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Ph (04) 473 4884; Fax (04) 473 4889
Email: office@psychology.org.nz

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2013 Editorial

During 2013 the New Zealand Journal of Psychology (NZJP) has continued to publish material demonstrating the broad range of psychological scholarship, practice and innovation in Aotearoa/New Zealand. We can all be rightfully proud of the sharp intellects, adventurous spirits, and diligent hard workers active within our discipline. It is the task of the Journal’s Editorial Board and reviewers to work with authors to ensure that the highest standards of publication are maintained, but we start by thanking the authors for their generosity in disseminating their work. Our journal is a scholarly record and reflection of what we do, of our development as a discipline, and a sharing of local resources and understanding. All contributions are respectfully and carefully considered.

In the three issues published this year you will find 21 papers and a book review. Seven of these papers are part of a Special Section on Counselling Psychology contained in this issue. On behalf of the Editorial Board I would like to thank Rhoda Scherman (Guest Editor), and her co-editors Jackie Feather and Elizabeth du Preez, for compiling this special section. The inclusions of Special Sections within the NZJP have been a useful development. When the Journal was produced in hard copy the financial limits on size meant that large collections of papers would necessarily restrict space for ‘regular’ papers, thus delaying publication. This made Special Issues a little difficult to manage. Moving to digital publication, with a theoretically limitless issue size, provides more options for producing collections of papers without needing to place restrictions elsewhere. Publishing Special Sections may require additional assistance from the Editorial Board and National Office and (usually) a guest editor, however, the opportunity to gather a body of work on a single topic into one place can be valuable … the total often being greater than the sum of the parts. We encourage anyone with an idea for a special collection of papers to approach the NZJP with your ideas.

The Journal is also looking to develop its Book Review section. Books reviewed for the Journal must be authored by a New Zealand psychologist, or have a substantial amount of the content contributed by local psychologists, or be on a topic that has substantial and significant relevance to the practice of psychology in Aotearoa/New Zealand. The purpose of the Book Review section is to assist readers in remaining informed about current local resources, and being able to identify psychologists with expertise in particular areas. We currently have a number of books being reviewed under the expert management of Ros Case. Unfortunately, Ros will be leaving the Journal after this issue, so we must thank her for her valuable contribution, and wish her well for the future.

We must also thank the many individuals who have provided manuscript reviews for the Journal. With the diverse range of topics covered it can sometimes be difficult to identify reviewers who are able to ‘cover all the bases’. We are particularly grateful to those who take on reviews which are on the periphery of their interest area, but who are willing to put in the extra time and effort to provide a review. We are also grateful to the overseas reviewers; your contributions have been much appreciated.

Reviewers of articles in 2013:

Stephen Appel
Ailke Botha
Stuart Carr
Kerry Chamberlain
Helene Cooper-Thomas
Cate Curtis
Nick Drury
Elizabeth du Preez
Bill Farrell
Pani Farvard
Jackie Feather
Ron Fischer
Ross Flett
Stewart Forsyth
Clare-Ann Fortune
Dale Furbish
Dianne Gardner
Nigel George
Kerry Gibson
Mary Grogan
Brian Haig
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Chris Stephens
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Armon Tamatea
Natasha Tassell
Paul Therly
David Thomas
Mark Thorpe
Keith Tudor
Keith Tuffin
Kirsten van Kessell
Tony Ward
Mei Williams
Carolyn Wilshire
Kumar Yogeeswara

Finally, I acknowledge the contribution of the ‘back room’, the members of the Editorial Board and National Office, especially Donna and Debra. Without the skill and hard work of these people the Journal would not be fashioned into the form you see today.

John Fitzgerald, Ph.D.
Editor, New Zealand Journal of Psychology
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– Steven C. Hayes, creator of ACT
This editorial introduces the special section of the *New Zealand Journal of Psychology* focused on counselling psychology in Aotearoa/New Zealand. Six articles cover a range of perspectives on this developing paradigm. These articles are introduced with brief reference to some of the historical and current issues for this scope of practice. These include strengths, weaknesses, threats and opportunities for not only practitioners and researchers within the field, but also for the community of psychologists and, most importantly, for the people we work with and the potential contribution of this distinct perspective to the wider community.

As the Guest Editor to the special section, I wish to thank Jackie Feather and Elizabeth du Preez for their vital help in the development stages of this special section, and for their behind-the-scenes support throughout the process. I also wish to thank the many people who served as reviewers—some of whom are themselves contributors, and all of whom are working in the field, who brought their experiences, knowledge and insights to the peer-review process. I would also like to personally and publicly acknowledge the amazing support of Donna Macdonald and Debra Ridgway from NZJP who worked tirelessly to keep the processes going. Tena koutou … Rhoda Scherman

On behalf of the *New Zealand Journal of Psychology*, we would like to welcome you to a special section focusing on counselling psychology. The discipline had its genesis in Aotearoa/New Zealand in 1985 when members of the New Zealand Psychological Society (NZPsS) formed a Division of the Society, which later became the Institute of Counselling Psychology. The New Zealand Psychologists Board has recognised counselling psychology as a scope and is in the process of approving competencies. There is currently one accredited training programme, at Auckland University of Technology (AUT), which has been producing graduates since 2011. Counselling psychology is well established internationally, and currently most counselling psychologists in New Zealand are overseas-trained.

Counselling psychology is perhaps unique as an approach, as its defining scaffolds are at once phenomenological, developmental, systemic, empowerment- and enhancement-focused, ethical, cultural and spiritual (Feather, 2011). The model is neither fixed nor necessarily representative of the ideas of all those who may classify themselves as counselling psychologists. In each context in which it has developed, the discipline has evolved in response to the needs of the community that it serves. In this country, counselling psychology continues to advance in consultation with colleagues, industry partners and the public. The overarching question is always, what do all these parties want and need from us that might be unique and different from existing psychological services? In part, this is the reason it is difficult to find a common definition of the discipline in the literature (Gibson, Stanley & Manthei, 2004). Having said that, historically and philosophically, counselling psychology very clearly positions itself as a union between scientific models of functioning and more humanistic contextual views.

Internationally, there are commonalities with our local development and experience (see for example, Pelling, 2004). The struggle for identity is a common theme, and this is evident in some of the articles in this special section. How do we differentiate counselling psychology from clinical psychology, counselling or psychotherapy, or for that matter, from educational or community psychology? What is unique and different about counselling psychology? Who or what is the focus of our endeavours? Connell’s Southern Theory (2007) gives some insight as to why these questions may be particularly pertinent in the New Zealand context. We have reason to value connection to theories and practices emanating from European and American centres of power and influence, but this can undermine our own ideas and experiences. We are a small, remote society and, notwithstanding the ubiquitous connection modern technology provides, it often feels like a mismatch: “You know, it’s right what you say, but it is not the way we think” (Balinese man to anthropologist Unni Wikan, 1991, p. 285). Māori have experienced this mismatch and marginalisation since the arrival of the first European settlers. In a way, all New Zealanders are now in a similar position to Māori (not to minimise the
devastating effects of colonisation) whether we are of indigenous heritage, well-established Pakeha or more recent immigrants. Northern voices are loud but don’t seem to fit. The idea of Southern Theory can help us assert the legitimacy and appropriateness of locally generated ideas with which to understand our experiences (Burns, 2009). This then is a rationale for a “ground-up” development of counselling psychology theory, research and practice in this country, and is evidenced in a number of the articles in this special section.

Farrell (2013) opens with a past-present-future look at the field of counselling psychology. As he describes the paradigm, he does so from the point of view of a counselling psychologist, showing his intersubjectivity as he positions himself squarely within the tradition. He describes counselling psychology from its place in the American Psychological Association and the British Psychological Society, before showing us how the discipline has been adopted in the larger therapeutic structures of New Zealand, ultimately forming a cohesive and synthesised interpretation of the field. From that, Farrell distils counselling psychology down to its core elements before reflecting on its genesis in New Zealand, where he proposes that counselling psychology “has actually been in Aotearoa/New Zealand since there were first people here”. He emphasises the intrinsic importance of indigenous voices in the development of counselling psychology in this country. Farrell concludes by outlining the challenges and opportunities currently existing in the field.

In the second article in the series, Drury (2013) moves us away from the broad conceptualisations to more specific implications of counselling psychology practice by drawing on the philosophical teachings of Wittgenstein. The general tenant of this author’s article is that therapists should consider an alternative to the medical model that labels the patient, and instead learn to take the client’s perspective—and the understandings that they give for their own situation. Drury does this by drawing on metaphors from Lewis Carroll’s Alice in Wonderland, suggesting a reorientation and a new way of relating to the environment that emphasises the need to be collaborative, intuitive and contextual—all concepts central to counselling psychology.

With Stanley’s (2013) contribution, we turn again to the broad constructs of counselling psychology. Here he critically discusses and analyses what he sees as the seven core components of the discipline as derived from the official definition endorsed by the New Zealand Psychologists Board (NZPB). This is contrasted with the definitions offered for the other NZPB scopes of practice (i.e., clinical and educational psychologies). Throughout his paper, Stanley emphasises counselling psychology’s unique commitment to a person-centred approach as he considers the practice implications of each of the seven (as he argues) perfectly and precisely interconnected components that define the discipline.

Thorpe’s (2013) article moves us into the realm of research and training, making links between the process of qualitative research and the process of psychotherapy. He begins by proposing that conducting qualitative research within postgraduate training programmes in psychology provides students with knowledge and experience that may augment the development of therapeutic skills. Thorpe supports this proposition with examples of students’ qualitative research studies from the counselling psychology programme at AUT. He argues that counselling psychologists are drawn to qualitative methodologies as these approaches, like therapy, are intensely personal and the topics often sensitive. The experiences, attitudes and values involved in both endeavours are delineated and compared using five postulated phases of qualitative research. Ultimately, the process of qualitative research is presented as a form of experiential learning that is valuable in therapeutic training, demanding personal and professional development in areas that can only be learnt in a personal encounter that encourages a rigorous enquiry into both self and other.

Reflecting on some of the key themes in the counselling psychology literature, du Preez and Goedeke (2013) take us into the ethical decision-making practices of counselling psychologists. The authors suggest that, when faced with an ethical dilemma, practitioners will necessarily turn to the Code of Ethics as endorsed by their professional board or association. The problem with this, the authors argue, is that for the counselling psychology paradigm, the current rational, prescribed and linear models that emphasise first-order change are not suitable. Counselling psychology privileges context and collaboration as central to the relationship—and therefore, central to the decision-making processes. du Preez and Goedeke propose a new ethical decision-making model for the field; one that is theoretically-aligned, holistic, integrative and ecologically-minded. Toward that end, several existing ethical decision-making models are critically considered, and their own model is offered that preferences second-order decision-making and emphasises relational and contextual aspects.

The final two articles in the special section further develop themes fundamental to counselling psychology: context, self and ‘other’, and power—specifically, who has it? These articles demonstrate how counselling psychologists in Aotearoa/New Zealand understand and work with these dimensions in practice, drawing on local theory, knowledge and experience. The perspective of Māori is of crucial importance here. Unfortunately, no Māori are represented in this special section, a reflection perhaps of the infancy of the discipline in this country. However, Seiuli (2013) provides a valuable contribution that addresses the psychological health of Pasifika people in New Zealand, framed within the Uputāua Approach—a Samoan-based perspective. Emphasising collective responsibility, relational spaces, and respectful dialogues as vital elements of the Uputāua Approach, the author describes the key components of this model as illustrated by the fa’atalimalo (Samoan meeting house). Seiuli shows us how working holistically, and
with cultural, familial, spiritual, and environmental awareness, therapists can help their clients achieve healing and restoration. Importantly, this paper provides a template for a therapeutic approach within counselling psychology that acknowledges and respects the worldviews of minority communities represented in Aotearoa/New Zealand.

Relevant to the experience of minority communities is Milton’s work on self and other. In the first counselling psychology keynote at the NZPsS conference in Queenstown in 2011, he reminded us that even though we often think of ourselves as the only ‘other’, there are many ‘others’. What is important in a psychological encounter is knowing ourselves and respecting others; being open, asking and not assuming; creating the space to be in a dialogue; being willing to do a dance; co-creating, exploring together and acknowledging the uncertainty. These aspects are evident in Kliem, Feather and Norton’s (2013) article that reports the therapeutic journey of an intern counselling psychologist and her client. This article highlights the central place self-reflection has in counselling psychology, and is an example of the collaborative and sensitive use of an evidence-based CBT protocol with a client with severely debilitating anxiety. It also demonstrates the triple focus that a counselling psychologist explicitly holds: (1) the primacy of the therapeutic relationship and contextual factors; (2) alleviating symptoms and enhancing coping skills; and (3) healing underlying causes. It shows how responsiveness to the client on all these levels contributes to an ever-evolving formulation that meets the client’s needs in a respectful and empowering way. The power balance within the therapeutic relationship was quite equal, and both client and therapist were able to express their difficulties and their progress through self-reflective writing and in-session discussions. The client’s personal development through the therapeutic process nicely paralleled the intern’s professional development through training and supervision.

In welcoming you to this special issue, it is our hope that you come away with an appreciation of the diversity yet commonalities manifest in the evolving paradigm of counselling psychology in Aotearoa/New Zealand. There are central themes evident as a common thread through all these articles that contribute to the “ground-up” development of counselling psychology, research and practice in this country. These include a privileging of the therapeutic relationship within a collaborative contextual empowering framework, and a balancing of these humanistic, systemic aspects with a scientific approach that emphasises practice-based theory and research. In this latter respect, counselling psychology is as yet a young field in this country. This special section provides a start, with locally developed frameworks and case study examples. As the discipline comes of age, we look forward to the development of a long and fruitful tradition of theory, research and practice that builds on these, and previous, seminal publications.

While the strengths and opportunities for counselling psychology have been highlighted, we must also acknowledge the gaps. A glaring omission is the lack of any contribution to this special section by Māori psychologists. We believe there is a natural fit between counselling psychology and the principles of Te Tiriti o Waitangi: partnership, protection and participation. This has yet to be explored in any published form, but certainly has been the subject of discussion in training and supervision contexts within the field. As Farrell noted in this special section, we are very keen to encourage indigenous voices, and are grateful to have been able to include Seiuli’s contribution that illustrates shared features of counselling psychology and a Samoan perspective on health, wellbeing and the therapeutic relationship.

One other point, also highlighted by Farrell, is that psychologists of other traditions may encompass similar elements to those described here, and may well read these articles and say, “but I practice like that and I’m not a counselling psychologist”. We propose that, as the Dodo said, “everybody has won and all must have prizes” (Rosenzweig, 1936). If we pursue a ‘them’ and ‘us’ dialogue, it is likely to be to the detriment of the people we work with and their communities. The contribution of counselling psychology may be one of emphasis: the discipline re-focuses the emphasis in therapeutic work on those very aspects that both research and practice have shown matter (Wampold, 2001). This could be considered something counselling psychology explicitly offers, and thinking and research in these areas in partnership with other traditions may then contribute to all.

We have been privileged to be part of the process of documenting the current ‘state of the art’ of counselling psychology in Aotearoa/New Zealand, and look forward to continuing the dialogue with our colleagues, both within and alongside our scope of practice.

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Farrell, B. (2013). Counselling psychology in Aotearoa/New Zealand—What is it, where has it come from, and where might it go? New Zealand Journal of Psychology, 42(3), 11-17.


Kliem, A., Feather, J. S., & Miranda,...


Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy: “At last the Dodo said, ‘Everybody has won and all must have prizes.’”. *American Journal of Orthopsychiatry, 6*, 412-415.


**Corresponding Editor:**
Dr Rhoda Scherman  
School of Public Health & Psychosocial Studies  
Auckland University of Technology  
Private Bag 92006  
Auckland 1142  
Email: rhoda.scherman@aut.ac.nz
Counselling Psychology in Aotearoa/New Zealand—What is it, Where has it Come From, and Where Might it Go?

Bill Farrell, Private Practitioner & Research Fellow, Faculty of Health and Environmental Sciences, AUT

As a formal professional entity, in the sense of having a state registration with a gazetted scope of practice, an approved training pathway, and its own professional body, the practice tradition of counselling psychology is a relatively new phenomenon in Aotearoa/New Zealand. This paper explores the origins of this practice tradition, both globally and locally, as well as its intrinsic nature. The author argues that counselling psychology aims to be distinctive in privileging relationship, and in supporting this position through both the art and understanding of practice, as well as the knowledge that comes from the application of scholarship and science, particularly human science, to this practice. This claim inevitably brings the practice tradition into relationship with others who occupy some or perhaps all of the same territory. The paper concludes with consideration of some features as well as some potential outcomes of this situation.

Keywords: counselling psychology; practice tradition; Aoteaora/New Zealand, origins; potential; knowledge, art and science.

In this paper, I want to look at and think about the emergence of counselling psychology as a practice tradition in Aotearoa/New Zealand, the origins of that tradition, and its potential to contribute and take us forward. Here and elsewhere in this paper I will at times be writing in the first person. This is partly to make the point that this is an intellectual tradition in which subjectivity (including intersubjectivity) is central. It is also because I will be referring to aspects of my own experience.

The usual argument for the convention of writing in the third person is that it contributes to achieving the major aim of objectivity. However, in fields where the foci of attention include the subjective and intersubjective experience of the participants (which includes the field of the counselling psychologist), it can be hard to justify the privileging of distance from this experience. Sufficient and variable distance is needed to allow a range of reflections on subjective and intersubjective experience, but making this distance permanently equal to that required to permit objectivity may lessen, obscure or miss altogether the knowledge that may be contained in that experience. In my view, it is hard to better the argument of Wolcott (1990, p. 19) in relation to the reporting of qualitative research,

The more critical the observer’s role and subjective assessment, the more critical to have that acknowledged in the reporting.

From a formal and recent perspective, the New Zealand Psychological Society’s Institute of Counselling Psychology was formed in September 2003, as a successor to the Society’s former Counselling Division. Aotearoa/New Zealand’s first training in counselling psychology, at Auckland University of Technology (AUT), admitted its first students in 2006. An application to the Psychologists Board for a Counselling Psychologist Scope of Practice was approved in 2010, and the AUT training received Psychologists Board Approval in 2011. At the time of writing, the Psychologists Board has recently begun a consultation on the Draft Competencies for the Counselling Psychologist Scope of Practice under the Health Practitioners Competence Assurance Act, 2003 (New Zealand Psychologists Board, 2012).

Counselling psychology – what is it?

In a sense it is problematic to separate (as I am attempting to do in this paper) what something is from where it has come from, but I will do so now as a way of beginning, and do the re-joining later, not least by including and where is it after I reach the issue of where has it come from. One place to start looking for an answer to this question what is counselling psychology is in the formal masthead definitions employed by professional bodies. The American Psychological Association’s Division of Counseling Psychology (Division 17 – The Society of Counseling Psychology) defines counseling psychology thus:

Counseling psychology is a psychological specialty that facilitates personal and interpersonal functioning across the life span with a focus on emotional, social, vocational, educational, health-related, developmental, and organizational concerns. Through the integration of theory, research, and practice, and with a sensitivity to multicultural issues, this specialty encompasses a broad range of practices that help people improve their well-being, alleviate distress and maladjustment, resolve crises, and increase their ability...
Finally, the New Zealand Psychological Society (NZPsS) has adopted the following definition:

*(Counselling psychology is)* a psychological speciality that utilises and applies psychological knowledge and research at the individual, group and organisational level. Counselling psychologists enable and empower clients experiencing typical and atypical problems of living to enhance their personal, social, educational and vocational functioning.

The speciality embraces a range of approaches including preventative and educational programmes, and acknowledges the importance of phenomenological perspectives as well as the influence of developmental and ecological factors.

This definition also adds:

The Institute is established with a commitment to biculturalism and cultural diversity, in the interests of the public and the profession, to promote the highest standards of knowledge and practice in counselling psychology in Aotearoa/New Zealand (New Zealand Psychological Society, 2012).

Apart from the fact that at times those of us in different countries use different spelling, what emerges from a comparison and contrast of these three definitions?

The American Psychological Association (APA) definition is succinct and broad, and highlights key parameters, bases and aims of the discipline (such as concern with a range of issues across the life span, the integration of theory, research and practice, and including a sensitivity to multi-cultural issues). The British Psychological Society (BPS) definition is more detailed, and brings in human science research and, interestingly, the principal psychotherapeutic traditions. It is also more elaborate in its expression, conveying a broad inclusion but also a certainty about some of what must be included (such as being practice led, including professional artistry, and recognising the importance of social context, pluralism, and anti-discriminatory practice). It seems to have a particular awareness of the role of power. The Aotearoa/New Zealand (NZPsS) definition is clear on the breadth of range of concern (including typical and atypical problems of living), and mentions preventative and educational programmes, and developmental and ecological factors. Like the BPS, it includes a phenomenological perspective, but uniquely it mentions biculturalism alongside a commitment shared with colleagues in the USA and UK to cultural diversity. In my view, these definitions are a representation of something of at least my own understanding of the professional worlds of counselling psychologists in the USA, UK and Aotearoa/New Zealand, and hence of what is counselling psychology.

I can flesh out this sense of what is counselling psychology derived from these masthead descriptions through reference to what have become core texts in the field, as well as reflections on my own personal experience as a professional counselling psychologist. There are published handbooks of counselling psychology in both the USA and UK (although as yet we do not have a handbook based on the practice of counselling psychology in Aotearoa/New Zealand, and the key local handbook on professional psychology (Evans, Rucklidge, & O’Driscoll, 2007) does not even mention the tradition explicitly). These are generally edited collections, both edited and written by those with acknowledged expertise in the local field. In the USA, Brown and Lent’s Handbook of Counseling Psychology is in its fourth edition (Brown & Lent, 2008) and there are also more recent examples (Almaier & Hansen, 2012). In the UK, Ray Woolfe and colleagues (Woolfe, Strawbridge, Dryden, & Douglas, 2010) have recently produced the third in a series of handbooks on counselling psychology, aiming to tap the breadth of the discipline as well as key areas of depth of discovery and debate. To complement these, Orlans and Van Skoyoc have written ‘A Short Introduction to Counselling Psychology’ (2009), which is actually an elegant account of their attempt, essentially a research undertaking, to address...
the challenge of their title. To further complement the handbook, Robert Bor and colleagues (Bor & Watts, 2011; Palmer & Bor, 2008) have produced handbooks for trainees and practitioners, although these are intended for an audience of counselling psychologists, counselors and psychotherapists, perhaps underlining the breadth of salience of the issues. In a different vein, Milton (2010, 2012) has edited two collections of work by UK counselling psychologists exploring their practice beyond therapy and beyond diagnosis, and, incidentally, contributed a keynote talk at the 2011 New Zealand Psychological Society annual conference (Milton, 2011) on the challenges of holding the tension between differing approaches in a pluralistic approach to practice.

Turning to my own experience, I want to include here elements from a piece I wrote recently as part of the Institute of Counselling Psychology’s attempt to scope the experiences and backgrounds of the founding members of our practice tradition in Aotearoa/New Zealand, as part of efforts to further the establishment of the practice tradition.

I have identified as a counselling psychologist since 1985. I was grandparented into the practice discipline in the UK, having gained a BSc (Honours) in Experimental Psychology and an MSc in Psychotherapy, as well as other training and experience. In the past, I worked in a range of health settings (adult and child mental health, child development, and primary health care), in university counselling, and as a trainer and clinical supervisor of a range of other health professionals. More recently, I have been in private practice as a psychologist and psychotherapist, working with individuals, couples, families and groups. I continue to supervise a range of other health professionals, and to contribute to postgraduate training in both individual and group psychotherapy. I have recently completed a PhD in which I developed a methodology for use in practitioner research and then applied that methodology to my own work as a trainer of psychotherapists. I have never had the job title ‘counselling psychologist’, but all of the practice that I have described has been from this perspective (Farrell, 2012).

I think the most significant element of what I have written here in relation to the themes of this paper is ‘from this perspective’. Much of what I do in my practice is psychoanalytic psychotherapy, and I am credentialled and experienced in that field, but my core professional identification is as a counselling psychologist.

To summarise thus far, I want to propose that fundamentally, counselling psychology is a practice tradition, based on a set of values (notably a privileging of the relationship between a counselling psychologist and their client or clients, as a means to both formulate and address the issues they bring), and aimed at addressing the whole range of problems of living across the lifespan, with diverse populations and with regard to the cultural and social and ecosystemic contexts of those populations. Essentially, I see it as the applied psychology of counselling and psychotherapy. In jurisdictions that identify counselling psychology as a distinct professional practice it seems inevitable that its formal practice will be limited in some way to those identified as counselling psychologists. However, in those jurisdictions and elsewhere, elements (if not all the elements) of the practice tradition will be practiced by those in many allied fields and contexts, including psychologists from other practice traditions (such as clinical, educational, industrial/organisational, community, forensic/criminal justice, and coaching psychologists), psychiatrists and other medical practitioners, psychotherapists, occupational therapists, nurses, social workers, teachers, clergy and others. In my view, rather than any attempt to limit or restrict the practice of those others, the challenge for counselling (and, indeed, for other) psychologists is to engage in relationship and dialogue with those others in order to enable them in their pursuit of the highest standards of understanding and practice.

In my personal view, two defining writers for contemporary counselling psychology are Bruce Wampold (2001) and Jonathan Shedler (2010). Wampold has the unusual provenance of being both a counselling psychologist and a statistician. He argues persuasively that the model that has been applied in the evaluation of the psychological therapies has been fundamentally a pharmacological or medical model, with the gold standard of the randomised controlled trial, and the comparison of ‘treatments’ (such as ‘pharmacotherapy versus cognitive-behaviour therapy’) as though they were discreet invariant entities, and in particular, relatively ignoring the contribution of the therapist and client as people and the quality of the relationship between them. For Wampold as for most counselling psychologists, what is relatively ignored in the medical model is the central concern of counselling psychology. Building on the work of Rosenzweig (1936) and Frank and Frank (1991), he puts forward the case for the construction of psychological therapy as an interpersonal process, based on a contextual model, including consideration of client characteristics, therapist qualities, change processes, treatment structures and relationship elements, as articulated by Greencavage and Norcross (1990).

Shedler furthers this argument, in relation to psychodynamic psychotherapy in particular, through an examination of pervasive myths amongst academics, health care administrators and planners:

There is a belief in some quarters that psychodynamic concepts and treatments lack empirical support or that scientific evidence shows that other forms of treatment are more effective. The belief appears to have taken on a life of its own. Academicians repeat it to one another, as do health care administrators, as do health care policy makers. With each repetition, its apparent credibility grows. At some point, there seems little need to question or revisit it because “everyone” knows it to be so (Shedler, 2010, p. 98).

Shedler demonstrates convincingly that where psychodynamic psychotherapy has been evaluated, it
leads to greater effect sizes than those seen in other forms of therapy, and indeed (consistent with the underlying theory) that these effect sizes are maintained at follow-up and may well continue to grow. Moreover, he goes on to argue that where other forms of therapy have been successful, it is frequently because the therapy has involved psychodynamic components (whether or not these are recognized explicitly by the clinician), and to produce an inventory of the components of mental health, the Shedler-Westen Assessment Procedure (SWAP), that can be applied to the examination of therapeutic practice (Shedler & Westen, 2007).

Although he is writing about psychodynamic psychotherapy, in my view Shedler is exemplifying the best of counselling psychology, including a perspective that can be readily derived from Wampold’s (2001) Contextual Model.

**Counselling psychology in Aotearoa/New Zealand – where has it come from, and where is it?**

I want to argue that counselling psychology probably represents a particular form of a very widespread if not universal human practice, that of being in relationship with another or others who may well be in distress or challenged, and simultaneously seeking to make thoughtful use of the best available resources of knowledge, skill and art in the service of that relationship and hence of the other or others.

In the light of this, one answer to the question of where has counselling psychology come from? is that it has actually been in Aotearoa/New Zealand since there were first people here. I am not equipped to articulate indigenous counselling psychology, but I long to hear from those who can, and maybe this special section and what follows will invite and enable them to bring their voices forward. However, taking the broad view, that the practice of some form of counselling psychology, in the sense of a systematic and theorised form of helping another or others through the relationship with them, is virtually intrinsic to humanity, it is clear that people have had ways of helping and being helped here for hundreds if not thousands of years. My focus in this part of the paper is on what has been available for import, and the roots of that. I do want to acknowledge that I risk privileging a colonial myth that knowledge of counselling psychology is inevitably exotic, but will seek to avoid that. Nor am I suggesting that the form of counselling psychology in any culture will be a universal one. As an aside, this tension, between risking becoming overwhelmed by cultural imports, and alternatively risking an indifference to what those imports might offer, is an issue shared by other countries in the world, but one which has particular salience in Aotearoa/New Zealand.

Counselling psychology as a formal practice discipline has identifiable starting points in the USA, UK, Canada, South Africa and Australia. In addition to these starting points, there are roots that are less distinct.

One root of counselling psychology stems from its relationship with clinical psychology, because the latter has developed very widely as a formal practice in health care throughout the world. Arguably, much of counselling psychology was amongst what was left out when Hans Eysenck and colleagues left the then Medical Section of the British Psychological Society in the late 1940’s in the pursuit of science as he understood it, in partnership with the new scientific psychiatry, to form the Society’s Division of Clinical Psychology (Burton & Kagan, 2007, p. 20). It can be argued that a process in the USA which could be seen as kind of converse of this led to Carl Rogers’ (1951) move, away from psychiatry and aspects of psychoanalysis and clinical psychology in America that had become associated with it. In other parts of the world, notably outside of the UK and the USA, such transitions seem less evident. When the UK was preparing for greater integration with the European Community in the early 1990’s, European professional associations began to get to know each other, and a representation of the response of continental European psychology associations to the institutions of British counselling and clinical psychology was, ‘...we recognize you (counselling psychology), but who are they (clinical psychology)?’ (van Deurzen, 1992). My argument here is that in the UK and the USA, a set of values became relatively overlooked in the locally dominant practice traditions within psychology and needed to be recovered. In some other parts of the world such as continental Europe, that process was arguably less complete, hence perhaps needing less of a formal remedy through the development of a separate practice discipline.

Looking at previous attempts prior to this Special Section to discuss counselling psychology in Aotearoa/New Zealand, arguably some of these did not get very far. Gibson and colleagues (Gibson, Stanley, & Manthei, 2004) opened ‘a window of opportunity’ for counselling psychology, but were met by a response from Fitzgerald and colleagues (Fitzgerald, Calvert, Thorburn, Collie, & Marsh, 2005) that could hardly be seen as welcoming, together with a letter from Vertue (Vertue, 2005) warning course directors of clinical psychology courses about counselling psychologists.

Despite this response to the attempt of Gibson et al to enhance the diversity of New Zealand psychology, including an argument that their article should not have been published and reference to the strength of numbers of clinical psychologists, the article by Fitzgerald et al has entered the literature as a claimed example of stereotyping of clinical psychologists (France, Annan, Tarren-Sweeney, & Butler, 2007) in the handbook of professional practice of psychology in Aotearoa/New Zealand mentioned above (Evans et al., 2007).

It is of interest that France et al’s book chapter promotes the Jericho principle (Culbertson, 1993), that the walls around and between professional specialisations need to come down in the interests of (and in a sense, for the protection of) the public. France et al also note Taylor’s account (1997) of how in 1967 the New Zealand university departments of psychology uncharacteristically acted in unison when they voted unanimously to exclude all educational psychologists from the newly formed New Zealand Psychological Society, a move which thankfully did not succeed. This key relationship, of counselling psychology
with clinical psychology has, I believe, developed considerably since 2005, but remains a focus for challenge and tension.

Another root in the origins of counselling psychology is the relationship with psychotherapy and counselling. It is notable that in the British Psychological Society’s definition above (British Psychological Society, 2012), phenomenological models of practice and enquiry are included alongside those of traditional scientifically, and the discipline is tasked with the continuing development of models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship. Much as there is a legacy from clinical psychology, there is also a strong legacy from counselling and psychotherapy, but with the addition of a commitment to a particular set of forms of research and practice development.

In both the USA and UK, as well as in parts of Europe and elsewhere, there has been a tradition of psychotherapy being a post-qualification specialization for post-qualifying psychologists alongside members of other health and helping professionals. However, alongside the long tradition in British psychoanalysis of ‘lay’ analysis, that is, analysis practiced by those other than medical practitioners, there are now a number of practitioners in various parts of the world including Aotearoa/New Zealand for whom psychotherapy is their first profession. Perhaps the main consequence of this latter development is to reinforce the notion that qualification (and registration) in psychology is but a basic qualification, that qualification (and registration) in psychology is but a basic qualification, producing a beginning practitioner, and counselling psychologists and others will have to contemplate continuing professional development that will require post-qualification training in various psychological therapies. Another challenge in this root of counselling psychology is the question of how the links between the professions of counselling psychology, counselling and psychotherapy will develop. In the UK, the emerging discipline was formed by psychologists who had taken postgraduate training in a range of psychotherapies after (or occasionally before) their first degrees in psychology, and were familiar with psychotherapy training requirements for the therapist to have some form of personal psychotherapy as part of their training. This requirement has been built into the British Psychological Society’s Diploma in Counselling Psychology (the benchmark in the UK for approving trainings), although this is not part of the requirements for the only Aotearoa/New Zealand training in counselling psychology at Auckland University of Technology.

This leads to where is counselling psychology in Aotearoa/New Zealand? The answer must be that it is continuing to form. Although its formal beginnings could be said to be 2003, with the formation of the NZPsS Institute of Counselling Psychology, I have outlined above how the relevant practice would have been here long prior. Personally, I have been here ‘under the radar’ since 1995, when I was informed by the then Registrar of the Psychologists Board that, “in New Zealand, psychology and psychotherapy are entirely separate”, hoping through my person to give a lie to that, and I am sure there are many other examples. As the discipline forms though, trainers and training supervisors will increasingly come from counselling psychology trainings themselves. Other contributions in this Special Section will outline the particular shape that counselling psychology is taking in Aotearoa/New Zealand. From a formal perspective, the profession needs to continue to form international links with counselling psychologists around the globe, but also with psychologist, psychotherapist, counselling and psychiatric colleagues and others in Aotearoa/New Zealand. Our arrival may have occasioned some discomfort, but we are here to stay, and, as outlined below, hope to be able to contribute to a range of challenges facing all of us.

**Counselling psychology in Aotearoa/New Zealand – where might it take us?**

Here I would like to turn to the challenges of the future. There is a range of these, some of them perhaps only relevant to those within the field of counselling psychology, whilst some face a range of professionals, and yet others are challenges that face all people in Aotearoa/New Zealand.

**Meeting the increasing and complex needs of an increasingly diverse population.**

It is widely understood that state systems of provision in countries such as Aotearoa/New Zealand, as in many places elsewhere face a demographic crisis as increasing numbers of elders and children look for support to a proportionally shrinking population of adult workers. Here, where psychologists and others are being urged to lead the response to this situation (Gorman, 2012), counselling psychology surely has a role to play. With its emphasis on empowering and enabling, there is immense scope for work, with others, in a range of partnerships, to which counselling psychology and counselling psychologists can contribute.

**Working in partnership with Māori, and across multiple cultures.**

New Zealand psychology, whether represented by the major professional organisations, the New Zealand Psychological Society, the New Zealand College of Clinical Psychologists, or the government regulator of the profession, the New Zealand Psychologists Board, embodies various forms of commitment to the Treaty of Waitangi and the principles of a bi-cultural relationship based on partnership, participation and protection. It behoves us all as psychologists to give meaning to that relationship in our practice and other work, whether it be research, teaching, training, consulting or whatever else we do. Looking at the definitions of counselling psychology, notably that of the British Psychological Society with its emphasis on models of practice that are non-discriminatory (see above), it is striking that counselling psychology is an area of psychology that can accommodate and would hopefully welcome as equals models of practice based on a Māori world-view, as well as models from all cultures represented in Aotearoa/New Zealand.

As in other psychological specialties, the core values of the discipline need to be acknowledged for these other models to be acceptable, but the epistemological position of
counselling psychology in relation to the commitment, for example, to elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing, offers a potential place for a meeting of bicultural and multicultural practices without a need to choose between them on the basis of a randomised controlled trial.

The Transit of Venus Forum 2012 – promoting step-change in understanding, highlighting, engaging public attention to, and addressing the challenges of the psychological and social forces that prevent or inhibit progress.

A forum was held in Gisborne, New Zealand in June 2012 by a partnership coordinated by the Royal Society of New Zealand (Royal Society of New Zealand, 2012). This event was initiated by the late Sir Paul Callaghan and colleagues. They made use of the occurrence of the infrequent astronomical phenomenon of the transit of the planet Venus across the sun as a focus to consider the future of Aotearoa/New Zealand. It was this phenomenon that led to Captain James Cook’s first voyage to Tahiti in 1767, and his subsequent orders to explore that took him to Aotearoa/New Zealand, and to some of the first contacts and creative exchange and partnership between Europeans and Māori, mediated by the Tahitian Tupia. In particular, Sir Paul asked how this country could become a place where talent wants to live.

I attended this event as an individual, but as far as I am aware there were no other practicing psychologists (or for that matter, psychotherapists) present among the 350 scientists and others who attended. One of the six strands referred repeatedly to issues that are human issues. I put it to the forum that psychology and psychotherapy as disciplines have a great deal to contribute to thought and initiatives, not least in relation to how positive psychosocial processes can be fostered and negative and destructive processes avoided. It occurs to me that this field is squarely in the sights of counselling psychology in Aotearoa/New Zealand.

A sustainable discipline with a place in Aotearoa/New Zealand

As well as the relatively outward stance described above, there needs to be a concern within counselling psychology in Aotearoa/New Zealand and in allied quarters with the future of the discipline. Our numbers are small, and those of us in positions of responsibility need to make eligible colleagues welcome and aware of what association with us can offer, and to grow our formal membership. Suitable people wishing to train as counselling psychologists need training opportunities, as do other psychologists looking for lateral transfer of their existing competence. These opportunities may come through tertiary institutions, but it may be possible to develop, or to adapt existing, innovative pathways, such as the Independent Route to Chartered Status as a Counselling Psychologist in the UK, or the Advanced Clinical Practice Route to Membership of the New Zealand Association of Psychotherapists (New Zealand Association of Psychotherapists, 2012), and hence to registration as a psychologist in Aotearoa/New Zealand.

A final challenge that I would like to highlight for the practice tradition of counselling psychology is the question of funding. There is the usual double-edged sword of ‘no workplace’. In other words, because counselling psychology has in general not had a distinctive, or indeed sometimes any, workplace, it has been freer to grow than a tradition which gets allied with a particular employment role, but at the same time it suffers from the lack of community investment and the subsequent demand on the resources of each practitioner. There is already concern that difficulties in getting initial employment in professional fields is serving to bias opportunities for access to those fields towards those already advantaged (who can, for example, offer to work for free as interns), hence increasing already damaging inequality.

Maximising the impact of counselling psychology

We do need as counselling psychologists to connect with each other, and with those entering and those interested in our profession. However, in order to maximize the impact of counselling psychology, it is vital for counselling psychologists to connect both with the community of psychologists but also with the wider community of Aotearoa/New Zealand. In this vein, the New Zealand Psychological Society’s Institute of Counselling Psychology has presented symposia at the last four Annual Conferences of the New Zealand Psychological Society. These have been valuable for a range of reasons, enabling us to form through speaking up, and through forming connection with others who are interested. It seems clear that we will now probably make the most impact and progress if we also contribute our distinctive perspective to the many foci that we share with others, as well as raising our unique profile with the general public.

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**Corresponding Author:**

Dr Bill Farrell
P O Box 60297
Tiritangi
Auckland 0642
New Zealand
Email: wfarrell@ihug.co.nz
Wittgenstein and the Red Queen: Attuning to the World and Each Other

Nick Drury

Wittgenstein showed us non-dualist mental processes that have relevance for psychotherapy and our ecology. His methodology is therapeutic in that it helps us realise that our attunement with nature and each other is natural and immediate. This thinking helps us redefine mental health, and with the aid of feedback tools enhance our attunement to clients and their attunement to the world. The values of counselling psychology, with its focus on conversational meaning-making, are highly consistent with the demands of this process.

Keywords: counselling psychology, ecological, being with, collaborative meaning-making

‘When, after being persuaded by Wittgenstein to read The Brothers Karamazov, Drury reported that he had found the figure of [Father] Zossima very impressive, Wittgenstein replied: ‘Yes, there really have been people like that, who could see directly into the souls of other people and advise them.’


In this paper, I will show some of the therapeutic implications of a revolution that has occurred in studies of cognition, with special emphasis on Wittgenstein’s contribution to this revolution. His philosophical investigations will be used to expose some of the grammatical errors rife in the ‘medical model’ view of what makes therapy work, that currently dominates mental health practice; as well as suggest that there is a path here for approaching ecological problems. As will be seen, the ‘medical model’ view runs a high risk of recruiting both practitioners and their clients into their own subjugation, and thus generating mental health epidemics (Watters, 2010; Whitaker, 2010). The revolution now occurring in cognitive studies provides conceptual support for a shift away from the ‘medical model’ view to what Wampold calls the ‘contextual model’ view, which enjoys greater support from empirical studies of outcomes (Wampold, 2001). For therapists seeking clinical excellence, this shift can be facilitated by the use of outcome feedback systems. I will utilise some of Lewis Carroll’s metaphors to scaffold this shift in understanding.

Expertise

In 1980 Dreyfus and Dreyfus put forward a five-stage model of the development of ‘expertise’, suggesting that as our proficiency increases we abandon rule-following in favour of embodied intuitions. Although this model has been refined since then, it continues to throw considerable doubt on the model(s) developed by Plato, Kant, and Piaget (amongst others), that proficiency occurs by abstracting and internalizing increasingly sophisticated rules. Rather it suggests that it is more useful to consider that a shift from ‘know-that’ to ‘know-how’ occurs as we move from ‘proficiency’ to ‘expertise’. By way of argument, Dreyfus and Dreyfus (2004a; 2004b) note that chess and draught-playing computers capable of learning will develop increasingly sophisticated rules, but never reach a level of sophistication where they can consistently defeat human masters. They also report an experiment where a chess grandmaster could defeat skilled opponents in a 5-seconds-a-move game whilst simultaneously adding numbers delivered at the rate of one a second.

Not only do experts “trust the force, Luke”, but it seems they are more situationally aware. The work of Ericsson (2009) indicates that if the expert is asked for the rules, she will regress to the level of the beginner and state the rules she learned at school; rules she no longer uses. Pattern recognition has replaced rule-following, and it is claimed that the chess grandmaster can recognise 50,000 types of position; which Ericsson claims takes 10,000 hours of deliberate practice to achieve.

Empirical research on psychotherapists also indicates that improvement in pattern recognition or situational awareness is a far more important variable for improving effectiveness than experience or training (Duncan, et al., 2010). Empirically supported treatments are only as good as the therapist delivering them (Nyman et al., 2010). Rule-following therapy, or doing it by the book (therapist adherence), seems to lead to decline in effectiveness (Wampold, 2001). However, deliberate practice, by way
of feedback to the therapist of success and failure, can improve performance remarkably (Duncan et al., 2010; Lambert et al., 2001; Sapyta et al., 2005). Current discussions amongst psychotherapists at the International Center for Clinical Excellence website, who have heeded this call to shift from evidence based practice to practice based evidence, are suggesting that comparisons with colleagues and one’s own previous performance of (client assessed) rate of change, drop out rates, clients returning for further service, and therapeutic alliance scores can facilitate this deliberate practice that enhances effectiveness.

A Revolution

“I see nobody on the road,” said Alice. “I only wish I had such eyes,” the King remarked in a fretful tone. “To be able to see Nobod! And at that distance, too! Why, it’s as much as I can do to see real people, by this light!”

The Dreyfus model of expertise can be seen as an expression of a new wave of thinking about the nature of mind occurring in philosophy and psychology under the umbrella of radical embodied (or enactive or extended) cognition (REC) (Chemero, 2009; Clark, 2008; Gallagher, 2008; Shapiro, 2011). REC considers cognitive processes can best be understood by considering the whole body, and not the brain, as the locus of sensing and acting; and the skin as not the boundary of mental pathways. Rather than ‘thinking’ being seen as something going on inside the head, it is possible to view ‘thinking’ as the subtle positioning and re-positioning of ourselves (and others) in the world (Harré & van Langenhove, 1999). Wittgenstein showed us how we are doing this through joint attention sharing activities, which he called ‘language games’.

Further, cognition can be understood without the necessity of the unfalsifiable dualist ‘executive functioning’ concept (Parkin, 1998). Developmentally, the sensorimotor stage is not abandoned or overcame, but rather refined as language and perspective taking develop (Thelen, 2000). There is no need to posit the existence of a ghostly ‘mind’ computing representations (Hutto, 2012). From this perspective, action becomes central to cognitive development as various sensorimotor systems dynamically couple with each other (Smith & Sheya, 2010). As we shall see, the task in therapy, as Merleau-ponty (1968), alluded to, is to facilitate the development of sensori-motor couplings as new perspectives develop. Although Fodor (a primary proponent of ‘computational cognitivism’, or the mind as computer metaphor)3 sees REC as ‘a bad cold’ cognitive science has been infected with (Fodor, 2008, p. 11); Hutto (2012) claims that REC is no longer the Barbarian at the gate, but now occupies the cafes and wine bars.

REC does not make the Cartesian assumption of ‘mind in here – world out there’; instead suggesting that we can view mind as both ‘in here and out there’. In other words, cognitive processes can be viewed as being immanent in the discourses and relationships we are having. Bateson (1972, p. 459) first voiced this by asking where the blind man’s mental system is bounded – the handle of the stick or the tip? Neither. The mental system can be seen as the circuit: the street, the stick, the man; news of difference is being transmitted around this circuit. When he sits down for lunch, a different circuit or ‘mind’ comes into play. A similar idea was developed by Maturana and Varela (1987) who showed that we can understand living things by viewing them as entities that ‘know how’ to produce themselves (autopoeisis) by living within a perceive-dependent circuit or world (constructivism). This ‘knowing’ resides in the organisational structure of the organism and the ecology in which it evolved.

A further source that REC draws upon is Heidegger’s (1962) notion of ‘Dasein’. This is the idea that most of the time we are so absorbed in our activities, so attuned to the world, that we are not aware of any ‘gap’ between us and the world. The hammer or car feels like part of me when I am using them (until something goes wrong). Anxiety, amongst other things can disturb this attuned familiarity with the world. It might be said, that the experience of having a Cartesian mind (‘mind in here, world out there’) is born of failure or doubt. Other phenomenologists, such as Merleau-Ponty (1962) and Levinas (1998), noted that this attunement is also social for humans; we are able to directly mind read each other in most situations without having to infer how it is with other via either empathic simulation or a theory about other minds (as the proponents of theory of mind (ToM) claim (Leudar & Costall, 2009)).

Noé (2004, 2009), strongly influenced by Wittgenstein, developed the idea that the primary function of perception is not to identify things in the world, or gain a clear picture of the world, as has been assumed for some centuries; but is ‘enactive’ in that it is the development of sensorimotor skills for the purpose of keeping track of our relationship with the world. As there are more motor pathways to the senses than input pathways, Noé suggests that an appropriate metaphor for enactive perception is that of a blind man with his cane, using his senses to probe the interdependent relationship he has with the world. A matter of ‘know how’. Change blindness and inattention blindness experiments are being utilised to demonstrate this new paradigm. The skill of attunement is now key, and a science based upon attunement rather than obtaining clear pictures of the world, has obvious ecological value. With regards to therapy, it might be said, that the task for the therapist is to attune to the client in his or her struggles to become better attuned to the world. This is quite different than obtaining an objective assessment of the client.

In brief, the REC revolution in cognitive studies finds much attraction to Nietzsche’s argument, that there is no more an “I” who thinks than there is a lightening apart from the flashing in the phrase ‘lightening flashes’. The noun-verb structure of grammar lured us into Descartes’ Weltanschauung. Further consideration of this point allows us to take the position that we don’t walk with our legs (a separate ‘I’ from the walking), but use our legs in walking. This allows us to also drop the prejudice that thinking occurs in the head, by recognising that legs and brains are crucial not causal for these activities (Noé, 2009; Heaton, 2010). A shift is being called for to recognise that ‘know how’ (performance knowledge)
can be considered primary. What Wittgenstein brings to this discussion is a way of eliminating numerous similar grammatical ‘ghosts’ in our thinking that keep us ensnared in dualism; and thus may facilitate a more ‘expert’ or attuned relationship with our world.

Wittgenstein’s ‘Language Games’

Wittgenstein is perhaps best known for his idea of ‘language games’. These are the ‘mental circuits’ mentioned above with respect to REC. ‘Language games’ are joint attention sharing activities; and words obtain their meaning, in most cases, not by representing things in the world, as dictionaries and traditional thinking suggests, but by their use in various language games. There is considerable research on joint attention and language development supporting Wittgenstein’s elucidations here, which can be summarised as: mimicry is present from birth, and between nine and 14 months the child begins to alternate between monitoring the gaze of (m)other and what other is gazing at, checking to verify they are continuing to look at the same thing, and during that period vocalizations begin to become part of these games (Hobson, 2002). Thus language is seen as ‘know how’ and not ‘know that’ (words representing things).

Although this appears to be simple behaviourism to some (e.g. Fodor, 2008), it must be noted that language is grounded, as Wittgenstein noted, in the immediate reactions we have with each other. It is primarily social (attunement/engagement). The infant only imitates if the other person is attending to it (Csibra & Gergely, 2009). It will turn away upset if a recording of its mother replaces the real thing (which it previously reacted lively with) through a TV link (Murray & Trevarthen, 1985). Thus as language users we are not independent from each other with a need to interpret each other (as even implicit ToM proponents imply (Low & Perner, 2012)), but engaging as participants in co-ordinated dances of attention where we (most of the time) understand each other immediately as we toss ‘conversational balls’ around. These language games can take a multitude of forms (giving orders, telling a joke, play acting, mathematics, etc., etc), and at times Wittgenstein called them ‘forms of life’. They ‘...are as much a part of our natural history as walking, eating, drinking, playing’ (1958, §25). We can all too readily lose our way when our attention shifts from the activity (language game) to the apparent representation; that is to say, when words become decontextualized from their use.

Wittgenstein’s therapy (and “thesis”?)

Many Wittgensteinian scholars have been instrumental in the development of REC. Recently Baker (2004) and the ‘New Wittgenstein School’ have suggested that Wittgenstein’s later philosophy can be regarded as a form of grammatical therapy for dissolving many of the false (or questionable) analogies and similes that have been assimilated into our discourse and mislead most of us at times. Whether his philosophy is solely a therapeutic endeavour for achieving clarity, and is not advancing any theses, is subject to some debate. However it may be useful for therapists to consider that previous philosophical endeavours attempted to present a general picture of the universe, and Wittgenstein’s method consisted of scraping the picture off the window so we can see the world (or be with the world as participants) more clearly. “Philosophy aims at the logical clarification of thoughts. Philosophy is not a body of doctrine but an activity” (1961, §4.112).

Wittgenstein saw his philosophy then, as a form of therapy for untying “knots in our thinking” (1967b, §452). Following Noé, this would facilitate a greater attunement with the world, for once the problem has gone, we can simply say “I know how to go on” (1958, §154). “For the clarity that we are aiming at is indeed complete clarity. But this means that the philosophical problems should completely disappear” (1958, §133). Although in our civilization “clarity is sought only as an end, not as an end in itself. For me, on the contrary clarity, perspicuity are valuable in themselves” (1980, p. 7). In this regard some see Wittgenstein as a form of Zen for the west. “The problems are solved in the literal sense of the word – dissolved like a lump of sugar in water” (2005, §421).

“The way to solve the problem you see in life is to live in a way that will make what is problematic disappear. The fact that life is problematic shows that the shape of your life does not fit life’s mould. So you must change the way you live and, once your life does fit into the mould, what is problematic will disappear” (1980, p. 27).

Hence the appeal of Wittgenstein to Solution-focused brief therapy (SFBT).

It could be argued that Wittgenstein is advancing a thesis; in that if the Enlightenment philosophers had scraped religious dogma off the window, Wittgenstein saw that a ‘scientism’ had replaced it, such that we have become enamoured by scientific explanation. The ‘scientism’ he was critical of shifts our collective attention away from the world to some imaginary mechanisms or so-called laws of nature working behind the scenes. “[T]he main source of superstition results from belief in the causal nexus” (1961, §1361). “Man has to awaken to wonder ...Science is a way of sending him to sleep again” (1980, p. 5). Developing Wittgenstein’s ideas, Winch (1958/1990) asserted that many of the issues social sciences are concerned with are not empirical ones, so much as conceptual; and thus an analysis of our ‘grammar’ can in many cases, be more useful. Although written 60 years ago, Wittgenstein noted that psychology could not excuse itself for its “confusion and barrenness” by claiming to be a young science, but rather: “in psychology there are experimental methods and conceptual confusions” (1958, p. 232e). Hutto (2009) and Williams (1999) say it still holds today, for to be just collecting raw empirical data, which can be interpreted in multiple ways renders it barren, whilst the conceptual confusions remain.

Both Bateson (1972) and Heidegger (1978), in different ways, warned that difficulties in our thinking or psychology are the source of our ecological difficulties. Wittgenstein tracks what he sees as psychology’s conceptual confusions to its beginnings when our collective attention endeavoured to find certainty in our conjectured causal accounts. Look at Freud’s ‘unconscious
The parallel that Wittgenstein had noticed between the therapeutic endeavours of Freud and his own work is that the difficulties both he and Freud were dealing with were a matter of people “not knowing our way about” (1958, §123). Wittgenstein saw these as relational difficulties or orientation struggles, that unlike intellectual problems which can be resolved by finding an answer, require us to us to discover how to relate to our environment in a different way so we now attend to certain aspects rather than others (Shotter, 2011). Once we have become reoriented, the intellectual answers become either obvious or simple. In this regard, he once noted: “What a Copernicus or Darwin really achieved was not the discovery of a true theory but a fertile new point of view” (1980, p. 18e).

Given the history of the ‘technologies of the self’ (Foucault, 1988), it is understandable how readily we might colonise patients with our views of what we consider the best orientation for the patient to take, based on our perception of the relational struggles the patient has. Indeed, those who view psychotherapy through the ‘medical model’ lens privilege the therapist’s assessment and formulation (diagnosis) of the situation, and tend to label patients who do not accept that view as ‘resistant’. Such human engineering efforts all too readily lend themselves to bullying and confusion. At the heart of the “abominable mess” (1993, p. 107) we have inherited from Freud, is a confusion that leads us to think we are identifying ‘causes’ (e.g. ‘depression’), when what we are needing to do is explore collaboratively with our clients for an orientation to their struggles that will allow them to “go on”. We need to attune to the reasons (understandings) the client gives for their situation. Shotter (2011) calls this different type of knowledge or skill ‘witnness knowledge’, which is quite different than the ‘aboutness knowledge’ science provides us with. It is a matter of ‘know how’ rather than ‘know what’; a matter of philosophy as Wittgenstein saw it (“what is possible before all new discoveries and inventions”) (1958, §126) rather than a scientific task.

Lewis Carroll illustrated this confusion when the bully of the story, the Red Queen (ironically the Queen of Hearts), directed Alice to play croquet with flamingos and hedgehogs. Clearly the creatures have reasons of their own as to which (language-) games they would prefer to play, and are unlikely to want to join in the Red Queen’s cause and effect games. Albee (1998) suggests clinical psychology sold its soul to the devil by embracing the medical model in 1949. A causal claim is a conjecture (1966, p. 15), and as such other conjectures may be equally fitting. There is risk of harm here, in that viewing themselves as objects, many patients may come to develop an identity based on these diagnoses. Labelling theory, or Hacking’s ‘looping’ (1998, 2007) argues that harm is done as classifications of people interact with the people classified; and what’s more, as these labels get into public circulation boundaries between ‘normality’ and pathology become blurred, resulting in more people seeking treatment (Rose, 2011). Mental health epidemics are thus spawned (Hacking, 1998; Watters, 2010; Whitaker, 2010). Some Wittgensteinian scholars have suggested that we give more respect to folk psychology language in order to avoid these muddles; that we remain within the language games of our clients (Hutto, 2009; Leudar & Costall, 2009).

Counselling Psychology

Despite the different origins of counselling and clinical psychology (Munley et al., 2004: Stanley & Manthei, 2004; Strawbridge & Wolfe, 2010), there has been a growing fusion of the two over the past few decades as work roles merge (Neimeyer et al., 2001). Counselling psychology has attempted

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Wittgenstein, Psychotherapy and the Red Queen

In the 1930’s, Wittgenstein took some interest in Freud, seeing a number of parallels with his own endeavours, even calling himself ‘a disciple of Freud’ for a while. Nevertheless he was highly critical: “Unless you think very clearly psycho-analysis is a dangerous & a foul practice, & it’s done no end of harm &, comparatively, very little good. (If you think I’m an old spinster – think again!) – All this, of course, doesn’t detract from Freud’s extraordinary scientific achievement” (quoted in Bouveresse, 1995, p. xix). He thought the original idea for this ‘extraordinary scientific achievement’

“came from Breuer, not Freud” (1980, p. 36); the idea that problems might reflect processes a person is unconscious of, but which can disappear when attention is redirected through talk (i.e., a change in ‘grammar’). However he was critical of “the idea of an underworld, a secret cellar” (1967a, p. 25): Freud’s seductive myth, where he substantivized the word ‘unconscious’; turning an adjective into a noun, that was neither verifiable nor falsifiable. “New regions of the soul have not been discovered” (1979b, p. 40).

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to maintain its unique identity by noting its phenomenological and humanistic foundations, and commitment to the primacy of the therapeutic relationship; or understanding people as “relational beings” rather than independent entities (Milton, 2010, p. xxiv). Although such efforts might have facilitated counselling psychologists to remain within the language games of their clients, this position has been eroding with exposure to the medical hegemony of mental health (Moller, 2011). In the US this erosion was halted and the identity of counselling psychology ‘saved’, not so much by the shoring up of its relational identity as it was by its commitment to multiculturalism (Atkinson et al., 2007). Its commitment to diversity provided a basis for critiquing norm-based assessments or diagnoses and evidence based treatments, as non-majority populations are those most likely not to fit these schemas. Our commitment to the Treaty of Waitangi not only invites the development of similar expertise here, but the Wittgensteinian philosophy outlined here is also much closer to Polynesian epistemology (Drury, 2011). The challenge is to not only remain within the language games of our clients, and at times, this can be very difficult, but also to invite our clinical colleagues to this.

**Intersubjectivity**

The poet John Keats, in a letter to his brothers, coined the term ‘negative capability’ as “when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason” (Ou, 2009, p. 9). Bion (Symington & Symington, 1996), Dewey (1934/1958) and others have stressed the importance of tolerating ‘not knowing’ for psychotherapy. This form of ‘mindfulness’ may be ameliorative to the “jumping to conclusions” tendency, which is an at-risk marker of psychosis (Lanzaro, 2010). In this regard, Seikkula and his colleagues (2011), who have considerably reduced ‘schizophrenia’ in northern Finland (no ‘consistent signs of disturbance for six months’, with 84% working and medication free at five-year follow-up), note:

“Earlier, we thought we first had to devise the treatment plan and then implement it; [but] by opening the boundaries of discussion, the joint process itself started to determine the treatment, rather than the team itself or the treatment plan of the team” (Seikkula et al., 1995, p. 64).

The task here is to ‘dwell’ as co-participant with the client, and not provide him/her with our solutions (diagnosis or conceptual frames):

“the difficulty – I might say – is not that of finding the solution but rather that of recognizing as the solution something that looks as if it were only a preliminary to it. This is connected, I believe, with our wrongly expecting an explanation, whereas the solution of the difficulty is a description, if we give it the right place in our considerations. If we dwell upon it, and do not try to get beyond it. The difficulty here is: to stop” (Wittgenstein, 1967b, §314).

Anderson and Goolishian (1992) describe this as the ‘not-knowing’ approach to therapy.

Furman & Ahola (1992) once offered the metaphor of therapists being pickpockets in a nudist camp. As Wittgenstein puts it, “philosophy simply puts everything before us, and neither explains nor deduces anything. – Since everything lies open to view there is nothing to explain. For what is hidden, for example, is of no interest to us” (1958, §126).

Or “The aspects of things that are most important for us are hidden because of their simplicity and familiarity. (One is unable to notice something – because it is always before one’s eyes.) …We fail to be struck by what, once seen, is most striking and most powerful” (1958, §129).

Unlike Freud and the analyst, with Wittgenstein we are not looking for a hidden essence that lies beneath the surface, we don’t shift our attention away from the world to some imaginary causal mechanism. Mindfulness is presence (Yadzi, 1992).

Wittgenstein’s ‘private language argument’ is the idea that as meaning-making is a shared public activity, and not a hidden inner process of a ghostly mind, there cannot be a private inner language created by and only intelligible to a single person. As we have seen language-games are joint attention sharing activities arising from the ability we have from birth to attune to each other. Merleau-ponty (1962) similarly described a direct resonance of bodily behaviour from infancy. In Māori culture this living connection or responsiveness is called whanauangataunga, a phenomena of ‘we-ness’ largely unrecognised in Pākehā culture16. We don’t describe our inner sensations so much as express them. Our natural expressions of pain such as groaning and wincing have been socialized into “exclamations and, later sentences” (Wittgenstein, 1958, §244). We usually understand each other immediately.

“ ‘We see emotion’ – as opposed to what? – we do not see facial contortions and make the inference that he is feeling joy, grief, boredom. We describe the face immediately as sad, radiant, bored, even when we are unable to give any other description of the features. – Grief, one would like to say, is personified in the face. This is essential to what we call ‘emotion’ “ (1980, §570).17

“ ‘I can only guess at someone else’s feelings’ – does that make sense when you see him badly wounded, for instance, and in dreadful pain?” (1982, §964). As Overgaard (2007) notes, like Levinas (1998), Wittgenstein sees an ethical demand in our intersubjectivity, especially with suffering: a “primitive reaction to tend, to treat, the part that hurts when someone else is in pain; and not merely when oneself is … - a response of concern, sympathy, helping” (1967b, §540).

This intersubjectivity can also be explored in family therapy.

**Dialogicity or being at home in the chaos**

What Wittgenstein calls a ‘grammatical investigation’ is not so much into the rules of language, so much as exploring what is actually going on within a conversation. One of the important aspects of this are those fleeting moments when we feel
called to respond or react in some way. These are quite spontaneous reactions, for your words arouse action or induce various anticipations in me as to where this conversation is going. With living creatures, we sense them moving inside themselves as much as we sense them moving in space, and we attune to that. If the conversation is more like a monologue, then, we treat the other person as just an object, and we pay minimal attention to our own responses as we enquire as to where they might fit on some pre-existing map. Some think this is being professional. However in dialogue, we remain open as a responsive partner. We remain aware of our own responses to their utterances.

Sensory motor systems are at work here, as in these ‘withness’ conversations we are both feeling out, like blind men with our canes, for a way forward for the conversation here. Our conversation begins to take on a life of its own, making demands on both of us to respond. The responses we are making are, by and large, not coming from our intellects, so much as from our feelings or heart. Katz and Shotter (1996) call these fleeting moments when we feel called to respond ‘poetic moments’ (from the Greek ‘poiesis’ meaning ‘creation’). It is from such reactions, or ‘striking moments’, that new language games arise. “The origin and the primitive form of the language game is a reaction; only from this can more complicated forms develop. Language – I want to say – is a refinement, ‘in the beginning was the deed’ [Goethe]” (Wittgenstein, 1980, p. 31). From the very beginning both the speaker and other are anticipating or expecting a response from other. And as our conversation develops we are both having these anticipations as to where the conversation is going, and these anticipations are becoming intertwined. Shotter (2003) calls this intertwining chiasmic, and like the optic chiasma which gives vision depth, it is this that gives the conversation a life of its own and depth. Our dialogue is being ‘shaped’ by our reactions to each other; we are co-authoring the conversation. As therapists we must allow ourselves to be changed by the dialogue also.

In such an atmosphere of mutual trust we reveal our inner depths to each other; not so that we can know each other as objects or intellectually, but to have a performance knowledge of each other. To repeat, nothing is hidden here. It is more a matter of each of us being drawn to what is inside an expression or reaction the other makes, rather than what’s behind it. So for example, we might slow the conversation down, and ask, “what’s that closed fist you just made saying, if it could talk”. Each word, each gesture, each response, is unique to how it is expressing itself in this dialogue. Rather than trying to manipulate the client, by allowing the conversation to take on a life of its own, changing both therapist and client, we witness a process, Shotter (1993) has called ‘knowing of the third kind’. ‘Knowings’ unanticipated by either emerge from the conversation. New language games that facilitate our client orienting to her environment differently emerge; new language games facilitating therapists to orient to their clients differently emerge. We might call this relational mindfulness.

Wittgenstein called this entering the primordial world, a world that precedes the scientific or known world. He said that to be a philosopher (-therapist) “you have to descend into primeval chaos and feel at home there” (1980, p. 65). Similarly Goethe proposed a ‘delicate empiricism’ as an alternative to Newtonian science (which required fitting phenomena to a theory), by becoming one with the phenomena being studied until it revealed its patterns to you (Drury, 2006; Seamon & Zajone, 1998). An example in clinical practice is how Pat Ogden, the sensori-motor psychotherapist (Ogden et al., 2006), has chairs on wheels for both herself and her client, so they can both respond more sensitively to nuances in their responsivity to each other. It is here we find the expertise Dreyfus and Dreyfus describe as therapeutic conversationalists.

The Red Queen’s Conjecture and Accountability

If the Red Queen can be seen as a representative of the scientific or ‘technology of the self’ weltanschauung, as we have depicted her here, there is a very useful observation she does make. In Through the Looking Glass, Alice complains to the Red Queen that where she comes from if you run very fast you generally get somewhere, but here the trees and other things round them never change their places, to which the Red Queen replies that where Alice comes from must be “a slow sort of country, ..[because] ..here it takes all the running you can do, to keep in the same place.” This has been called “the Red Queen conjecture” and has been proposed as a metaphor for evolutionary arms races, where co-evolution means that no one species gets an edge on its competitors. There are now over 500 schools of psychotherapy competing for recognition and resources as empirically supported treatments. Ridley (1995) proposed that in the evolutionary arms race, sexual reproduction gave some individuals and their offspring an edge and escape from this dilemma. Similarly, individual therapists, utilising ideas from various schools of therapy may become more effective than those who adhere to one particular school.

Wampold (2001) identified a problem that had been plaguing research into psychotherapy. Some researchers were endeavoring to make sense of why psychotherapy works by looking through a ‘medical model’ lens, which was based on pharmaceutical trials and randomised controlled studies. They favoured identifying Empirically Supported Treatments (ESTS). Other researchers were looking through a different lens, which he called the ‘contextual model’. These researchers took the view that therapy works because of an emotionally charged confiding relationship, where the client’s expectation of being healed was elicited, and a rationale that was acceptable to the client was provided, whilst they engaged in a procedure requiring the active participation of both. Wampold’s meta-analysis “compellingly supports the contextual model” (p.206).

In 2006, the American Psychological Association’s presidential task force on evidence based practice in psychology (EBPP) brought together proponents from both sides of this debate, and effectively put an end to the warring between the different schools of psychotherapy that were trying to stake out a claim that their approach was ‘best practice’ for a particular problem, by declaring that EBPP was
“the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2006, p. 273). Noting that “EBPP encompasses a broader range of clinical activities” than ESTs, they also comment that EST initiatives and the like, should not be misused as justification for inappropriately restricting access to choice of treatments, and “not to assume that interventions that have not yet been studied in controlled trials are ineffective” (p. 274). Finally they note that “ongoing monitoring of patient progress and adjustment of treatment as needed are essential to EBPP” (p. 280).

This shift to practice based evidence (ongoing outcome monitoring), as proposed by the Task Force, Lambert and colleagues (2001), and Duncan and colleagues (2010) fosters practitioners to mix aspects from various schools of therapy as they develop their expertise. It creates space for the development of the conversational expertise or relational mindfulness outlined here. It also shifts accountability from adherence to an EST to a more direct form of accountability to our clients. Effective therapists will become more readily identified.

Conclusion

The shift being suggested in this paper can be seen as a shift towards the values of collaborative meaning-making consistent with counselling psychology. A shift from a medical model perspective of what we do to a contextual model perspective, a shift from process based accountability to outcome based accountability, and a shift from the primacy of ‘aboutness’ knowledge to ‘withness’ knowledge. A shift to practice based evidence will allow more therapists to develop their expertise. Some may even embrace radical embodied cognition and further Bateson’s quest for an ecology of mind.

Notes

1 As we all know, ‘work to rule’ is a form of sabotage.
2 With Jabberwocky Lewis Carroll illustrates the REC idea that representations are unnecessary to cognition. We understand it without knowing what a ‘slivy tove’ is.
3 Fodor’s computationalism can be seen as foundational for CBT as it assumes that ‘know how’ stems from ‘know that’, and the therapeutic task is to ‘re-programme’ its algorithms.
4 From an REC viewpoint there would be no surprises to the observation some colleagues have made of witnessing a person attracting a body dysmorphia diagnosis struggling to park a car in a wide space.
5 Currently science prioritizes obtaining a clear picture over what it sees as the technical application of that knowledge to improve our relationship with nature; here those priorities are reversed.
6 To take a leaf from Lewis Carroll, it is perhaps understandable that when we first pass through the looking glass we run off in the opposite direction than intended.
7 Bateson (1972, p. xx) provides the delightful example of science putting us to sleep with conceptual confusion via Molière’s play where the medical candidate tells his examiners that opium puts people to sleep because it contains a dormantative principle. Of course the relationship is not causal but criterial.
8 Frazer failed to see that humans are not just manipulative but also expressive, as most just enjoy giving flowers or kissing pictures. Frazer thought ‘primitive’ rituals were pre-scientific attempts to manipulate fate (Wittgenstein, 1979a).
9 Wittgenstein once told a friend “Music came to a full stop with Brahms: and even in Brahms I can begin to hear the noise of machinery” (Drury, 1981, p. 112)
10 Zen Buddhists resolve this by saying anyone who talks about zen has the ‘stink of zen’
11 I use the word ‘patient’ when the person is treated as an object awaiting our intervention, and ‘client’ when they are an active participant in the process.
12 Maturana (1988) noted that a causal claim is a demand for obedience.
13 The face that inspires fear or delight is not the cause of fear or delight, but the reason. The cause is a conjecture as to how the association was first made. (Wittgenstein, 1958, §476). Reasons are generally known, causes conjectured (1966, p. 15). Desensitization to the face can occur without the cause ever being known.
14 As Kagan recently pointed out to Siegel, ‘attachment’ is but one of many possible causal hypotheses to explain behavior; temperament, birth order, social class, and poverty-wealth can serve equally well. Kagan noted the Adult Attachment Interview could more accurately be called an Adult Coherence Interview, as it is relying on narrative coherence to assess ‘attachment’. Many Auschwitz children went on to live happy and productive lives despite lack of secure attachment in infancy (Moskowitz, 1983; Psychotherapy Networker, 2012).
15 Duncan (2010) comes close to this in talking about the client’s theory of change.
16 Although see ‘communitas’ – Turner, 1969 and Drury, 2011.
17 Hence the Cheshire cat’s grin.

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Corresponding Author:
Nick Drury
nickdrury@clear.net.nz

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Defining Counselling Psychology: What do all the Words Mean?

Peter Stanley, Tauranga

This paper provides an explanation and an interpretation of the definition of counselling psychology that is endorsed by the New Zealand Psychologists Board. The individual meanings of seven components of the definition are discussed, and these are: ecology, development, phenomenology, empowerment and enhancement, assessments, interventions, and prevention. It is contended that the seven components are logically related and contribute to a consistent and coherent definition for the discipline of counselling psychology. It is also suggested that the values that the definition acknowledges are relevant for many other human service practitioners.

Keywords: counselling psychology, ecology, phenomenology, empowerment and enhancement

Counselling psychology is officially defined in New Zealand in the following terms:

“Counselling Psychologist” - Counselling Psychologists apply psychological knowledge and theory derived from research to the area of client empowerment and enhancement, to assist children, young persons, adults and their families with personal, social, educational, and vocational functioning by using psychological assessments and interventions, and preventative approaches that acknowledge ecological, developmental and phenomenological dimensions. (New Zealand Psychologists Board, 2013)

This definition is essentially the same as the definition of the discipline that was originally written for the Institute of Counselling Psychology (Cooper, Frewin, Gardiner, O’Connell, & Stanley, 2002); and it is identical to the definition that was subsequently put out for consultation (Stanley, Gibson, & Manthei, 2005), and that was ultimately contained in the application that was submitted to the New Zealand Psychologists Board for a vocational scope of practice for counselling psychology (Stanley, 2005).

On the website of the Psychologists Board there are also definitions for clinical psychology and for educational psychology, and probably in the future there will be definitions for other psychological specialties. Each of the existing definitions has a common structure and common components. All three specialties “apply psychological knowledge and theory derived from research”, “to assist children, young persons, adults and their families”, through assessment and interventions. The definition for counselling psychology is different from the other two definitions in its explicit acknowledgement of phenomenology, its emphasis on empowerment and enhancement, its reference to a breadth of typical functioning (and specifically, vocational concerns), and in the recognition that problems of living can and should be prevented. The definition is also special because of what it does not contain. For instance, there is no mention of mental health or diagnosis as is found in the clinical psychology scope.

What the words say in the definition of counselling psychology is that the practitioners of this discipline give a special priority to understanding the client’s world, and to assisting the client to attain for him or herself increased functioning and opportunities. This fundamental person-centred commitment has some conditions, however, as counselling psychologists acknowledge the impact of developmental state and of environmental influences on human behaviour and autonomy. The consequence of this acknowledgement is the preventative emphasis of the discipline, as there is an understanding that circumstances that have adverse effects can be changed. Counselling psychology is a specialty area of psychology and the methods that are used to facilitate client change will typically be supported by research.

What follows is an analysis of the implications, and the challenges, of the dimensions and commitments of the officially accepted definition of counselling psychology. As a corollary, it is also argued that counselling psychology’s composite view of the client and of the helping process is more widely applicable to the delivery of human services in this country.

Ecology

The commitment to fully embrace and understand the client’s environment is probably counselling psychology’s pivotal resolution and task. Principally as a consequence of work by Bronfenbrenner, and specifically the publication in 1979 of Human Ecology: Experiments by Nature and Design, psychologists have come to understand that the circumstances that
surround children, young persons, adults and their families are multilayered, multidimensional, interactive, and changing. People exist in many settings; they have physical, cognitive, socioemotional, aesthetic and spiritual aspects; and they engage with other people in a stream of microsocial events that shape who they are, and that shape the other individuals who surround them. Moreover, as people change, so do contexts and multigenerational and historical perspectives arise. Finally, behaviour is about adaptation: it serves purposes for people, and typically these purposes are in relation to other people.

At the end of a review of fifty years of resilience research Luthar (2006) says:

The first major take-home message is this: Resilience rests, fundamentally, on relationships. The desire to belong is a basic human need, and positive connections with others lie at the very core of psychological development; strong, supportive relationships are critical for achieving and sustaining resilient adaptation. (p. 780)

Luthar (2006) also states that for children the parent-child relationship is the single strongest predictor of adaptive functioning. Longitudinal data show that responsive, supportive, and structured care-giving contributes to self-esteem and self-confidence, empathy and social skills, and curiosity and problem solving (Sroufe, Egeland, Carlson, & Collins, 2005). Most importantly from a therapeutic perspective, sensitive and consistent parenting nurtures emotional regulation and it fosters expectations within the individual that they can cope with life’s adversities. And according to Dishion and Patterson (2006), emotional regulation is the most promising candidate for linking the individual characteristics that people possess to the ecologies that they function in.

The implications of adopting an ecological perspective are far reaching and profound for counselling psychologists, as they have been for educational psychologists who also embrace this position (Annan, 2005; Jimerson, Annan, Skokut, & Tyler, 2009; New Zealand Psychologists Board, 2013). It means that practitioners have to acknowledge the meaning and influence of culture, socioeconomic status, and community circumstances for their clients, while eschewing the simplicity and stigmatisation of ‘social address’ and the seemingly endless quest to personalise social problems. On another level, ecology challenges clinic-based counselling where the problem resides with the client and where solutions are sought away from where life is lived. Psychologists who acknowledge the significance of environmental influences are likely to visit families, childcare centres, schools, recreational facilities, and work places to truly understand their clients’ problems of living so that they might respond to them in meaningful and practical ways.

Development

As the foregoing discussion makes plain, individual development is inseparable from ecology. The linkages between the individual and context are central to contemporary conceptions of human development, which are variously referred to as interactionist, dynamic, or multiple-levels-of-analysis, and as holistic, organisational, or systems approaches (Cicchetti & Blender, 2006; Lerner, 2006; Magnusson & Stattin, 2006; Thelen & Smith, 2006). People develop through successful confrontations with environmental demands, which progressively alter the architecture of the self in biological, cognitive, and socioemotional domains, and the new complexity that is acquired gives rise to enhanced personal competence and increased adaptive capacities (Stanley, 2009).

For convenience, we label the environmental forces that have the potential to promote positive outcomes as protective factors, and those influences that can increase personal vulnerability are termed risk factors. Developmental pathways and trajectories are two other conventions that can assist in explaining, over periods of time, both positive and prosocial adjustment and maladaptive and antisocial behaviour. A developmental pathway is the actual course that an individual treads and, while there will be bumpy parts and smoother sections in all life courses, there can be distinctly different destinations at the end of alternate pathways with respect to personal security and satisfactions. The examination of a developmental pathway allows the client and therapist (and researchers) to discern steps, junctions, and turning points, and such appreciations can be very helpful for programme planning. It can also be really useful for a practitioner to plot a trajectory for a client and oftentimes this will show a vector veering backwards and forwards between positive and negative possibilities and consequences over periods of development. Nevertheless, with both pathways and trajectories it does need to be remembered that client outcomes are always probabilistic rather than certain, and this is because we cannot account for the impact of chance environmental events (Bowes & Hayes, 2004; Stanley, 2003; Stanley 2011a)

Some risk factors and some protective factors have been established, respectively, as particularly harmful, or as especially conducive, to positive human development. Poverty in childhood, for instance, is a persistent marker for maladaptation in adulthood (Doll & Lyon, 1998). Similarly, child maltreatment can be remarkably injurious, and arguably “it may represent the greatest failure of the caregiving environment to provide opportunities for normal development” (Cicchetti & Blender, 2006, p. 249). By contrast, a number of protective or resilience factors have been established by research with “compelling consistency” (Masten & Wright, 2010, p. 222). These positive forces are attachment relationships and social support; personal agency, mastery motivation, and self-efficacy; self-regulation of attention, emotion, and action; intelligence and problem-solving abilities; meaning making, faith, and hope; and beliefs, rituals, and practices from cultural and religious traditions.

It is contended that the study of human development is counselling psychology’s core discipline because, as well as providing frameworks for appreciating the course and continuity of adaptive and maladaptive functioning, developmental psychology and developmental psychopathology contain large vistas of research and theory on the processes that are implicated in
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personal outcomes. A sampling of relevant human development topics for counselling psychologists would likely include: genetics and the significance of biology for development; parenting styles; family systems and transitions; personality development; socialisation; perceptual, cognitive development, and memory; language development; gender development; schooling and careers; human sexuality; and moral development. Developmental concerns have a prominence in professional work with children, adolescents, and families; and they continue to contribute special depths of understanding to the work that is done with clients in adulthood and old age as well.

**Phenomenology**

The commitment to phenomenology is counselling psychology’s most distinctive characteristic. The progenitor of phenomenology was Husserl who urged psychologists to attend to the ‘phenomenon’, or the primary reality of what the client experiences (Spinelli, 1989). The emphasis then is on highly personalised interpretations, meanings, and beliefs which can be seen as constituting a client’s lifeworld. The question can be legitimately asked as to how such individual and unique experiences can ‘connect’ with the shared and standard emphases of conventional psychology. In fact, phenomenology aligns with a number of the current conceptualisations of human development. Firstly, person and environment relations are seen as transactions in both frameworks. Spinelli (1989) says that the one central assumption of phenomenology is its view of human beings “as active interpreters of their experience of the world rather than as passive reactors to both biophysical and environmental forces” (p. 180). Secondly, there are similarities in the holistic and integrative views that exist across phenomenology and the systems approaches of developmental science.

Furthermore, the integration of self-systems and environmental events is sustainable on a deeper level. We look with our eyes but we see with our accumulated life experience (Magnusson & Stattin, 2006). The store of beliefs that we possess is the product of successive restructurings of cognition and emotion, and these schema not only affect our personal perceptions, or phenomenology, but our planning and problem solving capabilities as well. Emotional regulation is central to the conscious control of thought, or executive functioning (Greenberg, 2006) and, as has been indicated, this capacity is embedded in relationships. It is probable that the important choices that we make in life are about choosing relational contexts that are conducive to our goals. In this regard, Elder and Shanahan (2006) suggest that when we change our personal direction or life style it usually involves changing our best friends.

The crucial implication of phenomenology for counselling psychologists is that we should endeavour to know our clients in the sense that we know ourselves. It is particularly important to understand the client’s perspective on relationships; and this applies equally to children as it does to adults, as research shows that children do know what help and support they require (Bannister, 2001). Understandably, accessing quality information from a client is usually dependent itself on a quality relationship with a client. Counselling psychologists typically prioritise the therapeutic relationship (Gibson, Stanley, & Mantchei, 2004; Grant, Mullings, & Denham, 2008), but what exactly is a ‘quality’ relationship and how is it achieved? Jung talked about the need for the therapist to be ‘infected’ by the client (Norton, 2009), and while this assertion pertains to a particular analytical position it does underline the importance of openness and empathy in professional encounters.

**Empowerment and enhancement**

As has been said, empowerment and enhancement are unique and special components of the official definition of counselling psychology. What these terms assert is that the specialty is concerned with the facilitation of power, and with the heightening of capacities for clients. Both empowerment and enhancement are ‘pro words’ in the sense that they are appealing and have connotations of a self-justifying good. For instance, Dearden (1968) says of personal growth that it “functions as a symbolic image, pregnant with meaning and rich in emotional appeal” (p. 25). Philosophically, empowerment and enhancement derive their justifications from the positive and unbounded conceptions of human nature associated with humanism and existentialism. Again, the linkages across the components of the definition of counselling psychology will be apparent as an emphasis on being as becoming is a logical and natural extension of an appreciation of the individual in his or her wholeness and uniqueness (Matson, 1973).

Probably the most common understanding of empowerment in professional discourse is in supporting clients to overcome barriers to their wellbeing; and these barriers can be within themselves, or across relationships, or they can be encountered with organisations and systems. With respect to institutional power, McDonald, Craik, Hawkins, & Williams (2011) warn us that it can be easy for practitioners to become agents of the established order since there are payments and validation for victim-blaming and for pathologising clients. In such circumstances, the counselling psychologist could, effectively, become a part of the problem instead of offering empowering and enhancing solutions. Moreover, Van der Klift & Kunc (1994) describe our relationships with our clients, and their families and communities, as invariably and inherently unequal. When we offer help to others our capacity, worth, and superiority is affirmed, and our own vulnerabilities are masked. For clients, receiving help implies deficiency, burden and inferiority, and their vulnerabilities are displayed.

This discussion takes us closer to understanding the meaning of a quality counselling relationship. In addition to possessing openness and empathy to individual perceptions and circumstance, it will be characterised by a close collaboration of therapist and client where judgements and categorisations have no place. More particularly, because empowerment and enhancement are action concepts, a counselling psychologist will also do
practical things on a client’s behalf, and these could include negotiating with teachers or employers, or representing the client before a tribunal, or navigating a shoal of social service agencies for them. Dealing with illness (and presumably other problems of living) in Western neoliberal economies can be interpreted as a matter of individual choice (Lawn & Battersby, 2009). Such a view, however, fails to acknowledge that people, through lack of ability, or lack of confidence, or distress, can be unable to present their own case. Nevertheless, while acknowledging the importance of proactivity and advocacy to the work of the counselling psychologist, it is critical that careful attention is also given to procedural and ethical aspects of these activities (McDonald et al, 2011). For instance, in work with children and parents, it can sometimes be difficult to specify who the client really is. As well, putting wind in a client’s sails can occasionally result in shipwrecks for other people, and in some sense we do have a responsibility to the larger ecology of interconnected lives.

Assessment

The foregoing analysis gives clear directions to counselling psychologists on the sorts of assessments that they should undertake with clients. We need to work with the client to consider the risk and protective factors that exist in all of his or her domains of functioning and across all relevant settings for them. In addition, particular attention needs to be given to the person’s perceptions of significant relationships, and to how they see their life purpose and direction. Quite simply, the more risk factors that an individual has the greater is his or her personal vulnerability. For instance, in research with children, Sameroff and Rosenblum (2006) determined that four-year-old participants with five or more risk factors were 12 times more likely to be rated as having mental health symptoms than a low risk group.

It needs to be recognised, however, that risk factors and processes are variable entities that do not always act in intuitive ways. For example, maternal substance abuse appears to be no more damaging to dependent children than maternal depression (Luthar & Sexton, 2007), and other apparent stressors can have negligible impacts on some people. The task for the psychologist then is to try and determine the significance, and the means of influence, of relevant risk factors with a view to ameliorating, modifying, or eliminating them. An exclusively risk-focussed assessment, however, is likely to result in a catalogue of deficits and this can have stigmatising effects. To reduce this possibility, and to obtain highly pertinent information, a similarly rigorous appraisal should be made of protective factors, and of the influences that have been identified in resilience research in particular. Toland and Carrigan (2011), for instance, argue that an adequate assessment will always include the identification of protective influences, and Hauser, Allen, and Golden contend (2006) that unless we look for positive qualities “we are nothing more than confused accountants, scrupulously totting up every jot and title of the debt of a bankruptcy-threatened client, but ignoring the very assets that might avert such an unhappy eventuality” (p. 287).

What the risk and protective factor approach does is codify the complexity of lived experience and make it more manageable. Inevitably, there are limitations, and in any assessment approach there are real difficulties in capturing what Zigmond (2009) describes as “the ambiguous, the nascent, the naturally evolving, the semiotics of symptoms, the creative possibilities of uncertainty” (p. 136). Nonetheless, we should avoid “the seductive dangers of agrandising our partial metaphors into didactic conclusions” (p. 134); and by this the author means psychiatric diagnoses. One response to the linguistic and conceptual difficulties that are encountered is to see assessment as an ongoing process rather than as a single event. We should return, over time, to the relationships and other salient features of our clients’ lives and continue to learn with them about the patterns, and the possibilities, of their pathways and trajectories.

Finally, the question needs to be considered as to the place that psychometric testing has within such an assessment scheme. This has been a major issue for educational psychology as well (Farrell, 2010); and for similar reasons, as that specialty has come to embrace ecological and developmental commitments. Standardised tests can provide useful data, both as test results and during the testing process, but what the psychologist gets to see in a test profile are some rarefied historical consequences of person-environment interactions rather than the client’s authentic and current exchanges, and the latter can be much more useful for interventions and programming. Additionally, the study of human development makes it clear that domains of functioning are interrelated and interacting and it can be inappropriate to assess intelligence, for instance, without also evaluating aptitudes, motivations, problem solving skills, social competencies, and communication abilities. In a sense, reliance on psychometrics can function as a default mode for psychologists that they return to because the tests provide answers with a semblance of meaning and authority. It is suggested here that psychologists should step forward more confidently, creatively, and constructively; eschew the location of the problem within the person, and assess for relationships, and for real-life skills, within the settings that are important to the client.

Interventions

The official definition of counselling psychology is explicit that it is a research-based discipline. This commitment to science demands some serious consideration, and actions, by a group of practitioners who may be comparatively more heterogeneous in its professional interests than other psychological specialties. As it happens, allegiance to an array of therapeutic approaches is encouraged by a number of sources including leading counselling authorities, and by the dynamics and complexities of psychotherapy itself. In the eighth edition of Current Psychotherapies, (and the last that he contributed to) Corsini argued that “the best theory and methodology to use must be one’s own. The reader will not be either successful or happy using a method not suited to her or his personality” (quoting by Dumont, 2011, p. 13). Similarly, there is remarkably inclusive quality to Paul’s
Studies have shown that the therapist, the therapeutic relationship, the treatment method, and the client all make critical contributions to the outcomes of professional engagements (APA Presidential Task Force on Evidence-Based Practice, 2006). Moreover, the individual psychologist is a key component of psychotherapy regardless of the nature of the treatment (Wampold, 2001). With the pre-eminence of personal and interpersonal factors and processes in counselling, what place does science have? Fundamentally, it is the means for really understanding problems of living, for specifying the numerous contributions to counselling outcomes, and for answering Paul’s question about what works for whom. In fact, scientific methods provide support at every step of the therapeutic process that is in addition to providing information about problems and effective practices. In assessment, a scientific approach facilitates an openness to data, it assists in the framing and testing of hypotheses, and it is helpful in systematising information. In interventions, it dictates a planful and experimental approach, and it is the means for evaluating whether, in any particular counselling relationship, there has been any change or effect. And with respect to evaluation, Kazdin (2006) says:

The stereotype of clinicians is that they enter clinical work in part because they care for people and are less interested in data and research. Let us hope this stereotype is a straw person. Clinicians want evaluation in clinical practice precisely because of the dramatic changes that can be observed in clients (Hamilton, 2005).

Prevention

A serious awareness of ecology and development gives rise to a clear understanding of the potential for preventing problems of living. Conceptually, prevention and intervention strategies are related and they are placed on a continuum of supports. However, a basic shift in orientation is still required to relocate the proverbial ambulance from the bottom of the cliff and to move beyond sticking plaster responses. Nevertheless, these moves might be prompted by an awareness of relevant statistics; and of logistical, and economic considerations. It is a fact that this country has comparatively high incidences of social problems and an under-skilled professional workforce to respond to them (Stanley, 2011b; Stanley, Manthei, & Gibson, 2005). Moreover, it is simply impossible to deal to endless waiting lists and to attempt to solve psychosocial problems one case at a time (Albee, 1999). Practitioners who work within a casualty repair framework often prioritise their attention to the most needing circumstances but these situations typically return weaker therapeutic effects and outcomes (Walker & Sprague, 2002). Nonetheless, despite the blatant and inherent limitations of reactive approaches, prevention is still a ‘hard sell’ to governments and agencies, and this is because it means the allocation of resources to emerging problems that are not yet demanding of attention. Equally, clients themselves may not see the need to seek help for issues which are no more than irritants at this time.

Intervening early in the life of the problem, and before the ecology has become modified to maintain it, makes good economic sense. For example, early childhood interventions, like the Perry Preschool Programme, can have benefit to cost ratios of over 8:1 (Heckman, 2006). These returns are much higher than are obtained from later investments in remedial education and in the criminal justice system. Church (2003) calculates that successful interventions for 5 year-olds cost $5,000 compared with $60,000 for a person who is 15 years of age. And overall, it has been estimated that the career of each antisocial individual costs our society $3,000,000 (Scott, 2003, cited by Ministry of Social Development, 2007). The concept of ‘career’ is also useful in appreciating the costs in terms of individual and personal suffering that are associated with problems of living. There are periods and stages along the pathway to adult disability and disadvantage (e.g., starting school, adolescence, intimate relationships) and each of the transition points will typically have its own issues and distress for the individual and his or her family.

Arguably, most threats to personal wellbeing are preventable, and as professionals and as a society we probably do not take the opportunities that are available to us to enact the measures that we might. Kauffman (1999) contends that, in the area of emotional and behavioural challenges in children, it is actually the professionals who actively thwart prevention by using an array of gambits including preferring false negatives to false positives in surveying, by encouraging developmental optimism (e.g., “He’ll grow out of it”), and by promoting nonpositivist paradigms as morally superior. This writer suggests that, if we are serious about prevention for individual clients, we should seek...
answers to the following questions in assessments: (i) Does the presenting behaviour increase the risk of negative outcomes? (ii) Is the behaviour and risk preventable? (iii) What are the costs and risks of prevention? (iv) Can we support other professionals who are taking preventive actions? (v) Are we able to effectively respond to those who argue against prevention? Counselling psychology contrasts with all other human services in the emphasis that it gives to prevention (Manthei, Stanley, & Gibson, 2004); and presumably it is a more worthy act to help people to avoid problems than it is to assist them to resolve them.

Conclusion

The purpose of this discussion has been to demonstrate both the meaning and the coherence of the official definition of counselling psychology. The discipline is committed to evidence-based interventions that are intimately connected to a careful assessment with the client of his or her beliefs, values, development, and ecology. This psychological specialty is also proactive in preventing problems of living and in supporting and enabling clients who are experiencing difficulties. Each of the components of the definition is logically and conceptually related to all of the others, and these components need to exist in a state of balance. Stanley and Manthei (2004) suggest that there is actually a risk of ‘self-harm’ to counselling psychology if any of the constituent parts becomes pre-eminent. For instance, if concerns with ecology or prevention came to dominate, the specialty may come to resemble a form of community work rather than counselling; and similarly, other distortions of the discipline would occur with the ascendancy of development, phenomenology, or empowerment.

The definition of counselling psychology is complete and sufficient, and it is untenable to add terminology like diagnosis and mental health disorders to such a detailed and cogent description of the specialty. Counselling psychologists can and do deal with severely challenging personal issues (Grant et al, 2008) but psychiatric interpretations of problems of living, as contained in the DSM-5 (American Psychiatric Association, 2013), simply do not ‘fit’ with the accepted characterisation of the discipline. A number of justifications has already been given for a noncategorical approach to the work of the counselling psychologist and to these may be added other catalogues of critique (e.g., Stanley, 2006a; Stanley, 2006b; Wyatt & Midkiff, 2006). It needs to be appreciated that the route to professional identity and recognition for counselling psychology does demand a close analysis of its many points of divergence from the biomedical model, and this has been a critical journey for a number of other human service professions as well, including social work and midwifery (D’Cruz, Jacobs, & Shoo, 2009).

A crucial point of departure for counselling psychology from the clinical view is in how the therapeutic relationship is seen. Comment has already been made about the significance of this relationship, and about the importance of such qualities as empathy, openness, and collaboration, but the defining difference is probably in the active and personal participation of the therapist in counselling. In this regard, Acceptance and Commitment Therapy (ACT) provides us with a detailed formulation of the therapist’s role, and of the demands that are to be made of him or her (Hayes, Strosahl, & Wilson, 2012; Luoma, Hayes, & Walser, 2007).

From the outset in ACT, it is understood that the therapist is actually in the same circumstances as the client; and they do not possess a vision of normalcy or health that the client or patient is expected to aspire to. Metaphor is a popular strategy in this therapeutic system, and the ideas of equality, sharing, genuineness, and compassion are exemplified in the Two Mountains allusion (Harris, 2009). In this metaphor, the therapist is described as climbing a mountain near the client, and as he or she is climbing upwards the therapist might see a foothold, or even an alternative pathway, from his or her mountain that is presently obscured to the client in the ascent of their mountain. The goal in ACT is for the client to have a richer and fuller life, and this means that the therapist has to be emotionally accessible to the client, and to show that they are vulnerable to the same cognitive, emotional, and behavioural traps as everyone else.

It is an interesting fact that psychology, and counselling psychology in particular, now has much more to contribute to the advancement of medical practice than it could ever gain from a misappropriation of a physical medical model to psychological problems. For instance, Lawn and Battersby (2009) report on a major collaborative research project in Australia that has looked at the competencies that primary health care professionals need to have to provide effective support to the burgeoning numbers of individuals who are experiencing chronic health conditions. The relevant skills and knowledge have been determined as those that promote collaborative, person-centred practice; that acknowledge the social determinants of health; and that empower people to effectively manage their own lives. These competencies all involve psychosocial knowledge and processes, and they include rapport development and communication abilities, interviewing and needs-assessments, identifying consumers’ strengths, goal-setting and advocacy, and developing culturally appropriate practice. It is interesting that these investigators found that there was currently a significant discrepancy between what health service providers believed that they were providing for their clients and what the service users actually experienced as recipients of health services.

In a sense, counselling psychology provides the ultimate generic scope of practice for the social services. On this question, I wrote a paper twenty years ago suggesting that there should be a common benchmark qualification in New Zealand for counselling, professional psychology, and social work (Stanley, 1993). The new degree that was proposed would integrate differing perspectives, develop new understandings, and promote professional standards. The practitioners from such a programme would be expected to have the capacity to offer ethical change programmes that have lasting effects and that “acknowledge the multidimensional nature of many personal difficulties and the complexities
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Corresponding Author:
Dr Peter Stanley
pstanley0@xtra.co.nz

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The Process of Conducting Qualitative Research as an Adjunct to the Development of Therapeutic Abilities in Counselling Psychology

Mark R. Thorpe, Auckland University of Technology

This paper argues that the process of conducting qualitative research augments the development of many of the fundamental psychotherapeutic skills needed by counselling psychology students. By conducting qualitative research the student optimally develops a psychologically sophisticated understanding of their own worldview and personality, an intellectual rigor, and trust in the process and an empathic, open, curious and respectful ability to become immersed in the research participant’s lived world. Leaving the security of the already known, maintaining an optimal distance from the data and resisting the pull for premature closure, the student learns to tolerate complexity, confusion and ambiguity. The student gradually identifies patterns and forges meaning at increasingly higher levels of abstraction. These skills are transferrable to the process of conducting psychological therapy.

Keywords: Counselling psychology, psychotherapy, post-graduate training, qualitative research

This paper postulates that there is an overlap between some of the basic attributes and skills employed by qualitative researchers and psychotherapeutically oriented psychologists. It is argued that one of the ways of augmenting the therapeutic training of post-graduate counselling psychology students is through the students’ experience of conducting qualitative research.

Some fundamental aspects of the counselling psychologist’s worldview, way of being, and style of relating to therapy clients cannot be learnt solely from books or lectures. This form of knowledge is primarily obtained experientially. In counselling psychology training programmes the experiential learning comes from interactive coursework including group work and role plays, conducting therapy with clients, writing case reports, supportive clinical supervision and the student’s personal therapy. Conducting qualitative research may be another important experience which indirectly augments the therapeutic skills of the training counselling psychologist.

This paper focusses on the qualities and skills developed by students while conducting qualitative research. Links to the therapeutic process are discussed. The reader is encouraged to consider whether these skills are similar to those required by a counselling psychologist conducting therapy. Therapy clients and practicing clinicians are invited to reflect on these processes and skills in relation to their own therapeutic experience.

Some authors (Braun & Clarke, 2006; Holloway & Todres, 2003) have argued that the skills employed by researchers across the range of qualitative methodologies are relatively generic. However, in order to undue confusion, this paper will focus on material from those methodologies that gather their data from interviewing the participants and are grounded in social constructivist paradigms such as phenomenology, hermeneutics, grounded theory, narrative and thematic analysis.

Counselling psychology

Counselling psychology positions itself between the orthodox science of psychology, the therapeutic practices of psychotherapy and counselling, and disciplines such as rhetoric, anthropology and philosophy (Davey, 2010). It has constructed an identity which espouses the complementary aspects of scientist practitioner and reflexive practitioner (Woolfe, Strawbridge, Douglas, & Dryden, 2010, p. 2).

Counselling psychology attempts to focus on the enhancement of wellbeing, prevention and the psychological development of the normal person. Practitioners are based mostly in primary health care organisations, non-governmental organisations and community-based organisations rather than in mainstream psychiatric services such as District Health Boards and Probation Services.

Presently Auckland University of Technology (AUT) offers the only professional training in counselling psychology in Aotearoa New Zealand. The six year programme consists of an undergraduate degree which includes traditional psychology papers such as abnormal psychology, psychological assessment, approaches to psychological intervention, qualitative and quantitative research methods and social psychology. The honours degree includes some specific counselling psychology foci. Selection for the counselling psychology programme takes place upon completion of the honours year. The masters and internship years share many fundamental aspects of the clinical psychology training with a specific focus on the counselling psychology epistemology and style.
The counselling psychology programme was approved by the Committee on University Academic Programmes (CUAP) in 2006, the first honours programme began in 2007, the Counselling Psychology Scope was approved by the Psychologists Board in 2009 and full accreditation of the AUT programme was achieved in 2011 (New Zealand Psychologists Board, 2012).

The first group of students were registered with the New Zealand Psychologists Board Health Practitioners Competence Assurance Act 2003 (Ministry of Health, 2003), under the Counselling Psychology Scope of Practice, in February 2011. Three cohorts are currently gainfully employed as counselling psychologists.

Qualitative research in counselling psychology

There has been a substantial increase in qualitative research conducted by postgraduate counselling psychology students around the world (Morrow, 2007). There are signs that Aotearoa New Zealand is following this trend. In the United Kingdom both of the major counselling psychology journals, the “Journal of Counselling Psychology” and “The Counselling Psychologist”, have published special editions on qualitative issues. Morrow asserts that within the field of therapeutic psychology, counselling psychology has led the way in qualitative inquiry in “...dissertation research, program curriculum, and overall acceptance of qualitative methods” (p. 209). Rafalin (2010) states that counselling psychology is clear in its commitment to research, but that the nature of research and how it fits within the broader domains of science is debatable. Pugh and Coyle (2000) maintain that non-traditional research is characteristic of counselling psychology. Qualitative research has moved beyond specific traditional methods such as phenomenology and grounded theory and has developed methods responsive to the experience-based questions that interest a practice-based discipline (Thorne, Kirkham, & O’Flynn-Magee, 2004). Many authors see this trend as exciting and long overdue.

These developments reflect a shift from the demonstration of the truth to the achievement of understanding, subject-object dualism to collaboration with participants, fragmentation to holism (Rennie, 1994) and multidimensional complexity (Rafalin, 2010). There is a focus on client-centred agendas (Rafalin, 2010), interpretivist-constructivist paradigms and clinical expertise arising from extensive experience where reality is seen as complex, contextual, constructed and ultimately subjective (Lincoln & Guba, 1985; Thorne et al., 2004). Politically this may be seen as an attempt to counterbalance the hegemony of globalisation, capitalism, managerialism, managed care and postpositivism.

Counselling psychologists are frequently drawn to researching topics that are personal, sensitive, emotionally charged and difficult to articulate meaningfully. Some examples of recent qualitative research conducted by counselling psychology students at Auckland University of Technology include: Chinese immigrants’ experience of their sense of identity before, during and after migration to New Zealand (Shen, 2012), the experience of identity and cultural adjustment for immigrants transitioning in New Zealand (Stewart, 2010), the experience of birth and becoming adoptive mothers in open adoption (Kalizinge, 2010), first time mothers’ experiences of returning to their careers (Walker, 2010), the therapist’s experience of the therapeutic relationship with clients diagnosed with autism (Lines-Sherwood, 2010), the therapist’s experience of mindfulness of their therapeutic relationship with clients in an alcohol and drug programme (Beherens, 2012), counsellors’ experience of counselling troubled adolescents in New Zealand secondary schools (Rethfeldt, 2011), risk and protective factors in young people (Stanley, 2010), Nichiren Buddhists’ experience of personal transformation (Baird, 2011), psychotherapists experience of using mindfulness as a stress-reduction tool in their psychotherapy practices (Gabites, 2011), psychologists’ experience of the breathing space when working mindfully with clients (Gabites, 2012) and the dynamics, concepts and issues of the psychotherapy learning group (Farrell, 2011).

The congruence between qualitative research and counselling psychology

It has been argued that qualitative methods are congruent with research and practice in counselling psychology (Cohen, Sargent, & Sechrest, 1986; McLeod, 2011; Morrow, 2007; Ponterotto, 2005; Rafalin, 2010; Rennie, 1994; Yeh & Inman, 2007). Qualitative research provides an alternative to the restrictive confines of traditional psychological methodology and offers the possibility of research designs that encourage detailed and in-depth consideration of complex and multifaceted human phenomena (Morrow, 2007) such as psychological therapy. Qualitative research has the potential for promoting counselling psychology’s multicultural and social justice agendas (Morrow, 2007; Ponterotto, 2005) and its focus on clinical health and illness phenomena (Thorne et al., 2004). Qualitative methods may also help bridge the gap between research and clinical practice which is a central aim of counselling psychology (Rennie, 1994; E. N. Williams & Hill, 2001).

According to McLeod:

...the activity of doing qualitative research (identifying and clarifying meaning; learning how the meaning of aspects of the social world is constructed) is highly concordant with the activity of doing therapy (making new meaning, gaining insight and understanding, learning how personal meanings have been constructed) (2011, p. 16).

Similarly Gair (2012) asserts that qualitative research has much in common with the professional helping philosophy, process, theories and ethical considerations of counselling psychology. Stiles (2011) and Grafanaki (1996) maintain that engagement in qualitative research tends to foster a compassionate view of human experience and deepens the researcher’s understanding aesthetically, emotionally and cognitively.

Many practicing clinicians and students show little interest in traditional academic research (Cohen et al., 1986) believing that it is irrelevant to their daily...
therapeutic work (Elliott, 1983). They are drawn to the potential of qualitative research because of its congruence with the paradigms and methods employed in their practice (McLeod, 2011; Morrow, 2007; Morrow & Smith, 2000). Counselling psychologists tend to do research that focuses on the psychological realm (Wertz, 1986), which understands “people and the world from a psychological perspective” (Chamberlain, 2009, p. 47), and includes meaning construction, psychological reality and unique individual subjectivity (Rafalin, 2010). The objective is to add greater depth of understanding to the already available therapeutic insights and practice logic in a manner consistent with the knowledge of experienced practitioners who have gained their understanding through pattern recognition and reflective practice observations (Thorne et al., 2004).

Some fundamental aspects of the counselling psychologist’s worldview, way of being, and style of relating to clients in therapy cannot be learnt entirely from books or lectures. This type of knowledge is primarily obtained from direct experience. In training programmes experiential learning comes from interactive coursework including group work and role plays, conducting therapy with clients, writing case reports, supportive clinical supervision and the student’s personal therapy (Rizq, 2010; F. Williams, Coyle, & Lyons, 1999). It is argued that the process of conducting qualitative research is another important experiential learning process that indirectly augments the therapeutic skills of the training counselling psychologist.

Phases of qualitative research

There are numerous ways in which the sequence of tasks in qualitative research may be described. In order to explicate the processes, skills and attitudes employed by researchers this paper proposes five sequential phases. The phases are a) reflexivity and the choice of topic, b) the research interview and data gathering, c) thematic analysis, d) meta-analysis and, e) presentation of the research. These phases are used heuristically to facilitate the present discussion and should not to be viewed as inflexible. The researcher does not move mechanically from one clear developmental phase to another, but rather moves between the phases reflexively reworking, re-contextualising and synthesising (Thorne et al., 2004) as in a hermeneutic spiral.

a) Reflexivity and the choice of research topic.

Reflexivity is an awareness of the researcher’s shaping and contribution to the construction of meanings in the research. Ideally qualitative researchers engage in an ongoing process of reflexivity - before, during and after the completion of the research. Willing (2001) describes two forms of reflexivity employed by the qualitative researcher, epistemological and personal. Epistemological reflexivity consists of reflecting upon the researcher’s assumptions about the world and knowledge, how the research question was defined and limited, and how the design and methods of analysis constructed the data and findings. Personal reflexivity concerns the ways in which the researcher’s “own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research” (Willing, 2001, p. 10). It is suggested that counselling psychologists should extend their personal reflexivity to include what may be termed “psychological reflexivity”.

Psychologically reflexivity is a mindful, psychologically sophisticated manner in which good clinicians understand their own latent and manifest motives, drives and processes. The task of the university is to provide a safe space in which researchers may curiously, openly and honestly reflect on their topic of investigation. Ideally supervisors and researchers reflect upon a variety of questions: How has the student’s background shaped the research question and their psychological motivation to investigate it? What would the social and personal implications be if the assumptions were invalidated by the research? Why would the student dislike finding something different? Thinking like a therapeutic psychologist, it is useful to be aware of the student’s research passion and how it connects to their cognitive structures (Beck, 2005), schemas (Young, Klosko, & Weishaar, 2006), internal working models (Bowlby, 1979), internal object relations (Fairbairn, 1952; Ogden, 1983) or complexes (Jung, 1969).

Paraphrasing Winnicott’s (1949, p. 70) famous statement on therapeutic research it is suggested that most qualitative research is to some extent an attempt on the part of the counselling psychologist to understand and resolve a central personal conflict. This may also apply to supervisors who direct the student’s choice of research topic. The extent to which this process is conscious depends on the psychological sophistication of the researcher, supervisor and their supervisory relationship.

Extending this line of reasoning, it is suggested that student researchers are encouraged to reflect upon and link their motives for engaging in the research with their psychological reasons for choosing to become a counselling psychologist. This involves a continual reflection upon the historical, characterological and dynamic reasons why they entered the helping profession and what their strengths, trigger points, biases and blind spots are. This deeper level of psychological understanding reflects why personal therapy, ongoing supervision and professional development are mandatory in counselling psychology, as they are in many other therapeutic traditions.

In the author’s experience a thorough psychological understanding of the student’s underlying motivation for researching the particular phenomenon, at that particular time in their life, often assists navigating the problems that inevitably occur during the research process.

b) The research interview and data gathering.

The research interview is the phase of qualitative research which is most overtly congruent with the process of engaging in psychological therapy. Some authors (Alma & Smaling, 2006; Gair, 2012) have highlighted the similarities between the process and goals of empathic counselling and qualitative research. Gair maintains that the common quest “is to be able
to hear, feel, understand and value the stories of others and to convey that felt empathy and understanding back to the client/storyteller/participant” (Gair, 2012, p. 134). This process has received less attention in the literature on qualitative research than it has in the arena of psychological therapy.

The quality of the research is fundamentally dependent on the depth and richness of the information gathered from the participants during the research interviews. This in turn is dependent on the skill of the researcher, the narrative and reflective capacities of the participant and the relationship that is developed between them (Grafanaki, 1996; Polkinghorne, 1991). Linking research and therapy, Grafanaki (1996, p. 331) has coined the term “research alliance” as the research counterpart of the therapeutic alliance. Similarly, Watts (2008) speaks of a “shared narrative space”. An open and trusting relationship facilitates the gathering of data that is authentically grounded in participants’ experience and gives rise to a greater depth, complexity and richness of the data gathered (Cowles, 1988; Grafanaki, 1996).

According to Morrow (2007) the responsibility to treat research participants with high regard and respect is paramount as they frequently disclose sensitive information. The interviews may re-stimulate painful memories and trigger unresolved emotional conflicts. A similar process may occur vicariously in the researcher and supervisor.

In qualitative research the amount of time and effort spent interviewing the participants is characteristically less than the time spent on the analysis of the data. On the other hand the face-to-face contact in psychological therapy takes up most of the time. Although some processing of therapeutic material takes place while writing up clinical notes, in supervision, clinical reading, personal therapy, and at other unexpected moments in life, much of the therapist’s reflection takes place during the therapy sessions.

A similar process occurs with counselling psychology students who may consult with their therapy clients on multiple occasions but characteristically only interview each research participant once. As there is less time for error, corrective feedback and the development of a working relationship, research interviews may be more pressured. This is exacerbated when students receive less training in research interviewing than they do in therapy skills. Fortunately some of the therapeutic knowledge is transferrable to the research interview. Kalizinje (personal communication, May 18, 2012) said that she was clearly aware of how her therapeutic training as a counselling psychologist influenced her ability to interview and understand her research subjects in her second dissertation.

Gair (2012) shows that there is agreement in the qualitative literature that the researcher needs to listen intently to understand the lived reality of participants. Wertz (1986, p. 569) recommends that the researcher engage in “empathic immersion” in the participant’s world rather than being a distant spectator. Smythe, Ironside, Sims, Swenson and Spence (2008) encourage the researcher to maintain an openness to the “play of the conversation” and to develop a great self-discipline to let the interviewee find their own way. Similarly, Stein (1971/1989) (as cited in, Gair, 2012) recommends a deep absorption so that the “foreign objective story” becomes the “felt subjective story” that connects with the researcher’s feeling, spirit and humanity.

In order to optimise the depth, quality and openness of the material shared by the participant the researcher needs to develop certain qualities. These include active listening, accurate understanding, warmth, acceptance, respect, genuineness, a non-judgemental attitude (Grafanaki, 1996; McLeod, 1994; Mearns & McLeod, 1984) the ability to be fully present, engaged, sensitive, respectful, non-judgemental (Grafanaki, 1996), to listen intently (Gair, 2012) and empathically and to engage fully in the unfolding relationship.

These attributes are similar to those employed by good psychological therapists. Coyle (1998) discusses how the therapist’s use of counselling skills can enhance the qualitative interview and Poulin (2007) shows how the use of self as an instrument of data collection and interpretation is used by the helper and the interpretive researcher. Morrow (2007) suggests that counselling psychologists are well skilled in developing positive, respectful, and collaborative relationships because of their clinical training and experience. Interestingly some of Goedeke’s (personal communication, June 19, 2012) respondents only agreed to participate in her research on embryo donation after they had thoroughly Googled her and decided they would be in professional, safe, trustworthy and knowledgeable hands.

For the participant to feel heard, accepted and understood the researchers need clearly to demonstrate their empathy (Alston & Bowles, 1998). This is manifest in the researcher’s style and content of questions as well as their verbal and non-verbal behaviour (Watts, 2008). As is well known in the therapeutic arena, research participants intuitively and subtly test the researcher to ascertain what material is safe to divulge (Grafanaki, 1996). The phenomenon of research participants frequently reporting personal benefits from the research interviews further extends the parallel between research and therapy.

Sounding a cautionary note, Hart and Crawford-Wright (1999) argue that the trend towards deepening the research relationship may blur the boundaries between the process of psychological therapy and research leading to new ethical dilemmas. These ethical issues become more pertinent when clients are enlisted as research participants.

c) Thematic analysis.

This phase marks the initial identification of recurrent meanings or themes (Braun & Clarke, 2006; Wertz, 1986). Thematic analysis is identified as one of the shared generic skills across different qualitative analyses (Boyatzis, 1988; Holloway & Todres, 2003). In order to obtain a felt sense of the participant’s lived experience; the researcher repeatedly listens to the audio recordings and reads the transcripts. The researcher develops a sensitivity to the emerging findings (Morrow, 2007) referred to as “emergent design” (Glaser & Strauss, 1967; Morrow & Smith, 2000). Researchers employ different styles of data analysis depending on
their chosen methodology and aim. According to Smythe et al. (2008) this is not a process of simply doing whatever the researcher likes but rather an extremely attentive attunement to thinking and listening to how the text speaks.

Throughout the data analysis the researcher continuously returns to the verbatim interviews. This allows for an iterative process of mutual influence between the data and the analysis thereby shaping the direction of the research. Thorne, Kirkham and O'Flynn-Magee state that the researcher “must remain sceptical of the immediately apparent, and must create data collection pathways that challenge, rather than reinforce, the earliest conceptualizations” (2004, p. 5). They go on to say that thematising too meticulously, too early or in too much detail can derail the process. They urge the researcher to let go of their “life raft”.

Deep and prolonged engagement with the data and analysis demands space and time. This is frequently a luxury in the modern postgraduate counselling psychologist’s life. Many student researchers only progress as far as summarising the text into obvious themes or headings. This form of “objective thematising” removes the experience from its specific context (Harman, 2007). This results in a failure to capture the experiential flow and to make the shift to an abstract and meta-analytic process. The analysis fails to achieve the primary task of making meaning of experience and runs the risk of collapsing into Cartesian dualism and positivistic empiricism.

d) Meta-analysis.

This vital phase marks the transition to a style of symbolic, sophisticated and meta-analytic thinking. This higher order process is the most complex, time consuming, unclear, frustrating, and anxiety producing. The lure of premature closure is at its apogee. The meta-theoretical and abstracting process shares much in common with some of the abilities employed by seasoned counselling psychologists while conducting therapy. As such, it is an indirect and unexpectedly fertile training ground for postgraduate students learning to conduct psychological therapy.

The process of engagement in this phase has been described as exciting, interesting, exhausting, overwhelming (Grafanaki, 1996; May, 1989), shocking, disconcerting, restless (Smythe et al., 2008) and frustrating. To tolerate these experiences and remain open, curious and resistant to the temptation of premature closure, the researcher needs to be sufficiently supported and grounded.

Thorne et al. state that many new researchers “cannot conceive of the intellectual chaos that inductive reasoning inevitably represents in the luminal space between the preliminary framework and the eventual structural decisions” (2004, p. 5). Remaining open to multiple perspectives and unexpected responses may conflict with the researcher’s need for control and structure. This is evident when students make the transition from positivist empirical research which deals with facts (Poulin, 2007) and for those who have a strong need for predictability and “near” data (Grafanaki, 1996).

Many authors consider the researcher to be the primary instrument of qualitative inquiry (Eisner, 1993; McAllister & Rowe, 2003; Poulin, 2007; Willing, 2001). The basic characteristics needed by the researcher have been variously described as the ability to be amenable to unexpected incidents (Grafanaki, 1996), to be flexible, open and willing to change, courageous, ready, wakeful (in the Heideggerian sense), still and expectant (Smythe et al., 2008). In order to perceive and interpret the experience, beliefs, desires and intentions of the participant the researcher needs to have a strong theory of mind (Baron-Cohen, 1995) or an ability to mentalize (Fonagy, Gergely, Jurist, & Target, 2002). It may be postulated that engagement with qualitative research develops interpersonal and empathic skills while doing qualitative research honed the abilities to use logic through statistical methods.

The ability to tolerate uncertainty is vital for the qualitative researcher. Employing the phrase “creative uncertainty” (van Deurzen, 2002) argues that an ability to attend is correlated with an ability to sit with uncertainty. To develop a qualitative stance (Eisner, 1993) the researcher needs the ability to block out the noise (Rock, 2009; Smythe et al., 2008) and distractions, and inhibit the pull towards that which is clear, easy and habitual. The ability to contain and channel frustration and to defer gratification helps the researcher tolerate the not knowing, and to stay immersed and “dwelling” (Wertz, 1986) in the ambiguous material. Neuropsychologists point out that the process of forging new neural pathways takes up greater stores of energy than when reinforcing the old pathways (Rock, 2009). This resonates with Carl Rogers’ (1951) view that increased insight is dependent on the development of sufficient psychological strength to endure new perspectives.

Merton ironically argues that as the qualitative researcher: “You do not sit down and solve problems; you bear with them until they somehow solve themselves” (Merton, 2007, p. 23) (as cited in Smythe et al., 2008). Similarly, Smythe et al., note: "If I try to force it, it doesn’t work. I don’t know how to make it happen but I know it when it does” (2008, p. 1394). The common adage is reversed and becomes “don’t just do something, sit there... and think”.

Discussing a similar theme, Epstein (1985, 2007) states that the thirst for certainty, craving for identity and the tendency to cling to whatever provides a sense of security, is unproductive. Practicing clinicians and researchers adapt to increased stress, frustration and uncertainty in personally specific ways. Passing successfully through this chaos leads to an illumination of the phenomenon under investigation in a new and meaningful manner (Thorne et al., 2004). It is here that book learning and didactic teaching most clearly need to be enhanced through direct experience. Once again the need for good supervision, reflection, introspection and personal therapy and is emphasised.

Many authors have described the optimal mental space needed for generating this form of creativity and insight. Smythe et al. (2008) speak about “the play in the unrest”. They refer to Gadamer’s bicycle wheel analogy – if the wheel too tight it cannot turn and if it is too loose the wheel will fall off.
This is the leeway between structure and freedom where there is room to play. This is similar to the tension between flexibility, consistency and coherence described by Holloway and Todres (2003).

The therapeutic literature is replete with similar advice. For example, Epstein posits that the ideal approach requires a middle ground, where the viewer surrenders to the unconscious experience of the object:

This attention is not just passive, receptive, empathic listening, it is a means of attending to all phenomena equally, impartially and dispassionately, with rapt interest and active, close scrutiny but with a slight distance, so that one allows a thought or impulse to completely exhibit itself, noting all of the reverberations created before acting (2007, p. 118).

Borrowing from “The second coming” (Yeates, 1994) Colcott (1986) describes therapeutic movement as “slouching towards” rather than “arriving at”. Similarly Ogden (1985) writes that reverie must be allowed to accrue meaning without the therapist or client feeling pressured to make immediate use of them. He goes on to describe how the use of reverie requires the therapist to tolerate the experience of being adrift (Ogden, 1997, p. 160). Khan (1977) speaks eloquently about the importance of “lying fallow”, while Bion (1967) urges therapists to focus on the material while eschewing memory, desire or understanding.

In his 1817 letter to his brothers, the poet John Keats famously defined negative capability as the: “capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason” (Gittings, 1970). This concept has been repeatedly discussed in the psychotherapy literature (c.f.Simpson, French, & Harvey, 2002). Eisold, for example, has written of the capacity to live with and tolerate ambiguity and paradox and, advises therapists “to tolerate anxiety and fear, to stay in the place of uncertainty in order to allow for the emergence of new thoughts or perceptions” (2000, p. 161).

This type of openness to uncertainty and curiosity paradoxically requires a firm base consisting of trust in the process, good supervisory support, a solid theoretical foundation, discipline, effort and time commitment (Grafanaki, 1996; Polkinghamore, 1991; Smythe et al., 2008). This is analogous to the view held by many therapists that a clear and firm therapeutic frame creates an environment which allows the therapist and client to delve safely into areas of experience they would otherwise defensively avoid (Casement, 1991; Cherry & Gold, 1989; Langs, 1975).

Throughout the process of analysing the data at increasingly higher levels of abstraction it is vital for the researcher to maintain a clear differentiation between the participant’s description and the researcher’s interpretation. This task requires the researcher to be securely grounded and attached (Bowlby, 1988) and to maintain a mindful awareness of how their own dynamics influence their understanding and interpretation of the respondent’s lived world. Similarly, an important task for therapists is to differentiate their own contribution from that of the clients (Ogden, 1985; Thorpe, 1989).

In this phase of data analysis the researcher has to take a risk and commit to making interpretations (Sandelowski & Barroso, 2002). According to Thorne et al. (2004) taking ownership of an interpretation is amongst the most challenging aspects of the analytic process, particularly for neophytes. Malan (2004) points to a similar tension by paradoxically stating that a therapist should not make an interpretation without first knowing about the patient, but that one cannot know the patient without first making an interpretation.

e) Presentation of the research.

Mainstream psychologists are directed to write research reports in a formal, dispassionate and precise manner (c.f. O’Shea, Moss, & McKenzie, 2007). In contrast, writing about qualitative research aims to capture the respondent’s lived experience by producing emotionally engaging, authentic and empathic stories. Far from being dispassionate, qualitative writing aspires to elicit the empathy and engagement of the audience (Gair, 2012; Smythe & Spence, 2012). Congruent with the focus of counselling psychology, it also attempts to make a direct social difference by empowering people to improve their lives (Liamputtong, 2007) (as cited in Gair, 2012).

Smythe and Spence (2012) argue that the qualitative researcher and reader need to share a commitment to constant thinking, a willingness to question and to remain open to emerging ideas without expecting to see the static truth. They remind us of Heidegger’s assertion that providing definitive answers shuts down and closes thinking. Good qualitative writing appeals to the reader to connect in a personal way. It aims to stimulate curiosity, reflexivity and creativity in the reader and invites them to make their own journey. Keen (2007, p. 130) speaks of a “triangulated empathic bond” formed by the perceived mutuality and empathic connection between the participant, writer and reader.

The qualitative style requires a shift from writing as reporting to writing as thinking (Smythe & Spence, 2012) and the use of the type of language which elucidates lived experience and meaning (Poulin, 2007). A style of writing which is congruent with qualitative research epistemology has only recently become accepted in counselling psychology departments in the United States of America and the United Kingdom (personal communication, Milton, M. August 21, 2011). The task of carving out a qualitative alternative within psychology is still in its infancy in Aotearoa New Zealand, the country once termed the “last bastion of strict behaviourism” (Oakes, 1999).

A similar epistemological debate occurs when counselling psychologists communicate with other professionals about their clients, be it in supervision, via case notes, formal case reports or journal articles. It is argued that in addition to a competent DSM diagnosis, coupled with a clearly argued treatment plan, counselling psychologists ought to communicate in a style that elicits the engagement, empathy, curiosity and reflexivity of the other professional by providing a psychologically sophisticated, detailed, nuanced description that is firmly grounded in the client and therapist’s lived experience. Davey (2010, p. 73) suggests that professional reports by counselling psychologists should convey facts and
formulations in addition to stimulating the reader into further thinking and “re-storying” in order to disrupt previously settled understandings and stimulate curiosity.

Experiential description

Ironically this paper, on the process of qualitative research, has been written in a traditional academic style. In order to reflect a qualitative discourse and worldview the following description, based on a reading of the literature and the author’s personal experience of the process, is presented. The style is similar to Giorgi’s phenomenological “general structure” (A. Giorgi, 1970; A. Giorgi & Giorgi, 2008) and embodies the necessary and sufficient conditions, constituents and structural relations which constitute the phenomenon of doing qualitative research:

The qualitative counselling psychology researcher, grounded in postmodernism and constructivism, develops a reflexive and insightful understanding of the links between their own personality, history, underlying motives, worldview and their choice of research topic. Firmly supported by a base of discipline, rigor, security, commitment and trust in the process, the researcher approaches the task with an attitude of curiosity, flexibility, compassion, empathy, respect, openness, non-judgement, self-awareness, and playfulness. Intellectually and emotionally, the researcher strives to remain deeply immersed in the material, while listening intently and remaining open to multiple perspectives and unexpected responses. By resisting the pull to premature closure, the researcher tolerates the experience of ‘not knowing’, uncertainty, ambiguity, chaos, restlessness, disappointment, being overwhelmed, surprise, and remains open to the emergence of new meaning. Maintaining an optimal distance the researcher lets go of the security of the already known, clarifies meanings, identifies links and patterns, and forges higher level abstractions. The research is presented in an emotionally engaging, detailed and in-depth manner which captures the lived experience of clinically related phenomena. The reader is emotionally and intellectually engaged and thinks deeply and reflectively about their life and practice of psychology.

Summary

This paper began by defining counselling psychology and locating it within the context of Aotearoa New Zealand. It argued that counselling psychologists are drawn to qualitative methodologies due to their interest in researching topics which are personal, sensitive and difficult to articulate meaningfully. The paper went on to illustrate the close congruence between counselling psychology and qualitative research in terms of aims, values and agendas. The experiences, attitudes and skills involved in qualitative research were then delineated using five postulated phases of the qualitative research process, namely: reflexivity and choice of the research topic, the research interview, thematic analysis, meta-analysis and the presentation of the research. The overlap and transferability between the skills needed in qualitative research and the therapeutic aspects of counselling psychology were highlighted. This led to the primary argument of the paper that one of the ways of indirectly augmenting the therapeutic training of post-graduate counselling psychology students is through the students’ experience of conducting qualitative research.

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Dr Mark Thorpe
Department of Psychology
School of Public Health & Psychosocial Studies
Faculty of Health & Environmental Sciences
AULT
Private Bag 92006
Auckland 1142
mark.thorpe@aut.ac.nz

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Second Order Ethical Decision-Making in Counselling Psychology: Theory, Practice and Process

Elizabeth du Preez, Auckland University of Technology  
Sonja Goedeke, Auckland University of Technology

Counselling psychology as a distinct professional identity aligns with an integrative approach to understanding psychological functioning, with particular emphasis on and recognition of the interpersonal and socio-political context and how this impacts on and contributes to psychological functioning (Stanley & Manthei, 2004). Yet ethical decision-making models have traditionally failed to annunciate a clear theoretical stance, practice guidelines, and a moral developmental process that correspond with this more constructive and contextual view of mental health. This paper presents preliminary ideas for an ethical decision-making model that provides a vehicle for the emergence of an ethical selfhood in counselling psychology by integrating communicative ethical theory, value-based ethics and ethical actions guided by a social constructivist process model of ethical decision-making.

Keywords: Ethical decision-making models, second-order change, counselling psychology

In recent years there has been an acknowledgement that the discipline of counselling psychology places an emphasis on systemic frameworks that consider the individual within a context of developmental and ecological factors. Counselling Psychology considers diversity as central to its work, and acknowledges the importance of working at the interface of science and practice, maintaining a balance between scientist-practitioner and practitioner-scholar frameworks (Woolfe, 2006).

When confronted with ethical dilemmas, practitioners have traditionally been guided by that particular country’s relevant professional associations or psychology registration board. Whilst they may have no separate Codes of Ethics specific to Counselling Psychology, these bodies may have guidelines for practice that assist in ethical decision-making.

Generally, Codes of Ethics set out the rules and principles related to professional practice. However these are often presented as linear, progressive models of decision-making, facilitating first order change, rather than recursive or systemic ones that bring about second order change. First order change processes traditionally focus on changing the problem as defined by the system, and second order change processes traditionally focus on changing the system as defined by the problem. An example of this would be conceptualising depression as an individual problem and treating it as such, without talking into account the relational aspects of the function of depression in the wider system, including the socio-political context of the client. Hoffman (1985) further contrasts second order change to first order change by suggesting that second order approaches are inclusive of the context of the therapeutic system (including the therapist), encouraging of a collaborative relationship between client system and therapist, view contextual changes as the preferred area for therapeutic goal setting and support a circular understanding of the presenting problem. It is therefore important that ethical decision-making models in Counselling Psychology reflect a second order, systems theory approach, in keeping with the principles that underlie Counselling Psychology, rather than reflect a first order, linear approach.

This article argues for the development of an ethical decision-making model for counselling psychology that is situated in a second order framework, providing a theoretical foundation and descriptive practice, as well as guidelines for the process.

History and Definitions of Counselling Psychology, and Ethical Decision-Making

In the past 30 years the discipline of counselling psychology has been established as separate from clinical psychology, counselling and psychotherapy. It gained divisional status as well as a professional identity within the British Psychological Society in 1995 (Pugh & Coyle, 2000; Woolfe, 2006), by differentiating itself from clinical psychology, and aligning more with counselling and psychotherapy. Pugh and Coyle (2000) suggest that in order for a profession to construct a unique identity, it must develop a separate line of inquiry into the social reality the discipline concerns itself with.

In 1947 the New Zealand branch of the British Psychological Society was established with the New Zealand Psychological Society becoming independent in 1967. The New Zealand Psychologists’ Board defines scopes of practice for registration under the HPCA with the scopes of practice initially
being available limited to the general, clinical and educational scopes. In 1983 an interest group formed at the New Zealand Psychological Society annual conference, resulting in a symposium in 1984, and the setting up of a division of counselling psychology in 1985. In 2003 the Institute of Counselling Psychology was formed, and AUT University made a commitment to develop a postgraduate programme of study in counselling psychology. The first students enrolled in 2008, the Counselling Psychology scope of practice was approved by the Board in 2010, and the programme received its final accreditation in 2012.

According to Stanley and Manthei (2004), counselling psychologists adopt an integrative approach to understanding psychological functioning that includes consideration of internal processes, relationship functioning and the effect of social-cultural and political factors on psychological wellbeing. Counselling psychology’s strength lies in the fact that it particularly recognises the contribution of the latter two aspects on a person’s functioning, and therefore informs the choice of intervention modalities.

For counselling psychology this has meant moving away from a medical model of assessment, diagnosis and treatment, as well as moving away from predominantly intrapsychic conceptualisations of mental illness and unwellness. It has also implied a move towards more humanistic, phenomenological and systemic values informing theory, practice and research. One of the most important distinctions has been the inclusion and highlighting of reflective practice, or of the reflective practitioner, which includes personal development and supervision. Initially, these values were regarded as not having a base in scientifically-oriented practice. This inclusion of the practitioner/researcher in the therapeutic or research system coincided with the move in the family therapy movement from first to second order thinking (Lane & Corrie, 2006).

A series of articles in the Counselling Psychologist in 1980 focused on predicting future directions for Counselling Psychology, and described a growing focus on systemic conceptualisations (Whiteley, 1980). Yet unfortunately, these predictions have yet to translate into the details of ethical decision-making within a systemic framework.

Systemic conceptualisations support the recognition of and working with reciprocity and patterns of recursiveness in relationships, and are focused on an effort to describe a cycle of behaviour that is embedded within a context, rather than asking “why” questions, which would lead to a more linear and causal understanding of behaviour (Goldenberg & Goldenberg, 2008). Within a recursive framework, reality is seen as being constructed by individuals’ own perceptions and the meaning they attribute to these perceptions. Systems thinking therefore has a bearing on therapy process, on research, as well as on ethical decision-making processes.

Hargrove (1986) re-iterated this notion that a systemic framework should be applied to all aspects of the work we do. If we think and do systemically in a therapeutic framework, then ethical decision-making should not be formulated as a linear process, only because we find it challenging to engage with second order paradigms, or the lack thereof, in ethical decision-making. Our decision-making model should reflect and be able to contain the complexity of the therapeutic systems we work with including consideration of the cultural and socio-political aspects of the system (Gallardo, Johnson, & Parham, 2009; Gauthier & Pettifor, 2010).

The New Zealand Code of Ethics

The New Zealand Psychologists’ Code of Ethics offers a decision-making model that is based on a linear and rational model requiring explicit cognitive input. This Code was published in 2002 and attempts to provide practitioners with guidance on desired behaviour, and values and principles driving this behaviour. The Code includes a step-by-step cognitive process that should be followed in all circumstances. This is a six-step model that is an example of a cognitive and prescriptive model and clearly demonstrates the influence of classical decision-making theory (Williams, 2004). The model suggests that in all circumstances, the following steps should be followed:

1. Identify the issues and practices that are ethically relevant.
2. Develop alternative courses of action, preferably in consultation with a professional colleague or supervisor.
3. For each identified course of action analyse the likely short-term, ongoing, and long-term risks and benefits for the individual(s) and/or group(s) involved or likely to be affected.
4. Conscientiously apply the principles, values and practice implications to each course of action in the light of the identified risks and benefits and decide which offers the best balance between these.
5. Take the chosen course of action, accepting responsibility for the consequences of the chosen course of action.
6. Evaluate the consequences of the action, correcting negative outcomes if possible and, if the issue(s) originally identified are not resolved, re-engaging in the decision making process.

(NZ Psychologists Board, 2002, p.4)

Criticism of this model focuses on the fact that correct process does not necessarily result in correct decisions – as is summarised in Haidt’s (2001) description of the “rational tail wagging the ethical dog”.

Of interest is that these steps were developed directly from the Canadian Psychological Association’s Code of Ethics (2000), but actively exclude references to subjectivity, context, and intuition. Rather than giving a general instruction, as in the Canadian case, “the following basic steps typify approaches to ethical decision-making”, the NZ Code begins with a prescriptive, “In all circumstances”. The Canadian process therefore acknowledges context and subjectivity and is future-oriented in that it considers the possibility of preventing a repeat of current difficulties. However, criticism of the Canadian approach includes the rank-ordering of ethical principles when faced with situations in which ethical principles conflict
and competing directives exist. Clark (2012) for example, has argued that such rank ordering is inappropriate and constitutes a decontextualized approach to decision-making, failing to account for differences across groups, cultures and political orientations.

Possible solutions that have been offered by Williams include that guidelines and models should “acknowledge the existence and value to practitioners of intuitive or non-deliberative cognitive processes in making ethical decisions” (2004, p.31), and should include recognition of personal and organisational resource constraints. These solutions, while an attempt to address the limitations of the linear rational model as outlined by the Code of Ethics, still require extension to include contextual, relational and intuitive dimensions. Counselling Psychology by its definition offers a second order perspective that could include contextual, relational and intuitive dimensions.

A brief review of ethical decision-making models

Although an in-depth discussion of existing ethical decision-making models is not the focus of this article, a brief review of ethical models follows, integrating Cottone and Claus’s (2000) review of theory, practice and process with the three inquiry frameworks of meta-ethics, descriptive ethics and prescriptive ethics (as proposed by Miner & Petocz, 2003).

Theory based models of ethical decision-making

Several models have been developed that rest on a theoretical or philosophical basis. These models offer an important contribution as they defend against the accusation that ethical models often fail to take into account the complexity of meta-ethical perspectives, and as a result fail to respond to the complexity involved in ethical decisions. Clarity on the moral/philosophical foundation of a model also provides the possibility of clearly distinguishing among descriptive, prescriptive and decisional models of the ethical process (Miner & Petocz, 2003).

Hare’s (1981) philosophical model included two levels of thinking – one that was concerned with rights and duties, and a second level that was concerned with attending to the interests of patients and based on utilitarianism. Rest (1984) developed a model pertinent to applied ethics in psychology that was based on developmental and cognitive theory, with specific reference to Kohlberg’s theory of cognitive development. Hill, Glasser and Harden (1995) proposed a model embedded in feminist theory considering both the emotional responses of the therapist as well as the context of the therapeutic relationship. The decision-making process was considered a collaborative one that included both intuitive and evaluative aspects of the situation at hand.

The model most relevant to a second order view of ethical decision-making is that of Cottone (2001). The theoretical basis of social constructivism considers ethical decisions to exist in the realm of social interactions and not as a product of individual psychological processes. It attends to the social and biological construction of reality, integrating the ideas of both Gergen (1985) and Maturana (1988).

Practice-based models of ethical decision-making

In addition to the theoretical/philosophically based models, some authors have proposed practice-based models for ethical decision-making. Practice-based models offer a distinct line of inquiry concerned with the process of coming to an ethical decision, in other words, attending to the “how” of the decision-making process (Miner & Petocz, 2003).

Practice-based models offer a sequence of practical steps that therapists can follow and imply that adhering to the practice will ensure an outcome that can be considered as ethical. These models include Kitchener (1984), Rest (1984), Keith-Spiegel and Koocher (1985), and Stadler (1986) and they all share a step-by-step process emphasising the four fundamental principles of autonomy, beneficence, nonmaleficence and justice.

Kitchener’s (1984) ethical decision-making model for counselling psychology is considered a seminal work that integrated and incorporated both Hare’s (1981) philosophical ideas on different levels of moral thinking, as well as the work of Beauchamp and Childress (2008) on ethical principles and rules of autonomy, beneficence, nonmaleficence, justice and fidelity.

Although practice models give little consideration to an explanatory framework for the decision-making process itself, the strength of these models lie in their attempt to apply and translate theory into practical steps. Concerns with this approach include that practice-based ethical decision-making models often don’t translate into ethical decisions, but rather function as a device to evaluate or examine a situation. Professional Ethical Codes can be considered as an example of practice-based models. Corey, Corey and Callanan (1998) raised similar concerns that these codes of practice cannot be applied in an automated or generalised manner, as practitioners often find themselves confronted with a complexity of personal values, social context, as well as a prescriptive professional code. Their model of decision-making fails to correspond with this reality or address the level of complexity they confronted.

Process-based models

Process-based models focus on the actual process of decision-making, and often don’t offer a comprehensive theoretical or practice-based framework. Rest’s (1994) later work attempted to present a model of processes involved in the production of behaviour, that considered how the context of a particular situation could produce a course of action in a complex interplay, rather than in a temporal order. Process-based models may however, also be considered prescriptive or normative, and are usually concerned with strategies that ought to be followed in decision-making (Miner & Petocz, 2003).

Other authors have integrated some of the principles of transactional analysis by addressing the interplay of values such as that people are inherently acceptable, that they are capable of understanding their problems, and that they are able to be active in making decisions. Hill, Glasser and Harden’s (1995) feminist perspectives’ model further offers some important ideas on the inclusion of the client in the
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decision-making process, and how practitioners’ personal values and characteristics should be taken into account in terms of the effect on ethical decision-making.

Cottone (2001) offered a more hermeneutic approach to decision-making. A hermeneutic approach includes consideration of first and second order aspects of communication. Cottone acknowledges how knowledge and decision-making occur within a context of relationships in which both party’s dynamics are critical to consider in the way in which ethical principles are interpreted and applied. These models thus represent a shift away from linear models towards interactive models, involving the processes of negotiating, consensualising and arbitrating. Other authors have presented frameworks on the process of decision-making, with varying degrees of integration with theoretical models or philosophical frameworks. Hillerbrand and Stone (1986), as well as Hundert (1987), articulated process models that emphasised engagement of clients in the decision-making process and the inclusion of intuition and affect as guides to reaching the best ethical decision.

According to Miner and Petocz (2003) ethical decision-making models are vulnerable to criticism as its developers fail to acknowledge fully the meta-ethical foundations of their models, resulting in a misalignment of suggested practice and process within models. What seems to be lacking, therefore, is a coherent, integrated model of ethical decision-making in counselling psychology that has a theoretical base aligned with the professional values of counselling psychology, and that offers a practice and process framework that is embedded in this theoretical base.

Considering theory, practice and process in a counselling psychology framework

Counselling psychology as a discipline values systemic and recursive dialogue which is mindful of the ecological context that people live in, and how that might influence people’s languaging practices and actions. This uniquely-defined professional identity creates a tension with existing models of ethical decision-making that are based on individualised conceptualisations of morality or lack theoretical integration with practice and process. An integrated second order ethical decision-making framework that is horizontally aligned with theory, descriptive practice and prescriptive processes, and vertically aligned with a systemic theoretical framework is proposed. This framework is not meant to be an exhaustive account of the theoretical ideas used, but rather attempts to function as the start of a professional dialogue in counselling psychology that may lead to the emergence of an ethical selfhood in the profession.

Theory

Ethical theory has traditionally been associated with Kantian ideas of individual consciousness, and for many psychologists, ethics/ethical practice forms part of an implicit backdrop to therapy – usually overtly formulated and accessible when needed, in a Code of Ethics (Donovan, 2003). However, from a systemic and counselling psychology perspective, the hermeneutic turn towards second order therapies in the 1980’s, which coincided with a rising awareness of the ethical-political realm - clearly seen in the feminist psychology literature of the time (Pipes & Holstein, 2005) represented a shift and a willingness towards positioning ethical practice within processes of communication.

Habermas’ (1990) work on moral consciousness and communicative ethics is considered as an appropriate and relevant theoretical framework for counselling psychology, as it attends to this hermeneutic turn from first to second order thinking and doing in the therapeutic arena. He proposed that ethical conceptualisations should exist in contexts that are inclusive of the political, philosophical and social reality of the day, as the concept of moral reality arises in the nexus of these domains, and not in isolation in the cognitive processes of the individual. Habermas (1990) re-formulates Kantian ethical theory in an attempt to align ethical theory with this paradigmatic shift from individual consciousness to language, objectivity to intersubjectivity, and individual to communicative ethical theory. A communicative ethical theory stance also requires a constant search for a rational grounding of ethics to defend against relativity and a myopic focus on meaning. This provides a platform where distortions in communication, as opposed to distortions in cognitive thinking, can be evaluated.

Practice

Communicative ethical theory puts dialogue at the centre of decision-making processes and attempts to answer the question: how does this view influence our understanding of moral development as a manifestation of dialogue/communication? Practice-based descriptive models traditionally focus on the questions, “who shall I be? What shall I do?”, rather than “what is ethics?” These models attempt to elucidate the development of moral reasoning, the relationship between individual and context, and the actions that are involved in coming to what is considered an ethical outcome (Donovan, 2003; Miner & Petocz, 2003).

The distinction in literature between practice and process, between the descriptive and the prescriptive is often blurred. Drawing on value-based ethics of Prilleltensky (1997), and the emergence of a dialogical moral self (Tappan, 1997; Haste & Abrahams, 2008), a descriptive frame may be adopted to answer the question, “who shall we, as counselling psychologists, be?” in the light of the development a moral selfhood and the relationship between psychologist and context. In the discussion of ethical process, the focus shifts to an action domain – attending to the question “what shall we do when faced with an ethical dilemma?”

Prilleltensky’s (1997) work on the importance of values in assessing the moral discourse in psychology is offered as a useful practice framework for an ethical decision-making model for counselling psychology. In clarifying a set of values that counselling psychology as a sub discipline identifies with, it can move towards internal and external congruence within an ethical model situated in a systemic theoretical framework. Prilleltensky (1997) describes five values that are considered as particularly relevant to
counselling psychology as it speaks to the core of its unique identity in the field of mental health service providers. These five values are: caring and compassion, self-determination, human diversity, collaboration and democratic participation, and distributive justice (p. 520). These fit well with the communicative ethical theory of Habermas (1990) as they draw attention to relationship as well as individual responsibility, the communication of interpersonal acceptance through professional language practices, and culminate in the holding of a balanced explanatory framework (distributive justice) between individual and socio-political contexts. Through attending to these values, counselling psychologists can ensure the development of a moral self that is created dialogically, more so than psychologically or socially (Tappan, 1997).

Process

Traditionally descriptions of prescriptive frameworks for ethical decision-making, where the goal is to specify the issues that psychologists should consider in arriving at an ethical decision, have been hampered by a lack of integration of ethical theory and the clarification of moral values and principles. Following on from a communicative ethical theory and values-based practice, this last section draws on Cottone’s (2004) constructivist model of ethical practice to start answering the question, “what do we as counselling psychologists do when faced with an ethical dilemma?”

Social constructivist theory is based on the acknowledgement of the biosocial realm – a relational understanding, as opposed to an individual understanding of human functioning. Cottone (2004) has proposed an ethical decision-making model based on the following principles: Ethical decisions are placed in a social context, ethical actions are always biosocially compelled; ethical decisions should involve a process of acting according to consensual reality (termed as consensualising by Cottone, 2004) and lastly, that negotiation and arbitration can be added as interpersonal processes to resolve dissonance when consensualising fails. Both Prilleltensky (1997) and Cottone (2004) offer the Canadian Psychological Association Code of Ethics (Canadian Psychological Association, 2000) as an example of a value-based, social constructivist model of ethical decision-making.

Since the New Zealand Code of Ethics is based on the Canadian Code of Ethics (Williams, 2004), the social constructivist model may be regarded as particularly relevant to the recent emergence of the profession of counselling psychology in New Zealand. The Canadian Code of Ethics (2000) attends to the context within which the ethical problem was constructed, the subjective biases of the psychologist involved in the decision-making process, and a responsibility to attend to a second order change in an attempt to prevent a re-occurrence of similar ethical challenges.

Whilst the argument put forward in this article is for the development of a theoretical model towards second order ethical decision-making, an example may help to clarify the contextual and relational aspects that need to be taken into account. In the example cited in the introduction of a depressed client, the linear, first order approach to decision-making would include an individual assessment of risk factors. A response guided by the Code of Ethics, given the risk of self harm, would be to commit the patient to inpatient care. A second order approach would include consideration of risk and resilience, impact on the family such as removing a family member, the effect on the system of healthcare provision in terms of cost and resourcing, as well as the referring psychologist’s values and resources. Depression is conceptualised as a symptom of systemic dysfunction and decisions are made to reflect this.

Conclusion

Counselling psychology differentiates itself through its alignment with an integrative approach to understanding psychological functioning, recognising the interpersonal and political systemic context, and how this contributes to psychological functioning. Ethical decision-making models have typically neglected to clarify their theoretical stance, or to draw on moral principles and practice guidelines that are aligned with a more constructive and contextual view of mental health. This article proposes an ethical decision-making framework that can serve as a vehicle for ethical selfhood in counselling psychology. It does this through integrating communicative ethical theory and value-based ethics and through considering the emergence of a dialogical moral self, and actions that are practically guided by a social constructivist process model of ethical decision-making. In so doing it offers a way forward for second order decision-making in Counselling Psychology in New Zealand.

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Second Order Ethical Decision-Making in Counselling Psychology: Theory, Practice and Process

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Corresponding Author: Dr Elizabeth du Preez
Department of Psychology
School of Public Health & Psychosocial Studies
Faculty of Health & Environmental Sciences
AUT
Private Bag 92006
Auckland 1142
elizabeth.dupreez@aut.ac.nz

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Counselling Psychology From a Samoan Perspective

Byron Malaela Sotiata Seiuli, University of Waikato

O le tele o sulu e maua ai se fagota, e mama se avega pe a ta amo fa’atasi
My strength does not come from me alone, but from many

Addressing the psychological health of Pasifika’ people in New Zealand continues to challenge clinicians and health professionals, particularly in the provision of therapeutic care that is both beneficial and culturally anchored. This article discusses the Uputāua Therapeutic Approach, a Samoan-based perspective in counselling psychology aimed at supporting clinicians and researchers in this important endeavour. A case-study example is provided to conceptualise this approach more specifically within a therapeutic setting.

Keywords: Therapeutic Approach, Samoan Health, Pasifika, Wellness, Fa’asamoa, Spirituality, Counselling Psychology

“...health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (W.H.O. Definition, 1947, see Morice, 2006).

The general advancement in psychological knowledge and health practices does not necessarily equate with actual experiences for minority communities, especially those that are submerged within predominantly westernised societies like New Zealand (Nikora, 2012). It is essential that one recognise what this disparity means for minority populations such as the Samoan, in order that their psychological and emotional health needs be examined and understood. That understanding can only come from a cultured platform that takes into account this population’s indigenous patterns, their ways of living, and their understandings of health perspectives, particularly if these endeavours are to make useful contributions towards supporting recovery and overall wellness (Samu & Suaalii-Sauni, 2009; Tamasese, Peteru & Waldegrave, 1997).

As such, there is a vital role required in recognising the pathways that help to connect Samoan or Pasifika understanding of health, with contemporary practices and knowledge, instead of assuming that both translate into similar or shared meanings. In order for this objective to be realised, or at least traversing the path towards its application, the proverb that opens this article urges the collaboration of more than one voice or perspective in the process of supportive dialogue.

It is on the strength of many—both Samoan (or Pasifika) and western—that Samoans and Pasifika populations everywhere will experience successful health outcomes.

Samoan Worldview

In many instances, health paradigms are understood and practiced differently by and among Pasifika people, compared to western ideologies or pathologies as outlined by the World Health Organisation definition quoted earlier. As Seiuli argues concerning Pasifika perspectives to health, this viewpoint takes into account the “totality of the person, especially taking care to address their spirituality, and the sacredness of their customs and traditions” (2012, p. 26).

Furthermore, addressing peoples’ physical, psychological and social needs must include the contexts of ola ga fa’aleagaga (their spiritual foundations), tu ma aganu’u (their customs and traditions), aiga (their kin and relationship network), and laufanua (their environment) (Mulitalo-Lāuta, 2000; Pulotu-Endemann, 1982). These contexts serve as vital links that connect, and importantly protect Samoan cultural imperatives, which are intrinsic of fa’asamoa patterns and ways of life.

It is within this context and understanding of health that the Uputāua Therapeutic Approach finds significance as a counselling perspective, especially in the supportive role of engaging Samoan people to therapeutic interventions that are beneficial to their healing or recovery, but which are also culturally anchored.

Although the Uputāua Approach is primarily conceptualised using Samoan examples, the meanings, experiences and values represented by this approach may find indigenous connections with other Pasifika groups, therefore, it can serve to support them in their quest for health and wellness, or be used as a comparative resource.

Significant Contribution

Over the years, many Pacific health researchers and clinicians have made important contributions in the...
field of holistic health perspectives (Ministry of Health, 2006; Morice, 2006; Neimeyer, 2001). As a result, the development of Pacific-specific models of health and research perspectives have been useful in supporting and achieving therapeutic outcomes so far. The Fonofale Model (Pulotu-Endemann, 1982) is one of the earliest examples in the collection of health-focused approaches that interweave Pacific ideas within a generalised health orientation. That is, in the context of addressing Pacific peoples’ health, the model urges health practitioners to consider cultural, spiritual and family values on top of the standard aspects of physical, social and mental wellbeing. Further, it encourages the consideration of clients’ environment, the context of their lives, and time constraints of their engagements. Constructively, the Fonofale model, amongst others, has been instrumental in theorising the Uputāua Approach, particularly as the conceptual framework that aided with the approaches initial development (Seiuli, 2012).

Needless-to-say, Pacific health models and perspectives continue to emerge with similar purpose to that of the Uputāua Approach. Hence, it is the cooperative endeavour of Pasifika researchers and clinicians to continually support healthcare research and delivery to Pacific people in New Zealand and beyond. Partly, these endeavours reflect the burden of collective responsibility that is commonly attributed to communal cultures like those of the Pacific. And also, a response to the growing needs of Pacific people that continue to be ignored, or worse, to be assumed to be the same as Māori people—the indigenous people of New Zealand (Ministry of Health, 2006). The needs of Pasifika people are unique and diverse, needing specific ethnic input and perspectives that correlate with each specific indigenous reference. Of additional importance is the need to highlight that the Uputāua Approach is not the only Samoan or Pasifika perspective in counselling psychology available. Further, the ideas presented to contextualise this approach, and the cultural references used to illustrate or express a point, do not necessarily correlate with an overall perspective or representation of Samoan worldviews. As such, the perspectives and ideas conveyed by the Uputāua Approach, although commonly practiced by the general Samoan populace, critically provide personal observations and research by the author within a therapeutic and research context.

An Intergenerational Gift

Uputāua Therapeutic Approach perspectives are firmly traceable to ancestral roots as suggested by Anae (1999) who states that, “...we are carrying out the genealogies of our ancestors ...over time and space” (p. 1). Genealogically, the approach represents a mealoafa (gift) handed down by the tua ā (ancestors). One of these ‘gifters’ is my grandmother ‘Uputaua’ Leitaaualaeā Seiuli, to whom this approach accredits its title. In reflection, she passed on a mealoafa that is reflective of her love and life. Indeed, she left a profound impact on those she cared for, where safety and security became the symbols of her compassionate nature, providing a safe refuge in troubled or challenging times. Kindness and gentleness with both words and deeds helped nurture confidence and minimised harm, both real and perceived. Grandma Uputaua’s enduring presence supports and maintains her gift and legacy in and through the important work of helping people in their distress, even many years after she passed. And like Uputaua, there are many instances where I am invited into these relational and consecrated spaces, to journey and collaborate with clients, during moments of distress, challenges and pain. For me, this is a privileged and trusted place, and the Uputaua Therapeutic Approach ensures that the work done is performed with honour and care; reflective of the clients’ status as those who come as important guests into the therapeutic engagement. These are vital steps in achieving holistic care, conducive to Pasifika healing paradigms and practices.

A Conceptual Framework

The Uputaua Approach uses the Faletalimalo (Figure 1) as its conceptual framework. The faletalimalo is a modern Samoan meeting house specifically built for hosting, welcoming and receiving esteemed guests. Uputaua contains two Samoan words: upu, meaning a word or a saying, and tāua, which is used to indicate value, wisdom or sacredness. The combination of the two words to form Uputaua is easily translatable to mean ‘words of wisdom’ or ‘sacred conversations’ (Seiuli, 2012). Likewise, ‘approach’ in this context, conveys the notion of advancement or progression towards a proposed space. In Samoan social organisations and cultural rituals, the proposed space is commonly referred to as the va fealoalo’ai, that is, the relational space that organises the relationship between people. There is also the space that is referred to as va tapuia, which emphasises the sacred divide between people and all living things, inclusive of genealogical connections (Su’ali’i-Sauni, 2012). Moreover, ‘approach’ significantly represents the method of positioning one needs to embrace or be attentive to, when engaged in these important spaces.

Counselling Psychology: Consideration

The Uputaua Approach endorses and encourages engagement of the key components of the faletalimalo (see below) in order to facilitate respectful talanoa (dialogue) within the therapeutic space, particularly when counselling a Samoan client. Although the Uputaua Approach finds correlation with the work of talking therapies (Te Pou, 2010), importantly, it recognises that the healing journey for Samoans, like their Pasifika cohorts, is far more encompassing beyond the therapeutic encounter.

It is helpful to briefly discuss the meanings associated with each component of the Uputaua Approach, especially as it relates to counselling psychology and therapeutic practices. The following section highlights the key components of the Uputaua Therapeutic Approach and outlines their significance to Samoan epidemiological foundations.
1. Roof – Ola Fa’aleagaga (Spirituality)
2. Land – Tu ma Aga’u Fa’asamoa (Culture and Customs)
3. Foundation – Aiga Potopoto (Family, Kin and Relationship Network)
4. Internal Boundaries – Le Va Fealoalo’ai (Relational Space)
5. Frontal Pillar – Ola Fa’aletino (Physical Wellbeing)
6. Frontal Pillar – Ola Fa’aletolo (Social Wellbeing)
7. Rear Pillar – Ola Fa’a’lemasuafau (Psychological Wellbeing)
8. Rear Pillar – Ola Fa’a’aleagona (Emotional Wellbeing)
9. Neighbourly Boundaries – Tausi Tua’oi (External boundaries)
10. First Step – Meaalofa (Gifting Process)
11. Second Step – Loto Fa’atasia (Collaborative ‘we’ approach)
12. Third Step – Mana ma le Mamalu (Maintaining honour and dignity)

Ola Fa’aleagaga or spiritual life is the covering that endorses safety and governance in the context of the aiga (kin and relationship network), ni’u (village) and ekalesia/lotu (church/religion). Spiritually is often equated with Christian or religious worldviews; however, Samoan people have also maintained an entrenched understanding and practice of spirituality from their past (Fraser, 1891; Kramer, 1901; Suuali-Sauni, Tuagalu, Kirifi-Alai, & Fuamuatu, 2008). Hence, people are not just an expression of some physical, social or emotional characteristics, but significant in their holistic being is the role of their divine connection to Tagaloa-a-lagi or Tagaloa-who-lives-in-heaven (Kramer, 1901; Tui Atua, 2004 & 2006). These connections strongly emphasise that we are inseparable, exquisitely attached to the physical and the natural, just as much as we are to the spirit worlds and the cosmos. It is on the basis of these perspectives that a central focus of pre-Christian existence for this group emerged. Nowadays, many people prescribe to predominantly Christian teachings and values (Taule’ale’a’ausumai, 1997; Va’a, 2001), where the church serves “…as an important institutional referent for Samoan ethnic identity” (Kallen, 1982, p. 104). In New Zealand, Samoan churches have developed as the hub of cultural growth and religious life for its ever expanding communities (Ablon, 1971; Anae, 1998).

Tu ma aga’u fa’asamoa is the cultural context that is represented by the land. The cultural context is essential to understanding Samoan people’s perspectives of health, environment and therapeutic engagement. This context advocates for the understanding and practice of appropriate protocols such as acknowledging the va fealoalo’ai (space to relate), or respecting the feagaiga (covenant) relationships and to give tautua (service) to all people. The principles of fa’asamoa essentially refer to their traditional customs (Lima, 2004). These traditions and patterns form a unique part of Samoan social identity (Mallon, 2002; Meleisea, 1995; Sahlins, 1985; Va’a, 2001). Consequently, fa’asamoa serves as the solid ground that upholds the family unit, endorses its cultural values, acknowledge its spiritual faith, providing pathways for customs, beliefs, and identity to be supported, elevated and preserved. The cultural component often represents a familial resolution for ordering one’s social life, by providing guiding principles for gauging one’s behaviour, and serving as the basis that underpins one’s ethnic cultural identification. It is on this basis that the cultural context finds allegiance with what Mulitalo-Lāuta (2000) reiterates as fa’asamoa being the “total make-up of the Samoan person” (p. 15).

The cultural context also represents one’s tulagavae (footprint) in locating one’s ancestral connections and birthplace. For many who live in New Zealand, it is a re-negotiated identity inclusive of multi-ethnic...
diversity resultant from their diasporic experiences. Because of this diversified identity, culture is fluid and evolving, dependent on context and one’s level of integration into the adopted community (Pulotu-Endemann, 1982). Therefore, culture is not rigid or concrete, but living and breathing, meaningfully forming Samoan identity wherever situated. More specifically, the flexibility of culture gives space for accessing both traditional and contemporary knowledge that support people in their development, and their healing and therapeutic journeys.

Aiga Potopoto is the family, kin and relationship networks. The aiga is situated as the foundation of the faletalimalo. For Samoan people, the aiga connects, supports and elevates them in their spiritual responsibilities, their physical spaces, their social relationships, their emotional wellbeing, their psychological functioning and in their economic sustainability. Samoan identity is germinated, nurtured, matured and replicated within the aiga. Gender issues, sexuality, roles and responsibilities, learning, observing, and activity all find their purposes and meanings within the family context. Furthermore, vital roles such as the family matai (chief, leader) and other statuses (minister, elder), feagaiga (covenant relationships), tautule’ae’a (untitled men), aualuma (unmarried women) and tama’iti (children) find their places, identity and belonging within family relationships. A Samoan proverb that reflects this sense of belonging says; o le tagata ma lona fa’asinomaga; exhorting that each person has a designated role and responsibility. It is the aiga, particularly those in leadership and decision-making roles, who define and designate these roles to its members.

Le Va Fealoalo’ai is the relational space as represented by the internal boundaries of the faletalimalo. These boundaries serve to protect the family while simultaneously maintaining safe limits with those outside of the family construct. A well-known Samoan expression that reflects the importance of safeguarding the internal boundaries advocates; ‘i a teu le va.’ This declares that one must always take care to ‘nurture, cherish and take care’ of the relational space, firstly within one’s family, and then with the wider community (Pereira, 2011, Seiuli, 2012). The internal boundaries encompass the practises of aga’a’alofa (love/charity), fa’alaloalo (respect/deference), agaga fesoasoani (support/helpfulness) and fealofani (relational harmony) (Mulitalo-Lauta, 2000; Seiuli, 2010). The relational space needs continuous attention so that the possibility of being soli (trampled) is avoided (Pereira, 2011). This concept is critical, particularly when considering engaging a Samoan family or community in therapeutic work. The proper context of va fealoalo’ai helps people understand their appropriate connections with one another. The lack of awareness or understandings of the important role required to nurture and take care of the va has invariably led to the dishonouring of the relational space (Pereira, 2011), in addition to the trampling of the sacredness of the people’s dignity. Resultant is the breakdown of communication between parties, or the refusal and withdrawal of some to further participate in any conversation until the space has been restored and healed. Healing the va represents by the notion of teu, that is, to restore back to its rightful condition and purpose. If the space is deemed unsafe, the prospect of achieving any beneficial outcome is minimal at best.

Ola Fa’atelefono represented by the left pillar of the faletalimalo stands for the physical aspect of life. Its forward position characterizes the physical presence and surrounding, which are easily recognisable when engaged with Samoan people. It represents their humble nature, their strong sense of loyalty, their happy attitude, their unique language, their cultural surroundings and their supportive community. The physical aspect of life encompasses a high regard for values of reciprocity and collectivity. Samoans understand that they are all connected in the larger tapestry of life, and that all are sacred and related (Morice, 2006). We are, therefore, an intimate manifestation of the greater whole (Tui Atua, 2009). It is both our duty and responsibility to nurture our physical, social and spiritual worlds in a harmonious relationship. Achieving this balance is conducive to healthy manifestations in the physical realm.

Ola Fa’a’alelelo represents the social dimension as the second frontal pillar. The Samoan social self is better understood as “socio-centric” (Mageo, 1998, p. 5), often as a reference of their friendly, obliging, warm and cheerful personas. Samoan people are inherently relational, generally with an abundance of social and community connections. Their social values emphasise collectivity and shared responsibilities. Significantly, all members are called to family loyalty as their tautua (to serve), not as independent or self-centred, but in close community. When the social dimension is positioned within the important context of family and fa’asamoa, the enactment of the customary responsibilities is motivated by the understanding that reciprocation will result in time and in kind. Therefore, the performance of reciprocal practices is done both to support, and to communicate connection, understanding that the cycle of supportive contribution will be reciprocated in future incidents. For many Samoan communities, the extended family social structure, and its adhering patterns of address, often provide the stabilising force in the face of personal or collective life cycle events such as death.

Ola Fa’a’alefaaau—one of the rear pillars—represents the psychological wellbeing of the person, which focuses on the thinking and decision-making processes of individuals and their families. This area is vital in examining and understanding one’s ability to cope and to process situations that one may face from time to time. From personal observation within clinical settings, although the psychological wellbeing is a vital component in the makeup of the Samoan person, it is often ignored or neglected altogether, thus, the primary reason for its rear position. This needs to be highlighted as crucial to their overall wellness, if Samoan people are to attain restorative health. For example, Te Rau Hinengaro: The New Zealand Mental Health Survey emphasized that it may be challenging for many Samoans accepting mental-health illness amongst its members (Ministry of Health, 2006), as mental illnesses are still being perceived or understood to be the
result of a curse or the consequence of a spiritual indiscretion (Te Pou, 2010). Ola Fa’alelagona or emotional wellbeing is another neglected but central component of the Samoan person, hence, its backward position as the second rear pillar. If the emotional capacity continues to be ignored or discarded, there are serious long-term repercussions for Samoan people everywhere. The aiga plays a foundational part in how emotions are cultivated, articulated and endorsed. Therefore, when there is a breakdown in communication that fosters strong emotional attachments, the likelihood of healthy emotional development and security can be disrupted or weakened. For example, fa’alavelave (life disruptions requiring financial and material support) is a common stressful aspect of Samoan people’s existence. It is well documented (see Maiava, 2001; Tamasese, Peteru & Waldgrave, 1997; Tui Atua, 2006, 2009) that a significant factor contributing to the highest level of stress in Samoan communities is the struggle for economic survival whilst balancing traditional responsibilities such as fa’alavelave obligations. In other words, stress amongst family members is particularly notable when financial demands are made on the extended members to contribute. As a result, fa’alavelave is an enormous “burden” (Maiava, 2001, p. 132) and many find such obligatory duties hard to bear.

Tausi Tua’oi represents the external boundaries that provide safe coverage for the aiga with their local community, health professionals or helping agencies. This secondary boundary provides the safe path to negotiate desired outcomes such as: specific timeframes, meaalofa (gifts, reimbursements, resources, food, etc.), accountabilities, and responsibilities of all parties involved in the engagement. Meaalofa2 or the processes of gifting, represents the first of the three front steps of the faletalimalo (Seiuli, 2004, 2010). The steps support healing and restorative practices that lead to beneficial outcome. Meaalofa emphasises the spirit of generosity with knowledge, time, resources and support.

Its processes serve as a cornerstone of the Samoan self (Seiuli, 2004; Turner-Tupou, 2007), particularly reflective of gifting performance as a reciprocal process. As such, gifting practices affirm and strengthen special relational bonds between families, churches and villages.

Loto fa’atasia is the second step which represents the practices of intentional co-collaboration (see White & Epston, 1990) or the ‘we’ approach. Loto fa’ataisia can be literally translated as ‘to be of one heart or one soul’. The collaborative approach is relational and community-based—not isolated or individuated. This perspective recognises the Samoan person as an integral part of the collective unit, rather than as an independent entity. Therefore, the ‘we’ approach as an integral component of the collective self serves as one of the core element that knits Samoan people together. It helps create a strong sense of affiliation, loyalty and oneness. In fact, life lived in this manner is critical to Samoan people’s identity in the family, village and church (Seiuli, 2004).

Mana/Mamalu specifically speaks about the code of honour, which is a vital part of Samoan life and cultural mores. Honour for Samoan people is intrinsically connected to the foundational practices of giving deference and respect to people. In the context of the faletalimalo, before approaching the sanctity of the aiga potopoto, one must do so with a spirit of humility. Additionally, honouring speaks about supporting and validating expressed life narratives of individuals, their aiga and their communities; that is, validating that their life stories are therapeutic and they can become valuable steps in the healing journey. Such validation is intimately connected to the recovery and preservation of Samoan epistemological foundations that are aligned with their struggles, challenges and emergence within Aotearoa/New Zealand. These shared stories provide a sense of community which can interpret therapeutic experiences as less isolated or exclusive incidents, and more collective and familiar to those within one’s own community. Ultimately, the honouring through validation helps reconcile contemporary perspectives and approaches with traditional customs and cultural expressions.

**Implications for Clinicians and Health Professional**

The Uputāua Approach challenges counselling psychologists, health clinicians and researchers who engage with Samoan individuals and families to consider self-reflective evaluation throughout the engagement process, as well as when the work is completed. This way of working tremendously supports the achievement of therapeutic allegiance, aiding in the process of healing. Following is a brief outline of some of the key components of the approach with implications that could be considered for more effective engagement by health professionals. Please note that not all of the components are discussed as some are self-explanatory; hence, only those that needed further clarifications are outlined in this section.

Ola Fa’aleaga: Within important engagement practices, spirituality plays a crucial role, drawing together and supporting members as they strive to achieve harmony with God, the gods, their fellow man and their environment (Tui Atua, 2006). When construed within a therapeutic context, spirituality offers so much more than just a prayer or religious teachings. For many Samoans, it is a way of being; one that governs and protects them in and throughout their existence, and especially their engagements.

Aiga Potopoto: The formation of the current Samoan family, especially in Euro-urban localities, could contain traces of both the traditional as well as a diversity of other ethnic mixes. It is important, therefore, that attention be given to both the family unit as well as the ethnic structure of that kin network. This consideration must account for the complexities of cultural variants that currently exist within each and every family group. Also important in the consideration of the family unit within western contexts such as New Zealand, are the changes and transformation that family structures have taken over time. Therefore, as much as one may presume that family structures for Pasifika people are strong, nurturing and communal; it may not be the reality for all. For example, Samu and

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2 Meaalofa concepts are discussed in more details in Seiuli (2010).
Sualii-Sauni (2009) in their study of cultural competencies in Pacific mental health, cautioned against the assumption that all Pasifika people ascribe to the idea of having supportive families. Additionally, they found that a decent number of Pasifika people in current times reflect a more nuclear arrangement in their family structure than the more traditional extended unit. The result is that for many of these people, their preference for support may in fact, be with State-funded services, churches or other avenues, and not their families, as would be traditionally expected.

Tu ma aganu’u fa’asamo’a: It is essential that clinicians have cultural knowledge, or are willing to access these as necessities to further their understanding of the unique identity of their Samoan clients. Practitioners are also cautioned not to presume that, given the Pasifika categorisation, all cohorts from the Pacific will share the same identities or cultural practices, or worse, to assume these to be the same as those of Māori people.

Va Fealoalo’ai: The Uputūa Approach advocates that the primary task for any practitioner is the need to teu le va; that is, to take time to address the relational and the consecrated therapeutic space. Their ability or inability to consider this important relational space reflects on the therapists’ desire to work within a healing context that is centred on Samoan and Pasifika paradigms.

Ola Fa‘alemafaufau: The continual ascription of focusing primarily on the social and physical wellbeing of the person can lead to isolation and ostracism of many who are experiencing mental challenges. It is imperative to examine and dialogue about the historical patterns of mental health or un-wellness within Samoan communities, thereby helping to normalise and demystify such life challenges. Acknowledging opinions and thoughts about such situations helps to nurture the va fealoalo’ai, especially within this psychological context.

Ola Fa‘alelagana: According to Suicide Prevention Intervention New Zealand (SPINZ, 2007), “if family expectations are not met, …or if a person’s conduct reflects badly on the family name, a person can feel guilty and shame” (p. 9). A consequence of this shame and guilt is that of self-harming practices or suicide ideations (SPINZ, 2007). Hence, the emotional wellness of Samoans needs to be addressed, especially within therapeutic settings; otherwise, these can continue undiagnosed, leading to possible detrimental effects.

Tausi Tu‘oi: It is also vital that health professionals maintain safety with and for individuals and families throughout the engagement period, and importantly, when the work is complete. The tu‘oi is an extension of the internal boundaries discussed earlier, which needs on-going cultivation. Instrumental is the capacity to stay alert to the responsibility of ensuring that harmony is achieved within these important social and relational spaces. The need for being alert is informed by past experiences, where Samoan communities have felt that their boundaries were regularly trampled as a result of being ‘over-researched’ as a community (Seiuli, 1997).

Meaalofa: In the context of counselling psychology, meaalofa is the ultimate representation of the gift of therapeutic allegiance and support. This gift takes place in the safe and sacred exchange that transpires within the relational space. In other words, the counselling engagement becomes a sacred gift, one that embraces the mauli (soul) of all parties involved. The exchange offers an important link between the giver and receiver; the client and clinician. Yet distinctively, the meaalofa exchange also allows for expressing safe human emotions, thus making room for the expansion of psychological capacity, which translates to safe engagement in rational reasoning. In this capacity, all exchange is regarded as a sacred gift, one that is held closely by all parties and is, therefore, treasured for generations.

Loto Fa‘atasi: Health professionals and clinicians are encouraged towards oneness in heart and mind with the participants or clients in their journey. Moreover, the needs of clients or communities must be elevated above the practitioner’s own sense of expert-ness. As such, the co-collaboration provides room to champion Samoan epistemological foundations, acknowledging that these communities are experts of their lives, their experiences and their environment. Collaborativeness acknowledges that clinicians and health professionals are welcomed into a privileged and honoured space as outsiders and invited helpers. It would be detrimental to disrespect or soli (trample) trust and mana (dignity) of those seeking support (Pereira, 2011).

Mana/Mamalu: It is valuable to be mindful that engagement in therapeutic process for many families leaves them vulnerable and exposed. In the past, some have trampled on this sacred relational space. Clinicians and health professionals must intentionally uphold the pride and mana of clients and their communities at all times. Engaging clients or communities in this manner can be a healthy reflection of helping done with people and for people, not on people (Hodgetts, Drew, Sonn, Stolte, Nikora, & Curtis 2010; Jovchelovitch, 2007). In the process of therapeutic restoration and healing, honouring and maintaining dignity recognizes the gifts handed on by ancestral forerunners, to help current and future generations in their healing and restorative journeys.

**Case Study**

Hamo (pseudonym) was referred for ACC counselling to address behavioural issues that he had been exhibiting as the result of being sexually abused as child. He was a Periodic Detainee (PD) serving time in a correction facility in the Upper North Island of New Zealand. As a PD, Hamo did not have a specified release date for his conviction. From the brief report that accompanied his referral, it appeared that his sexual abuse, both in Samoa and New Zealand, had subjectively shaped his thought patterns and core beliefs about his value and worth as a person. Consequently, his teen years reflected a destructive path that led to irregular school attendance, running away from home, living on the street, prostitution, drugs, alcohol, carelessness, criminal activities, and suicidality. Hamo was caught in a destructive lifestyle cycle as a way of isolation, and to hide the guilt and shame he continuously felt resultant

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2 This case study is a revised version of the one also discussed in Seiuli (2013, p.110).
of his abuse.

Hamo had previously engaged with a counsellor in another prison prior to being transferred. In prison locations, inmates may only access whatever counselors that are available because often, only one counsellor is approved per prison facility. In acknowledgment, there are psychologists and psychiatrists on location; however, they are normally assigned to specific treatment programme such as the Drug Treatment Unit (DTU) or Adult Sexual Offenders Program (ASOP). Outside of these clinical settings, health professionals rarely, if at all, engage with inmates in a private one-on-one capacity. In Hamo’s situation, he was not eligible for any of these programs due to the nature of his offence and sentencing condition. Upon receiving the referral, Hamo later revealed that he was excited when he was told that the counsellor he was being referred to was a Pacific person. He was unsure of my ethnicity until he was given my contact details by the referring staff. He recognized my surname as Samoan and wondered if there was any familiarity with his family name and genealogical connections.

In our initial sessions together, it was important to involve Hamo by engaging the components of the Uputāua Approach as a connecting point between us. Even from the first session together, Hamo advocated for the importance of recognizing and respecting our spiritual connection to God. This meant starting, and oftentimes, concluding our time together with a prayer; praying for him, for me, for our respective families and for our work together. From time to time, the embrace of spirituality also included poems and letters he had written, a song or hymn he had been singing in his cell, a bible verse he had read or heard, or a discussion about various church-related activities both in New Zealand and Samoa. Spiritual connection maintained a safe covering throughout our sessions together, as well as extending this spiritual umbrella of safety over his family. Acknowledging and engaging within this spiritual covering opened space for us to have lengthy conversations about his unmet spiritual needs; that is, recognising his need to regularly pray for his elderly parents, his siblings and his extended family. Interestingly, the embrace of his spiritual desire included praying for the victims of his crime, the inmates and staff in his unit. He also voiced his desire to get out of prison and to move closer to his family. Acknowledging the significant role that spirituality plays in his life opened the door for the rest of the therapeutic journey together. Furthermore, the sacred space created by this covering allowed us to weave together his physical, emotional, psychological, social, familial, and spiritual narratives in this journey of discovery, reconnecting, healing, and restoration.

We also interacted within the cultural landscape by exploring his ancestral village and his journey to New Zealand. These initial conversations brought a discovery that our villages in Samoa were neighbors, and shared the same district affiliation. Hamo made useful and important connections on a cultural landscape that were familiar to him, and importantly, gave him meaning that connected to the core of his Samoan identity. These vital connections provided hope for inclusion instead of isolation and exclusion; something he was very familiar with both in the prisons and the destructive cycle that eventually led to his criminal activities. The cultural links also opened opportunities for rediscovering his neglected relationship with many parts of his cultural identity that mattered. These were important values such as fa’aalola (respect), fa’aleaiga (family honour) and others that were dear to his heart but had long been discarded. This was also very evident when he spoke longingly of his ultimate goal of returning home so that he could take care of his elderly parents. Hamo tenderly expressed his deep love and respect for his elderly parents, who were both still alive and living in the lower North Island. In later sessions, Hamo gave this statement concerning his cultural foundations, saying “...this is an important part of my Samoan heritage.” Without the foundation of his family and kin network, Hamo’s sense of belonging and Samoan identity had taken a battering from the world in which he was trying to survive. The reconnection to his Samoan heritage in this context, provided him with the va fealoalo’ai (sacred relational space) to mourn, to grieve, to reconnect and to rediscover all that still contain a richness of meaning for him as a Samoan man.

Hamo continued to share his life narratives about being a migrant to New Zealand throughout our sessions, together with the counselling that was specifically targeted to help him address his post-traumatic stress disorder (PTSD) and anxiety problems resulting from his early sexual abuse. In this context, Hamo was encouraged to consider not only his spirituality, his culture and his family, but also to examine his physical, social, emotional and psychological capacity and coping from the effects and damage of the abuses he endured. The role of addressing these priorities correlates with the four pillars of his fa’alolotu (guest house), which needed to be mended and rebuilt; one piece at a time, one session at a time. It is important to note here that not all of the reconstruction work lies solely with an individual clinician. It takes more than one person to assist in lightening such a load. In the work with Hamo, those who contributed to the work included Correction staff, the New Zealand Accident Compensation Corporation (ACC), medical personnel, Chaplains, previous counsellors, and others. Although these persons and groups may not have been directly involved or present with the therapeutic work that was done, they were certainly present in our conversations, offering helpful support over time. Healing in this context is one of collaboration and collective support. It is a gift being fashioned in the exchange, one that takes time and dedicated energy. For a person in Hamo’s predicament, there was a lot of damage that needed gentle massaging and care in order to slowly journey towards the healing space. The work that takes place here aligns closely with the ideas of tausi le va or nurturing and healing the trampled space.

Amongst the myriad of therapeutic conversations that continued in this space was Hamo’s desire to hold on to his Samoan language, his need to reconnect with his aiga by being transferred to a prison closer to them, his longing to taste Samoan food again, and his remorsefulness over his
destructive life that led to his criminal convictions. The Upūtūa Approach provided continuous space for me, as the clinician, to continually uphold the clients’ holistic needs and to honor what was important for him to address in each discussion. Therapeutic work done this way speaks about collaboration, honouring and gifting—all of which are considered paramount in the client/therapist relationship. It reflects the work that is done with people, not on people; that often, clients themselves have validated expertise in their own lives and circumstances—an awareness that needs acknowledging.

In one of our sessions, Hamo reported that he had not explored his Samoan life and histories with any counsellors, yet he had engaged with department psychologists and an ACC-approved counsellor prior to being transferred to his current location. He reasoned that these health professionals were only interested with examining his criminal history in order to prescribe interventions to cure his maladaptive behaviours. His previous engagement in health settings led him to surmise that “...they were not really interested in me as a person ... just my convictions”. As a result, he merely told people what he thought they needed to hear so he would not be labeled as ‘un-cooperative’ or ‘non-compliant’, particularly when he already felt uncomfortable and alienated having to engage with them initially. To make matters worse, his cultural needs were neglected and ignored, or often assumed to be the same as those of Māori clients.

The components outlined by the Upūtūa Approach assisted in attending to Hamo’s holistic needs; both evident and unspoken. Hence, engaging the various components of this framework ensured that vital areas were not overlooked, neglected, or assumed to be the same as for other cultures, or even the same as those who share common ethnicity. For example, a significant step toward healing and restoration for Hamo included the need to move closer to his family so they could visit him regularly while he serves his time. His present location meant that his family had to travel at least seven hours for a maximum two-hour visit with him, at great financial cost in the form of petrol, food, and accommodation. Costs and inconvenience aside, his elderly parents were not in a physical state to endure the long drive safely. In support, we explored the possibility of him applying for a transfer to a closer prison so that the visits could be more affordable and regular with his family, but of considerable importance is that their physical presence would contribute greatly to his recovery. Hamo found a new surge of confidence and support to make this request. Amazingly, his application for a transfer was accepted. This was an answer to prayer—both our prayers, a collaborative that extended to the heavens. We were thankful and excited about the possibility that Hamo would finally be able to have regular visits with his family again; reconnecting with those who were dear to his heart, especially his parents. In the time that Hamo was an inmate in the correction facility near in the Northern part of the North Island, none of his family members were able to visit him, but the possibility of this changing was certainly looking like a reality.

In one of our last sessions, Hamo outline the time and date of his transfer, and then we parted company after another time of heartfelt prayer, encouragement and thanksgiving. A few months later, I was surprised to receive a letter from Hamo outlining his situation and new location. The letter expressed how pleased he was to be closer to his family and that he was doing well. Additionally, he was in the process of arranging approval for his parents and his siblings as regular visitors. Hamo expressed his appreciation for our time together, and added that he was praying for my counselling work, especially with other inmates in similar life challenges that he was in.

Concluding Thoughts

The role of counselling psychology towards facilitating and supporting holistic health for Samoan people is crucial, especially in the current environment. However, traditional perspectives and application were, and to a certain degree, still are predominantly Eurocentric. They have been often void of critical aspects to help clinicians wishing to work holistically to encompass the cultural, spiritual, familial, and environmental components of non-western groups like the Samoans. This article introduces the reader to the Upūtūa Therapeutic Approach, as a Samoan purpose-built bridge to help in achieving healing and restoration within counselling and therapeutic contexts. The approach invites the weaving together of Samoan cultural paradigms with western therapeutic perspectives in their collaborative role of supporting Samoan (and Pasifika) clients in their healing journey. Reflective of Hamo’s situation, the guidelines provided by the Upūtūa Therapeutic Approach provided a safe and familiar framework that allowed him to search, to find, to reconnect and to celebrate the totality of who he is as a Samoan person; with intrinsic worth and value that contributed significantly to his coping, and re-emergence with life in Aotearoa/New Zealand. Indeed, this way of working and living is a gift that spans the generations. Soifua ma ia manuia.

Author Biography

Byron Malaela Sotiata Seiuli is Samoan with ancestral connections to the villages of Malie, Manono and Faleula. Byron works in a private counselling and supervisory practice in Hamilton. He is a PhD candidate in the Psychology Department at the University of Waikato, based in the Māori and Psychology Research Unit (MPRU).

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Collaborative Partnership and Reflective Practice: An Intern Counselling Psychologist and Client Share Their Therapeutic Journey

Alexis Kliem, Auckland University of Technology
Jacqueline S Feather, Auckland University of Technology
Miranda,* Client, Psychology Clinic, Auckland University of Technology

Counselling psychology is an emerging scope of practice in New Zealand. This article outlines the core values of counselling psychology and illustrates how they can be applied to a case study. The case study involves a client with panic disorder and the use of a cognitive behavioural intervention. It is written from the perspective of an intern counselling psychologist and includes the reflection of both therapist and client. The aim is to provide some insight into both viewpoints of the therapeutic relationship and the course of the intervention, as well as outlining how the principles of counselling psychology can be applied to such a case.

Keywords: counselling psychology, panic disorder, reflective practice, intern psychologist, and case study.

Counselling psychology is a fairly new scope of psychological practice for Aotearoa/New Zealand with the only training institution gaining full accreditation in 2012. As counselling psychologists we are often asked for clarification around what makes it different to other psychological scopes of practice. This is a question that can be difficult to answer because it is an emerging field and counselling psychology is still establishing its identity as practiced in this country.

The existing literature describes the core values of counselling psychology as including an adherence to the scientist-practitioner model and a move away from the medical model and towards collaboration between client and therapist. Counselling psychology also places a focus on the promotion of wellbeing, an emphasis on the therapeutic relationship, takes an integrative and holistic approach, and places value and respect on individual differences and contexts (Howard, 1992; Strawbridge & Woolfe, 2010). These aspects characterise the counselling psychology approach in working with individuals, groups, or communities in Aotearoa/New Zealand. They are also analogous to the Principles of the Treaty of Waitangi (1840) that guide healthcare practice in this country; partnership (working together collaboratively), participation (active involvement by all parties) and protection (ensuring safety and enhancement of client well-being) (Herbert & Morrison, 2007).

Counselling psychology also encourages its practitioners to engage in reflective practice (Strawbridge & Woolfe, 2010). Reflective practice allows an opportunity for the different aspects of therapy to be examined such as: the application of the chosen approach, further development of the formulation, emotional or cognitive responses that arise, or client-therapist interactions (Bennett-Levy, 2003; Lavender, 2003). Reflection can be done in a number of ways, including through supervision, by watching a tape of the session, or in simply thinking or writing about therapeutic encounters.

Based on Schon’s (1987) model of reflective practice, Lavender (2003) suggests that reflective practice involves four main processes. Reflection in action is when reflection occurs during the process, and you are able to think about what has just been said, and what could be said next. Reflection on action happens after the experience has occurred, and can be completed either as thinking about the event alone or explored in supervision. Reflection about impact on others can involve eliciting feedback from others, to determine their feelings about the event. And lastly, reflection about the self can help therapists to examine themselves and any issues based on personal experiences and how this may impact their work with clients.

These reflection processes enable the therapist to develop awareness and further strengthen themselves as an individual and as a therapist. Engaging in reflective practice, whether structured or spontaneous, enables practitioners to develop effective professional knowledge and skill relating to themselves, their clients, and their practice.

The following case study describes a cognitive behavioural therapy (CBT) intervention with a client experiencing panic disorder symptoms. The article uses a co-authoring approach from narrative therapy (Morgan, 2000) in which both the therapist's and the client's perspective are examined in order to provide a deeper level of description of the therapeutic process. It is written in the first person by the first author (AK), in consultation with her internship supervisor (JF). This article also aims to outline how a counselling psychology framework was applied to this case.

*Pseudonym, the name has been changed to protect the identity of the client. Miranda has been fully involved in the preparation of this manuscript and has approved the material from her therapy which is included here.
On completion of this manuscript, AK still had approximately 4 months to go of her 1500-hour internship. At this stage, AK and the client had completed the CBT intervention described throughout this article and were continuing to work together on remaining issues with a third wave CBT approach.

Case Study

Miranda* is a woman of European descent in her 40’s. She was referred to the counselling psychology clinic after waking up in the middle of the night with difficulty breathing and heart palpitations on two occasions. These sensations were so distressing for Miranda that she was hospitalized. Miranda was told by medical staff that she may have a heart condition (supraventricular tachycardia) and was placed on medication (beta blockers). Miranda received follow up treatment with a heart specialist but they were unable to successfully record information about her heartbeat that confirmed a medical diagnosis.

After the initial hospitalisations Miranda continued to experience the physical symptoms, which she found very unsettling. Although they lessened in time and intensity she continued to experience them at least once per week. They often occurred during the night and Miranda became very anxious in the evening leading up to bedtime. Miranda had follow up contact with her GP and she was placed on further medication (Citalopram) to manage the anxiety she was feeling around these events.

Miranda is married with three children aged between 9 and 16 years. She described her relationship with her husband as good; he is an optimist and the spontaneous one whereas she is a bit more of a realist and cautious and so they balance each other out well. Miranda has a good relationship with her children but can find family life demanding at times as she has some very busy days during the week when she is busy with her children’s school and sport activities.

Miranda has two sisters who both live in Auckland, as does her mother. She sees her mother often and has regular contact with her sisters. She has a small social circle and a few close friends. Miranda’s father passed away a few years ago and she reported this was a very difficult and stressful time for the family due to the associated medical complications.

Miranda maintains a healthy diet and weight and she used to run several times a week. However, she stopped running for 5 months after the initial sensations occurred as she was nervous that something was going to happen while running. At the time this intervention began she had just started running again but was somewhat tentative about engaging in this activity.

Prior to this course of therapy Miranda had engaged in a breathing clinic and several therapy sessions with another intern counselling psychologist who was at the end of their training so had left the clinic. Previously, she had also engaged in six sessions of CBT, referred to by her family doctor. Miranda found these interventions helpful but she was still experiencing some symptoms and was finding these distressing. Furthermore, Miranda’s family were planning to travel overseas in a few months and she was not sure she felt she could go on this 3 week trip. She was keen to have further support that may enable her to manage the sensations and anxiety she was experiencing.

Initial assessment

In the initial sessions a psychological assessment was completed and Miranda was screened for psychological disorders. Miranda was under the care of her doctor and had some follow up appointments with a heart specialist to rule out possible medical conditions. She reported her main issues to be the experiencing of physical symptoms, including tingly limbs and digits, racing heart, shallow breathing, tightness of chest, and a tense abdomen. Miranda was also experiencing fear and anxiety around the symptoms occurring at any moment, without any known trigger. As well as poor sleep due to anxiety about experiencing the sensations again, Miranda had also begun to avoid staying overnight in places other than her home. This meant she was missing out on school trips with her children and family holidays.

My supervisor and I looked into possible alternative diagnoses or reasons for her symptoms. We came to the conclusion that Miranda’s presentation was best described by panic disorder after ruling out other possible conditions with similar presenting symptoms, such as other anxiety disorders. Miranda also reported low mood, although she did not meet the criteria for a major depressive episode at this stage. It was possible she had met criteria in the weeks after she experienced the initial sensations.

Miranda and I discussed her goals for therapy which were initially to reduce her symptoms so she was able to go on the overseas trip with her family. In consultation with my supervisor, I decided to base my intervention on the panic disorder CBT invention protocol described by Craske and Barlow (2008). This is an evidence based treatment that research has found to be more effective than other placebo type treatments.

After Miranda’s medical tests were completed she was encouraged to continue her running schedule. This was because Miranda had previously found this an effective method for managing stress and it was an important release for her as well as being a key element in maintaining her wellbeing and improving her mood.

My reflection. I felt that basing my intervention on a manualised treatment would be helpful as it would give me a good structure to start with, as well as being evidence based. A manualised intervention also helped somewhat with the terror I felt as an inexperienced intern and not having worked with this type of issue, as it gave me a stable base to follow. Miranda was very open into trying this intervention even though at this stage Miranda felt her symptoms were based on a medical issue rather than a psychological issue. Because of this Miranda and I coined a term for her experiences that she felt comfortable with (‘the sensations’) rather than using the term panic disorder.

Miranda was really distressed about her experiences so I tried to instil hope for her around what she was experiencing. As well as building rapport and validating her experiences as being very distressing for her, we also discussed the range of options for evidence-based interventions that had been found to reduce the symptoms that she was experiencing.
Miranda’s reflection. At this stage, I had many unanswered questions about what I was experiencing. I was still feeling very fragile and vulnerable and almost desperate to find something that would make me ‘normal’ again. When it was suggested I have some sessions with a counselling psychology intern I took this as a chance to hopefully gain some more insight or clarity into my experiences.

As I had engaged in a previous CBT intervention, I was a bit worried when the therapist suggested a CBT based treatment as the previous one had been very structured and left me with little chance to talk about myself or my experiences. I felt this would have been very helpful in terms of relieving some of the anxiety about what I was experiencing. However, I was willing to give a CBT intervention another chance from a different perspective.

I also found it very beneficial being able to learn the CBT techniques alongside being able to talk with the therapist about how I was feeling. It felt so reassuring to know that she cared and that she was not just there as a teacher of techniques.

Psychoeducation

The intervention began with psychoeducation and this involved a discussion about hyperventilation and how this can affect the body. Miranda was encouraged to induce hyperventilation in our session by breathing in a quick and shallow manner for one minute. This was so she could experience the effects of breathing style as well as learning how deep breathing could stop these effects.

In supervision we discussed how I could approach Miranda’s understanding of her problem in therapy and the models that I could use to explain this, such as the cognitive model of panic (Clark, 1986). It was helpful going through this model in supervision as I was able to practice how I could explain it to Miranda in the sessions to help her understanding.

Miranda and I discussed this model together and looked at how we could target the different areas of the cycle, including her thought patterns as well as the physical sensations.

My reflection. Miranda was very receptive to having reading material as homework and she particularly requested literature about other peoples’ experiences with these symptoms. I found this really helpful to me as a therapist as Miranda had such an enthusiasm for gaining an understanding to her problem. After undertaking a literature search I found minimal information available in this style, as it was either difficult for a layperson to comprehend or was from unreliable sources on the internet. This was frustrating as I felt that if Miranda was able to read about others’ similar experiences then this may have helped her to validate and normalise her experience. It was this experience that contributed to the development of this article.

Miranda’s reflection. I was able to make some connection between this material and what I was experiencing as I had learnt about this in prior interventions. Although the readings were helpful in gaining understanding, I was hoping to read something that really described what I was going through from another person’s perspective as this would have given me more understanding and possibly acceptance that this was what I was going through. As I was still undergoing specialist follow up, it was hard for me to accept that there was a psychological aspect to what I was experiencing. For me, it was easier to accept a medical cause for my symptoms, especially as there did not appear to be a trigger to my experiences and it all seemed to be so random.

Breathing/relaxation training

Miranda had previously participated in a breathing clinic so she had some awareness of effective breathing techniques. To follow the structure of the intervention we also practiced diaphragmatic breathing in these initial sessions to ensure she was engaging in the correct technique. Miranda was set homework of practicing diaphragmatic breathing a minimum of twice per day. We practiced some relaxation exercises, including mindfulness and progressive muscle relaxation. Stress was identified as a possible trigger for Miranda’s sensations so we looked at some problem solving strategies around reducing stress in her life and regular relaxation practice was recommended.

My reflection. I noticed that Miranda was not engaging in the relaxation and mindfulness exercises in her own time. While she engaged in them during the sessions she often did not complete them on her own accord, despite being frequently reminded about these in sessions. In my naivety, I found this quite frustrating and hard to understand; as “surely if I ask Miranda to complete these activities to help her get better, then she will do them?” I developed a number of hypotheses around why she was not completing them, including either Miranda did not think they would be helpful or she felt unable to prioritise any extra time toward promotion of her own wellbeing.

Miranda and I ended up working out that Miranda’s reluctance was because she did not like being ‘prescribed’ relaxation exercises, as she was still in the stages of accepting that there was a psychological element to what she was experiencing. We reframed the exercises to be considered part of her wellbeing, similar to her physical exercise, and Miranda then felt more able to complete the activities on a regular basis. This made me realise I needed to be careful in how I pose ‘homework’ tasks to clients, as if presented in an unconsidered way they may not be completed.

Miranda’s reflection. Although I knew the relaxation exercises would probably be helpful, it was hard for me to start engaging in this regularly. This was partly because it was hard for me to prioritise taking time for myself and also because in the back of my mind I did not feel comfortable with the idea of being ‘prescribed’ relaxation as I did not think this would be beneficial. However, I found the mindfulness exercises helpful in getting me back on track when my thinking became negative and they enabled me to break the negative thinking cycle at times.

Monitoring symptoms

Over the course of the intervention Miranda monitored her symptoms using a mood record. This record included a daily recording of Miranda’s average anxiety, average depression, and average fear about panic. Miranda would give a rating from zero (none) to 10 (most extreme) for each category. This record was modified from the one by described by Craske and Barlow (2008). This
allowed us to track her symptoms throughout her treatment.

Miranda initially used a recording sheet to record her panic attacks. However, as her symptoms reduced over time, this was discontinued after approximately three sessions into the intervention. Miranda continued to note the days and times that she was experiencing some sensations on her mood record and this allowed us to track back and find a pattern around when the sensations occurred. I compiled Miranda’s scores into a graph every few weeks and Miranda and I would review this so we were both aware of her scores over time.

As there were some days where Miranda’s mood was quite low, we discussed behavioural activation (Dimidjian, Martell, Addis, & Herman-Dunn, 2008) and how this may work in improving Miranda’s mood. Miranda created a list of brief and achievable pleasurable activities which she could do when feeling low.

**My reflection.** Although Miranda’s depression, anxiety, and fear of panic gradually declined over time, there were times where these scores peaked. I felt that Miranda found these peaks disheartening as I wondered if it felt to her that she was not making enough progress but I explained they gave us an opportunity to look for patterns in her scores. By involving Miranda in the monitoring of her symptoms over time I hoped this gave her a sense of collaboration in the therapy process. To be honest, I also found these peaks disheartening. In supervision, I was reminded of the importance of these peaks, as they helped to illustrate that increasing scores did not mean the end of the world, and that they actually helped strengthen Miranda’s resilience as she learnt to manage them more effectively.

**Miranda’s reflection.** I found logging my moods and sensations helpful as it enabled me to reflect on my moods and what I was doing each day. Having to log on a daily basis helped me realise it was important to do this for myself and to make it a priority as I could see my progress. I was aware I had been having some changes in my scores throughout the course of therapy. However, my therapist advised that I was doing well and that some increases in my scores were to be expected and was part of the process and that was reassuring.

**Cognitive restructuring**

In the next sessions Miranda and I looked at the cognitive side to her experiences, particularly the thoughts that were accompanying the sensations that she was experiencing. We examined this using the panic model by Clark (1986) which assumes a catastrophic inference is made alongside the experienced physical sensations. At this stage of the therapy, while Miranda was having a lot of negative thoughts, she was no longer having catastrophic thoughts. I raised this in supervision and we discussed tracking back to her cognitions to when she had initially experienced the sensations so we could get an understanding of her thought processes when she perceived most threat to herself: Miranda’s misappraisals to the sensations she experienced would end with the most catastrophic cognition of “I’m going to die”. It was apparent that the link between her sensations and her fear was not yet resolved, even though logically she had now accepted that she was not going to die.

In session, we looked at the cognitions that were maintaining Miranda’s anxiety around experiencing more of the sensations. Although Miranda had reduced the catastrophic element to these cognitions, the thoughts she was still having were negatively impacting her mood. Miranda used a thought diary to record her thoughts and moods. We then reviewed these thoughts in the therapy session and she was presented with the idea that a thought was only an idea or perception, not a fact. Miranda was given information about the different types of cognitive distortions that can occur. Miranda was encouraged to examine which cognitive distortions she may be using, such as catastrophisation or overestimation. Then Miranda and I worked together to dispute her negative thoughts, by looking for evidence for and against the thought, as well as seeing if there were any alternative explanations for her thoughts.

We applied this technique to the thoughts Miranda was having about going on the overseas trip with her family to examine why she was feeling unable to go. We did some problem solving around how Miranda and her family could make the trip less daunting and generated some ideas, such as breaking up the plane journey into smaller trips.

**My reflection.** While Miranda was receptive to cognitive restructuring in the sessions, I was aware that she was having some bad days and during these times it was difficult to find the energy to look for evidence against her thoughts. I noticed that when Miranda felt discouraged that after the session I also felt some distress. On reflection I realised that again, this was making me feel as though I was failing as Miranda’s therapist. Is this a common theme for new interns? In discussing this in supervision, I was reminded that therapy was a process and there is rarely a ‘quick fix’. This was helpful in reminding me that I cannot save the world singlehandedly, as much as I wish I could. Also, I could see how hard Miranda was working to get through this and greatly admired her courage to keep going even though she had some difficult moments.

**Miranda’s reflection.** Being able to learn how to look for evidence to dispute my negative thoughts was helpful. However, there were some times I was unable to get rid of the sense of doubt that would creep into my thoughts. As I was still having good and bad days, when I was feeling good I was able to dispute my thoughts well, but on days where my mood was low, it was harder for me to look for evidence and believe it.

**Exposure**

The next part of the intervention involved exposure techniques. In terms of in vivo exposure, Miranda chose to go on a short trip out of the city which she achieved. She reported she was anxious about this but was glad she had pushed herself to go through with it. Miranda then kept postponing making the decision to go on the 3 week overseas trip. As I felt it was important for Miranda to decide so we could work together with her decision, I encouraged her to set a deadline for her to do this. When the deadline came, Miranda chose...
not to go on the 3 week trip with her family as she did not feel that she would manage the long period of travelling. We discussed the possibility of Miranda working towards travelling overseas at some stage so she does not continue to avoid overseas travel. Miranda then made a decision to take a shorter overseas trip in the near future when it is suitable for her and her family to do so. Once this is planned, Miranda and I will work through any possible anxiety that arises around this trip, if needed.

Miranda was then introduced to interoceptive exposure and its purpose of eliciting the sensations that Miranda feared so she could use the strategies she had learnt in the previous sessions including relaxation, deep breathing, and cognitive restructuring, to reduce the sensations and the associated anxiety. Miranda was advised that she may experience some discomfort when doing the exercises, but we would finish each exercise by completing some deep breathing until she felt better.

Miranda completed a range of exposure exercises in the therapy sessions and on completion of each exercise Miranda would give a score out of 10 around the intensity of the sensations, similarity to the sensations she has experienced, and how distressing it was. Miranda completed a couple of exercises in each session and nine exercises were completed in total, ranging from Miranda holding her breath for 30 seconds to spinning around on the spot for 60 seconds. Miranda would also report the physical sensations she noticed in herself and her thoughts about the exercise. After Miranda had completed all the exercises in sessions we then chose the three exercises with the highest intensity and similarity scores. These were: hyperventilating for 60 seconds (4/10 similarity and 4/10 intensity), spinning on the spot for 60 seconds (3/10 for both similarity and intensity), and maintaining muscle tension for 60 seconds (4 for similarity and 3.5 for intensity). Miranda’s task was to practice one exercise each week, every day for 7 days and then we reviewed this in the next session.

My reflection. I had attempted some of the exposure exercises prior to completing them with Miranda, so I was able to talk to Miranda with honesty about what she may experience. I recall after Miranda did the spinning exercise, she just about dropped to the floor, and she looked rather unwell afterwards. I noticed I felt quite uncomfortable about being the one that inflicted deliberate discomfort on my client. I remembered reading that exposure techniques can be underutilised in CBT treatment and I did wonder if this was the very reason. I discussed my feelings around this in supervision and my supervisor reminded me that I was using an evidence based approach which helped to soothe some of my discomfort around this.

I noticed I felt like I had failed as a therapist, as Miranda chose not to go on the overseas trip. Whilst I know this was her decision and she did not feel ready, it somewhat felt as though I had not enabled this in our work together and I felt disappointed with this. This emotional reaction made me begin to wonder whose goal it was to go on the trip, Miranda’s or mine? I brought this issue to supervision and we discussed how it is important to be aware of goals and to ensure that when working with a goal focus, that it is actually the client’s goal rather than what you wish for the client, even if you are wishing the best for them.

Miranda’s reflection. Going on the short trip with my family was difficult but I was really happy that I pushed through the difficulties around this. I was very worried about being away from home and sleeping in a different place, but I felt that if I could achieve this, then maybe I could achieve the overseas trip. As it happened, even though I achieved this short trip when the time came to decide on the bigger trip, I just did not feel ready to commit to this due to the long period of travel. My therapist encouraged me to set a date for making a decision about the trip and to tell my husband. Although I really hated this at the time it was what I needed as I just kept avoiding the decision making. Although I was disappointed I could not go after I made this decision I felt a lot less pressure and could now focus towards getting well.

The exposure exercises were uncomfortable but it felt good to be doing these, like I was really achieving something to address the sensations. Although the sensations from these exercises were not identical they were similar and I felt like I learnt I was able to gain a sense of control over them.

Relapse prevention

After Miranda had completed the exposure exercises, the sensations and fear of sensations reduced. However, she was still experiencing some residual symptoms in these areas. In looking at Miranda’s logs of symptoms we noticed a pattern around the sensations often occurring on a weekend night, and hypothesised that this may be due to stress that Miranda experienced during the weekend days. We did some problem solving around how Miranda could reduce stress and decided on some strategies for Miranda to implement in her daily life.

As Miranda’s family were off for their 3 week trip during this time, Miranda was worried about how she was going to manage this time alone. We worked together to ensure she had some structured activities planned in this time to reduce her time to worry about the sensations. We also ensured that she had some pleasurable activities planned to boost her mood. As Miranda had this time to herself she was able to incorporate lots of relaxation practice and she developed a list of short relaxation activities that she could engage in regularly.

During this time, after several weeks without any sensations, Miranda woke up in the middle of the night feeling spacy, dizzy, and with hot flushes. Although she was distressed by these feelings she was able to use the tools she had learnt through the course of therapy until the sensations faded and then was able to get back to sleep. In the next session Miranda reported she was disappointed that this had occurred but we discussed the positive side, which was she had been able to successfully manage the experience which reduced some of her fear around further sensations.

When Miranda’s family arrived back from their trip her husband surprised Miranda by giving her a letter from his cousin. This letter outlined the struggle he had had with a very similar experience and how he had overcome this difficulty. Miranda brought this letter into therapy to show me and
was amazed to hear that someone else that she knew had gone through this experience.

**My reflection.** By this stage it appeared that Miranda had come so far in terms of accepting what she was experiencing and it seemed having the time to reflect as well as receiving the letter had both greatly contributed to this. I felt that this attitude shift was even more important for Miranda than not experiencing any more sensations as some of her fear of the panic sensations had lifted, which had been causing her much distress. This letter had great meaning for Miranda and it was exactly what we had been previously trying to find in the literature. I was very touched that Miranda brought it into the session to show me because it was so meaningful and helpful for Miranda. It also suggested to me that Miranda had also really valued my part (as her therapist) throughout her journey.

**Miranda’s reflection.** It was a big challenge for me to be without my family for 3 weeks. I was in two minds during this time, on one part I was excited to have this challenge presented to me but on the other part I was terrified about not being able to manage. However, this time enabled me lots of opportunity to reflect on my experiences and also lots of ‘me’ time, which helped me come to terms with my experiences.

Receiving the letter from my husband’s cousin was an invaluable revelation. It was that personal experience and hope that I had been desperately wanting to read about. It was like an acceptance of what I have been going through and has made my mind so much more receptive to all of therapy we have been through.

**Final Reflection**

**My reflection.** I found it very interesting reflecting on the therapeutic process with Miranda and tracking back to the start of our therapy as I felt I really had grown as a therapist. As cliché as that sounds, I remember at the beginning of the process when I first met Miranda I was so anxious due to my inexperience and knowing that Miranda really needed support, which led me to feeling some kind of desperation as I was not sure I really would be able to help her. Reading Miranda’s reflection about being so anxious and desperate to get help at the beginning of therapy I wondered if this was a form of counter-transference (O’Brien, 2010). Now that Miranda has learnt to accept her distressing thoughts and experiences I feel I am also now able to accept my inexperience and flaws as a therapist and not be so hard on myself as I gain experience and skills as a counselling psychologist. In supervision we discussed another aspect that may have been at play here as well: the fact I had prioritised my own needs by practicing new skills and self-reflecting, may have helped me to help Miranda to do the same.

In terms of reflective practice, I feel that this process really helped me think more deeply about this case, and allowed me create a individualised formulation for Miranda’s experience beyond the standard CBT formulation for panic disorder. I think that by being open to reflections that occur beyond the confines of the ‘working day’ can also allow for further insight to be gained, which then can enhance the detail of the individualised formulation. For example, the most insightful reflections would often come at an unexpected time, such as walking to the car at the end of the work day. This would result in a scramble to note them down in some way, so as not to lose important thoughts and ideas around a formulation or other therapeutic aspect. However, I am aware with reflective practice that clear boundaries need to be set, so you are not holding your clients in mind all the time. When I notice that my ‘reflections’ are creeping too much into my personal and family life, I will engage in practices, such as mindfulness techniques. These techniques enable me to return to the present moment, which works to ensure I am able to have my own space that is separate from my work and the lives of my clients.

**Miranda’s reflection.** Over the past 6 months I really do feel like I have been on a roller coaster of a journey. Not on my own, but with my therapist. From being a very frightened woman who was consumed by daily distressing physical symptoms and fearful thoughts, I am now able to face these sensations and accept them (most of the time). I still experience setbacks but now have the knowledge to understand that this ongoing exposure is a very important part of the recovery process. Having this opportunity to express my reflections in a written form about this ongoing journey of therapy and support has been a very positive experience for me and I am pleased to be able to share it with others who have a common interest.

**Summary and Conclusion**

This case study has outlined the practice of a CBT based intervention as applied to panic disorder. The core principles of counselling psychology were demonstrated throughout this process. For example, a focus on the therapeutic relationship was paramount and the relationship was built by keeping the client informed in each step of the process and by validating her concerns as they arose. Throughout therapy there were times when Miranda’s mood was low and anxious and, in addition to safety screening, counselling micro-skills were used including empathy and warmth, which allowed her to validate and normalise the way she was feeling. These aspects illustrate the importance of the therapeutic alliance in the therapy setting.

A scientist-practitioner model (Jones & Mehr, 2007) was used in deciding what intervention would work for this client. Once the assessment had been completed and a formulation and diagnostic impression was made, research was undertaken to find an intervention that was evidence based. The protocol offered by Craske and Barlow (2008) reports good results on treating panic disorder symptoms, therefore it was chosen as the base for the intervention.

Although a structured CBT intervention was used, it was adapted to allow for contextual aspects to be considered. For example, Miranda’s context was taken into consideration in determining the triggers to her stress. Although Miranda felt there was no clear trigger to the sensations, we looked closely at the meaning that Miranda attributed to certain events in her life and how these impacted on her situation. This enabled us to make a plan for how she could reduce stress in the different areas of her life, such as placing prompts around her home that reminded her to...
be mindful.

As a European New Zealander, to be able to have the chance to travel overseas had a lot of meaning for Miranda and her family as they had planned to connect with extended family they had not seen for some time. When Miranda decided she was unable to travel we tried to create meaning for Miranda in a different way, to help overcome her disappointment around this. This was done by scheduling in meaningful activities for Miranda to do while her family were away as well as enabling her to reflect in this time about her experiences. Miranda reported this time to herself as challenging but invaluable and we also noticed that her strength and confidence in herself grew over this period. This experience highlighted the fact that Miranda really appreciated having time to herself which had previous been limited because of her very full family life.

Reflective practice is a core element of counselling psychology (Strawbridge & Woolfe, 2010). Reflecting on the whole therapy process has enabled me (AK) to review what went well and what I could have changed, as well as my reactions to the therapy process and to Miranda. I feel this reflective process has enhanced the therapeutic relationship as it has given me a phenomenological understanding of what was really meaningful and helpful for Miranda in comparison to my own thoughts and processes. I feel it has also been incredibly valuable for Miranda, as revisiting the various stages of the therapy enabled her to see the changes she has made over the 16 sessions.

At the time this article went to review, Miranda and I were still working together. Although the frequency and intensity of Miranda’s sensations had reduced, as well as her anxiety about further sensations, Miranda was still experiencing some residual symptoms in these areas. We have started to work with an evolution of the formulation; that the sensations may function as message to her to prioritise her own needs. As the CBT based programme has been completed, we plan to address this by using an acceptance and values based perspective from acceptance and commitment therapy (Harris, 2009). This fits with the counselling psychology notion of taking an integrative approach with clients in order to adapt interventions to best suit the client (O’Brien, 2010).

This article has outlined my perspective as an intern counselling psychologist (AK) and the client’s perspective (M) as we journeyed together through a treatment programme for panic disorder with the support of my supervisor (JF). We hope it will be helpful and insightful for others to read as it has been for each of us to reflect upon.

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Corresponding Author:
Dr Jackie Feather
Department of Psychology,
AUT University,
Private Bag 92006,
Auckland 1142
jfeather@aut.ac.nz

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An Investigation of Internet-Based Information for Mothers in Stepfamilies

Anna Miller, University of Auckland
Claire Cartwright, University of Auckland

When mothers repartner or remarry, their relationships with their own children may be placed under stress. Research suggests that mothers are increasingly turning to the internet for information about parenting. This study investigated the information and guidance available on the internet for mothers in stepfamilies, and compared this information to the conclusions that researchers have reached about parenting and stepparenting. Information provided for mothers was extracted from 69 websites that purported to provide information for stepfamilies. The extracted data were analyzed using a process of thematic analysis. The content that was provided was relatively consistent with research findings in regard to parenting in a stepfamily. It emphasized the importance of mothers’ care and support, a supportive stepparent role, problems around stepparent discipline, and the importance of the couple’s relationship. However, the information provided was often brief, did not cover all important areas and was presented inconsistently across the websites, leading to a lack of consistent research-based information and guidance.

Keywords: stepfamily, mother-child, internet-based, stepparent role.

Approximately 90% of residential stepfamily households contain a mother, her children from a previous union, and her partner (Smith, 2008; Thomson, Mosley, Hanson, & McLanahan, 2001). Hence, the majority of stepfamily research has focused on stepfather families. Researchers have concluded that children often experience adjustment difficulties in the first two years of living in a stepfamily (Amato, 2001; Hetherington & Kelly, 2002) and that mother-child relationships can become more conflicted and less positive during this transition period (Cartwright, 2010; Hetherington & Kelly, 2002). Children in stepfamilies are more likely to rate their family climates as more conflicted (Kurdeek & Fine, 1993) and feel less secure in relationships with parents (Planitz, Feeney, & Peterson, 2009). Despite this, reviews of the stepfamily literature conclude that researchers have rarely given primary focus to mothers in stepfamilies (Cartwright, 2008; Coleman, Ganong, & Fine, 2000; Ganong & Coleman, 2004). This is surprising given the importance of mother-child relationships to children’s adjustment, and the crucial role that mothers play in the integration of children into the stepfamily (Ganong & Coleman, 2004; Hetherington & Kelly, 2002; Pryor & Rodgers, 2001). On the other hand, it may reflect the perception of an urgent need to understand more about the stepparent role in children’s lives (Ganong & Coleman, 2004) and a belief that the mother-child relationship is resilient (Cartwright, 2008).

The evidence of increased difficulties for mothers and children in stepfamilies suggests that mothers may benefit from the provision of research-based parenting information to assist them with the transition. However, there is concern that the dissemination of research-based knowledge for stepfamilies is “inadequate” and “sporadic” (Pryor & Rodgers, 2001, p. 270). The internet is a growing resource generally for mothers who are looking for information and guidance on raising their children (Radey & Randolph, 2009; Sarkadi & Bremberg, 2005) as it offers readily available and frequently updated content. A recent survey of 1,081 parents found that 76% reported using the internet as a parenting resource and mothers reported accessing online parenting information more frequently than fathers (Radey & Randolph, 2009). Hence, this current study aimed to investigate the information and guidance provided on the internet to mothers in stepfamilies in regard to the parenting of their children, and the quality and depth of the available information.

Mothers in stepfamilies

As is true for all family types, ‘authoritative’ parenting, which is high in warmth and support, and flexible discipline and control, is mostly strongly associated with child adjustment (Hetherington, 2006; Pryor & Rodgers, 2001). Hetherington and Kelly (2002), in their 20 year longitudinal study of families after divorce, concluded that authoritative parenting by mothers in stepfamilies is associated with children’s self-esteem, academic achievement, sense of security and development of social skills - all of which can mediate the risks of negative outcomes. The structure and involvement provided by authoritative mothers also strengthens relationships with children, which in turn reduces the likelihood of problems during adolescent years (Ganong & Coleman, 2004).

When mothers repartner or remarry, their relationships with their own children may be placed under stress. Research suggests that mothers are increasingly turning to the internet for information about parenting. This study investigated the information and guidance available on the internet for mothers in stepfamilies, and compared this information to the conclusions that researchers have reached about parenting and stepparenting. Information provided for mothers was extracted from 69 websites that purported to provide information for stepfamilies. The extracted data were analyzed using a process of thematic analysis. The content that was provided was relatively consistent with research findings in regard to parenting in a stepfamily. It emphasized the importance of mothers’ care and support, a supportive stepparent role, problems around stepparent discipline, and the importance of the couple’s relationship. However, the information provided was often brief, did not cover all important areas and was presented inconsistently across the websites, leading to a lack of consistent research-based information and guidance.

Keywords: stepfamily, mother-child, internet-based, stepparent role.
Authoritative parenting by mothers is particularly important during family transitions, however, there is evidence that mothers in stepfamilies are less like to parent authoritatively compared to mothers in first marriages, due to the increased stresses they may experience (Hetherington & Kelly, 2002).

A number of qualitative studies conducted in New Zealand have provided insight into the issues that may impact on the mother-child relationship. These include children’s experience of a loss of maternal time and attention that occurs when mothers gain a new partner (Cartwright, 2003, 2005; Cartwright & Seymour, 2002); a potential lack of consultation and preparation at the time of repartnering or remarriage (Cartwright & Seymour, 2002); children’s resentment or disapproval of the mother’s choice to remarry (Cartwright, 2005); and different expectations of relationships and roles in the new stepfamily (Cartwright, 2005). On the other hand, a number of positive themes emerged from these studies. Children and young adults reported appreciating parents who, after repartnering, continued dedicating one-on-one time and attention to their children in order to maintain a strong parent-child relationship (Cartwright, 2005). Children also saw it as important that the mother continue to take the lead parenting role, particularly in terms of support and discipline (Cartwright, 2005). Being respectful of the non-residential parent was also deemed important (Cartwright, 2005). Hence, these studies emphasized the importance of mothers in stepfamilies maintaining their authoritative parental roles of warmth/support and discipline/control. These New Zealand studies support similar findings from studies in the United States, including the longitudinal studies of Bray (1999) and Hetherington & Kelly (2002).

The impact of the stepfather role on mother-child relationships

Researchers have drawn attention to the lack of clarity that exists in regard to the stepfather role. For example, studies have found a lack of agreement between stepfathers themselves (Marsiglio, 2004) and between mothers, stepfathers and children (Hetherington & Kelly, 2002) in regard to an appropriate role for the stepfather. Couples often believe a stepfather’s role should be similar to that of a biological parent (Hetherington & Kelly, 2002) whereas children often view the stepfather as not having parental rights (Hetherington & Kelly, 2002; Pryor & Rodgers, 2001) and instead expect him to assume the role of a “friend” (Fine, Coleman, & Ganong, 1998). With confusion over the role, many stepfathers initially interact as ‘distant acquaintances’ with the child (Hetherington & Clingempeel, 1992), or alternatively tend to ‘over-parent’ and adopt an early authoritarian or even authoritative role (Ganong, Coleman, Fine, & Martin, 1999; Hetherington & Kelly, 2002). Children tend to respond to these approaches with resentment (Hetherington & Jodl, 1994; Papernow, 2006). Children are more likely to develop closer affinity with stepfathers who take a ‘laid-back’ approach, and focus on developing warm friendships (Ganong, et al., 1999). Ganong and Coleman (2004) in their review of stepfamily research conclude that is works best if stepfathers are supportive of the mother’s authority and gradually develop a relationship or friendship with their stepchild.

In summary, competent parenting by mothers during family transitions improves the quality of mother-child relationships and, in turn, has “the most proximate and pervasive influence on child and adolescent psychological distress” (Falci, 2006, p. 142). Despite this, reviews of the stepfamily literature have found little primary empirical focus on parenting by mothers in stepfamilies (Cartwright, 2008; Fine, et al., 1998; Ganong & Coleman, 2004). Given the difficulties and challenges that mothers in stepfamilies may face, it is important for them to have access to research-based information and guidance. To date, no studies have investigated the parenting information directed towards these mothers. This study, therefore, aims to investigate the information and guidance that is available on the internet for mothers in stepfamilies and to determine if this is consistent with research findings for mother-child relationships that have been discussed in this introduction.

**METHOD**

**Website selection**

This study investigated websites provided by organizations that purported or gave the appearance of providing reliable information or guidance for stepfamilies. Both the Google and Yahoo! search engines were used to search the internet for the term ‘stepfamilies’. The first 250 stepfamily websites from Google were selected. This selection was followed by a search of the first 150 websites from Yahoo! to ensure inclusion of the majority of websites for stepfamilies. Websites advertising books, courses, discussion forums, and social networking sites were excluded. While discussion forums and social networking sites might be of interest to mothers, this study examined sites that appeared to provide information for stepfamilies, as opposed to personal discussion of stepfamily experiences.

Two international websites which had a combined total of over 1000 pages of stepfamily information were excluded. These websites were the American National Stepfamily Resource Centre (ANSRC) and the Stepfamily Association of South Australia (SASA) websites, which were ranked numbers 6 and 15, respectively, on Google. These sites provided links to a vast array of other sites and articles, some of which were analysed for the study. The ANSRC was vast and difficult to navigate with links to a wide variety of publications from the early 1990s. An analysis of these links and publications could constitute a second study.

This left a total of 69 websites to be examined (see Appendix 1). The websites that were included in this study varied in their content and style. Some websites were general parenting sites with stepfamily information, others were online magazines (‘e-zines’), which contained stepfamily articles written by therapists working in the stepfamily area. Several were affiliated with churches and individual professional therapists. The majority of websites provided information in a magazine style using informal language, whereas other websites presented information
as ‘fact sheets’, ‘quick guides’ or ‘tip sheets’.

**Data analysis**

The data from the first 25% (18) websites were printed out and examined. Throughout the process described below, the first author did the preliminary examination of the data, and both authors reviewed each step of the analysis, made adjustment to the process where necessary, and decided on the next step.

The data relevant to mothers in stepfamilies were extracted. Each segment of the data was then examined and codes were developed to represent the data. These codes represented the content and meaning of each segment of data. A list of all the codes (or content areas discussed) was then created. The content areas fell into two broad categories titled ‘background information’, and ‘guidance for mothers’. The background information fell into two further categories, titled ‘stepfamily difficulties’, and “children’s reactions to stepfamily living’.

The category of data on guidance for mothers related closely to our research aims – understanding the information available for mothers. Previous researchers have investigated parenting and stepparenting using the two parenting dimensions of warmth/support and discipline/control (e.g. Hetherington & Kelly, 2002). Hence, a decision was made to analyze the data related to guidance for mothers using these two dimensions. This data was then divided into two categories – data related to warmth/support and discipline/control. This allowed for a more systematic analysis of the guidance in relationship to these parenting dimensions.

This process resulted in four categories of data. A thematic analysis was then conducted on each of these categories of data using the methods described by Braun and Clarke (2006). This process of data analysis was similar to that described above. Each segment of data was examined and coded for content and meaning. Once this was completed for a category of data, a list of codes was developed. Codes that represented related ideas were combined into provisional themes. These provisional themes and the data under them were reviewed by the authors, and areas of disagreement were discussed prior to development of the final themes.

**RESULTS**

**Website information directed towards mothers in stepfamilies**

Sixty-nine out of the 25% (18) websites met the criteria for this study. On average, 40% of the information on the stepfamily websites included in this study was directed towards mothers in stepfamilies and the mother-child relationship, although there was variability across the websites (range = 0% - 96.5%). For the majority of these websites, the remaining information was directed to stepparents. Six websites had no information for mothers - these sites were targeted solely at stepparents (3), children in stepfamilies (2), and grandparents in stepfamilies (1).

**Thematic analysis**

This section presents results from the analysis of the data within the data sets ‘Background Information’ and ‘Guidance for mothers’. Table 1 provides an overview of the categories and themes. The percentage of websites with data under each category is given.

**Background information**

This first section presents the results of the thematic analysis of the data within the background information in regard to stepfamily difficulties and children’s reactions to stepfamily living.

**Stepfamily difficulties**

Forty-five websites (65%) drew attention to some common stepfamily difficulties, problems with ex-spouses, roles and expectations, and resource issues.

**Roles and expectations**

Thirty-eight

<table>
<thead>
<tr>
<th>BACKGROUND INFORMATION</th>
<th>GUIDANCE FOR MOTHERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stepfamily difficulties (65%)</strong></td>
<td><strong>Warmth and Support (86%)</strong></td>
</tr>
<tr>
<td>▪ Difficulties with the ex-spouse (33%)</td>
<td>▪ Strengthening the mother-child relationship (62%)</td>
</tr>
<tr>
<td>▪ Roles and expectations (55%)</td>
<td>▪ Supporting the stepfamily (70%)</td>
</tr>
<tr>
<td>▪ Resource issues (38%)</td>
<td>▪ Nurturing the couple relationship (51%)</td>
</tr>
<tr>
<td><strong>Children’s reactions to stepfamily living (48%)</strong></td>
<td><strong>Discipline and Control (58%)</strong></td>
</tr>
<tr>
<td>▪ Unwanted changes (35%)</td>
<td>▪ Communication and consistency (29%)</td>
</tr>
<tr>
<td>▪ Resistance to the step-relationships (36%)</td>
<td>▪ Mother as the disciplinarian (45%)</td>
</tr>
<tr>
<td>▪ Age and gender differences (25%)</td>
<td>▪ Stepfather as a friend (35%)</td>
</tr>
</tbody>
</table>

*Table 1: Overview of the categories and themes*
(55%) websites referred to stepfamily difficulties resulting from uncertainty over roles and responsibilities of mothers and stepfathers, and stepfamily members having different or unrealistic expectations of stepfamily functioning. This role confusion results in “hardly anyone knowing what to do or how to act” largely due to a lack of “formal parenting roles, rights, responsibilities, and social etiquette” for stepfamilies.

Resource issues. Twenty-six (38%) websites said that resource issues place a particular strain on stepfamily members. Financial resources were mentioned several times as being “complex”, and “causing stress”, and resources relating to housing and the sharing of “territory” with stepparents and stepsiblings were also named as being problematic. Some websites said that stepfamily formation compromises parental resources because “sometimes the adults are so busy with their own upset and grief they don’t have much time for their children or for explaining things to them”. A lack of societal support/resources for stepfamilies added to the difficulties, with little “preparation or information on serial marriages in our culture” and “no rules on how to put together the various units of blended families”.

Difficulties with ex-spouses. Twenty-three websites (33%) in this category commented that challenges in stepfamily living arise due to the mother’s previous spouse, or the “ex-factor”. In particular, it was emphasised that stepfamilies “don’t start with a clean slate” because members bring with them grief and distress over their “losses” associated with the previous divorce. These losses include loss of a partner, parent, position in family, time, finances, lifestyle, and the unfulfilled “dream of what family life could have been”. In stepfamilies, it was observed that “this grief often remains unresolved and affects stepfamily relationships”.

Children’s reactions to stepfamily living

Thirty-three websites (48%) mentioned children’s reactions to stepfamily living. The themes of this category were: resistance to the step-relationship, unwanted changes, and age and gender.

Resistance to the step-relationship. Twenty-five (36%) websites stated children may react to stepfamily living through resistance to the stepfather because of feeling “threatened”, a perception that he is “a competitor”, feeling “left out of the loop of the new couple”, or “unimportant or invisible” to their biological parent. Children’s resistance to step-relationships may also be based on the loyalty binds that they experience. It was suggested that children may “feel something like, if I love you that means I do not love my real parent.” Children’s resistance to stepfathers can then result in difficult or challenging behaviour, such as “acting up” in order to “sabotage the new relationship”, “playing one grown-up off against the other”, ignoring rules, or being “defiant”. Other sites named specific adjustment difficulties that children can experience, for example changes in sleeping, eating and schoolwork, a loss of interest in their hobbies, withdrawal, or being more demanding than previously.

Unwanted changes. Twenty-four (35%) websites discussed the emotional reactions that children can have to unwanted changes in their family situation, including uncertainty, worry, grief, and anger. It was emphasised that children may feel uncertain about how relationships with their mothers will be affected by the presence of a stepfather and begin to “question even the most basic things in life, such as her parents love for her”. Websites also name other changes as causing children “confusion and worry” such as moving to a new home, neighbourhood or school, and sharing a house with new people. Several sites also commented that many children have a “fantasy” that their biological parents will reunitie. This hope, and the unwanted changes in parental time and attention, stability, and living situation, “add up in making kids upset, resentful and angry” and cause them to feel “like they have lost a parent, lifestyle and social position”.

Age and gender. Seventeen (25%) websites mentioned the importance of age and gender. Some mentioned gender differences and agreed that daughters feel more opposed to remarriage than boys, particularly during adolescence: “Remarriage when a daughter is entering adolescence promises to produce tremendous tension and resentment on the part of the daughter”. It was also concluded by these websites that adolescents and teenagers have the most difficulty adjusting to stepfamily living. These difficulties were attributed to the developmental stage of adolescence being a critical time of identity formation and “need for separation and independence”. It was also suggested that younger children’s “may feel a sense of abandonment or competition as their parent devotes more time and energy to the new spouse”.

Guidance for mothers

This section presents the results of the thematic analysis of the practical guidance given to mothers for the care of their children, in regard to warmth and support, and discipline and control.

Warmth and Support

Fifty-nine (86%) websites provided guidance for mothers on the parenting activities of warmth and support. Three themes emerged: Strengthening the parent-child relationship, supporting the stepfamily, and nurturing the couple’s relationship. These latter two themes were included as the websites argued that mothers’ support of the stepfamily and nurturance of the couple relationship is beneficial to the adjustment of children.

Strengthening the parent-child relationship. Forty-three (62%) websites advised mothers to strengthen their relationship with children in order to help them better adjust to stepfamily living. Specifically, some websites suggested that prior to remarrying, mothers “sit down and discuss the future with [your] children”, wait two years after divorce before remarrying, introduce the new person slowly before living together, have patience, and not force a relationship between new partner and children. Some websites also encouraged mothers to reassure children “that you and your ex-spouse will continue to love them and be there for them throughout their lives” and that “your new spouse will not be a ‘replacement’ for the father. In order to “maintain the security of relationships”, mothers were also encouraged to “carve out special time each day” with their children as well as “speaking well of former spouses” and ensuring “your children still get plenty of opportunities
to see your ex.”

Supporting the stepfamily. Forty-eight (70%) websites recommended mothers support the integration of stepfamily members into the stepfamily unit in order to help the adjustment of the children. An overarching message for mothers was to “abandon preconceptions” and “recognise that the stepfamily will not and cannot function as a natural family”. A large number of websites encouraged mothers to promote open communication with stepfamily members through regular family meetings to “resolve complaints and issues, and to discuss problems and explain things”. Some sites talked about the importance of respect, positive attitudes, and adopting “routines and schedules” to “give kids stability”. There was also emphasis on the role the mother should play in the development of relationships between her child, the new partner, and/or step-siblings. Several websites cautioned mothers not to “force love” and others suggested that mothers should “foster new family relationships” and “help the stepparent and child build a good relationship by encouraging them to share activities and helping them to understand each other”.

Nurturing the couple’s relationship. Thirty-five (51%) websites said that stepfamily functioning and children’s adjustment is enhanced when the couple nurtures their relationship through “protected and private time together on a regular basis”. It was suggested that giving the couple priority helps children by “creating security”, strengthening the family foundation, preventing further losses, and “showing the kids what it takes to have a successful relationship.” A number of websites emphasized the centrality of the couple relationship in the stepfamily. For example, one website recommended that “the couple relationship should come first, with the children a very close second” or suggested to mothers that “sometimes the reason that our previous marriage failed is because kids were in the centre of the relationship... keep you and your spouse in the centre of this new family”. Similarly, another wrote that “the number one priority in stepfamilies is the couple’s relationship” and that “your children will benefit much more from this than from you catering to their every whim.” In contrast, a small number of websites put more emphasis on the parent-child relationship in comparison to the couple’s relationship. One website wrote that “while the couple may be in love, the primary attachment still lies with the parent and the child”. Another stated that “the relationship between parents and children predates the new marital relationship. It may even seem to outweigh it”.

Mothers were also guided towards presenting a ‘united front’ to the children and to “create a boundary around their marriage, and become a real parenting team”. They were encouraged to “stand together, without being divided by the biological children”. Other websites mentioned the importance of the mother creating ‘a united front’ with the non-residential parent. This involved cooperating and sharing parenting amicably with their ex-partner through “a low-conflict co-parenting arrangement”. A small number of websites, however, considered that it was best to involve all the residential and non-residential adults as “the ideal is to form a parenting coalition among the parents and stepparents in both households”.

Discipline and control. Forty-five (58%) websites gave mothers specific guidance on parenting issues related to discipline and control. Three themes emerged from this category of data: communication and consistency, mother as the disciplinarian, and stepfather as a friend.

Communication and consistency. Twenty-nine (29%) websites recommended that disciplinary matters need to first be discussed with the new partner. They suggested that “house rules”, discipline and important values be agreed upon as “basic guidelines” with the new spouse before families blend. Consistency of discipline was discussed in two contexts. Firstly, it was seen as important that there was agreement on discipline between the stepparents and parents, as well as consistency of discipline for each child. The couple needs to “keep discipline the same... and don’t change the rules when [your] partner is not there”, as well as “treat all kids equally... be consistent and fair with each child”. Secondly, consistency of discipline between households (with the non-residential parent) was also mentioned.

Mother as the disciplinarian. Thirty-one (45%) websites advised mothers to take total responsibility for parental decisions with her children and “handle rules and punishments, at least initially”. It was common for websites to refer to the stepfather’s position on discipline in relation to the mother. For example, one website stated that the “biological parent needs to take the lead, with the stepparent standing beside them”. In the mother’s absence, some websites suggested a stepfather can act as a “babysitter”, “monitor”, or “an extra set of eyes and ears for the biological parent”.

Stepfather as a friend. Twenty-four (35%) websites discussed discipline and control and emphasised that the stepfather’s role was to focus on building a relationship with the children. Mothers were guided towards “establishing the stepparent as more of a counsellor” or “coach” rather than a parent, and instead have stepfathers work with the children on “creating a friendship, built on trust”. In order to develop “close bonds” the stepfather “should stay out of discipline until he has a positive relationship with them... he needs to slowly gain their trust and affection”. Once these “more solid bonds” have formed it was advised to mothers that stepfathers may then take on a greater parenting role.

DISCUSSION

When the internet search for the term “stepfamily” was conducted, two-fifths of the information provided on the 69 websites was directed towards mothers. However, there was considerable variation in the quantity of information across websites. For example, only 45% of the sites provided guidance about discipline, an area which is found to be central to stepfamily wellbeing (Hetherington & Kelly, 2002). Discipline is one of the most challenging issues faced by stepfamily members (Baxter, Braithwaite, & Nicholson, 1999) and there is evidence that children do better in stepfamilies when the biological mother is responsible for discipline, at least in the early stages (Hetherington & Kelly). Although a number of websites in this study...
supported this approach, this important finding was not discussed by over half of the websites. Even fewer sites (35%) talked about the benefits of the stepfather engaging in a ‘friend’ role initially.

Just under half of the websites provided information, and this was usually brief, about the adjustment difficulties that children experience in the formation of a stepfamily and children’s reactions to stepfamily living. This is surprising given the amount of research-based information available in this area (e.g. Hetherington & Clingempeel, 1992; Hetherington & Kelly, 2002), which would assist mothers to better understand their children’s responses to the family changes.

On the other hand, the content of the information provided generally reflected the findings from empirical research and stepfamily therapists. For example, when sites did discuss discipline, they often did so briefly, although their guidance was in line with research findings. The majority of websites also talked about the importance of maternal warmth and support. This is in line with research findings that supportive parenting by mothers helps children adjust to stepfamily living (Pryor & Rodgers, 2001) and can reduce a child’s sense of insecurity (Bray & Kelly, 1998). Many sites offered practical guidance for mothers about spending time alone with their children, giving reassurance, and communicating supportively. Some also guided mothers towards having realistic expectations of the stepfamily and to not attempt to make the family function like a “nuclear family”.

Finally, there was one area of information and guidance that was, to some degree, contradictory to research findings. This included an emphasis on the couple’s relationship and child adjustment. Some websites conceptualized the couple’s relationship as the primary relationship in the stepfamily and recommended that the mother prioritize her relationship with her partner in order to enhance marital satisfaction and thereby enhance her children’s wellbeing. This advice is consistent with some early clinical guidance (Mills, 1984; Vischer & Vischer, 1996; Webber, 1994; Whiteside, 1982). However, some stepfamily researchers have questioned the principle that places the couple’s relationship at the centre of the family as more applicable for first-marriage families than stepfamilies (e.g. Adler-Baeder & Higginbotham, 2004; Golish, 2003). Hetherington and Kelly (2002), in their longitudinal study, found that the quality of the step-relationship was more influential than the couple’s relationship on stepfamily adjustment. As they note,

_In first marriages, a satisfying marital relationship is the cornerstone of happy family life, leading to more positive parent-child relationships and more congenial sibling relationships. In many stepfamilies the sequence is reversed. Establishing some kind of workable relationship between stepparents and stepchildren may be the key to a happy second marriage and to successful functioning in stepfamilies (p.181)._”

Hence, the impact of the couple’s relationship on child adjustment is not supported by empirical research. While it is clearly important that couples need to foster their relationships, in terms of child wellbeing and relationships between mothers and children, it may be equally or more important to emphasize the parent-child relationship (Papernow, 2008) and recognize the importance of developing friendly relationships between stepparents and children (Ganong & Coleman, 2004).

In summary, this study investigated internet information and guidance for mothers in stepfamilies and found that many of the empirically-supported parenting practices were mentioned by some of the websites. The only area of significant disagreement is the emphasis, or not, on the couple’s relationships over and above other relationships in the stepfamily. However, while most information and guidance reflected empirical findings, the information was not provided consistently by websites. Many websites included accurate information but left out essential information, such as the importance of the mother maintaining responsibility for parenting in the early stages, including discipline. It seems likely then that mothers seeking information on the internet about parenting in a stepfamily could have a “hit or miss” experience, depending on which sites they choose to look at.

**Limitations and future directions**

The main limitation of this study was the problems associated with analysing the data on the websites given the variation in amount and type of information on each website. This study also only examined information that was addressed to mothers and analysis of other information within the stepfamily websites may have revealed information aimed at other stepfamily members, which may have been helpful for mothers to also understand.

This study is the first to investigate the information provided on the internet for mothers in stepfamilies. Little is known about what resources are accessed by parents who are repartnering, and future research could investigate if, and how, parents gain information about stepfamily living. This study is important in New Zealand that does not have a Stepfamily Association and draws attention to the question of how parents in stepfamilies are gaining information and guidance that supports their adjustment.

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**Corresponding Author:**

Anna Miller

amil686@aucklanduni.ac.nz

or Dr Claire Cartwright
c.cartwright@auckland.ac.nz

The University of Auckland

Private Bag 92019

Auckland 1142

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### Appendix 1

Table 2: Search Engines, Websites and Ranks

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<th>Rank</th>
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## Appendix 1

Table 2: Search Engines, Websites and Ranks contd.

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Further Validation of the New Zealand Test of Adult Reading (NZART) as a Measure of Premorbid IQ in a New Zealand Sample

Irene Tatjana Lichtwark, Monash University, Australia & University of Waikato
Nicola Jayne Starkey, University of Waikato
Suzanne Barker-Collo, University of Auckland

Premorbid IQ estimates are used to determine decline in cognitive functioning following trauma or illness. This study aimed to: 1) further validate the New Zealand Adult Reading Test (NZART) in a New Zealand population and compare its performance to the UK developed National Adult Reading Test, and 2) develop regression formulae for the NZART to estimate Wechsler Adult Intelligence Scale-IV (WAIS-IV) IQ scores. The 67 participants (53 females; 16 Māori), aged 16 to 90 years old (mean age = 46.07, SD 23.21) completed the WASI-IV, the NART and the NZART. The NZART predicted Verbal Comprehension Index (VCI) scores slightly better than the NART ($r = .63$ vs. $r = .62$) and explained 33% of the variance in FSIQ scores. Reasons for developing regression formulae for the NZART are discussed, regression formulas for the NZART based on the WAIS–IV are included and suggestions of alternate ways of determining premorbid IQ are made.

Keywords: National Adult Reading Test (NART); New Zealand Adult Reading Test (NZART); premorbid IQ; cross cultural differences; IQ estimation, WAIS-IV

Neuropsychological assessments are frequently conducted to evaluate changes in cognitive functioning resulting from brain injury or degenerative decline (Lezak, 2004). To evaluate cognitive decline, comparisons between current and premorbid functioning need to be made, however as baseline assessment results are rarely available estimates of premorbid functioning are often used. The suitability of these measures depends on the resilience of the underlying cognitive domains to neurological disorders and their strong correlation with current Intelligence Quotient (IQ) in the absence of neurological disorder (Lezak, 2004). As such, one of the most commonly used methods for estimating premorbid IQ focuses on current skills which are relatively resistant to brain injury, such as word reading.

Reading skills, and in particular single word reading skills, have been shown to be relatively free from the influence of age and gender (Crawford, Parker, & Besson, 1988), psychiatric diseases such as depression and schizophrenia (Crawford, 1992), and are resilient to mild to moderate dementia (McGurn et al., 2004), and mild to moderate traumatic brain injury (TBI) (Watt & O’Carroll, 1999). Reading skills are also highly correlated with IQ, a measure of the individuals’ overall level of cognitive functioning (Crawford, Stewart, Cochrane, Parker, & Besson, 1989).

One of the most widely used premorbid assessment tools based on current single word reading skills is the National Adult Reading Test (NART) (Nelson & Willison, 1991), which has been standardised against the Wechsler Adult Intelligence Scale-Revised Edition (WAIS-R). The WAIS scales are viewed as the ‘gold standard’ of IQ tests to which assessments of premorbid function are compared (Lezak, 2004; Silverman, 2010). The NART was developed in Great Britain to assess the severity of dementia. It consists of 50 single words which are irregular in their grapheme-to-phoneme translation. Thus, if the reader is unfamiliar with a word they are likely to pronounce it incorrectly (Nelson & Willison, 1991). The NART error score is inserted into a regression formula provided in the test manual to obtain an estimated premorbid IQ score.

The NART has a high split half reliability ($r = .93$), high inter-rater reliability ($r = .96$ to $r = .98$) and high test-retest reliability ($r = .98$) (Nelson & Willison, 1991). Criterion validity of the NART is reported to be good, explaining between 61% and 72% of the variance in Verbal IQ (VIQ), 55% to 66% of the variance of Full Scale IQ (FSIQ) scores, and 32-33% of the variance of Performance IQ (PIQ) (Crawford, Deary, Starr, & Whalley, 2001; Crawford, Stewart, Cochrane, Parker, et al., 1989; Sharpe & O’Carroll, 1991). The NART has been used extensively in Great Britain and other countries, either in its original form (Barker-Collo et al., 2008; McGurn et al., 2004; Watt & O’Carroll, 1999) or modified to better suit linguistic differences. The North American Adult Reading Test (NAART) (Blair & Spreen, 1989), the American National Reading Test (AMNART) (Gladsjo, Heaton, Palmer, Taylor, & Jeset, 1999) and the AUSNART (Hennessey & Mackenzie, 1995) in Australia are examples of modified versions of the NART. The addition of demographic variables (e.g., age, gender, years of education and occupation (Barona, Reynolds, & Chastain, 1984) to the NART-based regression formulae has been found.
to increase the formulae’s accuracy of premorbid IQ prediction (Bright, Jaldow, & Kopelman, 2002; Crawford et al., 1988; Crawford, Stewart, Cochrane, Foulds, et al., 1989; Watt & O’Carroll, 1999).

Other reading-based tests of premorbid functioning are also available, for example the Test of Premorbid Functioning (TOPF) (The Psychological Corporation, 2009) and its predecessor the Wechsler Test of Adult Reading (WTAR) (Wechsler, 2001). The WTAR, co-normed with the WAIS-III has been used widely due to its large U.S. normative database. Comparisons between the NART and the WTAR have found that both tests performed very similarly (Mathias, Bowden, & Barrett-Woodbridge, 2007). Unlike the NART-based tests country specific modifications of the WTAR (or the more recently released TOPF) are not yet available and the estimated IQ scores are calculated from regression equations based on US samples, which may not be suitable for use outside of the US. It should also be noted that the NART and its various adaptations are in the public domain and hence can be used at minimal cost. In contrast, the TOPF must be purchased as part of the ‘Advanced Clinical Solutions’ package (The Psychological Corporation, 2009) at considerable cost.

As indicated by the NART adaptations described above, a language-based tool such as the NART cannot necessarily be used in different countries without modification (Franzen, Burgess, & Smith-Seemiller, 1997). Two issues in particular need to be addressed: First, word use and understanding may differ between English speaking nations. Second, the pronunciation of words may differ between English speaking nations (Franzen et al., 1997). Ignoring these issues could lead to an underestimation of premorbid cognitive function and thus the extent of any impairment (Franzen et al., 1997; Odgen, Cooper, & Dudley, 2003).

This issue was highlighted in a New Zealand-based study by Freeman Godfrey, Harris, and Partridge (2001) who explored the reliability of the NART as a tool to estimate premorbid IQ in people with TBI. The NART was administered to 80 participants with TBI, 27 orthopaedic patients and 80 community participants. Regression formulae (incorporating demographic factors) developed by Crawford, Stewart, Cochrane, and Foulds (1989) were used to estimate the premorbid IQ for each participant. Findings indicated that 30% of the TBI group, 18% of the orthopaedic group and 11% of the community group had scores which indicated some level of cognitive impairment. In contrast, the rate of impairment in the community group was much higher than the rate of 1% reported in a Scottish population using the same NART-based regression formulae (Crawford, Stewart, Cochrane, Foulds, et al., 1989). This suggests that the regression formulae and perhaps the NART itself may not be a reliable means of estimating premorbid IQ in a New Zealand population.

Further questions regarding the suitability of the NART for use in New Zealand were raised in two other studies. Odgen et al (2003) assessed 20 Māori and 20 non-Māori participants with several neuropsychological tests, some of which had been modified to better suit Māori participants (seven words in the Māori language were added to the WAIS-R Vocabulary subtest and a Design Fluency Test was included). Māori participants scored significantly lower than non-Māori on the non-modified tests while there were no significant differences between Māori and non-Māori on the modified tests. Additionally, Māori participants scored similarly to New Zealand European participants on the modified vocabulary and visuo-spatial skills related tests. These authors concluded that more culturally suitable assessment tools should be available to lessen the disadvantages that Māori people face in testing situations (Odgen et al., 2003). Even though the NART was not used in this study the results still highlight the importance of adjusting a measure to the population sampled.

Barker-Collo et al. came to a similar conclusion in 2008 after exploring the accuracy of the NART with a non-clinical sample of 89 New Zealanders, 14 of whom were of Māori descent (Barker-Collo et al., 2008). These researchers compared participants’ scores on the WAIS-III, the NART and Spot-the-Word Test (STW). STW is a test of word recognition used to indicate premorbid ability where the participants are asked to identify the true word in each of 60 word pairs (the other word in each pair is a made up word without meaning) (Baddeley, Hazel, & Nimmo-Smith, 1992). For the New Zealand European participants the NART and STW scores correlated highly with the WAIS-III FSIQ scores ($r_{NART} = .70, p < .01, r_{STW} = .70, p < .01$), while for Māori participants there was no significant correlation between NART and WASI-III FSIQ scores. Interestingly, the WAIS-III FSIQ correlated highly with the STW scores for Māori participants ($r_{STW} = .91, p < .01$). Despite this high correlation the STW was only able to estimate 52% of the current IQs correctly. Barker-Collo et al. concluded that the NART was particularly unsuitable for people of Māori descent, probably as a result of differing word familiarity, and called for the development of a New Zealand version of the NART or at least for New Zealand specific regression formulae (Barker-Collo et al., 2008). Even though the study only included 14 Māori participants, the findings are in line with those of others and suggest that further research is warranted.

Awareness of the issues with the assessment of premorbid IQ in New Zealand led to the development of the New Zealand Adult Reading Test (NZART) by Starkey and Halliday (2011). The NZART consists of 60 single words which are irregular in their grapheme-to-phoneme translation (the NZART is 10 words longer than the NART to avoid possible ceiling effects). To better reflect the word familiarity of New Zealanders, the word order was changed, and 28 words of the NART were replaced with words more commonly used in New Zealand, for example ‘Meringue’ and ‘Whenua’. To increase the cultural suitability of the test, the NZART contained three Te Reo Māori words that are familiar to most New Zealanders. All words selected for the inclusion in the NZART were in the New Zealand Oxford Dictionary, were irregular in their grapheme-to-phoneme encoding and were likely to be known by most New Zealanders. To validate the NZART Starkey and Halliday...
Validation of the NZART

(2011) administered the NZART, the WASI (a short form of the WAIS-III), and the NART to 63 participants. The participants’ ages ranged from 17 to 61 years old (mean age = 25.05 years; SD = 9.35), 48 (75.2%) were female, and half (n=33; 50.8%) of the participants were of European descent, 21 (33.3%) were of Māori descent, and 6 (9.6%) were of other descent. All but three participants had completed high school and almost half of all participants had university level degrees. Estimated IQ scores were calculated using the NART error scores and the original NART formulae (NART

In addition, regression analyses were undertaken to develop a New Zealand equation for the NART (NART

The new NART equations explained 42, 49% and 17% of the variance of Full Scale IQ, Verbal IQ and Performance IQ (FSIQ, VIQ and PIQ), respectively. The regression formulae for the NZART were able to explain 46%, 55% and 19% of the variance of FSIQ, VIQ and PIQ respectively. In addition, the NZART formula was more accurate in estimating IQ score category for FSIQ, VIQ and PIQ across all IQ levels.

While these findings and those of Barker-Collo et al. (2008) are promising, there are still several issues to be addressed. Firstly, the regression formulae for the NART and the NZART need validation in a separate sample across a wider age range. Secondly, the regression estimates in these earlier studies were based on the WAIS-III (Barker-Collo et al., 2008) or the WASI rather than the recently released WAIS-IV which has a different index structure to the WAIS-III and WASI. The WAIS-III provided Verbal and Performance IQ scores in addition to Full Scale IQ. In contrast the WAIS-IV allows calculation of four index scores (Verbal Comprehension Index, Perceptual Reasoning Index, Working Memory Index and Processing Speed Index) as well as the full scale IQ score. The Full Scale IQ (FSIQ) and Verbal Comprehension Index (VCI) were used as the estimates of current IQ in this study as previous work has shown that the NART scores are more accurate at predicting FSIQ and scores based on verbal ability rather than performance scores (Crawford, Parker, Stewart, Besson, & De Lacey, 1989; Franzen et al., 1997). A further reason for this choice is that clinicians would find estimates of FSIQ most useful.

Therefore the present study was undertaken to validate the NZART in a separate sample, with a wider age range, and to develop regression formulae for the NZART based on the WAIS-IV. It was expected that the NZART estimated IQ scores would be more accurate than those based on the NART.

Method

Participants

To be eligible for the study, participants had to have been born in New Zealand, speak English as their first language and have a health history free of neurological conditions (e.g., stroke, TBI). Of the 75 participants who volunteered for the study, 8 were excluded because of a history of mild stroke or TBI. The demographic characteristics of the sample are shown in Table 1. The sample was predominantly female (76.8 %) and included participants across a wide age range (16-90 years). Overall, 75.4% of the participants self-identified as New Zealand European and 21.7% were of Māori descent. The male participants had spent slightly more years in formal education than the female participants, and most participants’ occupations were classified in the skilled labourer category (e.g., trades people and nurses). Female participants had spent more time in New Zealand on average than the male participants.

Materials

All participants completed the Australia and New Zealand adaptation of the Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV), the NART and the NZART. They also completed a short demographic questionnaire which requested information about their age, marital status, ethnicity, education and general health.

WAIS-IV (Wechsler, 2008). The WAIS-IV was used as the measure of current IQ. The 10 core subtests of Block Design, Similarities, Digit Span, Matrix Reasoning, Vocabulary, Arithmetic, Symbol Search, Visual Puzzles, Information and Coding were administered in accordance with the instructions in the test manual (Wechsler, 2008). The Full Scale IQ and Verbal Comprehension Index scores were used in the current study.

The National Adult Reading Test (NART) (Nelson & Willison, 1991). The NART is a word reading test developed in Great Britain to estimate the premorbid cognitive functioning in people who are suspected of suffering from cognitive deterioration (Nelson & Willison, 1991). As noted earlier, the test includes 50 irregularly spelt words and scoring is based upon the total number of pronunciation errors. The possible error scores range from 0 (all words correct) to 50 (no words correct).

New Zealand Adult Reading Test (NZART) (Starkey & Halliday, 2011). The NZART is the New Zealand version of the NART and was developed as a test of premorbid functioning suitable for the use in New Zealand (Starkey & Halliday, 2011). As noted earlier, the test includes 60 irregularly spelt words (ten additional words were included to avoid ceiling effects) and scoring is based upon pronunciation of each word. Again, the NZART provides a possible error score from 0 (all words correct) to 60 (no words correct).

Procedure

The 75 participants for this study were students of the University of Waikato, or members of the community. The study was advertised on posters around the University, on the electronic learning platform of the University as well as the Māori network at the University. Older participants (over 40 years of age) were recruited through contacting community groups such as exercise classes, gardening clubs, bowling clubs and through word of mouth. Ethical approval for the study was obtained from the School of Psychology Human Ethics Committee, University of Waikato.

Prospective participants registered their interest in the study during recruitment talks at various clubs and community centres by adding their name and phone number to a list or by contacting the researcher directly after reading one of the posters. The
Irene T. Lichtwark, Nicola J. Starkey & Suzanne Barker-Collo

A researcher contacted the volunteers on the list and provided detailed information about the study. Of 77 volunteers, 75 (97.4%) consented to take part. Participants were assessed either in an office at the University of Waikato (60%) or at their request in a quiet place in their home (40%). After ensuring that the participants were familiar with the purpose of the study and answering any questions they might have, participants provided informed consent and 2% course credit (for University students), or gift vouchers to the value of NZ$20 were provided to participants. The participants were reminded of their right to withdraw from the study at any time without having to give an explanation. The participants' responses were audio recorded during the administration of the NART and NZART for scoring purposes (after gaining permission from the participant). The tests were then administered according to standardised procedures. The tests of premorbid IQ were administered separately but in the same way. The participants were given a laminated chart with the words in 2 or 3 columns printed in large, bold font (font size 20) for each test. They were asked to read the words out loud at their own pace, after the warning that some of the words might be unknown to them or difficult to pronounce. Incorrect pronunciations were noted by the assessor on a score sheet.

Because the NART and the NZART share 56% of their words there was the possibility of a learning effect which could result in a higher estimation of IQ from the second measure administered. The tests could have been combined but because the purpose of the study was to compare the two tests and the word orders differed it was decided to administer them separately. To counteract any order effects the two measures were presented either side of the WAIS–IV administration during the test session and the order of administration was alternated between participants. Half of the participants started with the NART and the others began with the NZART. No significant differences were found between these two groups.

The participants took between 90 to 120 minutes to complete the assessments. At the end of the assessment, participants were thanked for their time and any questions they had about the study were answered. All data were entered into SPSS 20.0 for analyses.

In this study the NART-based regression formulae are from the new data supplement in the NART manual (Nelson & Willison, 1991) and will be referred to as NART<sub>gb</sub> in reference to the origin of the sample. Two NZART formulae are used: the formulae

<table>
<thead>
<tr>
<th>Variable</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age [mean(SD)]</td>
<td>41.56 (24.2)</td>
<td>48.58 (23.2)</td>
<td>46.07 (23.2)</td>
</tr>
<tr>
<td></td>
<td>Min- max</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>18 - 89</td>
<td>16 - 90</td>
<td>16 - 90</td>
</tr>
<tr>
<td>Ethnicity [n (%)]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Māori</td>
<td>2 (14.3)</td>
<td>13 (24.5)</td>
<td>15 (21.7)</td>
</tr>
<tr>
<td>New Zealand European</td>
<td>12 (85.7)</td>
<td>40 (75.5)</td>
<td>52 (75.4)</td>
</tr>
<tr>
<td>Years in formal education [mean(SD)]</td>
<td>15.6 (3.9)</td>
<td>14.23 (2.9)</td>
<td>14.60 (3.2)</td>
</tr>
<tr>
<td>Occupation [n (%)]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>4 (25)</td>
<td>8 (15.1)</td>
<td>12 (17.4)</td>
</tr>
<tr>
<td>Labourer/ clerical</td>
<td>1 (6.3)</td>
<td>7 (13.2)</td>
<td>8 (11.6)</td>
</tr>
<tr>
<td>Skilled labourer</td>
<td>8 (50.0)</td>
<td>36 (67.9)</td>
<td>44 (63.8)</td>
</tr>
<tr>
<td>Professional</td>
<td>3 (18.8)</td>
<td>2(3.8)</td>
<td>5 (7.2)</td>
</tr>
<tr>
<td>Years in NZ [mean(SD)]</td>
<td>38.19 (22.7)</td>
<td>47.97 (23.6)</td>
<td>45.52 (23.6)</td>
</tr>
<tr>
<td>Marital stat. [n (%)]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>8 (50.0)</td>
<td>15 (28.3)</td>
<td>23(33.3)</td>
</tr>
<tr>
<td>Married</td>
<td>7 (43.8)</td>
<td>15 (28.3)</td>
<td>22 (31.9)</td>
</tr>
<tr>
<td>De Facto</td>
<td>1 (6.3)</td>
<td>10 (18.9)</td>
<td>11(15.9)</td>
</tr>
<tr>
<td>Sep /widowed</td>
<td>0</td>
<td>13 (24.5)</td>
<td>13 (18.8)</td>
</tr>
</tbody>
</table>
Results

The results are presented in four sections. The first section describes the development of the regression equations based on the WAIS–IV. The next section summarises the performance of the participants on the WAIS–IV, NART and NZART and compares the performance across gender and ethnicity using independent t-tests (due to unequal group sizes it was not possible to conduct a 2-way ANOVA). The third section reports the correlation between participants’ scores on the NART and NZART and the WAIS–IV. The accuracy of the NART and NZART in predicting the current WAIS–IV IQ is described in the final section. Effect sizes were calculated as Cohen’s d, with d≤.2 as small, d≤.5 as medium and d≥ .5 as large (Aron & Aron, 2006). The incidence of missing data was less than 1% and the assumption of homogeneity of the data was met.

Development of Regression Equations (WAIS–IV)

Initially correlations were calculated between demographic factors and the NZART error scores. Lower NART and NZART error scores were related to more years in formal education, (r_{NART} = -.26, r_{NZART} = -.33,) and older age (r_{NART} = -.37; all p’s<0.05). Two new NZART regression formulae were developed to predict WAIS–IV FSIQ and VCI. The NZART error score, ethnicity and education (in years) were subjected to a forced entry linear regression. Surprisingly, the demographic variables did not make a significant contribution to the FSIQ or VCI regression equations. Thus, the resulting formulae for the prediction of WAIS–IV FSIQ and VCI were based on NZART error scores only:

\[
\text{NZART }_{\text{WAIS FSIQ}} = 121.56 - 0.65 \times \text{NZART ERR}
\]

\[
\text{NZART }_{\text{WAIS VCI}} = 122.55 - 0.69 \times \text{NZART ERR}
\]

Participants’ Test Performance

The participants’ performance on each of the tests is presented in Table 2. Overall, WAIS–IV FSIQ and VCI scores were within the average range. It is of interest to note that males obtained significantly higher WAIS–IV VCI scores compared to females (medium effect size). The estimated IQ scores from NART and NZART were in the average range and there were no statistically significant differences between male and female participants’ scores. The average number of errors made on the NART and NZART was 20.81 (SD = 7.37) and 20.41 (SD =12.01) respectively. Generally the mean estimated FSIQ scores were similar to the mean of the current WAIS–IV FSIQ however the NARTGB tended to underestimate FSIQ and VCI.

Descriptive statistics for the Māori and NZ European participants on each of the tests are provided in Table 3. Both groups of participants obtained WAIS–IV FSIQ and VCI scores in the average range, and the IQ estimates were also

Table 2: Descriptive Statistics (Mean and Standard Deviation) for Male and Female Participants’ Scores for the WAIS–IV, NART and NZART.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Overall mean (SD)</th>
<th>Male mean (SD)</th>
<th>Female mean (SD)</th>
<th>t</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 67</td>
<td>n = 14</td>
<td>n = 53</td>
<td>df = 65</td>
<td></td>
</tr>
<tr>
<td>WAIS–IV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAIS FSIQ</td>
<td>109 (11.64)</td>
<td>114 (12.61)</td>
<td>108 (11.17)</td>
<td>1.72</td>
<td>.52</td>
</tr>
<tr>
<td>WAIS VCI</td>
<td>109 (12.43)</td>
<td>116 (14.06)</td>
<td>108 (11.42)</td>
<td>2.44*</td>
<td>.64</td>
</tr>
<tr>
<td>NART_{GB}</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NART_{GB} FSIQ</td>
<td>105 (8.80)</td>
<td>106 (8.20)</td>
<td>105 (9.03)</td>
<td>.05</td>
<td>.11</td>
</tr>
<tr>
<td>NART_{GB} VIQ</td>
<td>104 (8.09)</td>
<td>105 (7.54)</td>
<td>104 (7.54)</td>
<td>.05</td>
<td>.12</td>
</tr>
<tr>
<td>NZART_{WASI}</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZART_{WASI} FSIQ</td>
<td>107 (9.24)</td>
<td>106 (8.68)</td>
<td>107 (9.44)</td>
<td>.51</td>
<td>.11</td>
</tr>
<tr>
<td>NZART_{WASI} VCI</td>
<td>103 (10.57)</td>
<td>103 (9.90)</td>
<td>104 (10.81)</td>
<td>.50</td>
<td>.10</td>
</tr>
<tr>
<td>NZART_{WAIS}</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZART_{WAIS} FSIQ</td>
<td>109 (6.62)</td>
<td>108 (6.13)</td>
<td>109 (6.78)</td>
<td>.48</td>
<td>.15</td>
</tr>
<tr>
<td>NZART_{WAIS} VCI</td>
<td>109 (7.56)</td>
<td>110 (7.80)</td>
<td>109 (7.56)</td>
<td>.22</td>
<td>.13</td>
</tr>
</tbody>
</table>

Note: *IQ scores have mean of 100, SD = 15.

aScores are not scaled for age.

*bdenotes statistical significance at p<.05

NART_{GB} calculated from formulae provided by Nelson and Willison (1991).

NZART_{WASI} calculated from formulae provided by Starkey and Halliday (2011).

NZART_{WAIS} calculated from formulae developed in this study.
Regression Formulae

The formulae that are compared in this paper are the NART GB (Nelson & Willison, 1991), NZART formulae based on the WASI (Starkey & Halliday, 2011; NZARTWASI) and the NZART formulae developed as part of the current study, based on the WAIS-IV (NZARTWAIS).

The equations used are as follows:

FSIQ

\[
\text{NART}_{GB} \text{ FSIQ} = 130.6 - 1.24 \times \text{NART}_{ERR} \\
\text{NZART}_{WASI} \text{ FSIQ} = 124.18 - 0.903 \times \text{NZART}_{ERR} \\
\]

VCI

\[
\text{NART}_{GB} \text{ VCI} = 127.4 - 1.14 \times \text{NART}_{ERR} \\
\text{NZART}_{WASI} \text{ VCI} = 123.07 - 1.025 \times \text{NZART}_{ERR} \\
\text{NZART}_{WAIS} \text{ VCI} = 122.55 - 0.69 \times \text{NZART}_{ERR} \\
\]

Accuracy of the Premorbid IQ Estimations

The scaled scores obtained from the WAIS-IV can be allocated to one of seven categories: (Wechsler, 2008, p. 126): Extremely low (69 and below), Borderline (70-79), Low Average (80-89), Average (90-109), High Average (110-119), Superior (120-129), and Very Superior (130 and above). These WAIS–IV categories are a common way for clinicians to describe the level of performance of a client in qualitative terms.

To explore the accuracy of each of the formulae in predicting a participant’s current WAIS–IV FSIQ and VCI scores, the participant’s current IQ category was compared to the category in which they were placed by each of the regression formulae. This was conducted separately for FSIQ and the VCI. The number and percentage of participants who were correctly categorised by their estimated IQ score were calculated (Table 4; note only five of the seven categories are displayed because there were no participants in the ‘Extremely Low’ and ‘Borderline’ groups).

For people with extreme scores (Low Average or Very Superior) the estimated IQ scores were largely inaccurate. However, estimated IQs were more accurate for the middle categories (Average, High Average and Superior). All three formulae were most accurate at categorising FSIQ scores in the Average range however the NZARTWASI and NZARTWAIS were twice as accurate as the NARTGB in accurately categorising participants with FSIQ scores in the High Average range. The prediction of VCI was more accurate in the lower categories (from Low Average to High Average) than the higher categories. The NARTGB was most accurate at estimating VCI in the Average category, placing 90% of participants correctly. The NZARTWASI formula was also most accurate for the Average VCI category (placing 77% of participants correctly). In contrast, NZARTWAIS was most accurate in the High Average VCI category (placing 73% of participants correctly).

Discussion

The aim of the present study was to validate the NZART in a separate New Zealand sample with a wide age range. We also sought to develop regression formulae for the NZART based on the WAIS-IV. It was hypothesised that the NZART estimated IQs would be more accurate than those calculated with the use of the NART.

The hypothesis was only partly supported by the findings because the NART-based formula was most...
Validation of the NZART

The percentage of the variance explained in current IQ scores by the NART and the NZART was low, around 33% for the NZART and only 26% for the NART. These figures are lower than previous reports for the NART (42%) and the NZART (46%) when compared to current WASI scores (Starkey & Halliday, 2011) or when NART estimates were compared to current WAIS-III FSIQ scores (49%) (Barker-Collo et al., 2008). Interestingly, the proportion of variance explained in these two latter studies is also lower than that reported in other overseas validation studies - typically around 50-60% of the variance of FSIQ scores is explained (Crawford, Parker, et al., 1989). These discrepancies may be a result of differences between the groups of participants and the small sample sizes. Earlier NZ studies were focused on younger, university educated participants, rather than including older community-based participants (Barker-Collo et al., 2008; Starkey & Halliday, 2011).

It was surprising that the NZART did not perform much better than the NART because the NZART was developed in New Zealand and words were selected carefully to ensure they were suitable in terms of familiarity (Barker-Collo et al., 2008), and cultural suitability (Odgen et al., 2003). It also incorporated some frequently encountered Te Reo Māori words. One possible explanation for these findings may relate to differences between the two NZART samples. The development sample for the NZART consisted of mainly young student with a mean age of about half of that of the present study (25 compared to 46 years of age). Use of language changes over the years and different age groups are familiar with different words. The mean age gap of 21 years between the two samples could well have a great influence on word familiarity. This seemed to be the case for the Te Reo Māori words. The three Te Reo Māori words used in the NZART were in positions 5 (Māori), 15 (Whenua) and 18 (Kaitiaki). Words number 15 and 18 had fewer correct pronunciations than their surrounding words. This indicates that participants in our sample, of which about half where over 45, had more difficulties pronouncing these words correctly than the participants of the development sample.

Overall the sample’s current WAIS–IV FSIQ and VCI were in the Average range and males obtained significantly higher VCI scores compared to females however this difference was not apparent in any of the estimated IQ scores. There were no significant differences between Māori and New Zealand European participants on any of the measures. Although these findings differ from earlier studies (Barker-Collo et al., 2008; Barker-Collo, Kelly, Riddick, & de Jager, 2011; Odgen et al., 2003; Starkey & Halliday, 2011), these results should be interpreted with caution because our sample size was small and all Māori participants were current students or graduates of a University (and had a long history of formal education). This is not representative for the general Māori population where only 3.1% reported to have a Bachelor’s degree in the 2001 census compared to 7.3 % of the New Zealand European population (Statistics New Zealand, 2001).

Table 4: The accuracy of NART and NZART-based formulae for placing participants into the correct FSIQ and VCI category.

<table>
<thead>
<tr>
<th></th>
<th>Low Average</th>
<th>Average</th>
<th>High Average</th>
<th>Superior</th>
<th>Very Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(%) correct</td>
<td>(%) correct</td>
<td>(%) correct</td>
<td>(%) correct</td>
<td>(%) correct</td>
</tr>
<tr>
<td>FSIQ (N = 67)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NART&lt;sub&gt;GB&lt;/sub&gt;</td>
<td>0 (0)</td>
<td>22 (73.3)</td>
<td>5 (25.0)</td>
<td>4 (30.8)</td>
<td>0</td>
</tr>
<tr>
<td>NZART&lt;sub&gt;WASI&lt;/sub&gt;</td>
<td>0 (0)</td>
<td>18 (60.0)</td>
<td>9 (45.0)</td>
<td>2 (15.4)</td>
<td>0</td>
</tr>
<tr>
<td>NZART&lt;sub&gt;WAIS&lt;/sub&gt;</td>
<td>0 (0)</td>
<td>19 (63.3)</td>
<td>11 (55.0)</td>
<td>1 (7.7)</td>
<td>0</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>VCI (N = 67)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NART&lt;sub&gt;GB&lt;/sub&gt;</td>
<td>1 (20.0)</td>
<td>25 (92.6)</td>
<td>10 (43.5)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NZART&lt;sub&gt;WASI&lt;/sub&gt;</td>
<td>3 (60.0)</td>
<td>21 (77.8)</td>
<td>12 (52.2)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NZART&lt;sub&gt;WAIS&lt;/sub&gt;</td>
<td>5 (100.0)</td>
<td>16 (59.3)</td>
<td>17 (73.9)</td>
<td>1 (16.7)</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: NART<sub>GB</sub> calculated from formulae provided by Nelson and Willison (1991).
NZART<sub>WASI</sub> calculated from formulae provided by Starkey and Halliday (2011).
NZART<sub>WAIS</sub> calculated from formulae developed in this study.
Limitations

Although the current study attempted to address issues with earlier work by ensuring we recruited participants from the community and across a wide age range, our sample size was still small and not representative of the general population in terms of age, years in formal education, ethnicity, gender, and location. Further research should endeavour to recruit a larger study sample which is representative of the general population. This would increase the validity of such a study and would address some of the issues raised in this study pertaining to age and ethnicity. In addition, efforts need to be made to recruit Māori participants in greater numbers possible by basing a future study at a Marae (a communal Māori meeting place).

A further limitation of our study is inherent to the method of estimating premorbid IQ with the use of regression formulae; ‘regression towards the mean’ is a well-known phenomenon and shared by all studies based on regression formulae. Typically, low current IQ scores get overestimated while high current IQ scores get underestimated. For a review please see Veiel and Kooperman (2001) and Graves (2000).

Future Directions

The tests to estimate premorbid IQ used in this study did not predict participants’ current IQ well and only explained around 30% of the variance in IQ scores. All these tests are based on word recognition and the ‘hold/don’t hold’ paradigm which was proposed in 1954 (Lezak, 2004). These tests are based on the assumption that word recognition is one of the best preserved abilities following injury or illness.

It is possible that the assumptions on which these tests are based are now no longer valid. The exposure to irregular words might not be as common as it was 60 years ago as a result of changes in people’s reading habits. A well educated person 60 years ago would have spent a considerable amount of time reading books and as a consequence would have maintained their familiarity with these irregular words. Since the appearance of the personal computer a lot of people, educated and otherwise, spend more time reading short, simply worded messages or snippets of information on their computer or mobile phone screens. Irregularly spelt words are no longer very common or their spelling has often been simplified (for example ‘night’ to ‘nite’). As a consequence of this, familiarity with irregular words might be decreasing across the population and the ability to pronounce these words may no longer be an indicator of IQ. Further studies using other tests of premorbid IQ such as the TOPF (The Psychological Corporation, 2009) with a large representative sample would be helpful to fully explore the utility of these tests in the New Zealand context.

Another approach to estimating premorbid IQ which does not rely on the use of regression formulae and is therefore not in danger of the regression towards the mean phenomenon, is the Best Performance Method (Lezak, 2004). This method relies on the combination of observation, test results, interviews, assessment of past achievements, school records, employment records and so on to find the patient’s best performance level (Lezak, 2004). The assessing clinician decides which information to gather and include and based on these findings will build up a profile of the person before the brain damage which can be compared to the current level of cognitive functioning. The advantage of this method is that the assessment is not restricted to the cognitive abilities tested by the IQ test and can be easily adapted for any individual circumstances. On the other hand the quality of the assessment is very vulnerable to clinician’s subjectivity. This method has often been criticised by researchers because in some studies only the best test score of an IQ test subtest was used as a predictor of premorbid IQ which was not Lezak’s (2004) original intention. She proposed that these estimates be based on a clustering of scores of abilities.

Because the vocabulary-based tests in our study did not perform as well as expected we recommend that future research looks for alternative methods such as the Best Performance Method or the development of more complex regression equations (such as the Barona estimates) to better estimate premorbid IQ in New Zealand. In reality it is unlikely that a single test can accurately reflect the premorbid functioning of an individual – however such test scores can provide additional evidence to help piece together a picture of the pre-injury functioning of a client.

So does this study provide evidence to support the validity of the NART or the NZART for use in New Zealand? Disappointingly, it seems the answer is no - the fact that less than a third of the variance in current IQ could be explained by these premorbid IQ tests brings into question the practical utility and clinical validity of these measures.

Author Note

Irene Lichtwark is now at the School of Psychology and Psychiatry, Monash University, Melbourne, Australia.

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Corresponding Author: Irene Lichtwark, School of Psychology and Psychiatry, Monash University, Melbourne, Australia. irene.lichtwark@monash.edu

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John Fitzgerald, Ph.D.
Editor, New Zealand Journal of Psychology
Email: nzjp-editor@psychology.org.nz

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New Zealand Journal of Psychology
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