional Geropsychology in 2006 led to
Finally, clinical experiences and contact with older adults can improve attitudes and can increasegeriatric as a career choice among psychology students. Trainees also need careful introduction to and exposure with persons with dementia and nursing homes settings, so that latent biases are not merely further reinforced through work in these settings.

If every psychologist with the means to do so would have a plan to address this shortfall in psychologists working with older adults, such as improving their own knowledge about ageing, examining how they could outreach better with older clients, volunteering their site as a training placement, or acting as a supervisor for a student seeing older persons, we could make a difference. I feel confident that we can and will make such a difference.

References


Educational and Therapeutic use of Communications Technology: Issues and Applications

Barry S. Parsonson, PhD1, and Trevor F. Stokes, PhD2

Barry Parsonson and Trevor F. Stokes first met in Perth, Western Australia, in 1971 when researching with Professor Donald M. Baer during the latter’s sabbatical there. Both subsequently completed their PhDs in 1977 under Baer’s supervision at the University of Kansas and in more recent times have jointly trained teachers in New South Wales in behaviour management. Trevor has an endowed Professorship and heads the Alvin V. Baird Center for Attention and Learning Disorders at James Madison University, Harrisonburg, Virginia. In 2012 he hosted Barry as a Visiting Professor, during which time the research for this paper was undertaken.

Advances in communications technology and its extensive use in our society have provided numerous opportunities and a variety of risks for educational and clinical applications by psychologists. Recognising the emergence of “telepsychology”, guidelines for its use were drafted by New Zealand Psychologists Board (NZPB, 2011) and the American Psychological Association (APA, 2012). These provide information on the various communication technologies in use, identify the advantages and risks involved in their application, and provide guidance on resulting ethical and practical issues. Current technologies include telephone, E-mail, fax, E-mail, and interactive videoconferencing, including publically accessible. Voice over Internet Protocol (VoIP) systems (e.g., Skype”). Blogs, self-help websites and social media also provide assistance to psychological service consumers, although in these instances, therapy is generic rather than client-specific. Communication may be written and/or use images, sounds, or data (APA, 2012; NZPB, 2011) and may be in “real time” or delayed transmission. Both individual and group interventions are possible, as is delivery of services into home, workplace, classroom or remote clinic locations.

Telepsychology offers several advantages to clients, practitioners and employing organizations. For clients, telepsychology permits distance communication with their practitioner by accessing relevant technology. This removes limitations imposed by: remoteness or travelling away from home, and inability to attend a practice because of mobility or transport limitations. Further, it removes barriers to consultation due to work, child-care, or in emergencies, and it can prove less expensive than face-to-face interventions.

Practioner benefits are numerous. These include, first, consultation with clients in home or work settings, potentially increasing insight into factors contributing to their problems and enhancing therapeutic benefits and generalization of new skills. Second, there is the potential to increase the frequency of client contacts over the traditional 1-hour weekly session, with possible benefits in rate of improvement and more effective client monitoring and feedback. Third, telepsychology permits real-time guidance and support for “in situ” parent-training in home or teacher training in classrooms, with benefits resulting from immediacy of feedback (Hays, Richardson, Hindle, & Grayson, 2011). Finally, there are economic advantages from serving a wider client community without additional travel or office rental expenses, and potential savings from a home office practice.

For health and education organizations employing numbers of psychologists, telepsychology offers savings by reducing transport and travelling-time costs when servicing clients in outlying centres.

There are, however, risks and challenges associated with technology. A major concern is confidentiality (Luxton, Kayl, & Mishkind, 2012; Perle, Langsam, & Nierenberg, 2011) which can be breached in a number of ways. For instance, electronic communications are potentially subject to interception (e.g., WiFi; mobile phones) and hacking. Also, e-mail accounts may have multiple users, increasing the risk of unauthorised access. Additionally, communications equipment can be lost, stolen, inappropriately disposed or accessible to unauthorised persons sharing their use. Further, files stored on discs are accessible even after deletion, and, finally, information transfer can be monitored and stored by service providers or, increasingly, by government agencies. Both parties using telecommunication can experience confidentiality breaches. For example in clinics, homes, workplaces and public settings, either party in a professional communication may be heard or seen by others. Additionally, many VoIP and other communication providers offering encryption do not guarantee freedom from hacking or employee monitoring. These are all issues to be addressed in the informed consent process.

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To minimise the risk of breaches of confidentiality, several precautions can be taken. For the practitioner, software options include encryption to secure communications and files, plus installation of anti-spyware, anti-malware and quality anti-virus software on computers used in telepsychology practice. Also, use of dedicated, strong password-protected computers, e-mail and VoIP (e.g., Skype”) addresses, and similarly protected and encrypted external hard-drives and flash-drives for all information storage further restrict unauthorised access. Additional protection can be achieved by adopting coded or pseudonymous personal identification information, which enables the service provider to disguise client files and records. Use of a dedicated work cell-phone and agreed cryptic text or voice communications for appointments, emergency contacts or exchanging information with clients is also recommended. Encryption software for data storage is readily available, but the options for encryption of communications (e.g., phone, text, VoIP, e-mail) appear to be more limited (Luxton, et al., 2012). Clients may not be able to apply many of these precautions, depending on their devices and the expense of software purchase, so when consenting to receiving telepsychology services they must be informed of all risks, including those relating to communications and stored information that is not encrypted. Clients’ computers, mobile phones, e-mail accounts and fax machines may have multiple users and computers may lack good password, antispy and encryption protection. Also, private spaces may be unavailable to some clients. Any other persons likely to be directly or indirectly involved in the professional interaction (e.g., pupils in a classroom) require the same standards of protection regarding confidentiality and consent as the client. In giving informed consent, clients need to be aware of these risks and the risk-minimisation strategies that both parties may need when entering a telepsychology relationship. Conditions on access, such as frequency, duration, response expectations and limitations, and emergency contacts also should be clarified and agreed.

There are, however, risks and challenges associated with technology. A major concern is confidentiality which can be breached in a number of ways.

Some services in the US offer support or interventions through blogs, chatrooms and “computer-based treatment packages” (APA, 2012). A major ethical issue arises in terms of duty of care and who takes responsibility in such remote therapy if, or when something goes wrong. For example, if a participating client’s problems intensify or if they begin engaging in self-harming or harming of others. In a one-to-one therapist-client telepsychology relationship provision for emergency referral (e.g., suicide threat) to a local professional is possible. However, telepsychology interventions using packaged online programmes without direct therapist contact raise the question of professional responsibility and risk. Additional risks may result when persons seeking help to access programmes on the internet which originate from other countries, as complaints or litigation in the event of harm may be constrained by legal barriers. Presumably, these issues will eventually be clarified through legislation, international agreements or professional complaint proceedings and legal action taken by affected individuals or organisations. Currently, the Code of Ethics for Psychologists working in Australia/New Zealand (2002) does not include any specific reference to telepsychology services.

1 Applied Psychology International, Napier, New Zealand
2 Alvin V. Baird Center, James Madison University, Harrisonburg, VA, USA
although the general guidance offered on informed consent, confidentiality and duty of care would certainly apply. However, consideration should be given to reviewing whether further protections are necessary to safeguard the public from any possible negative consequences associated with telepsychology services and, if necessary, amending the Code of Ethics and the NZPB (2010) guidelines accordingly.

In the US, health data communication standards are set by the 1996 Standardized Health Insurance Accountability and Privacy Act (HIPPA). However, the emergence and increase in the range of technologies has raised concerns about a lack of standardization and limitations on confidentiality and security associated with their use (Luxton, Kayle, & Mishkind, 2012). In Australia (New Zealand the Privacy Commission) (1994, revised 2008), which primarily offers guidance on obtaining, storage and use of health information and data, with some reference to, and guidance on, use of secure e-mail communication. More recent applications such as telepsychology are not covered but awareness of that Code’s requirements and constraints on electronic storage and communications, as well as control of access to, and confidentiality of, client information and its disposal should be understood and complied with. It is possible in the US to access private and state government providers who, for a fee, offer secure, HIPPA approved telecommunications services. Similar services are not yet available to private practitioners in this country.

Any psychologist planning to practice telepsychology will need to work through these issues, taking guidance from the NZ Psychologists Board’s guidelines (NZPBI, 2011) and, where appropriate, those of the APA (2012). Further, a discussion paper by Perle, et al., (2011) outlines issues and pitfalls in telepsychology service provision. Additionally, dialectic behaviour therapy (Linehan, 1995) has used telephone monitoring of clients for some time and recent articles by Manning (2011) and Steinburg, Steinburg and Miller (2011) outline some of the challenges and ways of responsibly managing this process which are applicable to other forms of telepsychology.

Applications: Applications in educational and clinical setting have been reported, each indicating promise for effective delivery of professional services for both training and therapy.

In the educational context the primary focus has been on provision of “real time” distance training and support to teachers in classrooms. Scheeler, McKinnon, and Stout (2011) delivered remote pre-service professional development support to trainee special education teachers via videoconferencing. The trainees received direct, real-time feedback on their teaching skills, but school authorities forbade direct observation of face-to-face interactions with individual pupils, although the students’ responses could be heard and their work could be seen by the trainers. The findings demonstrated effective skill acquisition by the trainees and they reported that the procedure was acceptable and the immediate feedback was appreciated. The children involved received explanations of the use of the equipment and had not been distracted by it. Another study (McDonnell, Jameson, Reisen, et al., 2012) compared training delivered via videoconferencing with conventional on-site training modes for teachers of children with special educational needs and demonstrated the efficacy and potential benefits of teletraining. Unlike the Scheeler et al. study, their participants had access to local support and supervision, but the outcome data showed no disadvantages for those trained via videoconferencing.

... telepsychology interventions using packaged on-line programmes without direct therapist contact raise the question of professional responsibility and risk

Intervention studies in education are rare, but Budd and Stokes (2012) and Devers, et al. (2012) have used bug-in-the-ear technology to support teachers’ behaviour management, using Teacher-Child Interaction Training (TCIT), with the trainer sitting in the classroom providing direction and feedback. Encouraged by their findings, Stokes (personal communication, December, 2012) will now, with new technology, evaluate the efficacy of remote application as an extension of this research at James Madison University (JMU).

Delivery of Speech Language Therapy services to remote schools (Dudding, et al., 2012) is also being trialled at JMU, along with a range of other educational applications. These developments all offer potential to serve clients in remote locations more efficiently and effectively than is currently possible.

Clinical psychologists in the USA have quickly adopted telepsychology interventions. Backhaus, et al. (2012) analysed 65 articles (out of 821 identified in a web search) on the basis of 10 issues, including the types of intervention offered; the formats used; the client populations receiving the services; the degree of client satisfaction; effectiveness of delivery; and, outcome data. They concluded that telepsychology was feasible for cognitive behaviour therapy, behaviour therapy, EMDR, and family therapy, with both individual and groups, and across a variety of conditions (e.g., PTSD, anxiety, eating, and mood disorders). In general, studies comparing client-therapist relationships found quality little affected in the video clients compared with those in face-to-face client, while studies collecting client satisfaction data showed that this typically remained high. Outcome data revealed no loss of efficacy compared with clinic-based interventions. While their evaluation of telepsychology was positive, the authors noted a lack of large sample studies to validate their conclusions.

... this is an opportune time for our profession to work through the issues and challenges that telepsychology presents in terms of ethics, oversight, practice standards, efficacy, and safeguarding the interests of, and benefits to, clients.

In a review of technical advances in Post-Traumatic Stress Disorder (PTSD) interventions, Paul, Hassija, and Cropp (2012) identified programmes using videoconferencing, including individual and group psychotherapy, e-health (internet) as well as virtual reality (VR) media. They report that videoconferencing PTSD interventions, for both individuals and groups, delivering prolonged exposure therapy (PE) and cognitive behaviour therapy (CBT), generally produced therapeutic outcomes and client satisfaction ratings equivalent to face-to-face interventions. Some evidence identified therapeutic alliances as less strong and considered less satisfactory by group videoconferencing clients, although efficacy was unaffected. The authors’ evaluation of e-health (internet) services concluded that PE and CBT were suited to modular internet delivery and that their efficacy, within standardized internet-delivered PTSD programmes, showed promise. Once again the paucity of randomly controlled studies, small samples and questions of the diagnostic status of some participants raised concerns about interpreting findings. Virtual reality studies using Vietnam veterans were less efficacious than those including soldiers from the conflicts in Iraq and Afghanistan. This may reflect a higher degree of sophistication and experience with technology among the younger veterans, suggesting that younger, more technologically savvy clients may also benefit more from telepsychology interventions, although no studies have evaluated these variables.

A few studies have evaluated home-based interventions involving children with Tourette’s Syndrome (Himle, Olufs, Himle, et al., 2010) and children with the Autism Spectrum (Vismara, Young, & Rogers, 2012) and their parents. These have shown promise for delivering support to families when local services are unavailable and may prove useful in New Zealand for parents of special needs children living outside of main population centres who have difficulty accessing professional support.

Conclusions: In both educational and clinical applications, telepsychology shows promise in service delivery to locations remote from specialist clinics or from professionals providing interventions, training and/or support. While the need to demonstrate efficacy with larger scale studies is generally acknowledged, technological advances are increasing the feasibility of such services. In addition, demand is likely to increase as potential clients discover its availability and application in other contexts. Consequently, this is an opportune time for our profession to work through the issues and challenges that telepsychology presents in terms of ethics, oversight, practice standards, efficacy, and safeguarding the interests of, and benefits to, clients.

The New Zealand Psychologists Board Guidelines (2011) and those of the American Psychological Association (2012) and issues identified by Perle, Langsam, and Nienburg (2011) offer timely practical advice. This guidance includes telepsychology’s potential benefits and risks, risk mitigation, and professional and ethical responsibilities, including those relating to international practice.

However, actual application and related research will, necessarily, provide the learning and experience essential for establishing the efficacy of telepsychology and associated ethical practice standards.

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External professional clinical support

Psychoanalyst Mario Fleishl gave professional supervision on difficult emotional problems that arose, and, through a simultaneous honorary consultancy I held in the Department of Psychiatry at Wellington Public Hospital, young registrars shared the latest advances in their field.

The very near occasion I very nearly gave my subject away for its irrelevance on critical social issues, when psycho-endocrinologist Frank Beach, himself from Berkeley, said not one word of the student riots in this keynote address to a conference of psychologists. Instead, he held forth about his latest experiment on the changing hormone concentrations of ‘normal’ infant Douglas Merritte - aka ‘Little Headed’ focus on sensory systems. Their epistemological stance required the rejection and denial of subjective factors in favour of the ‘hard-headed’ focus on sensory systems. They favoured psychophysiological approaches to be imprinted on my mind. He said that the ‘psycho’ prefix minimal attention. They allowed no room for compromise, and kept the opposition at bay by indulging in the latest statistical analyses, whether appropriate for use or not. Professor ‘Barney’ Sampson of Auckland University - a graduate of McGill University - exemplified the stance in his 1968 presidential address to the New Zealand Psychological Society that he entitled ‘That man has no mind’: although he failed to say exactly what he had in mind when preparing the lecture.

In the United States of America, the restrictive appraisal of human functioning led Abraham Maslow, Carl Rogers, and Rollo May to open the field of humanistic psychology (cf. Bugental, 1967). Some of their followers went to the extreme, with gurus from the Esalen Institute in California travelling extensively to promote the cause by running emotionally focussed encounter groups (cf. Goldstein, 1944; Skinner, 1953). Many taught pernicious courses in personality theory that dismissed Freud, Jung, and Adler before firming up solidly in favour of behaviourist theory that Wolpe (1958) espoused. Their epistemological stance required the rejection and denial of subjective factors in favour of the ‘hard-headed’ focus on sensory systems. They favoured psychophysiological approaches to

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For the record: the pre-history of student counselling and guidance in New Zealand - Part II

A.J.W. Taylor PhD

J.W. (Tony) Taylor PhD is an Emeritus Professor of Psychology at Victoria University of Wellington. A Britisher by birth, after service in the Royal Navy in World War 2, he trained as a Probation Officer at the London School of Economics and Political Science and the Home Office Trainer House in Chelsea. He migrated to New Zealand to join the Department of Justice in 1951, and undertook more university part-time courses to become a prison psychologist and further training to become a psychotherapist. In 1961 he moved into academia, but maintained professional links with the prison service and established current clinical and teaching links with the Department of Psychiatry at Wellington Hospital. He started the very first counselling service for university students in the country, and also became involved with the selection and performance of people for Volunteer Service Abroad (Taylor, 1959) and Antarctic winter-over crews. Following the 1979 DC10 Air NZ crash on Mt Erebus in Antarctica, he extended his clinical and research interests to include the disaster stress of emergency personnel involved in body-handling. After retirement in 1992, he created a small research interest in crime and delinquency, and broadened his concern for victims to include victims of crime (cf. Taylor, 2009). He has over 290 publications on topics that range from criminality, the effects of isolation, psychopathology, and disaster work. He has received a number of prestigious awards that include a Distinguished Service Award from the University of Reims, and a Companionship of the Royal Society of New Zealand.

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Zealand were familiar with disaster work (cf. Taylor & Frazer, 1980), the Anglican clergy in New Zealand tried to assert their right to take over the counselling and debriefing of the body-recovery and mortuary staff from the psychologists. After the 1988 earthquake in the Bay of Plenty, the social workers of the Social Welfare Department were at odds with those at the hospital because of differences that remained unresolved from another matter entirely (cf. Taylor, 1988). After the November 1990 massacre of 13 people at Aramoana (cf. http://en.wikipedia.org/wiki/Aramoa/ massacre retrieved 9th February 2012), local psychologists resisted the arrival of a contingent of trained family counselors that the Victim Support organisation had sent to relieve their Dunedin-based colleagues: they argued that it was their job to provide such assistance.3

3 Prior to the 1990s when David Johnson and Douglas Paton of Massey University broke the ground, few psychologists in New Zealand were familiar with disaster work (cf. Counselors on assignments abroad to provide a post-trauma service must be prepared to face similar friction. No matter how much expertise they might have on cross-cultural issues, they should still be prepared to face resentment from counselors already at work in an overseas territory whose government has been involved by a visiting consultant. Both to draw on their expertise, and to try to avoid causing resentment, it is wise for them to seek information in advance about the indigenous political and tribal systems, administrative organisations, social structure, and local customs of target groups. Personally, on a series of such assignments in the Cook Islands, Fiji, and Tuvalu, I was able to recruit local people to assist with making and implementing screening plans, affirming and applying appropriate procedures, overcoming difficulties with language, and remaining in situ to deal with delayed issues as they arose (cf. Taylor, 2003).

Obligations to undertake research
Accountability is a sine qua non for professionals. Important as commitment and self-confidence might be as placebo elements in counselor practice, they need to be buttressed with data that are being generated independently from research. Without such validation, claims for the efficacy of any procedure for specific groups (Taylor, 1986; 1991; 2002b; Long & Paton, 1996) the situation changed markedly after the 2010/11 state of calamitous earthquakes and continuing aftershocks in Christchurch that caused death and destruction (cf. Van Beyden, 2012). Presently more psychologists will have experience and insights to share and develop into theoretical models to guide future applications. No doubt, they will reflect on methods they used to cope with the personal demands and emotional pressures of their clients. In due course, if they were to form an Institute of Disaster Studies they could develop their professional skills and be accountable for promoting research and being guided by that outcome. cannot properly be substantiated, nor data-based improvements be made to any interventions. However, in this matter counselling, de briefing and psychotherapy, all remain in limbo. It is no consolation to know that the issue remains unsettled with regard to a multitude of other aspects of establishing medical help in general practice and specialists.

Long ago Hans Eysenck (1961, ch.18), a staunch critic of psychodrama, did a useful job by advising that therapists should use an appropriate combination of intrusive methods, objective-reliable and valid personality tests, rating scales, social action effects, physiological measurements, and precise laboratory experiments to validate their procedures. Regrettably, few responded adequately to his challenge. In the most recent retrospective meta-analysis of 720 doctoral theses on treatments for troublesome adolescents who form one of the most pressing sectors of the needy population, Township, Walker, Sargent, Vostanis, Hawton, Stocker, and Sithole (2010) found only 10 whose epistemological designs included control groups, and acceptable measures taken before/after and at follow-up phase.

Sad ly, a recent world-wide panel of experts on the study and treatment of those exposed to disasters and mass violence, reported that ‘no evidence had been reached supporting a clear set of recommendations for intervention during the immediate and the mid-term post mass trauma phase’ (cf. Hobfoll, Watson, Bell & others, 2007). However, it did identify empirical support for five principles of intervention that brought benefit to those in need - i.e. a sense of safety • calming, a sense of self and community efficacy • connectedness.4

4 I am pleased to mention that one of the ten experts was mine!

...and hope , With regard to the vexed issue of debriefing emergency workers to prevent the development of post-traumatic stress disorder, Rose, Bisson, Churchill, and Wessley (2009) reiterated their earlier two previous findings that ‘empirical evidence for its success is noticeably lacking’.

The outcome of interpersonal intervention calls for a detailed approach of the process and the most appropriate methods by which it might be assessed. Counselors could make a following UK consultant Martin Milner’s (2011) clarification of the principles and practice of counseling, and by encouraging university departments teaching clinical psychology not to cling so firmly to short-term treatments for specific identifiable conditions that yield definable outcomes - at the expense of people whose problems are more complex, deep-seated, and unclear. In the expansion of a process, general practitioners should take professional, in which scholars and scientists find common ground by respecting their separate endeavours (Taylor, 2002).

Summary
The present two-part article describes the early efforts of a few academics to establish educational counselling of a generic kind in New Zealand. It also touches on the professional, and at follow-up phase4.

References


1990s and at follow-up phase.4


An Interview with Ian McEwan, Executive Director Addictions

A social worker, Ian has been working for 43 years in the treatment of addiction. Currently, he is on the faculty of the University of Otago, chairs a trust working for families experiencing addiction, is executive director of the Addiction Practitioners’ Association, consultant to a pilot project for youth at high risk and works with clients who have been barred from local treatment services.

The Addiction Practitioners’ Association, Aotearoa/ New Zealand has members from the addiction treatment workforce (including psychologists)- what areas of addiction do your members work in?

We have 1,300 members (90% of the addiction treatment workforce) providing a range of interventions, from brief advice to long-term therapy across problematic alcohol and other drug use, gambling and smoking cessation. Increasingly the presentations are of co-existing disorders, including depression, anxiety, compulsion and behavioural disorders of excessive appetite.

Addiction practitioners can become registered-what do they need to do to achieve this?

Practitioners firstly join the Association as standard members, then they can apply for provisional registration as an addiction practitioner. Provisional registration requires an applied degree in addiction studies or allied health/social work interventions, six months post-qualification experience and be under supervision. Before they can apply for full registration they must have a further 1,000 hours of practice including 500 hours of direct client work, an applied addiction specific qualification at level 7 or higher and continue to be under supervision. They must continue with professional development to maintain registration.

What do you consider to be the main skills that addiction practitioners need to function effectively in their roles?

The skills are primarily those of engagement and motivation: the principles of the absolute worth of the client, his/her autonomy in making decisions about their life, accurate empathy and the evocation of the possibility of change. The ability to work across age, ethnicity, gender, orientation in a variety of contexts: family/whanau, general practice, intensive treatment and therapeutic community. Good knowledge of case management, cognitive behavioural and spiritual/values based pathways. They also need an ability to work with common mental health problems and the experience to weave all these together into a collaborative experience toward wellbeing for the client and their significant others.

What are the major changes in addiction treatment that have occurred in recent years?

The major changes are to be found in the workforce with a growing professionalism and confidence in managing pharmacology and in identifying, assessing and managing the mood disorders common to those experiencing addiction. New wine out of old wineries to use a probably inappropriate phrase: the importance of the social and family context, the importance of work as a major distraction from addiction foci, recruiting therapeutic allies from the client’s milieu and the growing emphasis on spiritual or value-based motivations to change. Other changes include the growth of drug treatment units in prisons, youth services and the growing awareness of allied professions that addiction issues prevail in our client/patient groups and that recovery from managing presenting problems can be achieved by also attending to co-occurring problematic addictive behaviours.

What are some of the barriers that you are aware of that prevent people who would benefit from addiction treatment receiving it?

The biggest barrier is that of health professionals not asking about addictive behaviours when people present with other issues. The anxious mother drinking to manage, the young workers drinking the equivalent of a bottle of whiskey each after work on a Friday, the couple sharing a bottle and a half of wine each night, the truck drivers smoking cannabis late into Sunday night, the lawyer on methamphetamine: true stories from the last month, these people presenting to health practitioners for a range of problems and not being asked about their alcohol or drug use. Barriers for the individual include the hope that you don’t have to change (this resistance is often ambivalence under pressure), failed previous attempts, fear of failure, not being able to identify one’s own needs, cannot identify the events to satisfy needs or cannot launch the appropriate goal-directed behaviour. All these are responsive to good counselling if the client can overcome organisational barriers, e.g. agency needs taking early precedence (e.g. waiting lists, abstinence), treatment budgets post-engagement, the acute care model (e.g. eight hours of funded treatment) and for an often chronic disorder that may have taken years to develop with loss of work and a fractured family in the mix.

How do addiction workers ensure that they are culturally competent in their work?

Addiction practitioners must be able to demonstrate competence in working with Māori and in working with Pasifika. They are required to have done level 7 studies in working safely with both and they are expected to have met the Te Pou Real/Wellbeing competencies in both. With 50% of our clients being Māori or Pasifika, there is a high expectation on practitioners being able to provide according to the more accessible models (eg Te Whare Tapa Wha/Takarangi/Poutama/Te Whare or Fonofale/Te Whare o Tikihina). Service auditing assesses for skills, knowledge and receptivity in providing for Māori and for Pasifika.

What self-care strategies do you consider important for addiction practitioners to put in place?

Good regular supervision with a supervisor that you can take anything to, no matter how upsetting. Deal smartly with a drop in confidence around self-efficacy as this is fertile ground for burn-out. Keep up professional development. Develop interests and establish friendships that have nothing to do with work in order to create balance and to keep grounded.

If you could do three things to reduce the burden of addiction in Aotearoa New Zealand- what would they be?

Decriminalise drug possession and make it a health issue; have alcohol treated as a legal but Class B drug (ie severely restrict marketing, sponsorship and availability to developing brains); teach parenting and employment skills to everybody right through school. Can I have one more?......full employment.

Practitioners’ Association, Aotearoa/ New Zealand

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One on One - with new NZPsS Fellow Beverley Burns

Bev was bought up in Hamilton attending school and Waikato University there. Her first career was that of a primary school teacher and on graduating she taught in schools in and around Hamilton and the Bay of Plenty. An interest in children with learning difficulties led her to further study at Waikato and into the Clinical Programme. She has worked for the mental and child health services of a DHB, the Ministry of Education, the Department of Social Welfare (as it was known then) and in private practice. Currently she works in her own busy practice engaged in a range of work that includes supervision and supervision training, project work, and learning and development. Supervision is a particular area of interest and she has written and published in this area. Bev believes that it is important to be part of the profession so has been on the local branch committee, ethics committees and on the executive. She is currently on the New Zealand Psychologists Board. Bev continues to live in Hamilton with her husband. She has two sons and a newly arrived grandson.

One aspect of your role that you find really satisfying

I have been incredibly lucky throughout my career as I have worked in a range of organisations with many people across a number of disciplines and have been able to be involved in a variety of satisfying activities which were both work related and voluntary. A bit like patchwork really all fitting together to make something that is both personally and professionally satisfying. Among other work activities I’m currently supervising a number of professionals and there are days when I have an enormous sense of awe and gratitude to be able to be part of these people’s lives. These are long term relationships and seeing people’s personal and professional development, and their growth in confidence and competence is inspiring.

One event that changed the course of your career

Isn’t it interesting how quickly negative events come to mind! Yet the negative events have been valuable – having a senior lecturer say to me at 17 and just entering Teachers College and university, that university wasn’t the place for me, (sexism was very much alive then); then failing two history undergraduate papers (not surprising as they were deathly boring); experiencing three miscarriages; experiencing a client suicide plus other life events. Each of these events caused me to stop and think and to take an action that was different to the path I was on. I guess they shaped me in some way and I learnt about looking for the good in a moment and not being too hard on myself.

One of the more significant events occurred while I was teaching. I was teaching at an independent school and had a class of five boys, all aged ten, none of whom could read or write. I wanted to know more about what was happening for these boys and how I could help them to learn. I started by researching learning difficulties, joined SPELD, completed their training and some education university papers. In the process I discovered psychology which then led me to clinical psychology. I am grateful to those boys for getting me started on this path and wonder where they are now and what they have achieved.

One alternative career path you might have chosen

My first career was as a primary school teacher. I sometimes wonder what I’d be doing if I had stayed teaching but with the knowledge I have gained from psychology.

One learning experience that made a big difference to you

I think the learning experience that made the greatest difference for me was being involved with the clinical programme. Not only did I learn a great deal about myself, the world and psychology I was studying with six other amazing people – Philippa, Anne, Katharine, Caroline, David and Alan. My recollection is of a diverse but pretty tight, supportive and very able group and I am grateful to all of them for the impact they have had on my life.

One book that you think all psychologists should read

My introduction to positive psychology was by way of Martin Seligman and his numerous publications and books and in particular those that relate to optimism. This then led me to Barbara Fredrickson. Her book "Positivity (2009) is one of the most useful that I have read. While written for a general audience it’s a useful starting point for understanding her "broaden and build" theory of positive emotions broadens people’s minds and sense and have great application. She has researched learning difficulties, joined SPELD, completed their training and some education university papers. In the process I discovered psychology which then led me to clinical psychology. I am grateful to those boys for getting me started on this path and wonder where they are now and what they have achieved.

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My first career was as a primary school teacher. I sometimes wonder what I’d be doing if I had stayed teaching but with the knowledge I have gained from psychology.

One learning experience that made a big difference to you

I think the learning experience that made the greatest difference for me was being involved with the clinical programme. Not only did I learn a great deal about myself, the world and psychology I was studying with six other amazing people – Philippa, Anne, Katharine, Caroline, David and Alan. My recollection is of a diverse but pretty tight, supportive and very able group and I am grateful to all of them for the impact they have had on my life.

One book that you think all psychologists should read

My introduction to positive psychology was by way of Martin Seligman and his numerous publications and books and in particular those that relate to optimism. This then led me to Barbara Fredrickson. Her book "Positivity (2009) is one of the most useful that I have read. While written for a general audience it’s a useful starting point for understanding her "broaden and build" theory of positive emotions broadens people’s minds and sense and have great application. She has...
Karen Cohen

The services of Canada’s other licensed health care providers – psychologists among them – are typically covered by Canada’s public health insurance plans only if that health provider is employed by a publicly funded institution such as a hospital, correctional facility or school. With funding pressures on public institutions, cuts to salaried resource positions become contracted ones or cut altogether. This has meant that over the past 10 to 20 years, more psychologists graduate to begin careers in private rather than public practice. Though psychologists in private practice in Canada are largely successful, their services are not funded by public health insurance systems and are therefore inaccessible to people of modest means or without private health insurance. Though much is said about not creating a two-tiered health system in response to the rising costs of publicly funded health care, the reality is that, at least when it comes to mental health, Canada already has a two tiered system. The services of psychologists, Canada’s largest group of licensed, specialized mental health care providers (outnumbering psychiatrists almost 4:1) are increasingly available only within the private sector.

Needs and demands in mental health... In Canada and elsewhere, awareness about the incidence and prevalence of mental illness is on the rise. One in five Canadians will experience a mental health problem in a given year with a toll on the Canadian economy of approximately 51 billion dollars annually. Mental health claims are the fastest growing type of disability costs with 30 to 40% of claims to major employers related to mental illness. Mental illness takes a toll of about 20 billion dollars in lost productivity annually in the Canadian workplace.

Canada’s Mental Health Commission; now in its 6th year of operation, has done a tremendous job mobilizing Canada’s stakeholders in mental health; producing a national mental health strategy as well as standards for psychological health in the workplace, to name only two of its accomplishments. The challenge now is for Canada’s community of funders and decision makers to take up the Commission’s recommendations which include enhancing access to mental health services and supports. Less than half of Canadians who have a need for mental health services seek them. Further, of those Canadians who perceive an unmet or only partially met need for mental health service, they are most likely to cite a need for counselling or psychotherapy rather than for other kinds of treatment like medication.

One in five Canadians will experience a mental health problem in a given year with a toll on the Canadian economy of approximately 51 billion dollars annually. While stigma is the oft cited reason why Canadians don’t seek and receive the mental health treatments they need, Canadians themselves cite the expense – as mentioned, psychological treatments are inaccessible to people with modest means or no private insurance.

Now what about supply? There are approximately 18,000 licensed psychologists practitioners in Canada for a population of about 35 million. Half of this number resides in the province of Quebec which has a population of about 8 million. While the ratio of psychologists per capita nationally is one in about 2,000, it decreases to 1 to about 3,500 if we exclude Quebec, where the ratio of 1 to under a thousand is an outlier among Canadian jurisdictions.

So how many psychologists does the country need? Benchmarks are hard to come by. The National Association of School Psychologists suggests one psychologist to every 1,000 students. Given that about 70% of mental health problems begin before young adulthood and that the best return on mental health investments are investments in children and youth, it makes sense that ratios of psychologists to youth should be lower than ratios for the general population. At a meeting of the International Association of Applied Psychologists in 2006, the European Federation of Psychology Associations suggested

Dr. Karen Cohen is the Chief Executive Officer (CEO) of the Canadian Psychological Association (CPA). In that role, Dr. Cohen participates in national and international work and alliances dedicated to topics relevant to the science and practice of psychology and to health and mental health. Dr. Cohen has prepared and presented briefs to standing committees of the Senate and House of Commons of Canada on matters pertaining to health and mental health as well held a ministerial appointment to a national advisory group on disability. She currently serves as Co-Chair of the Health Action Lobby, Chair of the mental illness awareness activities of the Canadian Alliance of Mental Illness and Mental Health (CAMIMH) and co-chair of the Mental Health Table. Dr. Cohen completed her undergraduate work at McGill University, earned her masters and doctoral degrees in Clinical Psychology at the University of Windsor. She went on to complete a post-doctoral fellowship in rehabilitation psychology and neuropsychology at the Ottawa Rehabilitation Centre.

I was most delighted to receive this invitation to share with colleagues in Aotearoa some of the issues and opportunities facing psychology in Canada. Like the New Zealand Psychological Society (NZPsS), the Canadian Psychological Association (CPA) has a formal mandate by virtue of its incorporation that commonly call for advocacy and promotion - promotion of the health and welfare of Canadians; promotion of psychological research, education and practice; and promotion of psychological knowledge. To address the issues or opportunities in each of these domains would far and away exceed the 2,000 words I have so generously been allotted. Accordingly, I will focus on one which directs our practice advocacy agenda for 2013/2014.

First a bit about CPA... CPA is Canada’s largest national association of psychologists. We have approximately 6,000 members and affiliates whose interests and expertise span 35 areas of science and practice – each of these organized into Sections, such as clinical, developmental, industrial organizational, criminal justice psychology (to name only a few). CPA as an organization is founded on three pillars (Science, Practice and Education) that form the foundation of our activity. Common to all three pillars is advocacy – on behalf of the discipline and profession - with government and other funders and stakeholders in psychological science and practice. It is advocacy activity that shapes the days (and a sleepless night or two) of CPA’s leaders and senior staff. The organizational activities that fulfil our research, education and practice mandates, as well as the advocacy agendas attached to them, often overlap. For example, the accreditation of doctoral and internship programs in professional psychology is as relevant to education as it is to practice. Our annual convention and the publication of our three peer reviewed journals meets the needs of researchers and practitioners alike. Advocating for more research funding advances science but also helps meet the policy needs of funders and the practice needs of service providers. Although what follows focuses on our practice advocacy agenda, access to effective practice depends upon the resourcing of psychological research and training. The reader who wants to most fully understand the scope of CPA’s mandate, activities and advocacy is directed to www.cpa.ca.

Health and healthcare delivery in Canada... Much is said nationally and internationally about Canada’s public health system. It is really a collection of systems of some sort would say non-systems) that are administered separately by each of Canada’s provincial and territorial governments in accordance with the Canada Health Act. While it is true that Canadians’ visits to their family physicians or admissions to hospital are paid for by the public purse, it is not entirely accurate to say that we have a publicly funded health system.

We have a publicly funded medical system that pays designated providers http://www.cmha.ca/mental-health-facts-about-mental-illness/1aUAnpgMg_Y to deliver designated health services in designated venues. The services of physicians are funded for much of the service they provide either in the venue in which they provide it – a private office in the community, a clinic, a correctional facility or a hospital.

Though psychologists in private practice in Canada are largely successful, their services are not funded by public health insurance systems and are therefore inaccessible to people of modest means or without private health insurance.

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Psychological Services for Canadians. The report, commissioned from a group of health economists, builds and costs alternative models of public spending to provide its citizens with better access to psychological services. By commissioning this report, CPA endeavoured not just to raise awareness about a problem but to participate in its solution. We have developed an advocacy tool kit to accompany the report to help provincial and territorial associations of psychology dialogue with government and other funders about implementing its recommendations. CPA itself has embarked on a strategy to engage stakeholders in mental health inclusive of government, the insurance industry, Canada’s employers and the organizations that represent them. It is also critical to raise awareness among the public, not just about the incidence and prevalence of mental illness but about the effectiveness and indications of psychological treatments and the barriers to accessing them. CPA’s media pages detail our media outreach.

Canadians get what’s on the menu (e.g. a prescription) rather than what might work best (e.g. psychological treatments)

Other of CPA’s activities to address need, demand and supply include a soon to be released paper by Dr. John Hunseley at the University of Ottawa on the effectiveness of psychological treatments for three sentinel health conditions: depression, anxiety and heart disease. This is a companion piece to the access report mentioned earlier. In November of 2013, we will also host a Summit on need, demand and supply where we have invited public agencies that house information about Canada’s supply of its professorial and health human resource as well as leaders from among Canada’s science and practice communities. The goal of the Summit is to review and discuss indications for further investment and data gaps where more surveillance is needed so that we can more effectively chart the course of Canada’s psychological resource; one that at least in my view, needs to do a better job of training its scientists and practitioners to address the questions and needs of public policy and of communities.

The horizon. At least in Canada, mental health has never been more top of mind. I would say further that recognition of the need for and barriers to accessing psychological services is garnering more and more support from our partners and the public. The Mood Disorders Society of Canada and the Canadian Mental Health Association have both joined us publicly in calling for better access to psychological services for Canadians. The Mental Health Commission of Canada has called for enhanced access to evidence based psychotherapy and a recent report from Statistics Canada let us know that 1, 5 millions of Canadians have a perceived unmet or partially met need for counselling and psychotherapy – the greatest barrier to which was personal circumstance such as whether individuals could afford to pay for care or had access to private insurance. This finding echoes a survey done by Canada’s own provincial and territorial psychology associations (chapter 3), and briefly covers different levels of measurement and includes distribution, an overview of inferential statistics and hypothesis testing. When it comes to mental health care, psychological treatments work. It is time to get them on the menu – funding to support research into their indications as well as their evidence-based use. CPA adds that our funding policies and practices further limit care so that when it comes to publicly funded mental health service, Canadians get what’s on the menu (e.g. a prescription) rather than what might work best (e.g. psychological treatments). It is time to get them on the menu – funding to support research into their indications as well as their evidence-based use.

With this book, Davis takes a pragmatic approach to providing an introductory overview of statistics and statistical analyses applicable to social sciences. By drawing on the minimum of background theory and no mathematical formulae, Davis tackles a central issue that tends to send undergraduate students and beginner audiences running for the hills. Over its three parts the book presents a concise, easy-to-grasp guide to the basic analyses within the framework of the SPSS software.

The introductory part provides a brief overview of descriptive statistics (chapter 2), including discussions of measures of central tendency and data distribution, an overview of inferential statistics and hypothesis testing (chapter 3), and briefly covers different levels of measurement and includes a brief discussion on parametric and non-parametric data (chapter 4). While these chapters do not develop a notable depth of theory, the most important concepts are clearly presented, including discussions on data distribution and principles of hypothesis testing. Also provided is a refreshingly clear guide to data entry and basic manipulation in SPSS (chapter 5), with systematic illustrated instructions, as well as a chapter reviewing various research designs with examples and guides on exploring the descriptive statistics of real data (chapter 6). These chapters are well positioned within the introduction of data analysis in SPSS and engage the reader in data entry and developing datasets. This approach of developing datasets rather than providing pre-made ones is employed throughout the practical components of the book. Part two of the book presents detailed guides to conducting the basic analyses. Suggesting common imperfections of data distribution in real-world research,
The art of the sale: Learning from the masters about the business of life.

Reviewed by Peter Stanley, Tauranga

Broughton takes a broad view of ‘salespersonship’ and he tells us that while some people sell goods we all sell ideas and emotions. There are various levels of sales as we typically understand it from buying an ice cream at a convenience store to international trade negotiations but, essentially, all business is about problem solving for others. To meet other people’s needs the salesperson has to be empathetic and to establish a relationship. The empathy that is evidenced involves identifying the customer’s characteristics and the motivations that matter most, and this may require the sales agent to “sort rapidly through his mental filing cabinet of experience to find the closest match” (p. 31). Certainly, the effective salesperson has to regulate his or her own emotions to listen closely to the customer; and to be mindful, and to inhibit the moment. Relationships are facilitative, but this does not mean that the salesperson is the client’s best friend. Instead, it is his or her job to make a sale happen.

In addition to empathy and relationships, salespersonship can rely on an array of sales strategies and techniques. Included here are the use of open questions, storytelling, teaching, and the use of authority. Practical salespeople will endeavour to maximise their investment of energy relative to outcomes. And as it happens, ethical concerns are a major preoccupation for the author of this book and he cites car dealers, pharmaceutical companies, and banks that sell subprime mortgages as sales operations that can engage in dodgy practices and promote false hopes. The problem, says Broughton, is the power inherent in the sales relationship;

The Art of the Sale: Learning from the Masters about the Business of Life.


New York: Penguin

ISBN 1594203526

“Put a formidable salesman together with a hateful idea, and you could end up with the Nuremberg rallies” (p. 8). Nevertheless, there is an attempt to reconcile customer service and the self-interest of sales and, according to the author, the Zen salesperson can accept the paradox of simultaneously pursuing collaborative goals and his or her most basic human needs.

There are clearly some interesting parallels between psychological practice and sales, and there are also instructive perspectives when these activities diverge. The author of The Art of the Sale contends that the two fundamental qualities that a successful salesperson has to possess, which are ego drive and empathy, must exist in a state of balance. Too much ego and the sales agent will not understand client motivations, and an excess of empathy and the sale is unlikely to be closed. Salespeople are regularly exposed to rejection and there are continual emotional challenges in their work. Broughton suggests that energy, discipline, optimism, and resilience are important responses to failure but, as well, “You need to love the battle itself, to revel in playing the odds” (p. 98). In effect, being a successful salesperson has to be consistent with who you are and how you define yourself.

Despite all the similarities and possible lessons psychologists are not salespeople. As Broughton sees it, a sales exchange can often involve far more than ownership of a product, and what really transpires is a change in emotional state and the meeting of a psychological need. These benefits of ‘retail therapy’ are not small attainments, as the weekend crowds in shopping malls attest. However, if psychologists saw their practice in this way they would simply sell ‘helpful and hopeful scripts’, and perhaps even prescribe medications that would give symptom relief. Presumably, there are other purposes for counselling, such as helping ‘clients’ to clarify their personal values and to acquire the strategies that allow them to independently pursue these commitments. Nonetheless, the commonalities across sales and psychology are worth considering because they do have the potential of being enlightening.

Essentials of psychiatric diagnosis: Responding to the challenge of DSM–5

Reviewed by John Fitzgerald, The Psychology Centre, Hamilton

It may have been a year late in its arrival, and been the subject of a long and difficult incubation, but the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) is now with us. The king is dead, long live the king.

It would be fair to say that there was a fair amount of debate and disappointment while the newest member of the DSM family was in development. We will all have heard the tales of dissent and Work Group walk-outs and resignations, petitioning and major last minute revisions, and post release criticism. When the dust settles, what exactly have we been left with? How are we to make use of the DSM for ethical and professional practice? How are we to implement the changes, and more crucially should we implement the changes? The author of Essentials of Psychiatric Diagnosis is Emeritus Professor Allen Frances, former chair of psychiatry at Duke University, one of the top medical training facilities in America. Prof Frances chaired the DSM-I V Task Force, so is eminently credentialed to comment on the new DSM. In all fairness, you have to understand the author’s position to fully appreciate the courageous position he takes in this book, which is ‘DSM-V … don’t buy it, don’t use it’.

This book provides a brief summary of all the disorders contained in Section II of the DSM-V. Disorders are covered in separate chapters, which also generally include a few suggested screening questions, a prototypical description of the presentation of each disorder, advice on differential diagnosis, diagnostic tips, and associated ICD 9 codes. All this material is very useful and easy to digest. If the nearly 700 pages in the original edition are too indigestible then the nearly 200 pages in Essentials may be more to your taste.
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However, it is not the main course of disorders which are the most memorable fare in this book, but the sides. Each chapter also includes a range of thought provoking cautions against diagnostic inflation and fad diagnosing, as well as drawing attention to questionable aspects of the DSM-V. Elsewhere Frances has noted that it is not the introduction of new medications that should be our primary concern, but the introduction of new diagnoses which open the market for new medications. While there is nothing wrong with a new diagnosis which clarifies a presentation, it is based on sound and credible science. diagnoses which do not clarify and which are unreliable just make it more difficult for relatively untrained primary mental health practitioners. Eighty per cent of mental health prescribing takes place in primary care settings. Frances laments that “DSM-5 suffers from the unfortunate combination of unrealistic lofty ambitions and sloppy methodology” (p.5).

So, when you are reading this excellent text look out for the ‘CAUTION Boxes’ which generally advise the reader to be wary of the changes introduced by DSM-V. There is nothing wrong with a new diagnosis which clarifies a presentation, but the perspective of a man who knows what he is talking about.

This is a useful and entertaining book. The author does offer guidance about how to use the DSM-V, despite comments elsewhere which would appear to caution against its use. However, surely it is better to step into this brave new world with our eyes open … if we decide to step in at all. This book is well worth reading, as is another recent book by the same author, Saving Normal: An insider’s revolt against out-of-control psychiatric diagnosis, Big Pharma, and the medicalization of ordinary life.

A very recent Revised Edition of this text is available which cites ICD10 codes.

disciplines

Effects of Psychiatric Diagnosis: Responding to the Challenge of DSM-5

Allen Frances (2013)

NY: Guilford

ISBN 9781462510498

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Pbk NZ$49.69

This is the last editorial that I will be writing in the role of Editor of the Student Forum in Psychology Aotearoa. It’s been a great privilege to be able to interact with and read the submissions of graduate and postgraduate psychology students from universities around New Zealand over the past two years. One of the things I’ve really valued about this experience is that it has forced me to engage with research outside of my own field of study – from social psychology, to organisational and beyond. It’s been inspiring and interesting to see the huge range of research topics that students in New Zealand are currently investigating. I am continually reminded of how diverse psychology is as a field and what a great deal of opportunities are available to those who choose this study and career pathway.

What unites these diverse study areas seems to be an underlying motivation to enhance and improve lives, whether those be human or animal, or via interpersonal or systemic means. How we approach the enhancement and improvement of others’ experiences is often up for debate, but I think it’s important for us to remember that our different approaches are very often underpinned by altruism. In editing the Student Forum, I’ve really enjoyed being reminded of this by students who seem passionate about psychological research and the benefits that this research can have in our communities.

The theme of this year’s NZPsS Annual Conference, Building Bridges: Dialogues across Psychology, reflected that diversity and the efforts that we go to unite in spite of differences.

The annual conference is always a great time for us to become engaged with new and exciting research that is currently occurring around the country. If submitting a conference abstract is something that you’re yet to do, I would encourage all graduate students to include this as a learning goal – and the NZPsS conference is a great place to start. Not only does it provide both students and more experienced researchers with an opportunity to disseminate research amongst the New Zealand psychology community, it’s also an excellent chance to develop presentation skills, build your profile and network with your psychology colleagues.

Well done to those who presented their research either orally or in poster format at this year’s NZPsS conference. It was excellent to see so many student presenters of such high calibre. We’re very pleased in this issue to be able to publish research from several of this year’s student presenters, giving us an opportunity to engage with their topics in perhaps a little more depth as it’s sometimes hard to do these things justice in a brief presentation.

In this issue, Matthew Hammond from the University of Auckland describes his research into the way in which sexist attitudes might impact on intimate relationships. Also from the University of Auckland and along the relationships theme, Yutika Girmur elaborates upon her conference presentation which examines how partners of insecure individuals provide support and overcome interpersonal defences. We would also like to thank Tia Neha, the winner of last year’s Karahipi Tiumiaki – President’s Scholarship, for her submission which is included in this issue.

This brave new world with our eyes open … if we decide to step in at all. This book is well worth reading, as is another recent book by the same author, Saving Normal: An insider’s revolt against out-of-control psychiatric diagnosis, Big Pharma, and the medicalization of ordinary life.

This brave new world with our eyes open … if we decide to step in at all. This book is well worth reading, as is another recent book by the same author, Saving Normal: An insider’s revolt against out-of-control psychiatric diagnosis, Big Pharma, and the medicalization of ordinary life.
Me Whakamoemiti

Tāia kou tautomo e ngā whānau whānau. This PhD is dedicated to my late father Koroni Neha Toki and my majestic Kōkā, mother Hēpēa Morell. I thank you both the most for your unequivocal support, throughout, as always, for which my mere expression of thanks likewise does not suffice. A special mention of thanks goes to Te Rūpū Māta Hinengaro o Aotearoa for my being awarded the 2012 Karahipi Tūmāki scholarship. This assistance has in part enabled dissemination at world-wide conferences. I would like to thank my supervision team Elaine Reese, the late Tamar Murachver, Poia Rewi and Mele Taumoepeau and friends for their constant support, valuable insight, guidance and feedback on my thesis progress.

Te Tino Kaupapa

The main aims of this longitudinal study were to address the gap in the literature on what are some strengths that help to build Māori autobiographical memory? One description of autobiographical memory refers to cultural variation on the retrieval of past events (Fivush & Nelson, 2004). We wanted to further identify whether or not there was a link between autobiographical memory and Māori children's school readiness competencies. Aside from space considerations that preclude the inclusion of the whole thesis, further details on autobiographical memory to children's school readiness prior and post school entry are best left to the thesis document. This sub-section of the study, however, is the first to address whether home based measures dyadic book-reading and reminiscing are linked to Māori children's oral language growth. We wanted to further identify whether or not there was a link between autobiographical memory and Māori children's school readiness competencies.

He kōrero whānau or elaboration strengths is one style of maternal reminiscing. It has been identified when talking about shared past events (Reese, Hayne, & MacDonald, 2008). Some mothers are highly elaborative, affording useful detail through questions and statements. As the child follows with a memory answer, the adult confirms the child's response and follows-up with further open ended questions and statements. This particular style of narrative expression provides a major contribution to children's memory development (Fivush, Hadwin, & Reese, 2006). That is, child participation in parental-assisted conversations helps children learn about the form and function of talking about past events that map to their autobiographical memory.

Adherence to protocols of transparency and research aims were discussed from the outset. Violation to tikanga might potentially result in whānau attrition, mistrust and discontinuation of the current and future research. Initial and dissemination hui whānau involved karakia, waiata, discussion around the project, kai and karakia. Further discussions with whānau were central to their children's learning and autobiographical memory. This study is part of a bigger study that involves whether he kōrero whānau is linked to Māori children's school readiness. For the purposes of this study, however, does he kōrero whānau relate to whānau Māori and their children's oral language readiness? Sixty whānau were recruited from two sites. Whānau filled out an adapted questionnaire that contained demographic information (Crengle, 2004; Senechal & LeFevre, 2001). Participants self-identified as 43% Māori-European, 32% Māori, 16% European-Māori and 9% Māori-Pacific Islander. Whānau came from diverse socio-economic backgrounds. There were 32 (53%) girls and 28 (47%) boys. Children from both sites spent on average 12 months in preschool prior to Time 1 at M = 4.4 years. A follow-up visit took place at M = 4.11 years. 54 (90%) whānau primarily spoke in English. 6 (10%) whānau mainly spoke in Te Reo but could speak in English as well. Maternal education was 4.2 years on average spent at the tertiary level.

Māori mothers who used higher-level talk in book-reading and he kōrero whānau had children with better oral language skills, which replicates prior research.

Fifty Māori mothers recorded a conversation about past events; including a birth story, and other shared past events. Mother also read a book to their children. All conversations were transcribed and coded for higher-level talk (predictions/ inferences and elaborations). Children's vocabulary (Reid & Hresko, 1980), story comprehension (Reese, 1995), story retell (Sparks & Reese, 2013) and letter sounds (Cummins, Kaminski, Good, & O'Neil, 2011) were assessed. Mother-child book reading was coded for lower-level (description) and higher-level talk (predictions/ inferences).

Ngā Wakaana Putake

The findings demonstrated that the children were performing in the expected range on all oral language measures. Correlations were conducted between children's oral language competency to he kōrero whānau about books and past events (see Table 1). Children's language understanding, story comprehension and letter sounds were moderately correlated with he kōrero whānau. We conducted further correlations with the shared reading activity. Children's language expression was moderately correlated with their mother's inferences and predictions during the activity. Importantly, these correlations remained significant after parent education and child's age were partialed out.

Kei Muri, Kei Mua

Māori mothers who used higher-level talk in book-reading and he kōrero whānau had children with better oral language skills, which replicates prior research. These results extend this line of work because they suggest that different contexts of maternal language input (e.g. book reading and he kōrero whānau) with their children provide different language outputs for Māori children. Therefore, he kōrero whānau during memory conversations and book-reading are both important contexts for Māori children's oral language growth.

Further work might address the role of storytelling between elders, significant others and the children as these enriched stories might help to also complement he kōrero whānau and their child's repertoire of language skills and memory.

Hoei ano, ngā mihi aroha ki ngā whānau ano. Tāia koutou, tāia koutou, tāia tātou katoa.

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Table 1: Partial Correlations between He Kōrero Whānau, Book Reading with Child Characteristics.

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<th>Expressive vocabulary</th>
<th>Story comprehension</th>
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<td>He Kōrero whānau, Maternal elaborations</td>
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*p<.05, **p<.01, controlling for parent education and child age
The Effects of Video Self Modelling on Three Children with Dog Fears

Megan Sweeney

Megan Sweeney is a 4th year student in the Child and Family Psychology Programme at the University of Canterbury. Her thesis research investigated the effects of video self-modelling (VSM) on three children with dog fears. Megan also works part-time undertaking behavioural therapy with children with autism and will start her internship next year.

Fears and avoidance of certain stimuli in childhood are common, but these can also become problematic and challenging due to the persistence and intensity of the fear and avoidance (King, Muris, & Ollendick, 2005). Fears, such as a fear of dogs, should not be overlooked in childhood as they can interfere with everyday living and this fear can carry on into adolescence and even adulthood (King et al., 2005). Not only do these fears have an effect on the child but they can have an adverse effect on the family as a whole.

Feedforward video self-modelling (FFVSM) is an intervention where individuals view themselves on an edited video doing a certain behaviour that is not normally within their repertoire. Inappropriate behaviours are edited out of the video and only the positive or desired behaviours are shown. The concept was first introduced in the 1970s by Peter Dowrick, and has been used with a wide range of behaviours, ages and abilities (Buggey, 2005; Dowrick & Dove, 1980; Dowrick & Ward, 1997; Dowrick, Kim-Rupnow & Power, 2006). The different types of behaviours that FFVSM has been used for include increasing reading fluency (Dowrick et al., 2006), decreasing negative social behaviours (Buggey, 2005), treating children with selective mutism (Kehle, Owen, & Creasy, 1990), and helping a young girl with cerebral palsy to walk (Dowrick & Biggs, 1985). According to the literature, VSM had not been used thus far to treat simple fears, although a study conducted at the University of Canterbury used VSM with spider phobic adults (Hoss, 2004).

The aim of this study was to measure the effects of FFVSM on three children with dog fears. This research was approved by the University of Canterbury Human Ethics Committee. Child One was aged 13 years and had been frightened by a dog at an early age. Child Two was 9 years old and while her mother could not remember any specific negative encounters with dogs, the noticed Child Two’s avoidance to dogs at an early age. Child Three was 7 years old and had been bitten by a dog approximately 18 months prior to the study. They all disclosed that they avoided situations or locations where they believed that they would encounter dogs. All children were recruited through their school newsletters.

Each child and his or her parents met with myself and my supervisor where a clinical interview and functional assessment was carried out to assess the child’s fear and avoidance of dogs. The children were asked about any techniques or strategies they knew of, or used, to help them cope with their fear and avoidance of dogs, and other difficulties were ruled out. Another meeting was then held a couple of weeks later to discuss the location for each child’s FFVSM video. Each child was asked to think of a place which they enjoyed, but could not currently visit due to their avoidance of dogs. At this meeting, the children were also taught internal and external coping skills such as positive self talk (e.g. “I’m being so brave right now”) and breathing relaxation skills to perform on camera for their FFVSM videos.

Feedforward video self-modelling (FFVSM) is an intervention where individuals view themselves on an edited video doing a certain behaviour that is not normally within their repertoire.

A considerable amount of time was spent discussing appropriate baseline measures, but it was believed that it would be ethically unacceptable to expose the children to dogs during baseline. Exposing the children at the beginning of the study may also have had detrimental effects on the children and it was also important to consider how parents would feel if their child was exposed to dogs prior to the intervention. Instead, baseline was measured using the Dog Scenario Questionnaire, a 9-item questionnaire scored using a five point visual analogue scale (VAS), which was based on the Dog Phobia Questionnaire by Hong and Zinbarg (as cited in Vorstenbosch, Antony, Koerner, & Boivin, 2011). The Dog Scenario Questionnaire assessed the level of the children’s fear in hypothetical scenarios. For example, “seeing a dog 10 metres away”, “seeing a dog outside of the house while inside” and “walking through the park and seeing a dog on the lead”.

It was important that the children were taught coping skills rather than complete mastery and elimination of their avoidance of dogs, as it was felt to be unsafe for children to have no fear of all dogs at all. Safety was considered to be a major component of this study, and so to teach dog safety to the children, a book was used alongside the children’s VSM videos. A book, named This dog is happy: How to tell what a dog is thinking and feeling was based on Pang and Louie’s (2008) children’s book about dog behaviour and training.

Filming with the children for their individual videos took place at their chosen location. During filming, each participant was asked to pretend to see a dog at their chosen location and to perform the positive self-talk and breathing techniques. The dogs used in the study were filmed at the same locations but on a different day from the children. These dogs, a Border Collie and Pointer Cross, were trained specifically to be around children and were provided and handled by a dog trainer based in Christchurch.

Footage of both the children and the dogs was edited together to depict each child being at the same location as the dog. Along with the dog book, these edited videos were given to each child to watch for two weeks. After the two week period, each child was then taken back to his or her chosen location, but this time the dogs and the dog trainer were present. The children were asked to rate their levels of fear on the Dog Scenario Questionnaire when they first saw the dog (Post Intervention Phase 1), and again after they had been exposed to the dog for a period

References

of approximately 30-45 minutes (Post Intervention Phase 2). The dogs were placed a distance from the children and were bought closer when the child said they felt comfortable in it doing so.

Figure 1 (see previous page) depicts the average scores for each child across situations scored as eliciting fear. Results showed that for Child One and Child Three, the self-modelling videos appeared to have decreased their dog fear, while Child Two had more variable results. Child One and Child Three were observed to be calm around the dogs and reported low fear levels. Child Two was observed to be calm around the dogs at the two Post Intervention Phases but had reported moderate fear levels. Child Three had said after the study that it was the happiest he had been around dogs, since he was bitten prior to the study.

This study indicates that FFVSM appears to be a promising intervention with children and fear. However, the main limitation of this study was that it was not clear whether it was the children’s VSM videos, the book, or the combination of both that contributed to the final results. More research is also needed to support the use of FFVSM and children and fears.

Given that this study was one of the first of its kind, there are various ways in which it could be built upon. For example, baseline measures could also include a Behavioural Avoidance Test (BAT) along with a functional behavioural assessment (FBA). Future studies could also look at using two experimental groups where one group views only a FFVSM video with the other group only reading the book. Hopefully these future considerations will lead to more success with treating childhood fear of dogs in the future.

References

Overcoming Insecurities
Yuthika U. Girme

People supported by intimate partners experience better psychological health, are at lower risk of disease, and live longer (Uchino, Cacioppo & Kiecolt-Glaser, 1996). Greater partner support also builds closeness, boosts mood and self-esteem, and fosters greater personal achievement and relationship quality across time (Feeney, 2004; Overall et al., 2010). Unfortunately, not everyone can reap the benefits of support from their partners. For example, people who have inconsistent or rejecting relationships with their caregivers in times of need become uncomfortable seeking support, when coping with stress, or feel anxious within intimate contexts in adulthood (Collins & Feeney, 2000). My primary research goals involve identifying the ways people can manage their partner’s insecurities to provide support and generate closeness in ways that overcome the defences of insecure people, and thus enable insecure partners to experience the benefits of supportive relationships.

Visible versus Invisible Support

Given the crucial role of support in protecting psychological and physical health, determining what kinds of support are effective – and when – is a central goal of my research. My next studies advance this important point by investigating whether visible and invisible support has different benefits and costs for individuals high in attachment insecurity. Attachment insecurity is linked with poorer psychological wellbeing and physical health, such as higher blood pressure, heart disease, asthma and strokes (Paug et al., 2013), in part because insecure individuals have difficulty seeking support and coping with stress (Rholes et al., 1999; Simpson et al., 1992). Individuals high in attachment anxiety, for example, fear rejection and constantly need reassurance (Mikulincer & Shaver, 2003). Thus, visible and overt support is likely to be most effective in helping anxious individuals cope, whereas more indirect invisible support that goes unnoticed will only exacerbate their distress. In contrast, individuals higher in attachment avoidance believe they cannot trust and depend on others, and so avoid closeness and become rigidly self-reliant (Mikulincer & Shaver, 2003). Accordingly, invisible support has been shown to produce defensive withdrawal and anger in avoidant individuals (Collins & Feeney, 2004). However, invisible support should be very effective for individuals high in avoidance because it is less likely to challenge autonomy and signal intimacy.

Shared Relationship Activities

Insecure individuals also struggle with maintaining or building intimacy outside of any relationship problems, an integral part of maintaining relationship satisfaction over time (see Carney et al., 1993; Guerrero, Eloy & Wabnik, 1993). My research (Girme, Overall, & Faingataa, in

My recent research (Girme, Overall & Simpson, in press) extends prior research by demonstrating that visible forms of support have both costs and benefits depending on what the support recipient needs. I assessed behaviours during couples’ video-recorded support-relevant discussions. Independent coders rated the support provider’s provision of visible support (e.g., overt reassurance) and indirect, invisible support (e.g., gestures in the form of care and advice). Greater visible support was associated with recipient’s feeling more supported and able to cope for recipient’s who were distressed and needed direct reassurance. However, this kind of support undermined feelings of efficacy and reduced confidence about goal achievement when recipients were not distressed and did not require direct support from their partner. In contrast, invisible support did not produce these costs and instead worked ‘under the radar’ to facilitate greater personal achievement across the following year. These results provide the first evidence that both visible and invisible support can help depending on the particular needs of the recipient.

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Activities that were satisfying, stress-free and increased closeness predicted greater relationship quality concurrently and longitudinally. However, positive activity and relationship outcomes depended on the degree to which partners were dedicated to the activity, indicating that shared activities sustain relationship quality only when partners are responsive and want to share relationship activities.

References

Although New Zealand ranks relatively highly in the world in relative gender equality, women in New Zealand earn comparatively less than men, and are less represented in career and legal domains. Ambivalent sexism theory states that two distinct sets of sexist attitudes underlie these gender inequalities (Glick & Fiske, 1996). Hostile sexism describes all of the attitudes which we typically think of as ‘sexist’, such as characterisations of women as warm and infantile, beautiful and delicate and needing men’s care and protection. This form of sexism is particularly insidious because it encourages women to support men’s societal power while reducing their felt competence. Although these sexist attitudes function to uphold gender inequalities across the world, a less-explored facet characterising women as warm and vulnerable in career and education domains. First, men’s endorsement of hostile attitudes toward women fosters more negative views of intimate partners, which prompts dissatisfaction and negative or aggressive behaviour. Second, women’s endorsement of benevolent sexism, and its idealization of intimate relationships, puts women in a more vulnerable position when relationships are less than perfect.

Men’s hostile sexism prompts destructive relationship behaviour. The more overt and antagonistic hostile sexism has primarily been linked with more negative and derogatory evaluations of women who could challenge men’s societal advantages. The more men agree with hostile sexism, the more negatively they view career women and feminists, but not housewives or homemakers. However, men’s agreement with hostile sexism has also been linked with aggressive behaviour and lower satisfaction within intimate, committed relationships. My research has examined this puzzling finding – why do men who agree with hostile sexism behave negatively and aggressively towards the women they love?

In two studies (Hammond & Overall, 2013a), we gathered reports from committed heterosexual couples on their own behaviour and their perceptions of their partners’ behaviour. Results showed that men who endorse hostile sexism perceived their female partners to behave more negatively than they actually did. These biased perceptions led men who agreed with hostile sexism to behave more aggressively toward their intimate partners and experience lower relationship satisfaction. This research is the first to indicate that the views of women contained within hostile sexism are carried over into intimate contexts, and mean that committed partners can become the target of the hostile side of sexism.

Benevolent sexism makes women vulnerable within intimate relationships

Benevolent sexism is a collection of attitudes which emphasizes men’s responsibility in caring for and protecting women. The subjectively positive aspects of benevolent sexism are critical in the maintenance of men’s societal power because they encourage women to adopt relationship-focused roles and invest in men’s societal advantages through supporting their male partner’s career. Previous research has shown that benevolent sexism can reduce women’s ambitions and abilities in career and education domains. However, it should also have effects within relationships. For women, the idealized promises of care and reverence, along with the heightened reliance on their partner, should mean that they are likely to experience heightened drops in satisfaction when facing relationship difficulties.
In two studies (Hammond & Overall, 2013b), participants completed records of their relationship evaluations over two- and three-week periods. We examined the degree to which women's daily relationship evaluations changed as they experienced relationship problems and hurtful partner behaviour. For women who endorsed benevolent sexism, experiencing relationship problems or hurtful behaviour was linked with much sharper drops in their relationship satisfaction. Furthermore, these drops in satisfaction were even steeper for those women who were in relationships of longer duration, and so had much more invested in the promise of reverence and care contained within benevolent attitudes. In comparison, women who did not agree with benevolent sexism did not experience the same drops in satisfaction, and for those who were in longer relationships, problems or hurtful behaviour had very little influence on their satisfaction. This line of research highlights the danger of benevolent sexism even within intimate relationships – although benevolent sexism promises women a cherished place within the intimate domain, it leaves women more vulnerable to problems and conflict which inevitably arise even in stable and well-functioning relationships.

Future research
The next stage of my research involves investigating how men and women adopt and endorse sexist attitudes. In particular, I am investigating how interactions within intimate relationships can foster, or reduce, the endorsement of sexist attitudes. Altogether, my research is building a clearer understanding of how people’s beliefs about ‘men’ and ‘women’ influence how they behave, and expect intimate partners to behave, in intimate contexts. Further, these interpersonal interactions eventually inform the wider norms of heterosexual relationships in society.

References
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