Jubilee Edition
Psychology
Aotearoa

50TH

JUBILEE

The New Zealand
Psychological Society

Te Rōpū Mātai Hinengaro o Aotearoa

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

Being part of *Psychology Aotearoa*

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

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

Contents

Greetings to you all,

I have started writing my first President's Kōrero sitting in the *Rise* café on the ground floor of the tower block housing the Society's new offices in Wellington. It is the morning of our first Executive committee meeting, which is scheduled to commence in just over one hour. This is a meeting I have been anticipating since taking over the role of President from Quentin Abraham at the Jubilee Conference in Auckland. Without doubt I feel a buzz of excitement, and some trepidation about the full agenda for the day and the heavy workload for the next two years.

At the Annual General Meeting in Auckland we joined together in thanking Quentin and the other outgoing Members of the Executive (Rose Black, John Eatwell, Sarah Christofferson) on behalf of the Society. Over the last two years, and for the two years before under the guidance of President Kerry Gibson, the Society has worked to develop a clearer stance on a number of social issues, and a higher profile in speaking out on these. In the definition statement of Principle Four (Social Justice and Responsibility to Society) in our Code of Ethics it is stated that this Principle, "… is about addressing and challenging unjust societal norms and behaviours that disempower people at all levels of interaction." The linking of high-quality psychological research, analysis, and practice with social issues is entirely appropriate and will continue during the period of my Presidency. The Executive cannot manage this task alone, and we rely on Members to identify issues which are important to them and their communities and support the Society in developing and promulgating position statements and submissions.

The Jubilee conference was a wonderful event. Again, there is well earned gratitude to be expressed. We thank the office staff for their sterling work in this regard. Pam Hyde (our hard-working Executive Director) and the Office team (Heike Albrecht, Vicki Hume, and Helen Weststrate). Their efficiency and congeniality were highlighted by local delegates and international visitors alike. I would also like to thank the local scientific convenors (Jade le Grice and Angela Arnold-Saritepe) and all the symposium organisers and presenters for contributing to such a stimulating and wide-ranging programme. With nearly 500 delegates it was one of the Society's largest conferences, and certainly one of the most innovative. The inclusion of the archival

material marking the 50th anniversary of the Society as an independent entity, and the presence of so many past presidents reminds us of our origins and is an inspiration for the next steps into the future.

So, what does the future hold for the Society? Lifting the cover to glimpse the future reveals a daunting workload of exciting opportunities, but three projects loom large at this time.

Our Code of Ethics is now 16 years old and the environment within which psychologists work has changed markedly over the years. The HPCA Act (2003) was not on the statute book when the Code came into force, and much has changed in access and use of digital technology. We work in systems more aware of diversity, the harmful effects of unequal access to resources, and global issues such as the impact of population displacement, and climate change. While the Code was drafted in such a way that new developments can be encompassed within its format of overarching Principles and Values, it is necessary to review this to ensure it is still 'fit for purpose'. We are at the very early stages of this work in collaboration with the New Zealand College of Clinical Psychologists and the Psychologists Board, who are co-owners of the Code. There will be ample opportunity for all interested parties to contribute to this review and revision process.

Secondly, we are preparing for the imminent release of findings from the Government's Mental Health & Addictions Inquiry. The Inquiry team will have something to say about access to services, including psychological services, and associated workforce issues. These were among the reasons for establishing the Inquiry in the first instance and were a primary focus on the Society's submission and subsequent communication with the Inquiry panel. If the Inquiry challenges the sector to innovate and explore new models of working, our discipline may need to move quickly to offer evidence-based solutions which will enable those in greatest need, and those at greatest risk, to access high quality psychological services in a timely fashion. To achieve this, we will need a high degree of unity and cooperation between our professional organisations, and within the Society. Ongoing collaborations with various organisations employing, training, and representing psychology in Aotearoa New Zealand are bearing fruit, but more ideas and action is likely to be required.

The third area of endeavour is internal to the Society as we start reviewing and reinvigorating our Branches and Institutes. There is a great deal of variability across

the branches and institutes in their level of engagement, and this potentially leaves a gulf between the National Executive and the membership. The Executive has approved additional funding for National Office to employ a person primarily to support sub-groups within the Society. We are also exploring ways to increase the role of Branch and Institute Chairs in Society governance and provide more resources to our grassroots.

There are a number of other work streams occupying members of the Executive, National Office and members. We understand that a majority of the work undertaken by members is voluntary, and we are grateful for the time and effort everyone contributes. We will keep you appraised of our progress, but also welcome your comments and ideas.

Best wishes

John Fitzgerald PhD
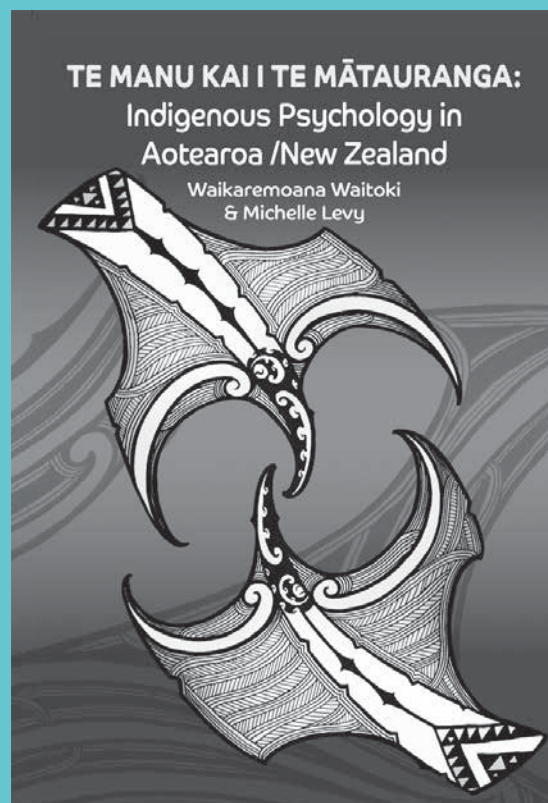
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Kia ora koutou katoa

I hope you are all looking forward to the summer ahead as I am. The winter brought its fair share of cold weather and long days including for some of us a focus on the annual conference. Many who attended shared the benefits of this as it was a great success. But I am biased! You can see for yourself if you didn't attend as this edition includes as usual, some of the many offerings from the conference including some keynotes.

You will get a flavour of the discussion at the international 'roundtable' where our recent President Quentin Abraham was joined by Frances Mirabelli, CEO of the Australian Psychological Society, Nicola Gale, President of the British Psychological Society (BPS) and Sarb Bajwa, CEO of the BPS. They each responded to the topic of "Equity: Making Psychology available to everyone."

Many of you will be interested to see the keynote speech on 'Advances in Suicide Assessment and Treatment' by John Sommers-Flanagan from the University of Montana. If you missed the conference, you will be able to read the latest on this topic. John was a very popular speaker this year who managed to dispel some myths and offer some useful strategies for practice.

Patrick McGorry's keynote on "Youth Mental Health Reform and the Mental Wealth of Nations" is a call to action around the provision of services for youth. According to McGorry, '75% of mental illness emerges early in adult life and as such poses the greatest threat from a health standpoint to economic and social development of nations.' McGorry makes a compelling argument for why we must turn around our approach to the provision of services.

Anthony Grant also appealed to our desire to be at the forefront of change within society, in his keynote entitled 'What is Coaching Psychology? Who are we? Where are we going?' Despite the diversity of skills within this profession he noted that all psychologists may consider themselves potential coaches, yet the field now has developed to a state where there are recognisable and valid coaching competencies 'and "coaching psychology" is now a small, but well-established sub-discipline of mainstream psychology.'

By contrast, 'Psychology at the Margins' - the keynote

presented by Siautu Alefaio, a 'Samoan woman and daughter of the Pacific' was a heartfelt plea for greater appreciation of the 'Pacific-indigenous ways of 'knowing, being and doing' to help reset a niu -mission of psychology for the future.' Siautu describes herself as a Pacific-Indigenous researcher, who champions the need to consider different cultural approaches to research, and re-theorising within the 'practice' of psychology.

The final offering from the conference are two papers by Marg O'Brien, one entitled 'Climate Challenged: Our need to change', and one entitled 'Climate Challenged: Where to focus change efforts?' Climate change featured strongly at the conference and is rapidly capturing the focus of psychologists as we seek to address what many would say is the biggest challenge to us all. Marg presents compelling summaries of where the field is at with respect to what psychologists can contribute and urges us to join in tackling the 'bigger-than-self' issue of climate change from an ethical standpoint. I suggest you watch this space intently.

In other matters, Angus and Sonja MacFarlane present a position paper prepared under the auspices of the Māori Research Laboratory, Te Rū Rangahau, at the University of Canterbury. The importance of cultural competence and cultural safety in research endeavours and their significance in terms of a national guiding policy cannot be understated.

Other offerings include the heartfelt one-on-one interviews with two psychologists with no doubt very diverse worldviews, Emeritus Professor Tony Taylor and Dr Jade Le Grice. Peter Stanley presents four book reviews, all about, as he terms it, 'reasonably common problems of living' including fear of flying, sleeping, young women dealing with pressures to excel and responding to illness and disability. Something for everyone I suspect, and many thanks to the book reviewers!

Lastly, the student section again looks set to offer some creative and fascinating reading for you all. Thanks to Kelly Howard for collating this latest set of offerings. The first of these by Angus Craig will no doubt capture the hearts and minds of psychologists who've been around a while, entitled: *Aotearoa Psychology and CBT: A fraught love affair!* Further, Amy Mauer presents: *Disability - the elephant in the room* which challenges us to develop our cultural competence in this sphere. Well done Amy! This is followed by an interview about whether or not psychologists should have personal therapy during or beyond training. This is a fascinating topic and one which will engage many readers! Further interesting reads include *The problem with problematic pornography use; Dysregulation in the stress response system, culturally enhanced mindfulness and adverse*

childhood experiences among Māori women; and finally, *Can mHealth "Apps" help parents to establish children's oral hygiene routines?* Again, I applaud the students' section for its richness and diversity!

I shall sign out now and wish you much pleasure in your reading, assuming you will take the time to pause over a cup of coffee or tea and absorb something a little different from the usual feed of social media, newspapers or novels, whatever your poison might be!

Kia kaha,
Hei konā mai,
Fiona Howard

NZPsS News

A brief summary of the NZPsS 2018 AGM

The 51st NZPsS AGM was held on Friday 7 September 2018 at the Owen G. Glenn Building, The University of Auckland with more than 50 members attending. NZPsS Kaihautū Angus Macfarlane opened the meeting with a karakia.

Minutes and Reports

The 2017 AGM minutes were accepted without amendment.

There was a discussion of the withdrawal of last year's remit from the Otago/Southland branch regarding undergraduate student registration of interest with the NZPsS. It was agreed that an alternative action of ensuring the new NZPsS website will have a page for undergraduate students to inform and link them with the NZPsS would achieve similar objectives to that of the original remit.

It was confirmed that last year's remit regarding a senior membership category had been enacted.

President Quentin Abraham spoke to his report outlining the advocacy work the NZPsS had undertaken with the Ministry of Health, Ministry of Education and other organisations. He noted the submissions made by the NZPsS in a number of areas and progress on member services including publications, Ethics Help Desk and professional development. He noted the growing connections between the NZPsS and international psychology associations.

Election of officers

Dr John Fitzgerald took over as President of the NZPsS and it was noted that Dr Waikaremoana Waitoki had been voted into the position of President-Elect. Other positions confirmed on the Executive were, Fiona Howard -Director of Professional Development and Training; Tania Anstiss- Director of Social Issues, Diane Bellamy- Director of Professional Issues; Brian Dixon -Director of Scientific Issues. Dr Hukarere Valentine has been seconded as Director of Bicultural Issues while Dr Julie Wharewera-Mika is on maternity leave, and Kyle Smith has taken up the second Bicultural Director position.

Farewelled from the Executive were President, Quentin Abraham; Dr Rose Black- Director of Social Issues; Dr Sarah Christofferson- Director of Scientific Issues; and John Eatwell- Director of Professional Issues.

New Fellows

Dr JaneMary Castelfranc-Allen and Associate Professor Ian Lambie were awarded Fellowship of the NZPsS at the AGM.

Other members who had been made Fellows since the last AGM were congratulated. These were:

Jean de Bruyne
Peter Coleman
Stewart Forsyth
Crispin Garden-Webster
Assoc. Professor Kerry Gibson
Dr Barbara Kennedy
Dr Iain McCormick
Jasbindar Singh

Remits

A remit from the 2017 AGM to adopt a new membership category- Psychology Teacher Affiliate was supported.
A second remit allowing the Executive to postpone the election of two Executive roles for the maximum of one year (excluding President and President-Elect) whose terms were expiring, to provide for continuity on the Executive was carried.

General Business

Issues were raised regarding Family Court work and the management of Family Court complaints.

Equity: Making psychology available for everyone

The kōrero below was part of an international roundtable at this year's NZPsS Annual Conference, Auckland, 6 September 2018. Quentin Abraham, then President of the NZPsS, Frances Mirabelli, CEO of the Australian Psychological Society and Nicola Gale, President British Psychological Society and Sarb Bajwa CEO of the BPS each responded to the issues below. Quentin outlines his responses to the issues raised:

Ā, tēnā koutou, ngā kaiwhakahaere, te kāhui o ngā hou e whā, ngā mihi hoki anō ki te hunga mātakitaki.

(1) What do you do in your country to ensure psychology is delivered to all members of your communities?

We have had initial success in training psychologists in broader paradigms, to embrace research that goes beyond

Western-style psychology in our universities including Waikato, Massey and Canterbury introducing concepts such as Mana Motuhake, Mana Tū, Mana Ūkaipo, Mana

From left, Quentin Abraham; Nicola Gale; Sarb Bajwa; Frances Mirabelli

Tangatarua, Mana Whānau which have been established as vital to Māori success.

Our publications are increasingly disseminating a broader range of psychology, such as the Professional Practice Handbook and Te Manu Kai i te Mātauranga. The New Zealand Psychological Society has entered into a genuine power sharing arrangement with the NSCBI. We support self-determination, such as He Paiaka Totara, a Māori-led network of Māori psychologists and students.

We have made strong submissions on mental health and poverty to the government. With our literature review we established the research base for the causal role of poverty/inequality in mental health. We then lobbied the government with our submission to the Mental Health and Addiction Inquiry to rethink the medical model of mental health. This reframes the response to those who are distressed and therefore it demands that we change the way we deliver psychological support to our communities.

(2) What are the barriers to the delivery of psychology to diverse communities within your countries? What do they tell you about what they want?

For brevity I will focus on the context of Tangata whenua whilst acknowledging the special place of Pasifika peoples and the ethnic diversity in Aotearoa today, noting that Auckland is the fourth most diverse city in the world.

Julia Ioane a keynote at last year's conference spoke about Pasifika psychology and questioned if we are really there yet in delivering an equitable psychology for Pasifika peoples. The Waitangi claim against the structures of psychology in Aotearoa also questions if we are meeting the needs of

Tangata Whenua.

There have been small gains, but are these enough when only 6% of the psychology workforce identify as Māori? We need to equip our psychologists to support Tangata Whenua and deliver a psychology to a broader range of clients in our country. We need to think about how we report our findings. A Māori psychologist told me how hard it was to work in Corrections, when she was constantly bombarded with selective, negative statistics about our prison population with little or no context.

We need to challenge racism in our institutions when it occurs. Do we know what to say when a senior member of staff refers to someone as a "Born again Māori"? One of the implications of this statement was that this person had recently discovered or revealed their whakapapa and that they were now flaunting it too much. Presumably you can have your identity as long as you do not threaten the status quo.

We need to address the rural/urban divide and ensure that psychological support is available to those in more remote areas. We need assessments that are fit for purpose. The Wechsler Individual Achievement Test now has Australian/New Zealand norms. Even if we ignore the cultural assumptions about achievement, how culturally safe is this stratified sample from 4 to 19 years when there is a maximum 20 Māori students normed in each band. These types of assessments potentially exclude large sections of our communities.

(3) What improvements could be made to ensuring equity of access to psychological services, research and policy in your country?

For those of us who have benefited and continue to benefit from resources that have been unfairly appropriated, if we are serious about a Treaty framework we may need to give up our place at the table, to make space for real power sharing.

We need to be thoughtful and cautious about importing overseas models such as Increasing Access to Psychological Therapies (IAPT). We need to question if it meets all our communities needs or if it is a stop gap to meet the increasing demand from the worried well without real increases in resources.

We can read our recently commissioned Levy report which indicates how we can make a robust response to the disproportionate staffing ratios in which DHB's only employ 4.0% Māori and who equally are underrepresented in Corrections, Education, Ministry of Social Development and the Defence Force. The former Families Commission and SUPERU research units have provided a framework for how we can collect more holistic wellbeing data from whānau. They offer an alternative to assumptions that are made when the unit of analysis is the 'individual' or the 'sole parent'.

We do need to be brave about challenging the individualising and privatisation of psychological care. We need to learn from the collapse of large-scale social care providers such as Carillion in the UK. These types of commissioning models run the risk of contracts going to the lowest bidder, with poorest quality care and ethics being compromised, for example, where private data is demanded for purposes other than psychological wellbeing.

(4) How can we collaborate as international organisations to deliver psychology to all sections of our communities?

There are obvious actions for international collaboration such as sharing innovation, reciprocal training and acting as critical friends. However, what about a collective global action? In the 10 years since the financial crisis, Global Wealth increased by 27%. Forty-two people hold as much wealth as the 3.7 billion people who make up the poorer half of the world's population. This level of inequality is devastating for the mental health and wellbeing of our communities.

Yes, we know many of our psychological interventions such as Grit and Mindsets do work but often the effect sizes are small. As psychologists before we consider any psychological intervention we need to feed those who are hungry and house those who are homeless. Psychologists will have the largest impact on wellbeing if we address inequality in our communities.

A good example is Stuart Carr's work on the GLOW project which has established a multi-site international research programme to collect data on paying a living wage not only to lift people out of poverty but to enhance their wellbeing. They have been effective at disseminating their finding via media at both a local and international level. They have lobbied the UN Economic and Social Council and linked this research to policy via the Sustainable Development Goals. They have established that paying a living wage is good for individuals, good for whānau and good for business. My local Council now pays a Living Wage.

Think what impact we could have if psychology could help shift the wealth from 42 people to the 3.7 billion?

Mauri ora!

Our history - ā tātou pūrākau

The 50th Jubilee of the NZPsS provided the opportunity to look at and celebrate our history. Working parties delved into the archives and found interesting and sometimes surprising information. A big thank you to all who assisted to tell the story of the NZPsS. There is the potential for an even fuller and bigger story and we hope that will be told in the future. The following are a series of posters that arose from the work of the history researchers.

Our history researchers from left: Raymond Nairn, Waikaremoana Waitoki; Jackie Feather; Julie Wharewera-Mika; Neville Blampied, Jhan Gavala; Aloma Parker; Peter Coleman

One of the highlights of the NZPsS Jubilee Conference was a debate between Postgraduate Psychology Students (affirmative) and Past Presidents of the NZPsS (against) on the topic "**We need to hold onto the psychology of our elders in order to move into the future**." On the Past President's side was Andrew Hornblow, Freda Walker and Barry Parsonson. On the student team were Rhiannon Lehndorf Moore, Jess Gerbic, and Api Taiapa. The debate was ably chaired by Diane Bellamy- Director of Professional Issues on the NZPsS Executive. The student team won the audience's support with their rousing speeches and were considered the champion debating team- congratulations!!! Many thanks to you all for a very entertaining and interesting debate.

While not on the winning side, Dr Barry Parsonson provided much entertainment with his poetic contribution to the debate below. Our warm gratitude to Barry for making psychology history so interesting, humorous and accessible!!

On the "against" side, Andrew Hornblow; Barry Parsonson and Freda Walker

On the "affirmative" side Rhiannon Lehndorf Moore, Jess Gerbic and Apiu Taiapa

A grim theory-tale: A tour de farce of bad science and wasted learning

Barry Parsonson

Personality theory began, according to rumours,
When Hippocrates divided us according to humours.
He said spleen, blood and bile cause us to frolic
Or to otherwise become somewhat melancholic.

Hippo's vision of character was later destroyed
By the arrival on scene of one Siggy Freud
He declared sex sent neurotics all out of whack
As Superego fought Id until their Ego would crack.

Siggy also said infants and tots struggle with sex
And that fear of castration turns boys into wrecks
Girls just had to accept their sad castration fate
Resulting in Penis Envy just to com-pen-sate.

Carl Jung came along next, proposing archetypes
This got Siggy mad and he made many snide swipes
At the roles of the Wise Old Man and the Earth Mother
Hoping that Carl's theory he could completely smother

Carl was Jung and Restless, not keen on failure
He believed in the great power of the Mandala.
Freud's ideas Carl now seriously began to query
So leaving Siggy behind, he formed his own theory

Alfred Adler wasn't worried about kids' fixation on mothers
The more obvious struggle was with one's older brothers
The challenges caused by this evident sibling rivalry
Created in younger sibs complexes of infe-ri-ority.

In the 1930s J.B. Watson said past theories were rot
Instead behaviour was now what was most hot.
He trained a phobic response to a tiny white bunny
Producing Little Albert's neurosis. That was not thought
very funny.

Intervening variables paved the way to Hull
With such complexity that his theory proved null.
Many felt that Hull's ideas were a dog's dinner
They saw learning as simpler when explained by Fred
Skinner.

Fred Skinner's three-term contingen-cy
Made his learning theory simple as A-B and C.
Fred's work on "Verbal Behaviour", Noam Chomsky
panned
For replacing 'deep structure' with Tact, Echoic and Mand.

The Neo-Freudians eschewed Freud's focus on sex,
Neuroses now caused one's inferiority complex.
Karen Horney, Eric Fromm and Melanie Klein
Saw that Should, Escape and Must all were malign.

Then in the 50s, as quick as a blink
There arrived on the scene, one Hans Eysenck.
Influenced by ideas from Jung, Pavlov and Hull
Hans considered all prior theories incredibly dull.

Introversion, extroversion and Factor Analysis
Set out to challenge Freud's fixation on phalluses
Conditioning, Hans Eysenck loudly informed,
Was how personalities initially were formed.

Hans encouraged Joe Wolpe to move on from cats
And to create a therapy for the fear of rats
Using desensitization while deeply relaxed
Joe showed phobias and panics could quickly be axed.

This movement became CBT with the odd variation.
Albert Ellis warned clients against "musturbation"
Aaron Beck led the field in treating depression
Having clients practice fun between every session.

Baer, Wolf and Risley defined ABA
Used to treat human problem behaviours today
By applying regular doses of positive reinforcement
ABA has achieved a widespread endorsement.

Psychs who didn't want to be tied to one theory
Declared themselves eclectic, being rather leery
Of any alignment with Freud, Jung, Perls or Rogers.
The theoretically bound termed eclectics artful dodgers.

Of these ancient theories, only two currently survive.
Through good science, Pavlov and Skinner continue to
thrive.
Computerised therapies by some may be prized.
But these resist being indiv-id-ualized

So be glad you didn't have to learn all this stuff
About theories composed of meaningless puff
Most, lacking in research or utility,
Eventually serving as an exercise in futility

Hence my message to you, dear psychologist youth,
From a so-called 'elder', deemed long in the tooth,
Be mindful of the future, ignore long dead zealots.
But be wary of being displaced by psycho-robots.

Toitū te Mātauranga: Valuing culturally inclusive research in contemporary times

A position paper prepared under the auspices of the Māori Research Laboratory, Te Rū Rangahau, at the University of Canterbury

Angus Macfarlane and Sonja Macfarlane
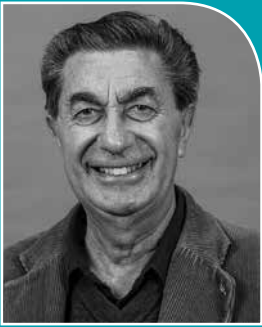
Angus Hikairo Macfarlane (Ngāti Whakaue) is Professor of Māori Research at the University of Canterbury, Director of Te Rū Rangahau: The Māori Research Laboratory, and Kaihautū of the New Zealand Psychological Society. His research focuses on exploring Indigenous and sociocultural imperatives that influence education and psychology. Avid about Māori advancement, he has pioneered several theoretical frameworks associated with culturally-responsive approaches for professionals working in these disciplines. Professor Macfarlane's prolific publication portfolio and exemplary teaching abilities have earned him national and international standing in his field of scholarship. In 2010, he received the Tohu Pae Tawhiti Award from the New Zealand Council for Educational Research for outstanding contributions to Māori research. In 2013, he was awarded the University of Canterbury Research Medal – the highest honour that the UC Council can extend to its academic staff. In 2015, he received the national Ako Aotearoa Tertiary Teaching Excellence Award for specialist services in the field of kaupapa Māori.

Sonja Macfarlane (Ngāi Tahu, Ngāti Waewae) is Associate Professor in the School of Health Sciences at the University of Canterbury, a Senior Research Fellow on A Better Start National Science Challenge, and a member of the New Zealand Psychological Society. Her research, publications and teaching focus on culturally-responsive evidence-based practices in education, psychology, counselling and human development. Her career pathway has seen her move from classroom teacher to itinerant teacher, to special education advisor, to the National Professional Practice Leader: Services to Māori (Pouhikiahurea) in the Ministry of Education, Special Education. In 2014, Dr Macfarlane received a University of Canterbury Research Award, and in 2015 the Research Team Award was conferred by the University's College of Education, Health and Human Development. Her most recent distinction was the Tohu Pae Tawhiti Award from the New Zealand Council for Educational Research for outstanding contributions to Māori research, which she received in 2017. Dr Macfarlane is a research and advisory member on several ministerial-funded projects.

Aim

This position paper presents a discussion about the importance of cultural competence and cultural safety in research endeavours, their significance in terms of a national guiding policy (Vision Mātauranga), and the place these imperatives have within the Aotearoa New Zealand research landscape.

The purpose of a position paper is to explain and contribute to potential courses of action. On that basis, an extensive and detailed explanation of the deeper theoretical positionings or philosophical understandings is not included here. Rather, the impetus is geared toward the axiom 'toitū te mātauranga', sustaining Māori knowledge.

Background

Developing research and researcher cultural competence involves growing an awareness, knowledge and understanding of the cultural values, beliefs, traditions, and customs of those with whom we work - in this case Māori, the tangata whenua of Aotearoa New Zealand. Key to the development of cultural competence is the notion of cultural safety, which requires researchers to know their cultural self, including their cultural power, privilege and positionality, before engaging in research with those whose culture is different to their own. Cultural safety is pivotal to cultural competence and the ability to grow one's skills, knowledge and understanding to work effectively in a quest for better outcomes. Understanding Vision Mātauranga is the degree to which researchers can access, respect, and responsibly apply mātauranga Māori (Māori knowledge) and its associated protocols and systems. Cultural competence, cultural safety and understanding Vision Mātauranga are directly related to facilitating culturally responsive and effective approaches in carrying out research activities.

Data Sources

Many of the seminal works which underpin the domains of cultural competence, cultural safety and mātauranga Māori were primary references in providing a platform for this position paper - one that offers some guidance for better practice. Selected journals from the last 50 years were deemed relevant, and books and other supporting scholarly sources were also used. For the purposes of guiding research practice, three key frameworks are introduced in this position paper: *Braided Rivers/He Awa Whiria* (Macfarlane, Macfarlane & Gillon, 2015), *The IBRLA Framework* (Bishop, 1996) and *He Poutama Whakamana* (Macfarlane, 2018). These frameworks provide a platform from which researchers (or a group of researchers) may respond to issues associated with the requirements for better (and safer) research practices.

No one researcher, or group of researchers, is compelled to follow this guidance, as the paper is meant to be taken as a contribution to a broader discourse on cultural competence, cultural safety, and mātauranga Māori.

Challenges

It is important for researchers to grow an awareness that Māori culture, knowledge and understanding, are dynamic and evolving realities. Research therefore will often combine traditional concepts and understandings from within a contemporary context. Māori knowledge rarely, if ever, starts from the here and now. In recent decades, numerous discussions and written records relating to Indigenous cultures worldwide indicate that Indigenous peoples globally appear to have a common experience, and a common cause. They collectively share a history of domination, injustice and prejudice, despite extensive diversity

between them. Regardless of different geographic locations, they reflect universal chronicles that provide accounts of the confiscation of their lands, the demise of their languages, knowledge systems and practices, the loss of autonomy, disproportionate poverty, over-representation in poor health and educational outcomes, incarceration, and marginalisation. Throughout the world's history, Indigenous cultures have continually fought for the recognition of their identities, practices and traditions, including their right to retain their languages and resources and their ways of proposing educational practices and research methodologies.

A consistent failure to understand a Māori worldview has often been reflected in the absence of culturally-appropriate forms of responsivity. Traditional Māori society valued high-level thinking and analytical skills, exemplified in compellingly clear understandings of cosmology, geography and industry. These skills might be exemplified in quite different ways. For example, Māori practices of producing resources made from flax required a precise knowledge of the physical properties of raw materials, their source, the details regarding tikanga (customary practices) surrounding the collection and processing, their sustainability and so on. A second example shows that as a result of successive generations of purposeful voyaging across the oceans, an intensive knowledge of navigation was carefully acquired.

Such knowledge was not just happened upon. It was acquired through active participation within culturally-responsive and authentic learning contexts, and research. Māori did not just instantly and instinctively know about the qualities, properties and habits of birds, plants and other natural resources. They had to work

all this out systematically, and their scientific endeavours were recorded and transmitted through song, symbol, story, dance and everyday practices. Good research practice, one might assume. However, it is clear that the scientific endeavours and knowledge of Māori and other Indigenous people, as well as their ways of transmitting this knowledge are seldom recognised as ways of knowing, and ways of researching (see Macfarlane et al., 2008).

Responses

The declinations to accept Indigenous ways of knowing may prove to be the catalyst for new opportunities to innovatively reshape and reorganise our theoretical and empirical positionings, of what it means for research communities to be accepting, in the 21st century, of renewed approaches. It seems it is more urgent than ever before to ask: who is influencing these renewed approaches and how do, and can, Māori researchers participate in them, and indeed, lead them? At stake is the need to rethink the meanings and practices associated with the changing face of research conventions. There is a need to carefully assess some of the major research elements such as structure, rationality, managing, and leading, because simply giving the appearance of acceptance of renewed approaches is not enough. Assessment of these elements leads to a response and this often means venturing into research spaces that may push boundaries and test others' views. And this takes courage. However, if the creation of new thinking and practices will lead to improved outcomes, then the benefits outweigh the costs.

The trials and tribulations of the past have marred the research landscape, but today increasing numbers of researchers are proclaiming that it is time to re-engage in a dialogue that

would liberate a need for change that must go beyond the 'add-on' attempts that have characterised the tokenistic gestures of past practices. The move toward encompassing genuinely transformative approaches has arrived. In more recent years, it would seem fair to assume that there has been reasonable indigenisation of the research sector whereby cultural epistemology is a salient rather than an obscure reality. Vision Mātauranga (Ministry for Research, Science and Technology, 2007), a framework that was developed in consultation with researchers, funders and users, including Māori communities, is expressing itself more acutely. This guiding policy for the Ministry of Business, Innovation and Employment (MBIE), has been integrated across MBIE's investment priority areas and is also referred to in the Request for Proposals (RFPs) for science investment rounds, including those for the National Science Challenges. There has been an upswing in the use of Māori terminology, consultation with Māori tribal communities is largely a more galvanised process, and greater numbers of Māori scholars are participating or taking leading roles in research programs. What began as a cathartic and liberating epistemological revolution might now be described as an embedded and rightful entitlement. A repositioning of the emphasis in the research realm is beginning to occur. But, we're not there yet, essentially because Vision Mātauranga tells us the 'what' with regard to carrying out culturally-responsive research, not the 'how'. It is argued, therefore, that we need culturally-grounded models and frameworks to guide us, and systems for tracking progress. We acknowledge that many such tools are now available to support researchers. For the purposes of this position paper, it is to a small selection of these that we now turn.

He Awa Whiria

He Awa Whiria is an innovative framework that draws inspiration from Indigenous and Western streams of knowledge, while maintaining a consciousness of Māori data sovereignty. Macfarlane, Macfarlane and Gillon (2015) propose that:

Western knowledge and theory, although fundamentally sound, are culturally bound (Durie, 2006), and are therefore not able to be transferred directly into another (Indigenous Māori) culture. It is therefore necessary to make a plea for an interdependent and innovative theoretical space where the two streams of knowledge are able to blend and interact, and in doing so, facilitate greater sociocultural understanding and better outcomes for Indigenous individuals or groups. (p. 52)

Two key suggestions are evident in this extract. First, Macfarlane, Macfarlane and Gillon (2015) suggest that it is inappropriate to seek solutions to Indigenous challenges solely from within Western knowledge streams, and second, they propose that a blending of Indigenous and Western bodies of knowledge creates an approach that is potentially more powerful than either knowledge stream is able to produce unilaterally (see Figure 1). Figure 1 also illustrates that inherent within the He Awa Whiria framework, there is the recognition of Indigenous knowledges and a space for Kaupapa Māori research as a distinct stream. In this autonomous stream, where some tensions in blending Kaupapa Māori theory and practice may arise, Kaupapa Māori researchers can engage with critical issues in ways intended to impact on Māori advancement. It is important to acknowledge historical bias in the research environment toward 'one-only' stream of knowledge approach. He Awa Whiria encourages researchers to recognise the value that resides in both streams of knowledge, and to adopt an

Figure 1: He Awa Whiria: A Braided Rivers Approach (Macfarlane, Macfarlane & Gillon, 2015)
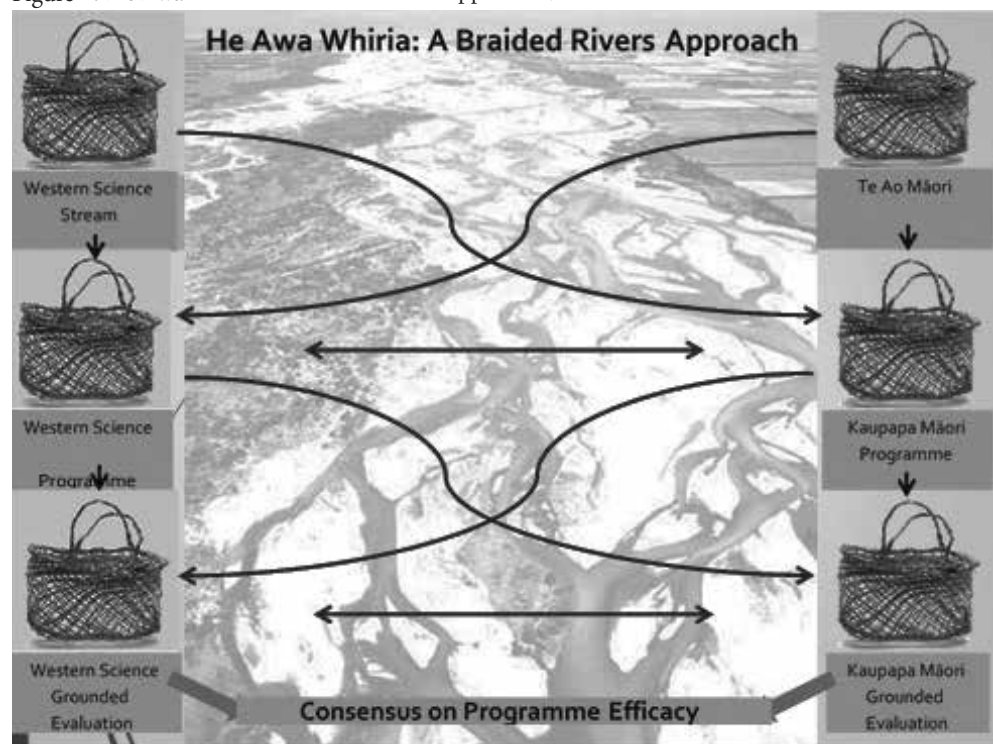
approach that has relevance to the research context.

A Steering Group of the Social Policy Evaluation and Research Unit (2018) made some astute observations of the braided rivers metaphor, noting that both streams start at the same place and run beside each other in equal strength. They come together on the riverbed and they move away from one another. Each stream spends more time apart than together.

When they do converge, the space created is one of learning, not assimilating. This indicates the potential for research projects to create new knowledge that can be used to progress understandings in both worlds, in order to represent better outcomes for all.

IBRLA Framework

Research initiatives that involve and impact on Māori need to be guided by members of the Māori community, with the opportunity to determine, from the outset, if benefits will accrue for Māori should the initiative proceed. To that end Bishop's (1996) IBRLA framework (Initiation, Benefits, Representation, Legitimation, Accountability) is able to guide how power-sharing relationships are established, even before the initiative begins. Drawing on this concept and applying it to research paradigms, Macfarlane (2018) has built on Bishop's

framework in order to create a template to guide the planning of research activities wherever (and however) Māori feature in the process. A set of reflective questions accompany each of the five

IBRLA components and are presented so as to encourage researcher reflection during the conceptual-design research planning phase, as well as to support researchers to monitor and evaluate their progress, both during and at the conclusion of the research activities.

Kaupapa Māori approaches to social change initiatives must include Māori thinking and Māori voice (Bishop, 1996; Moewaka Barnes, 2013). It is important to recognise that many researchers use the nomenclature of Kaupapa Māori in a number of ways and express a variety of standpoints within the Kaupapa Māori space. However, it is generally accepted that Kaupapa Māori approaches can be seen as reflecting the elements of social change that are common

to both revitalisation and resistance activities for Māori. Further these signal that there is a need for change initiatives that are targeted towards Māori to be based within distinctly Māori-oriented frameworks. The Treaty of Waitangi (specifically the principles of partnership, protection, and participation, highlighted in black in Table 1) provides a moral, ethical and strategic impetus for enabling an authentic Māori presence to become more widely premised in the research endeavours.

Table 1: IBRLA Framework (Adapted from Bishop, 1996)

	Component	Considerations to reflect upon
I	Initiation	• Who conceptualised and initiated this research project? • How did Māori participate in the conceptualisation and initiation process? • How was the agreement to proceed with the research achieved?
B	Benefits	• How will the research (process and outcomes) accrue benefits for Māori? • How has information been shared with Māori about the intended benefits? • How will these benefits be determined and measured – and by whom?
R	Representation	• Whose ideas will be represented in the methodology, design and approach? • How will Māori thinking and knowledge be represented at all research phases? • How will this be monitored so that ongoing agreement/partnership is maintained?
L	Legitimation	• Who will legitimate the analysis and interpretation of information/ research data? • How will Māori understandings be legitimately represented? • How will this be structured so that research fidelity is achieved/protected?
A	Accountability	• Who is accountable to whom – and in what ways? • How will on-going and mutual accountability be built into the research process? • How will this be monitored and evaluated to ensure safety for all stakeholders?

He Poutama Whakamana

In traditional Māori meeting houses (known as 'wharenui'), walls are frequently adorned with mirror-imaged panels – referred to as Poutama Tukutuku – stepped patterns (see Figure 2) that depict a series of steps that climb upwards from both sides to reach the top at the centre.
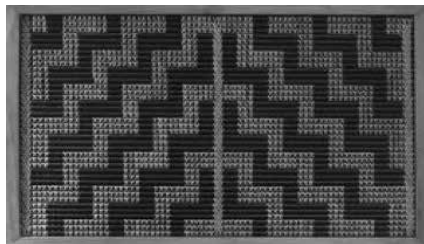
Figure 2: Poutama Tukutuku

A poutama has the potential to offer both spiritual and educational meanings. Māori regularly draw on this classical metaphor to encapsulate ways of knowing, being and doing; consequently, the poutama represents a journey of growth and development in order to attain greater knowledge and understanding. The steps symbolise levels of attainment, learning, advancement and insightfulness. So how might a poutama framework be used to guide and inform culturally-responsive research planning that is focused on envisioning the potential of Māori, as espoused in the Ministry of Research, Science and Technology's (2007) Vision Mātauranga policy document? He Poutama Whakamana is to be applied as an aspirational tool for tracking researcher and research progress (see Figure 3). It was developed as a means of drawing on the threads of information presented previously, by identifying four imperatives that are deemed to be of significance to preparing research proposals and carrying out plans that seek to encapsulate the intent of Vision Mātauranga:

- Kaitiakitanga (K): Guardianship: Ensuring that the Treaty principles are upheld

- Mātauranga (M): Knowledge: Envisioning the innovative potential of Māori knowledge

- Tikanga (T): Protocols: Employing culturally-responsive research methodologies

- Rangatiratanga (R): Leadership: Embodying an equitable leadership approach

At each of the three levels of He Poutama Whakamana (see Figure 3), it is proposed that these four imperatives be addressed when planning research activities that include Māori phenomena – for example people, perspectives, and sites. The Poutama starts at step one (mōhiotanga), with researchers needing to have an open mind and a desire to explore new learning and knowledge as a prerequisite to embarking on research that involves Māori phenomena. Step two requires researchers to actively explore new knowledge (mātauranga) and enhance their own understandings about how the research planning needs to progress.

Step three is the stage of enlightenment (māramatanga), and it is where researchers integrate and apply their new knowledge and understanding into the planning.

Figure 3: He Poutama Whakamana (Macfarlane, 2018)

Māramatanga – Integrating and applying Vision Mātauranga	
Integrating and applying culturally-responsive principles and practices in research planning • (K): apply the three Treaty of Waitangi principles (partnership, protection, participation) throughout research proposals • (M): demonstrate how and why the innovation potential of Māori knowledge will be actualised throughout the research proposal • (T): adopt and embed kaupapa Māori methodology and methods throughout the research proposal • (R): address how Māori leadership and participation will be authentically incorporated throughout the research proposal	Māramatanga | Application
Mātauranga – Exploring and enhancing understandings of Vision Mātauranga	
Identifying and interacting with culturally-appropriate ideas, concepts and knowledge to inform research planning • (K): understand how the three Treaty of Waitangi principles (partnership, protection, participation) are able to guide research planning • (M): identify and articulate the 'new knowledge' benefits that are intended to accrue for Māori as a result of the research activities • (T): adopt kaupapa Māori methodology and methods in research design to ensure power-sharing approaches are utilised • (R): ensure that equitable and adequate resourcing is allocated to facilitate authentic Māori leadership and participation at all stages	Mātauranga | Understanding
Mōhiotanga – Acknowledging and respecting the aspirations of Vision Mātauranga	
Co-constructing research planning in partnership from the beginning • (K): acknowledge the centrality of the three Treaty of Waitangi principles (partnership, protection, participation) in guiding research processes • (M): accept the innovation potential of Māori knowledge, aspirations and worldview perspectives in research objectives • (T): appreciate the relevance of kaupapa Māori research methodology and methods in research design • (R): recognise the importance of engaging Māori leadership, participation, advice and guidance in all research planning, processes and activities	Mōhiotanga | Awareness

When researchers have attained māramatanga they are aware of the impact that the three Treaty of Waitangi principles have on the research process; they understand that Māori knowledge and ways of knowing, being and doing are critical to the research objectives, they insist on implementing a research design that embodies and employs approaches that are culturally-responsive to Māori, and they ensure that Māori leadership is palpable throughout the entire research process.

Conclusion

Pursuing cultural competence and cultural safety in research planning, activities, and monitoring is more important than ever before, given the projected increases in diversity and disparity across the world, and the growing prominence of Māori phenomena in the many and varied research opportunities that are present in Aotearoa New Zealand. While the goal of becoming culturally competent and culturally safe in all research activities that involve Māori may be perceived by some as being too great a challenge to overcome, commitment to the goal – by way of the aspirational tenets of Vision Mātauranga – must never waver.

The inclusive approaches and frameworks that have been offered in this position paper are intended to assist researchers to become more confident in enhancing their awareness and knowledge bases as they prepare to adopt culturally-adept research practices in the field.

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Thank you to our Jubilee Conference keynote speakers John Sommers-Flanagan, Patrick McGorry, Anthony Grant and Siautu Alefaio for their contributions below, based on their keynote presentations.

Advances in suicide assessment and treatment

John Sommers-Flanagan

John Sommers-Flanagan is a clinical psychologist and Professor of Counselor Education at the University of Montana. He is author or coauthor of over 60 professional publications and eight books. His books, co-written with his wife Rita, include Tough Kids, Cool Counseling (2nd ed., 2007), How to Listen so Parents will Talk and Talk so Parents will Listen (2011), Clinical Interviewing (6th ed., 2017), and Counseling and Psychotherapy Theories in Context and Practice (3rd ed., 2018). Dr. Sommers-Flanagan has been publishing articles, book chapters, and videos on suicide since 1995 and is a sought out keynote speaker and professional workshop trainer in the areas of (a) counseling youth, (b) working with parents, and (c) suicide assessment/intervention. He is also co-host of the Practically Perfect Parenting Podcast. In his wild and precious spare time, John loves to run (slowly), dance (poorly), laugh (loudly) and produce home-made family music videos.

Abstract

Recent increases in death by suicide in Aotearoa New Zealand have led to calls to improve suicide prevention, risk assessment, and treatment practice. Unfortunately, several unhelpful myths about suicide persist. In this article, I describe contemporary approaches to: (a) inquiring about suicide, (b) formulating risk, and (c) collaborative treatment. Although suicide rates are difficult to change because they are imbedded in geo-political and sociological dynamics, it remains incumbent upon psychological practitioners to embrace contemporary knowledge and practice strategies that will enhance national suicide prevention efforts.

Keywords: Suicide, assessment, clinical interview

Suicide is a major global health problem, with national implications. In particular, suicide rates in Aotearoa New Zealand have risen for four consecutive years, with the 2018 rates reported as 13.67 suicide deaths per 100,000 people. This steady rise in suicide deaths have brought the issue to the attention of the national media, government officials, and psychotherapy practitioners.

 Suicide has culturally universal and culturally specific dimensions. As someone who teaches and practices in the United States, my understanding of suicide in New Zealand is limited. Consequently, in this article I describe universal or global suicide myths and recent advances in suicide assessment and treatment. Although I am geographically restricted in my perspective, I hope some of what follows is applicable and, if not, I hope you can find ways to modify these suicide assessment and treatment approaches to fit the Aotearoa New Zealand culture and population.

Four stubborn myths

I've studied suicide and worked directly with clients who are troubled by suicidal thoughts and impulses for over 30 years. During this time, I've seen significant shifts in how suicidologists and practitioners view and respond to clients who are suicidal. I've also noticed several persistent and unhelpful conceptual and practical suicide myths. I begin with a description of these myths and offer more helpful narratives to replace them.

Suicidal thoughts are signs of deviance

In truth, "normal" people have thoughts about suicide, if only as a byproduct of existential choosing to affirm life and living. Typically, over the course of one year, about 50% of adolescents report passive suicide ideation, with an additional 5-7% reporting active suicidal thoughts (Vander Stoep, McCauley, Flynn, & Stone, 2009). Normalizing suicidal thoughts is foundational to suicide assessment and treatment.

Instead of deviance, it is healthier, more accurate, and more useful to view suicidal thoughts as a communication of distress. When individuals share their suicidal thoughts, it is accurate and useful for listeners to conclude: "This person is telling me about his/her/their personal distress." When suicidal thinking is viewed as a communication of distress, a therapeutic relationship becomes possible.

A corollary to this myth is that because suicide ideation is bad, healthcare practitioners should eliminate their clients or patients' suicidal thoughts. Unfortunately, setting a goal to eliminate suicide ideation can backfire (Konrad & Jobes, 2011). This backfiring may be related to Nietzsche's classic statement,

"The thought of suicide is a great consolation: by means of it one gets through many a dark night." For some clients, suicide ideation can serve as a Nietzschean coping strategy that relieves distress.

Clinicians should conduct suicide risk sssessments

Most clinical and actuarial efforts to predict suicide fail (Large & Ryan, 2014). The problem is multi-faceted. At about 13 completed suicides for every 100,000 people (in New Zealand and the U.S.) suicide is an infrequent behavior. When predicting low base rate behaviors, it is statistically common to have many false positives (predicting suicide when it does not occur) and false negatives (predicting no suicide, but it occurs). Australian suicide researchers Large and Ryan (2014) have lamented the poor utility of risk factor assessment: "Estimates of the probability of particular and rare events such as suicide . . . are of no assistance in [clinical care]" (p. 416).

Most suicidologists and suicide treatment researchers have shifted away from medical model case formulation and treatments (Jobes, 2016). Instead, modern assessment and treatment approaches are characterized, more than anything else, by a single word: Collaboration.

Another problem is that some risk factors also serve as protective factors. For example, self-mutilation (or cutting) is an empirically documented risk factor. However, cutting can also be protective when clients use it to regulate affect. Similarly, a previous attempt, loss of employment, a new antidepressant prescription, and physical illness can also confer risk, protection, or both. In the end, unless you place risk factors within your client's individual, familial, cultural, and societal context, it is impossible to

know if a risk factor is increasing risk, protecting from risk, or neither.

Patients or clients with suicidal thoughts or impulses need medical interventions

Most suicidologists and suicide treatment researchers have shifted away from medical model case formulation and treatments (Jobes, 2016). Instead, modern assessment and treatment approaches are characterized, more than anything else, by a single word: *Collaboration*. Current professional practice standards involve collaboration from first contact, to ongoing psychotherapy, to hospitalization (if needed), and beyond.

Collaboration with clients involves empathy, interest in the client's world-view and experiences, and trust-building (Sommers-Flanagan & Shaw, 2017). Large and Ryan (2014) recommended that clinicians have direct discussions with clients about the risks and benefits of treatment vs. no treatment. Specific evidence-based protocols emphasize collaborative assessment, collaborative safety planning, and collaborative progress monitoring (Jobes, 2016; Stanley & Brown, 2012).

Asking about suicide

Asking directly about suicide is de rigueur for clinicians. Despite this expectation, it can still be difficult and anxiety provoking to initiate conversations about suicide.

Suicide prevention protocols often recommend asking, "Have you been having thoughts about suicide?" This question, although reasonable, lacks clinical nuance. Mental health professionals can and should use more sophisticated clinical skills (this next section is adapted from Sommers-Flanagan, 2018).

Using a normalizing frame. Questions about suicide can be framed to imply that suicidal thoughts are normal. A normalizing frame might sound like, "When people are feeling down, it's not unusual to think about suicide. I'm wondering if that's the case for you?" This question lowers the barrier to disclosing suicidal thoughts.

Using mood ratings with a suicide floor. I've written elsewhere (and recently presented at the NZPsS Jubilee conference), on how to use a mood rating scale with a suicide floor. This procedure should be implemented with flexibility. For example, if a client begins talking about trauma and shows signs of wanting to talk more, you can temporarily abandon the scaling process in favor of trauma exploration.

Questions about suicide can be framed to imply that suicidal thoughts are normal. A normalizing frame might sound like, "When people are feeling down, it's not unusual to think about suicide. I'm wondering if that's the case for you?"

The following questions are a general guide. You should use your own words, paraphrase, and show empathy (see Psychotherapy.net, 2018, for a video resource demonstrating this assessment technique and other collaborative suicide strategies).

1. Do you mind if I ask you some questions about your mood? (This question invites collaboration; patients can say "no," but rarely do.)

2. Please rate your mood right now, using a zero to 10 scale. Zero is the worst mood possible, meaning you're totally depressed and just going to kill yourself. Ten is your best possible mood. A 10 means you're as happy as possible. Using that zero to 10 scale, what rating would you give your mood right now? (The clinician anchors the bottom and top of the scale.)

3. What's happening now that makes you give your mood that rating? (This links the mood rating to the external situation.)

4. What's the worst or lowest mood you've had over the past two months? (This informs you of the lowest lows; you can change the time period to relate to how long the client has been feeling depressed.)

5. What was happening back then to make you feel so down? (This links the lowest rating to an external situation; it could lead to discussing previous attempts.)

6. What would be a normal mood rating for you on a normal day? (This gives you a sense of your client's normal.)

7. What was the best mood you've had over the past two months? (You should end with a positive mood rating.)

8. What was happening then? (This links positive mood to an external situation.)

The preceding protocol (adapted from Sommers-Flanagan, 2018) is a flexible method for integrating suicide into a conversation about current mood, worst mood, best mood, and average mood. Reasons for dying and reasons for living also can be explored. Assessment of other protective factors can be woven into the interview (e.g., social support, hope, religion). Later, specific suicide interventions can be introduced.

Formulating risk

After learning that risk factor assessment has poor predictive utility, many clinicians wonder what they should do instead. After all,

healthcare professionals are expected to know the answers and engage in decision-making, including determining whether psychiatric hospitalization is needed. As Large and Ryan (2014) recommended, it is reasonable to employ a collaborative decision-making model wherein providers directly explore the pros and cons of various recommendations. However, in addition, clinician decision-making is aided by examining the presence or absence of eight overlapping higher order suicide dimensions. As you read about these dimensions, keep in mind that traditional risk factors (e.g., insomnia, clinical depression, unemployment, cutting, etc.) may load, one way or another, onto these higher order dimensions (these dimensions are also adapted from Sommers-Flanagan, 2018). Additionally, each of these dimensions has treatment planning implications.

Unbearable psychological/emotional distress

Shneidman's (1985) introduced "psychache" as a condition involving unbearable *negative emotions and psychological pain*. He referred to this pain as "the dark heart of suicide; no psychache, no suicide" (p. 200). Many different unique life factors contribute to unbearable distress (e.g., relationship break-up, illness, unemployment, etc.). Treatments for suicide should always address client distress.

Problem-solving impairment

Problem-solving impairments are associated with depressed mood and can take "the form of seeing only two choices: either something painfully unsatisfactory or cessation" (Shneidman, 1984, pp. 320–321). Contemporary researchers report that depression is linked to problem-solving deficits (Lau, Haigh, Christensen, Segal, & Taube-Schiff, 2012). Consequently, clinicians should evaluate client problem-solving and intervene, as needed, with problem-solving support.

Agitation or arousal

Agitation is linked to death by suicide (Ribeiro, Silva, & Joiner, 2014). When combined with high distress and impaired problem-solving, agitation or arousal pushes patients toward acting on suicide to solve their distress. Trauma, insomnia, drug use (including starting on a trial of serotonin-reuptake inhibitors), and other factors, can increase agitation (Healy, 2009). Clients who are suicidal may benefit from learning methods for lowering arousal.

Thwarted belongingness and perceived burdensomeness

Joiner (2005) posited that thwarted belongingness and perceived burdensomeness were contextual interpersonal factors linked to suicide. Suicidal thoughts and impulses are often triggered or exacerbated when patients experience social disconnection (e.g., romantic rejections) or believe they are a burden. Social reconnection is a common target for suicide prevention and treatment.

Hopelessness

Hopelessness is the belief that distressing life conditions will never improve. If patients view their disturbing symptoms or situations as transient, suicidal thoughts and impulses may emerge, but hope for a better future protects patients from suicide. Building hope from the bottom up, is a strategy for empathically increasing client hope (see Sommers-Flanagan, 2018).

When combined with high distress and impaired problem-solving, agitation or arousal pushes patients toward acting on suicide to solve their distress.

Suicide desensitization

Fear of death and/or pain are natural suicide deterrents (Klonsky & May, 2015). However, some clients are predisposed to high pain tolerance. Alternatively, chronic pain, self-mutilation, or other experiences can desensitize clients to death and physical pain. Treatment goals can include sensitization to joy and positive affect.

Suicide plan or intent

Suicide plans and suicide intent are the triggers that move clients from suicide ideation to suicidal behaviors. Collaborative exploration of suicide plans and intent is essential, but difficult unless you have established a positive therapeutic relationship.

Lethal means

Access to lethal means increases suicide risk. In Aotearoa New Zealand, suffocation or strangulation is the most common suicide method. Safety planning around suffocation as a lethal factor may be important.

The preceding pre-suicide dimensions are not empirically validated suicide predictors. Instead, these eight suicide dimensions are unique patient and contextual variables that can be collaboratively assessed during an initial clinical interview (Sommers-Flanagan & Shaw, 2017).

Concluding comments

It is essential for psychology practitioners to be able to directly and calmly inquire about suicide ideation and plans, collaboratively assist in problem-solving, address distress, increase connectedness, and promote safety. In truth, suicide rates are difficult to change because they are imbedded in geo-political and sociological dynamics.

Nevertheless, it remains incumbent upon psychological practitioners to embrace contemporary knowledge and practice strategies. I hope this article helps you partner with clients in ways that contribute to suicide prevention in Aotearoa New Zealand.

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Youth mental health reform and the mental wealth of nations

Patrick McGorry

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The concept of mental wealth

Mental wealth is an increasingly popular term which is increasingly embraced by both economists and mental health advocates. The term was coined by Beddington and colleagues(1), who showed that economic and social capital builds to a peak in early adult life and declines only very slowly thereafter, provided people remain fit and well. However, 75% of mental illness emerges prior to or during this period and it therefore poses the greatest threat from a health standpoint to economic and social development of nations. Prevention, early intervention and effective treatment for children and emerging adults represent the keys to safeguarding "mental wealth". Its timing in the life cycle is essentially why mental illness has the highest economic impact among all the non-communicable diseases upon GDP worldwide, twice as much as cancer (2). This makes mental health a striking exception in the debate about the financial sustainability of modern health care, simply because only here is a significant return on investment possible, through the restoration of decades of productive life. Possible because evidence-based treatments are relatively effective and yet only a small minority of people gain timely and sustained access to them. Investment is way too little and way too late to reap this return on investment, and what is more, the current serious underinvestment is resulting in enormous secondary costs. The attraction of stemming these burgeoning costs and preserving decades of productive life, free of welfare and other fiscal burdens, should be tantalizing to politicians, preoccupied with competing budget demands and the holy grail of economic growth. These rich seams of mental wealth are undoubtedly within our reach, yet to mine them, genuine reform, new investment and prioritizing the most potent strategies are vital. Equally vital is engaging and mobilizing the public in our own self-interest to empower politicians to act.

So, despite unprecedented levels of awareness of mental illness, there is a huge paradox. Despite this awareness juggernaut, we continue to suffer from serious underinvestment in accessible and effective mental health care, and this is costing modern economies many billions annually through huge downstream productivity and welfare costs. The potential of so many of our young people is being wasted due to untreated or poorly treated mental ill health, which grinds on into a diminished middle age and a long career as a mentally ill person. This spans the social strata, sparing no community. The awareness industry may have drawn mental illness out of the shadows, but we can no longer allow awareness alone to substitute for decisive action.

Prevention, early intervention and effective treatment for children and emerging adults represent the keys to safeguarding "mental wealth".

The art and science of implementation: doing the right things for the "wrong" reasons

"With very rare exceptions, the right things are done for the wrong reasons. It is futile to demand that men do the right thing for the right reason – this is a fight with a windmill."(3)

Implementation science is concerned with the translation of the best currently available evidence into clinical practice. This is easier said than done. Even when, rarely, we reach the pinnacle of level 1 Cochrane evidence, the synthesis of multiple RCTs, – a current youth mental health example being psychosocial intervention for subthreshold psychosis (4) -implementation can still fail to occur. The evidence-based paradigm has been misused by vested interests through the tactic of raising the bar and demanding ever-perfect evidence to block an overdue reform(5). This is otherwise known as "*clutching at flaws".* Reform can never depend on perfect evidence. The perfect is the enemy of the good and so we must make decisions now on the best available evidence, and just as importantly know how to implement these decisions in the face of inertia, discrimination against mental health in funding allocations, and predictable undermining by vested interests. What is clear is that the "right" reasons, such as relieving suffering, reducing disability, and the logic of making the latest scientific advances available to patients in a reliable and equitable manner are necessary, but nowhere near sufficient.

Some of the "wrong" reasons are actually to be found within the concept of mental wealth, for example the fact that effective forms of mental health care are now certain to have a better return on investment than any of the other communicable diseases, especially cancer. Some might argue that this is another of the "right" reasons, yet even this argument is not as potent as it should be. Cancer care and research are extraordinarily well funded, but not for this reason: more through fear and other emotional factors. It is certainly not the cost-effectiveness of cancer treatments that has delivered major funding growth, but the understandable imperative to give people the best chance of survival. In Australia, the most dramatic recent example of this is that, despite the huge level of unmet need in mental health, the first tranche of funding from the new Medical Research Future Fund was allocated to research in rare children's cancers, which affect only a small number of patients annually. These days there is an implicit political cost of not funding cancer generously, and a political benefit in visibly responding. Collective self-interest might seem like a "wrong" reason, but it turns out to be potent and virtuous – politics trumps economics and logic. So characterizing reasons as right or wrong must yield to pragmatism. Unless we broaden the focus to the full spectrum of mental ill-health, prioritise young people, and get into the frontline of advocacy and reform, we will be unable to channel these socio-economic and political forces. The international youth mental health reforms of the past decade provide an illustration how this can be done more widely and deeply in mental health, and they are manifestly the best way to stem the tide of mental illness and start generating mental wealth.

Novel stigma-free, developmentally-appropriate models of care for young people are scaling up

The peak incidence and prevalence of mental ill-health among young people in transition to adulthood calls for a new approach to service provision that offers both the capacity to deal with the high volumes involved, which while it allows a role for new technologies, must offer the depth and expertise necessary to manage the diversity, complexity and persistence of this need. The capacity to cope with the extent of the need for care is crucial if early intervention is to be feasible. Different service levels that cover the entire spectrum of illness complexity and severity are required: from e-health, primary care services or enhanced primary care services for those with earlier mild to moderate forms or stages of mental ill-health, and then specialised 'back-up' services for those with complex presentations or more severe illness.

The key principles of such systems can be summarised as follows.

- Youth participation at all levels, to enable the creation

of youth-friendly, stigma-free cultures of care that provide what young people and their families really need, while acknowledging the evolving developmental culture of emerging adults.

- A preventive and optimistic framework that emphasises early intervention and offers holistic, evidence-informed, staged care governed by risk-benefit considerations and shared decision-making, with social and vocational outcomes among the key targets.

- A 'one-stop shop' or 'integrated practice unit' (6) in which multidisciplinary teams of providers are organised around the customer (the young person and their family) and their needs, and through which a dedicated team of clinical and non-clinical personnel provides the full care cycle for the young person's condition. This fundamentally changes the way clinicians are organised to deliver care. The ideal version involves both horizontal and vertical integration.

- The elimination of discontinuity at age 18 during the peak periods of need for care during this crucial developmental transition.

- Positive and seamless linkages with services for younger children and older adults.

- Flexible tenure and re-entry to care as needed during the critical period of transition to adulthood.

headspace, Australia's National Youth Mental Health Foundation, is a potent example of this type of integrated youth health care reform which has attracted bipartisan political and community support that actually works on every level. A growing number of major countries

internationally are following Australia's lead. Why? Designed with a "start-up" mentality, headspace proved to be a "minimal viable product" or MVP (7). As such, it met requirements for launch but could be refined through later evolution. It tapped into a huge instant "market" among young people and parents, because it was an immediate solution to a real need which had not been well-defined and for which there was little competition. Ten years ago, young people with mental ill health had the worst access of all to health care, and yet the greatest need and capacity to benefit. Young people were clearly *not* (as some have tried to imply) getting better all by themselves. The relative failure of standard primary care meant that one million young Australians on the threshold of productive life were at risk of premature death, the economic scrapheap or serious underachievement. Something had to be done. A new model of enhanced primary care was co-designed with young people and families, and locally led. headspace's stigma-free MVP of "one stop shops" proved to be highly successful, and the system has been progressively expanded, with strong bipartisan political support, to a total of 110 centres by the end of 2018. Young people voted with their feet, and local communities, particularly in rural and regional Australia, and their political representatives, value headspace very highly.

Now headspace was conceived principally as a strategy for improving access and acceptability of health care for young people, so that the range of evidence-based interventions on offer could have a chance to work, and as a platform for generating new knowledge and skills through clinical research. In itself, headspace is not a new treatment, so existing treatments were not necessarily expected to work

better within the model unless through better coordination. Collectively however, outcomes would certainly improve through better access and engagement, assuming of course that our current treatments work for at least a substantial minority. So, headspace represents a new entrance hall and front room of our health system, not a total solution. For full effect and to transform outcomes, prevention and early detection programs, novel, technology-assisted "on-ramps", and the addition of other spaces in the building, where more specialised expertise can be accessed, need to be built. The advent of headspace has further exposed the latter gap, which we have termed "the missing middle". This is preventing the waiting list for specialized care being hidden or denied, and will eventually force State and Federal governments to fund this gap.

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The independent evaluation of headspace (8), stated that if headspace did not exist,

> *"large numbers of young people would not access services or would access them at a much later stage in the development of their disorders, potentially incurring significant costs to the government as well as difficulties for the young people and their families".*

This evaluation was conducted in 2013-2014 by researchers from the University of NSW and has been

publicly available since May 2016 (8). Its findings were welcomed by the Federal Government and paved the way for the government's decision to expand headspace by a further 10 more centres by 2018. 100,000 young Australians annually now receive direct help and treatment through headspace services, and over 30,000 more do through online interventions at e-headspace. The independent report was overwhelmingly positive, and highlighted significant successes achieved by headspace, and top of the list was the improved access, engagement and satisfaction. In particular, some particularly at risk and marginalised groups, those in rural and regional Australia, indigenous young people and LGBTIQ young people have been able to obtain access at unprecedented levels.

While around 60% of headspace clients have derived benefit, not unexpectedly in a primary care setting, some patients have failed to improve or even got worse, highlighting the need for more intensive or specialized interventions. However, the evaluation showed some unexpected and important benefits over and above standard primary care. Headspace services reduced suicidal ideation and self-harm, the major risk factors for youth suicide. Young people accessing headspace services also had fewer days out of school or employment than young people receiving traditional care or no treatment. And young people and families are overwhelmingly positive about headspace, and highly satisfied with the services they received. Communities around the country value their local headspace centres very highly, and those who don't yet have them campaign to have one. This, added to the visibility factor and the dispersal of stigma in local communities, is why political support is so strong. The evaluation also pointed to several ways that headspace can improve further. The 'soft entry' or "frictionless" approach of headspace favors simple solutions, with minimal professional input for those who do not need this. It also means that those with emerging complex disorders can be fast tracked into stepped care and preemptive care, provided this is available.

However, headspace is still a work in progress and important gaps remain such as for recent migrant groups, and for many young men. The most serious gap is in its capacity for vertically integrated specialised care. While headspace provides a valuable entry point to the health and welfare system and can deal with the needs of perhaps two-thirds of its clientele through its enhanced primary care capacity, the remainder need a more expert, specialised, and at times more intensive approach, which may include mobile home-based and outreach care, specific disorder-based expertise, and acute and sub-acute residential care.

This would respond to the needs of the "missing middle" group of more complex patients and turn back the tide of late presentations and "last resort" care now overwhelming emergency departments. It will need substantial new investment in this "mid zone" to relieve the pressure on acute services, but the soft entry, stigma free "on ramp" has been critical to reveal the need and create momentum for this second stage of reform. To begin to address this gap, the Australian Government has funded the creation of six 'enhanced headspace' services, which are linked with a local cluster of headspace centres and resourced to deliver fully-fledged evidence-based early psychosis services, and also created a much more modest but diffuse stream of funds for non-psychotic yet more complex presentations. The latter needs to be much better defined and similarly embedded with headspace platforms. These embryonic initiatives cover the more complex presentations that standard headspace funding models cannot manage, but which currently fail to jump the impossibly high barriers into State funded systems of specialized mental health care.

Many other nations have embarked on a similar reform journey though it is still early days. In New Zealand, the "Youth One Stop Shops" were an early version of the same basic idea on integrated youth health care. Similar models to headspace have been implemented in other countries, such as the Canada, Ireland, Denmark, Israel, France, the Netherlands, and Singapore. Similar services are being developed in some parts of the United States and the UK. A common sequence is for initial catalytic philanthropic funding to develop services and demonstrate effectiveness, which is then followed by government funding to scale up and sustain the venture. The long-term aim of these global reforms is to develop a nationwide youth mental health stream that fully integrates care for young people, in order to provide a seamless coverage of mental health care from puberty to mature adulthood at around 25 years of age, with soft transitions between child and adult mental health care. The global experience to date has been reviewed recently (9). Distinctions between the tiers of primary and specialist care will be blurred, in order to utilise a staging approach which aims to pre-empt progression of illness (10). This means youth-friendly stigma-free primary care portals for young people with undifferentiated needs, backed up with intensive community education, mobile detection and assertive treatment teams, and specialised streams of expert care. The latter streams would cover not only early psychosis, but also the other major macrophenotypes that emerge, notably complex mood, borderline, substance use and eating disorders. Such

vertical integration of care could deliver EI and secure tenure of care during the critical period of transition to adulthood when the major mental disorders emerge and embed. Clearly, the success of these reforms will ultimately only be able to be assessed after careful evaluation, and evidently more health services research is necessary to develop, refine, adapt and evaluate new service models, both within their individual contexts and cross-sectorally.

Early intervention and youth mental health are twin reform paradigms that have the potential to transform the landscape of mental health over the coming decade and expand the mental wealth of nations.

Conclusion

Early intervention and youth mental health are twin reform paradigms that have the potential to transform the landscape of mental health over the coming decade and expand the mental wealth of nations. They will need activism, advocacy and collaborative global leadership if they are to succeed. An essential enabler will be the creation of a professional field of knowledge and expertise to be known as "youth mental health" or even "youth health", which is quite distinct from child and adolescent psychiatry and from paediatrics. The concept of adolescent health falls short because it retains the outmoded concept of adolescence, has failed to capture the full extent of the developmental processes in play in the current era, and has minimised the salience of mental ill-health as the major health threat to a flourishing generation

and productive society. This new endeavour must build a new and dynamic workforce which will comprise a wide range of disciplines and skills, some quite new, which may help to redefine the emergent field in a way that we can currently not imagine.

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What is coaching

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Abstract

Coaching psychology is becoming an established psychological sub-discipline. The coaching industry per se continues to grow, and psychologists with their specialist training in behavioral science have much to contribute. This article details the development of the coaching industry and explores the emergence and growth of coaching psychology. An overview of the current state of research and practice is presented. It is argued that to some extent all applied psychologists can be considered "coaching psychologists" however,

psychology? Who are we? Where are we going?

those psychologists that wish to present themselves as specialist coaching psychologists really need to ensure that they have requisite postgraduate coach-specific training in order to develop the appropriate coaching competencies. It is concluded that coaching as a valid intentional change methodology has much to offer a world in which increasing levels of complexity, change and uncertainty are manifest in our personal, professional, political and psychological lives, and that, as psychologists we should be at the forefront of such endeavours.

Introduction

There has been sustained and growing public interest in coaching as a methodology for facilitating positive intentional change over the last twenty to thirty years. From original and somewhat derogatory concerns that coaching may be merely an ineffective fad (Barry, 1994), there is now a growing and substantive body of research to show that coaching can indeed be an effective means of facilitating goal attainment and personal and professional development (Athanasopoulou & Dopson, 2018). Indeed, one would be hard pushed to find an organisation of any manageable size that did not use coaching methodologies in some form.

However, mainstream psychology has not always embraced the so-called "positive" applications of psychological science (Seligman & Csikszentmihalyi, 2000) - and coaching psychology can indeed be understood as an applied positive psychology. Yet despite this initial reluctance, over the past twenty years psychology as an applied and academic discipline, has slowly but increasingly engaged with coaching, and "coaching psychology" is now a small, but well-established sub-discipline of mainstream psychology. There are now coaching psychology interest groups and universities that have specialist coaching programs in a wider range of countries including New Zealand, the UK, and many European countries as well as South Africa. In the USA the Harvard based Institute of Coaching has taken up the cause of promoting the development of evidence-based approaches to coaching.

This paper outlines the historical emergence of coaching as a methodology for facilitating intentional change, explores the central tenets of coaching psychology, discusses who are "coaching psychologists", and looks at the current status of coaching-specific research and speculates on potential future directions for coaching psychology.

The emergence of the coaching industry

Although coaching methodologies had some small measure of use in organisations since the 1930's (Gorby, 1937) and the concept of executive coaching began to make inroads in organisations during the late 1980s and early 1990s (Barry, 1992), it was only in the mid to late 1990s that "coaching" began to truly emerge as a more accepted means to help people set and attain goals and make positive changes in their lives (Ellinger & Bostrom, 1999). At that time organisations were using coaching methodologies in a relatively *ad hoc* fashion – certainly in a far less sophisticated fashion compared to today's approaches.

In parallel with the use of coaching in organisations, the 1990s witnessed the emergence of the "life coaching" industry, fueled predominantly by ideas and methodologies adapted from large scale personal development seminars such as EST and Landmark (Smith, 2014). Where coaching in organisations focused on workplace issues, organisational goals and leadership development issues, "life coaching" focused on helping people live more fulfilling and purposeful lives. In many ways life coaching was a popular, de-stigmatized (and unregulated) alternative to counseling and psychotherapy (for legal reasons to do with the licensing requirements for therapists in the USA, USA life coach training schools took great pains to distinguish coaching from counseling).

The emergence of coaching psychology

During the formative years of the coaching industry, psychology as a profession and an academic discipline systematically distanced itself from the coaching industry. One had the sense that the established psychological bureaucratic hierarchies viewed coaching with some distain, even revulsion. It was commonly stated at that time within university schools of psychology that coaching was not worthy of serious consideration or attention given that it was 1) atheoretical being based on "pop" psychology, and 2) lacking in evidence as to its effectiveness. Both of these points were true at that point in time, but not now.

In 1995 the USA-based International Coach Federation (ICF; the world's largest and original professional coach association, founded in 1995) defined coaching as "partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential" - a simple but comprehensive understanding of coaching. However, the

vast majority of ICF accredited coach training programs during the mid 1990s to the 2000s were completely atheoretical. The typical reference or reading list for such programs consisted of one or two self-help books such as Stephan Covey's (1990) Seven Habits of Highly Effective People or a few articles from the Harvard Business Review.

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Mainstream psychology at this time was yet to be open to the ideas central to so-called positive psychology (Seligman, 1998). The later wide-spread acceptance of the foci of positive psychology as the scientific study of the strengths and virtues that enable individuals, communities and organisations to thrive (Gable & Haidt, 2005), points to a ground swell of interest in both the general population and psychologists in developing psychological understandings of facets of the life well-lived, and the means and methods by which such goal-striving and positive intentional change can be better facilitated. It was this zeitgeist that provided the impetus for the emergence of coaching psychology.

Coaching *per se* is a relationship formed between a coach and the coachee (or group of coachees) for the purpose of attaining valued professional or personal goals and outcomes (Spence & Grant, 2007). Coaching psychology is a branch of psychology that is focused on the systematic application of the behavioural science of psychology to the enhancement of life experience, work performance and wellbeing for

individuals, groups and organisations. Coaching psychology focuses on facilitating goal attainment, and on enhancing the personal and professional growth and development of clients in personal life and in work domains. It is not aimed at directly treating mental illness (Grant, 2011). In essence, coaching psychology is simply the psychology or the behavioural science of coaching.

Coaching psychology as a defined psychological sub-discipline emerged concurrently in Australian and British universities in the late 1990s. In Australia, Anthony Grant at the University of Sydney founded the Coaching Psychology Unit (CPU) in 1999 and shortly afterwards Stephen Palmer did the same at City University, London. The aims of both CPUs were the same - to develop a contemporary psychology of coaching, a psychology that would provide a solid theoretical grounding and to build an empirical evidence-base for coaching methodologies. There are now established coaching psychology groups in a large number of countries including Australia, Canada, China, Denmark, Ireland, Israel, Italy, Korea, New Zealand, Poland, Portugal, United Kingdom, USA, Greece, South Africa, Spain, Sweden and Switzerland and at many universities worldwide.

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Who are Coaching Psychologists?

Given that applied psychologists in general are interested in helping enhance their clients' life experiences

and well-being, either through clinical practice, counseling modalities, or in organizational and health settings, and given that some of such work involves goal setting, relationship building and may well include some aspects of coaching, the question arises as to who are "coaching psychologists"?

In a sense, all applied psychologists can be considered to some extent "coaching psychologists". To the best of this author's knowledge though, there is currently no psychological society approved specialist "coaching psychologist" designations anywhere worldwide. However, there are a growing number of psychologists who refer to themselves as specialist coaching psychologists.

There are a number of key criteria that distinguish specialist coaching psychologists from psychologists who coach. These include specialized training in coaching methodologies; enough familiarity with the coaching-specific literature to formulate a conceptually-coherent, evidence-based approach to coaching; the ability to clearly distinguish coaching psychology from clinical or counseling psychology; the ability to apply the principles of coaching psychology to specialised areas of practice including (but not limited to); executive coaching, workplace coaching, health coaching, life coaching, and peak performance coaching. Another key, but a rarely discussed criterion, is the ability to work within coaching-specific codes and protocols of ethical practice and to distinguish those from the ethics and domain-specific protocols associated with other applied psychological domains. Finally, many specialist coaching psychologists have elected to join Coaching Psychology Interest Groups (or similar) within their country's professional psychological society, or to join

professional societies such as the International Society for Coaching Psychology.

Where is coaching psychology at?

It was not that long ago (in 2007) that experienced and respected commentators such as Mihaly Csikszentmihalyi, Manfred Kets de Vries, Stephen Palmer, Martin Seligman and Sir John Whitmore (see Grant & Cavanagh, 2007) warned that unless coaching and coaching psychology developed an evidence-base it ran the risk of fading away into irrelevance. Professor Ken Sheldon summed this position up succinctly:

> To me, the single most important thing for coaching (and positive psychology) to keep in mind is the necessity of collecting rigorous empirical evidence. This may be the only thing that separates the field from earlier humanistic psychology and from current non-validated self-help books, while also dealing with difficult scientific issues concerning demand effects, placebo effects, and just plain wishful thinking. … coaching … I believe, is especially vulnerable to these problems because of the commercial and money-making possibilities it presents. (see Grant & Cavanagh, 2007)

However, these concerns have not materialized. Indeed, to the contrary, as can be seen in Figure One there has been a steadily increasing volume of coaching-specific research since the early 2000s.

It is beyond the scope of this article to present a detailed review of the coaching literature (Athanasopoulou & Dopson, 2018; Jones, Woods, & Guillaume, 2016; Theeboom, Beersma, & van Vianen, 2013). However, it is worth mentioning that there is now sufficient coaching-specific research for there to have been five meta-analyses to date (Burt & Talati, 2017; De Meuse, Dai, & Lee, 2009; Jones, et al., 2016; Sonesh et al., 2015; Theeboom, et al., 2013). Meta-analyses can be considered the most sophisticated form of quantative outcome research, as it combines and conjointly analyses a number of previously published research studies in order to calculate the average effect size of a number of different coaching interventions. All of these meta-analyses indicate that coaching is indeed an effective change methodology. The ongoing growth of coaching research is evidence that coaching has moved beyond fad status (for early concerns see Tobias, 1996) and is now well-established as a change methodology. As a newcomer, coaching research is well behind established clinical, counselling or organisational psychology, but nevertheless there has been good progression in a relevantly short period of time.

As regards the current state of coaching practice in the coaching industry: The number of individuals working as professional coaches continues to grow. In a 2016 survey that utilised 15,380 responses from 137 countries, the International Coach Federation (ICF) which is the largest coaching-specific professional organisation, estimated that there were 53,300 professional coaches worldwide (up from 47,500 in 2012) (ICF, 2016). It should be noted that the majority of these coaches are not psychologists. Yet psychologists have much to offer the coaching industry. Indeed, it has been found that coaches with an academic background in psychology are more effective in terms of executive coaching effectiveness as reflected in greater improvement in coachee self-awareness and job performance as reported by their direct supervisor (Bozer, Sarros, & Santora, 2014).

The demand for coaching is growing. Coaching methodologies have continued to be utilised in a wide range of settings including heath (Hale & Giese, 2017), education (Van

Figure 1: The Pattern of Publications (approx.) in the Scholarly Coaching Literature from 2000 to 2017
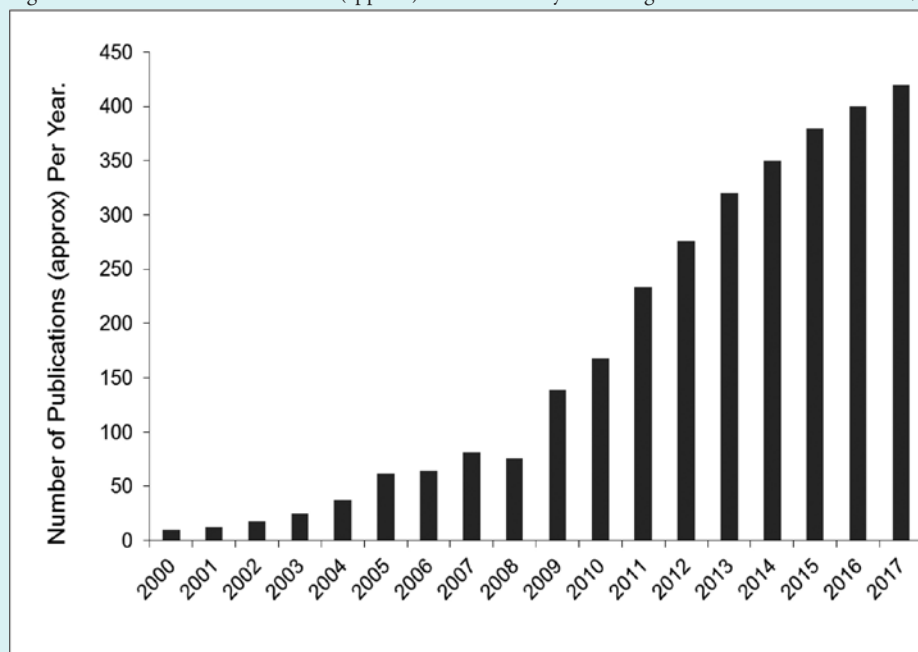
Nieuwerburgh, 2018), in organisations with executives (Athanasopoulou & Dopson, 2018), with front-line staff (Embregts, van Oorsouw, & van den Bogaard, 2017), with sales persons (Mallin, 2017), weight loss (Venditti et al., 2014) and in life coaching with a wide range of different populations (Knudsen et al., 2017). Coaching is here to stay.

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Summary and future directions

The research and practice of coaching and coaching psychology continues to develop. There is increasing demand for coaches who have a solid grounding in the behavioural sciences - and there continues to be a need for more psychologists to offer coaching services. Psychology as an academic discipline and an applied practice should keep on engaging with the coaching industry. Ideally we would see more universities offering specialised coaching psychology programs. Indeed, the experience at the Coaching Psychology Unit at the University of Sydney is that, since 2000 to date, there has been a consistently growing interest in specialised coaching psychology postgraduate degrees. Although coaching psychology postgraduate programs are not as yet (to the best of this author's knowledge) offered in New Zealand, if the Sydney experience is a measure, such offerings would be well-received. Coaching as a valid intentional change methodology has much to offer a world in which increasing levels of complexity, change

and uncertainty are manifest in our personal, professional, political and psychological lives. As psychologists we should be at the forefront of such endeavours.

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Psychology at the margins

Siautu Alefaio

Dr Siautu Alefaio (Samoan lineage from the villages of Matautu-Tai, Sasina, Manunu ma Fagamalo) is a Senior Lecturer at the School of Psychology Massey University and an International Fellow of the Humanitarian Innovation Initiative (HI2)-Watson Institute, Brown University. Siautu trained in educational psychology and has worked in education, health, social services, community, family violence, forensic rehabilitation and disaster humanitarian response in Aotearoa. Her research expertise draws on extensive applied psychology experiences to develop a New Indigenous Understandings psychological research platform for re-informing psychology theory and practice.

Drawing on my Pacific forefathers faith-interpretations of the jubilee year, the significance of this milestone is not only reaching 50 years as New Zealand's Psychological Society. But moreover, symbolically it is a sacred year - a year of freedom and celebration, of *lagimalie* (bringing things into harmony or back into balance), where there is no great imbalance between those who are wealthy (psychology) and those who are poor (Pacific peoples). We are in a pivotal time in our nation's history, there has been a change of guard at the highest of levels. Aotearoa New Zealand geographically embedded within the Pacific of Oceania now has the most 'Polynesian cabinet' leading the country. Polynesian voyagers are described as the best wayfinders in history, they travelled vast distances of the largest Ocean in the world – the Pacific. Navigating only by traditional knowledge such as sun, stars and other natural instinctive cues. Wayfinding is the process of travelling over unknown or unmarked spaces/places. This presentation draws on my own wayfinding journey in psychology as a Samoan woman and daughter of the Pacific, navigating on the margins of psychology in Aotearoa New Zealand, bringing to the fore Pacific-indigenous ways of 'knowing, being and doing' to help reset a niu[1] -mission of psychology for the future.

As Pacific peoples, we have been developing our own understandings of psychological phenomenon for centuries. It is time to bring some of these ideas into conversation with the global discipline. In doing so, this presentation considers the importance of culture and insider knowledge

1 Literally translated niu means baby coconut in Samoan. It is used in text as a 'symbolic representation' of new encounters in knowledge formation.

for research and practice in psychology with Pacific people. I do this from a Samoan perspective that is contextualised in relation to scholars from other Pacific nations. This presentation also responds to the fact that we have always been explorers and people on the move. As such my primary focus is on how Samoan cultural understandings and practices are influencing psychological practice and research both in Samoa and Aotearoa New Zealand where 144,138 (48.7% of the Pacific population in NZ) people of Samoan descent now live. This transnational focus is important because psychology is not yet well established in Samoa, and New Zealand-based scholars such as myself are working to develop approaches to psychology that are relevant to people in Samoa and New Zealand. Emphasis in this presentation is also placed on the fabric of knowledge traditions of Fa'aSamoa (Samoan-Indigenous cultural knowledge), that resides within the Samoan language, heritage, customs, and beliefs that people carry with them. This presentation should also be seen in the context of a Pacific-Indigenous researcher paradigm, which champions the need to consider different cultural approaches to research, and which has ignited exploration of re-theorising within the 'practice' of psychology.

Aotearoa New Zealand geographically embedded within the Pacific of Oceania now has the most 'Polynesian cabinet' leading the country.

Fa'asinomaga is a central tenet of Samoan cultural identity and is conceptualised as one's inheritance designated by the designator – God. This designation is located in the heart,

mind, essentially the soul of a person. It is what gives one meaning and belonging. It is what defines ways of relating to others (vā fealoaloa'i) and boundaries (tua'oi) between one's self and others, one and the environment, one and the cosmos, and a person and God (Alefaio-Tugia, 2015). Figure 1 below, illustrates the inter-connectedness that the cosmology of Fa'aSamoa extends. Fa'aSamoa is the epi-center that extends and impacts Cosmology or Worldview, which is the central nervous system of Samoan culture, language, time,
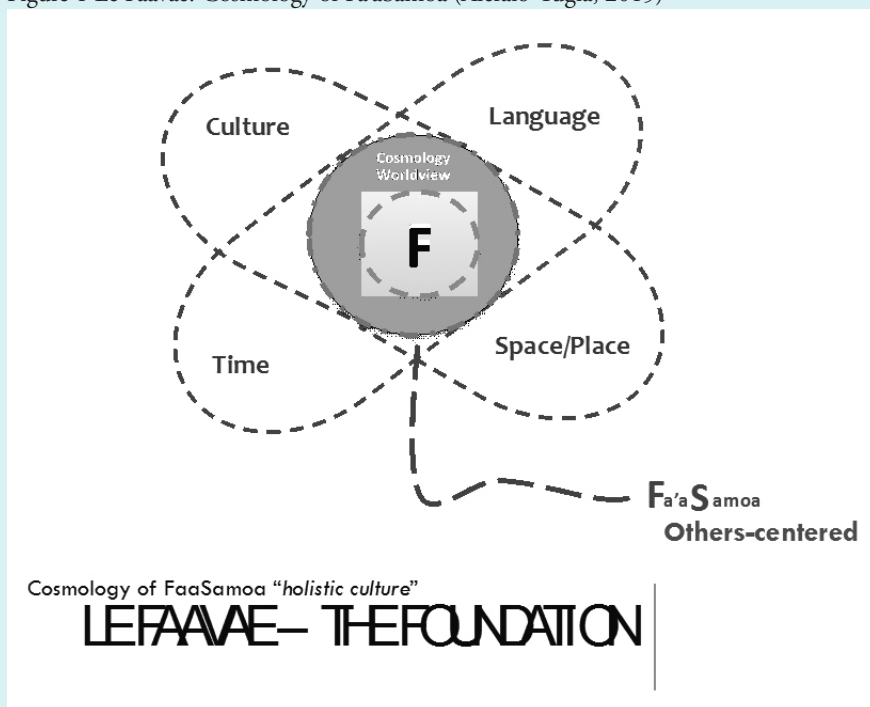
notes that: "although most cultures, no doubt, have proverbs, Samoans' understandings of language, and words – and *alaga'upu* as 'the path to knowledge' – are distinctive" (p. 226). As Samoan language moves and encounters new and foreign lands, it is transported across time (history) and place (cultural context). Samoan culture today is visibly connected with Christian beliefs and principles. In working locally within Aotearoa New Zealand, my colleagues and I have been working to integrate the rich lineage of cultural knowledge

North American colonisation, our native language remains a key medium for the preservation of Samoan cultural histories, genealogy, cosmologies, values, and beliefs. Therefore, in the realm of psychological talking therapies language is imperative. The emphasis on Samoan language is particularly relevant to areas of practice such as clinical and educational psychology that draw primarily on talk-based interventions. To be effective it is important for practicing psychologists to recognise the limitations of Eurocentric psychological therapies and have some understanding of key Samoan cultural concepts and the meaning of these as expressed through the language.

Figure 1 Le Faavae: Cosmology of Fa'aSamoa (Alefaio-Tugia, 2015)

space and place. Cosmology is an all-encompassing understanding of universality expressed through the interconnectedness of evolutionary beliefs, worldview, philosophy, science, culture and history.

Samoan's are others-centered (Alefaio-Tugia, 2015) and Samoan language in which its cultural artefacts were maintained is steeped in metaphorical proverbs enacted through chiefly systems of rich oratory. Salesa (2009)

(specifically cultural knowledge of Samoa - the largest Pacific ethnic group in Aotearoa New Zealand) into education and research in psychology. *Fa'aSamoa* (Samoan-Indigenous cultural knowledge and traditions) offers cultural principles and practices that are vital for conceptualising an engaged psychology that is more responsive to the needs of Samoan people and other groups to varying degrees. As with many indigenous groups who have faced European and

Much of the psychological research which I have been involved in is social problem focused. Addressing disparities for Pacific peoples in contexts such as Aotearoa New Zealand is an ongoing struggle that is recognised as a priority area for different governing bodies (see Department of Corrections, 2005-2008; Ministry of Education, 2013–2017; Ministry of Health, 1998 ; New Zealand Police, 2002-2006). Ensuring that research and practice conducted with Samoan people is culturally relevant and safe has been one of the key issues raised by a number of Pacific scholars (Anae, Coxon, Mara, Wendt-Samu and Finau, 2001;

Health Research Council of New Zealand, 2014; Mila-Schaaf, 2009). The Pasifika Education Research Guidelines (Anae et al, 2001), and Pacific Health Research Guidelines (2005), are examples of reports produced by Pacific peoples to educate the broader research community and to address issues of misrepresentation through research. Although crucial to the institutionalisation of change, these reports are somewhat generic in orientation towards 'Pacific peoples'.

In this context, the term Pacific is a generic term that, as the authors of these reports openly acknowledge, does not adequately reflect the diverse group of distinct Island cultures that make up the Pacific. The depths of culture and heights of tradition steeped in unique ancient histories are important to ensuring safe and culturally responsive research and practice. A profound assertion of shared distinctiveness that comes with being peoples of the Ocean is emphasized by one of the most revered Pacific-Indigenous scholars, the late Epeli Hau'ofa (1994), who writes:

> *We are the sea, we are the ocean, we must wake up to this ancient truth and together use it to overturn all hegemonic views that aim ultimately to confine us again, physically and **psychologically**, in the tiny spaces which we have resisted accepting as our sole appointed place, and from which we have recently liberated ourselves. **We must not allow anyone to belittle us again, and take away our freedom**. [emphasis added] (p. 16)*

Such statements reflect the re-awakening of cultural scholarship among Pacific peoples to which myself and other Pacific psychologists contribute. This involves turning back the tide, to shed light on the depth of cultural knowledge encompassed by the homogenous term 'Pacific', showcasing our diversity as Pacific people to reshape foreign hegemonic forces that have led to the empirical domination of knowledge about Pacific people by outsiders.

Cultural considerations when working with Pacific peoples

The first edition of the New Zealand psychology handbook (Love & Whittaker, 1997) included a Pacific perspective on psychology, captured by Gherardi & Tanoi (1997). The Pacific-specific chapter outlined key elements of cultural knowledge, customs, and traditions to raise awareness within the predominantly non-Pacific psychologist workforce. Examples of considerations when working with Pacific people included: accurate assessments of a client being made only by *placing the person within their immediate and wider family* and *"religious and home-land cultural rituals being a central form of understanding"* [emphasis added] (p. 160). The importance of insider cultural knowledge and cues to body language and other cultural practices as being central forms of communication in many Pacific communities were also emphasized as being important considerations in the production of valid assessments of mental health, and in understanding educational difficulties and needs of Pacific peoples.

Renewed effort has been put into better attuning

psychological theory and practice to the needs of Pacific peoples. For example, following the inaugural 'Education Leadership Conference' convened by the American Psychological Association (APA) in October 2001, a paper titled after the theme of the conference Rethinking education in psychology and psychology in education (Belar, Nelson, & Wasik, 2003) highlighted major issues that coincide with the indigenising of psychology in the Pacific. The authors outlined eight major issues identified by the forum. Those most relevant to the Pacific include:

- The knowledge base of psychology as a discipline and profession is rapidly changing and expanding.

- Concern raised as to whether psychology as taught then reflects what is most relevant to the present world and societal needs.

- The demographic profiles of many societies are changing and diversifying. Psychology must do more to respond to these changes to increase the relevance of our work and to avoid the discipline and profession being perceived as irrelevant and marginalised.

As Pacific peoples, we have been developing our own understandings of psychological phenomenon for centuries. It is time to bring some of these ideas into conversation with the global discipline.

These three assertions are shared by many psychologists working to indigenise the discipline and to champion the relevance of emic knowledge to effective research and practice. The acknowledgement at the APA convention of a rapidly changing world and knowledge base of the discipline raises further issues around the relevance of the ruling psychology from contexts such as North America to contexts such as Samoa, Cook Islands, Tonga and Aotearoa New Zealand. It has sparked considerable conversation about whose knowledge is taught in psychology degrees and is practiced in our clinics and schools.

Charting a niu-course

Saili Matagi as a Samoan metaphorical proverb was used to describe a forensic psycho-therapeutic rehabilitation initiative pioneered by the Department of Corrections in Aotearoa New Zealand. Involvement in the redevelopment of the programme as a Samoan practitioner of psychology provided the opportunity for me to contextualise Samoan cultural knowledge within a psychological practitioner framework. This work has proven ground-breaking for the local context of offender rehabilitation in Aotearoa New Zealand. This is, as Jackson (2005) described, 'a

starting point', one that is forged by indigenisation on the rugged landscape of new knowledge formation in the established global discipline of psychology. The use of Saili Matagi as a cultural-psychological intervention foregrounds the efficacy of our traditional cultural knowledge in therapeutic interventions. Central here is the reshaping of the 'dialogue' of therapy by cultural knowledge/ principles so as to ensure relevance to the people with whom we are working.

To be effective it is important for practicing psychologists to recognise the limitations of Eurocentric psychological therapies and have some understanding of key Samoan cultural concepts and the meaning of these as expressed through the language.

In closing, a new expedition is now needed. One that is birthed from within the regions of the deep ocean of the *Vasa Pasefika* (Pacific Ocean). As we move rapidly within a globalised world, many of our people have become consumed by hard urban lives that feature socio-economic exclusion. Too many have become dispossessed from our traditional knowledge and are struggling with issues of violence, crime, and disparities in employment and education. As part of the response to these social issues, psychologists need to work with such groups to re-vive (bring back to life) our dispossessed knowledges. Globally recognised interventions based on behavioural modification and other such imported technologies have not proven effective with our people and our collective efforts to address the socio-economic issues we face together. Our ancient knowledge and practices can once again guide us in the healing and recovery activities that must occur in our communities in new contexts such as Aotearoa

New Zealand. After all, these Pasefika ways of 'knowing, being, interacting, caring and doing' have guided our Samoan ancestors across the most difficult of terrains. Understanding values and beliefs of Samoan communities as explicated through indigenous cultural knowledge such as *Fa'aSamoa* provides a *niu* (new) way forward in psychological research and practice in the Pacific. For example, the intercultural dialogue of psychological therapy, Fa'aSamoa informs new therapeutic interventions with Pacific offenders. For peoples of the Pacific, this has highlighted the value of traditional Pacific-Indigenous knowledge in extending our modes of research and practice.

The use of Saili Matagi as a cultural-psychological intervention foregrounds the efficacy of our traditional cultural knowledge in therapeutic interventions. Central here is the reshaping of the 'dialogue' of therapy by cultural knowledge/ principles so as to ensure relevance to the people with whom we are working.

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Climate challenged: Our need to change

Marg O'Brien

Marg O'Brien offers two papers on climate change and our need to change and where to focus our efforts

As an earlier trained clinical psychologist Marg moved into environmental work 30 years ago. In consulting and research roles, she has worked at the people-environment interface with an emphasis on building community resilience and progressing sustainable lifestyles. Marg is a member of the Society's Climate Psychology Taskforce where her interest is in ensuring that local and central government understand and use the expertise psychologists can bring in progressing the country's transition to sustainability.

At the 2014 NZ Psychological Society Annual Conference the AGM passed a remit on the Society's responsibility on climate change and sustainability issues. This year the essence of the remit was encapsulated in the Society's Position Statement on Environmental Wellbeing and Responsibility to Society[1]. To support this work, the NZPsS Climate Psychology Taskforce convened a Psychology for a Sustainable Future Symposium at the 2018 Jubilee Conference in Auckland.

Essentially, the Society has acknowledged the profound impact that humans are having on the environment and the urgent need for us to work to counter the detrimental effects that are anticipated on human health and well-being.[2] Recognized are the needs to strengthen our capacity as practitioners to address a climate turbulent future; promote a wider understanding of the human and psychological dimensions of sustainability and particularly, global climate change; track and reduce the Society's own ecological footprint; and work with government and political organisations to ensure they understand the expertise that the discipline can offer re human adaptation, mitigation and transformation efforts in response to sustainability and climate disturbance issues.

Climate change, of course, is not the only factor undermining sustainability, but no other phenomenon carries such risks to life on the planet. Climate change interacts and exacerbates many other issues critical to environmental integrity and/or human well-being, e.g. biodiversity loss, ocean acidification and food security…. to name but a few. Our challenge is to acknowledge the new responsibilities this brings to the profession: to understand the psychology behind the destructive role that humans have had in precipitating these events; determine what can and needs to be done to address this situation, and further, to work facilitating the transition to a more sustainable way of being.

In a nutshell, we are running out of time. There is an urgent need for us to slow down global warming and reduce risk by reducing emissions.

The 2013 report on the state of our global climate conditions from the United Nations body, the Intergovernmental Panel on Climate Change (IPCC), indicates that climate change is getting worse and man is the main cause[3]. Further, they stressed the importance of maintaining global warming below the 2ºC mark. This is widely considered to be the dividing line between warming which is just about tolerable and that which is dangerous.

Figure 1[4] depicts the projected warming relative to high and low growth emission scenarios.

Specifically, a budget has been calculated - to have a two-thirds chance of keeping global warming below 2ºC "will require cumulative CO2 emissions from all anthropogenic

1 See http://www.psychology.org.nz/wp-content/uploads/NZPsS-2018-Statement-on-Environmental-Wellbeing-and-Responsibility-to-Society-Reviewed-Final-Version-20-April-2018-1.pdf

2 See also https://royalsociety.org.nz/assets/documents/Report-Human-Health-Impacts-of-Climate-Change-for-New-Zealand-Oct-2017.pdf and MANNING, C. & CLAYTON, S. 2018. 9 - Threats to mental health and wellbeing associated with climate change. Psychology and Climate Change. Academic Press.

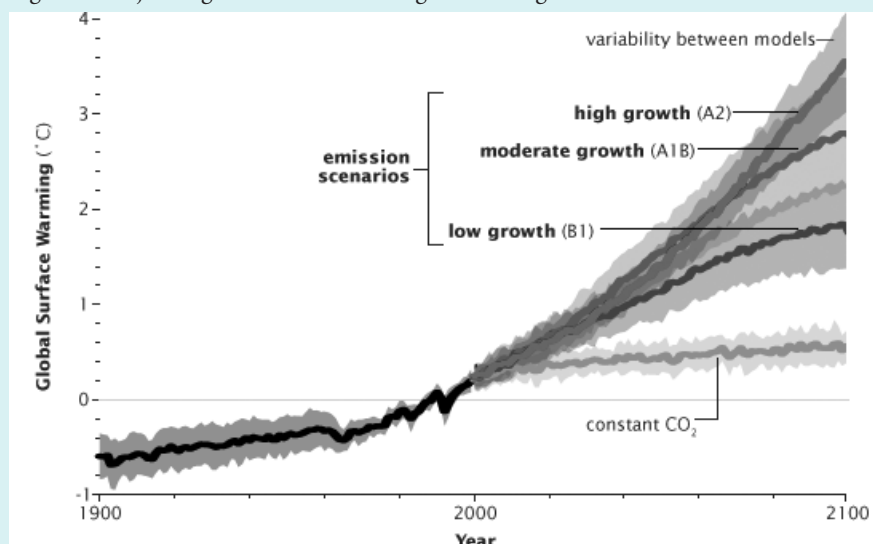3 The points made in this paragraph are drawn from http://www.economist.com/blogs/babbage/2013/09/ipcc-climate-change-report

4 From the NASA Earth Observatory on IPCC https://earthobservatory.nasa.gov/Features/GlobalWarming/page5.php

sources to stay [below] about 1,000 [trillion tonnes]". In 2011, the world had already gone through just over half that amount (531 trillion tonnes).

Figure 1: Projected global surface warming relative to growth emission scenarios

In 2015, when I first presented this information at the NZPsS Conference, the rate of greenhouse-gas emissions (through the burning of fossil fuels, cement production, land use change, etc.), meant that the rest of the budget would be spent before 2040.

However, the IPCC report was released prior to the events at COP21[5] held in December 2015. This is where, via the Paris Agreement, the international community agreed not only to limit temperature rise to below 2ºC but also to pursue efforts to limit the temperature increase to 1.5ºC. We are already at 1.1ºC above pre-industrial levels and estimates indicate that, if we maintain present day emission rates, we have a window of opportunity of 7-10 years to keep global warming to 1.5ºC and 15-20 years to keep it at 2ºC[6].

5 COP21 was the 21st yearly session of the Conference of the Parties (COP) to the 1992 United Nations Framework Convention on Climate Change (UNFCCC)
6 Personal communication 17th May, 2018 from Prof James Renwick, Victoria University, Wellington

In a nutshell, we are running out of time. There is an urgent need for us to slow down global warming and reduce risk by reducing emissions. This means a move to what we call a decarbonised economy, one in which we move to low carbon energy sources (e.g. wind, solar and hydro-power). This will ensure that the world's oil and coal sources stay in the ground, or if used, be used by developing countries to ensure an equitable starting place in their drive for a prosperous future. As Prof Chris Ryan from Melbourne[7] has discussed, a paradigm change is needed – the old story based on human progress enabled by fossil fuels no longer works. We need a new story to help shape our lives.

We are already beginning to experience extreme environmental changes so why is responding to this reality being so resisted?

Implicitly, our personal values, our worldviews and ideological frameworks – our shared stories provide us with direction on how we shall live (Corner and Groves, 2014, Korten, 2015). Challenged

7 From a 2011 seminar at VEIL: Victorian Eco innovation Lab, Melbourne, Australia

personally and professionally as we now find ourselves, we will need to live differently, and we need a different story to take effect. But it is more than we as individuals reducing energy usage or consumption patterns or carbon footprint. It is a story that will need to acknowledge our interdependence with one another and with our planet. Taking on the responsibilities outlined in the Society's Position Statement for social and environmental well-being will be part of our new professional story. This is our ultimate climate challenge. Business as usual is not an option.

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Climate challenged: Where to focus change efforts?

Marg O'Brien[1]

It is increasingly clear that understanding human responses to climate change is just as important as – if not more important than – understanding climate change itself. (Weintrobe, 2013b)

The present situation is clear. Scientists are in consensus with regard to the evidence in support of human induced climate destabilization (Cook et al., 2013, Cook et al., 2016). Fundamental changes in our behaviour, our attitudes and values are required if we are to avoid a catastrophic future. We are already beginning to experience extreme environmental changes so why is responding to this reality being so resisted? The causes and consequences of anthropogenic emissions of greenhouse gases have been long understood but we are not noticeably changing our actions. Does this mean that we have not understood the significance of what is happening?

We know from substantial national research done a few years ago that over half of those surveyed believe in the reality of climate change and its cause by human activity. A smaller percentage believe in climate change but not its human cause. Under a third of us are undecided while 10% remain sceptics (Milfont et al., 2015). So, a good half of us are aware that we have a problem and that change is needed. Yet even for those with a thorough understanding of the issue, moving to make a change is slow when not given the requisite priority.

Have communications about climate change fallen short of expectations? The science world's ability to convince people to change certainly has been denied or slow to work (Moser, 2010, Moser, 2016, Pearce et al., 2015, Somerville, 2012), although there are examples of effective communication as presented by David Holmes[1] at the NZPsS 2018 Jubilee Conference (Holmes, 2018). There are so many ways to defend ourselves against the reality of what is happening. The reactions you'll hear even now are varied:

- The climate isn't changing. We're just experiencing a natural cycle… we've had them before.

- Nothing we can do in New Zealand will change the situation.

- I'm sure there will be technological breakthroughs to solve the problem… won't there?

- I can't think about it. I just get too depressed.

- I don't think there's much that I can do… the government needs to make the changes.

In attempting to understand this type of response, we find that an overwhelming factor that determines whether or not we reject climate change is linked to our values - our worldview, political orientation or ideology (Lewandowsky et al., 2012, 2015, Lewandowsky and Oberauer, 2016, Whitmarsh and Capstick, 2018, Bliuc et al., 2015). In one of the early reviews of public engagement with climate change, Corner and colleagues (2014) state: "Although people possess a range of different and sometimes conflicting values, those who identify strongly with self-enhancing values (e.g. materialism…) tend not to identify strongly with self-transcending values (e.g. …respect for the environment), and vice versa." p.412.

The science world's ability to convince people to change certainly has been denied or slow to work

Similar results were established here by Milfont and colleagues, who in analysing data from 36 countries found that national-level pro-environmental scale scores[2] were higher in countries that value harmony, collectivism, and intellectual and affective autonomy and lower in countries that endorse conservative and materialist values (Milfont et al., 2013, Milfont et al., 2008). And more recently, a smaller study expanded on the notion of conservative, and linked right wing authoritarian and social dominance, particularly anti-egalitarian dimensions to climate change denial (Stanley et al., 2017).

The question then to be asked is whether our values relate directly to our engagement with environmental issues? Certainly this is supported by research. Corner et al. (2014) write: "…people who endorse self-transcendent values and who exhibit high levels of altruism are more likely to engage in sustainable behaviour; …perform specific actions such as recycling; …engage in indirect and direct political engagement on environmental issues… engage positively with climate change… and [be] prepared to make significant changes to their own lifestyles…." (p.413-4). Working to inform and change the values people hold

would benefit pro-environmental engagement. But how is this developed?

Reflecting on this type of research, Clayton et al. (2015) write, "…evidence indicates a need to further examine relevant social identities, to better understand how beliefs about climate change have become ideologically polarized in certain populations, and to develop educational interventions and communications tailored to values and possible misperceptions of specific audiences." (p.641)[3]. The rationale for this work is to enable communicators of climate science to craft communications to effectively target each distinct cultural worldview. The implication is that there will be some 'expert' out there who will know how to strike at the heart of those holding contrary views – a method that unfortunately risks being construed as control or manipulation.

Another unintended impact of this work into worldviews and its application to campaigns is that it can give prominence to ways of construing the world that add to conflict and resist change. As Corner and colleagues have further discussed, framing the issue in this way where one worldview is denigrated just contributes to polarization. Conventional climate change communications have distanced people from one another. So, if we are to avoid framing the views on climate change in ways that contribute to prolonged or intractable conflicts should we move past 'diagnostic type framings' to achieve a more constructive debate (Whitmarsh and Capstick, 2018).

3 See also the work of BOSTROM, A., BÖHM, G. & O'CONNOR, R. E. 2013. Targeting and tailoring climate change communications. Wiley Interdisciplinary Reviews: Climate Change, 4, 447-455.

It is clear that we need to work in ways that reach the 'disengaged', counter polarization and overcome the denial and disbelief in climate change, as other psychologists have begun to do (Whitmarsh and Corner, 2017, Swim et al., 2018, Kasser, 2017). But will an awareness and acceptance of the climate crisis really necessitate the behavioural changes we seek? Will individuals feel free to talk to friends and colleagues about climate change? Will they reduce, reuse, recycle; use public transport; buy an e-bike or engage politically on carbon neutrality? Or will we just be adding to the majority who are aware but making slow progress on the 'action' front? Or, even worse, be adding to those who are now depressed and grieving at the state we are in?

While there has been a profound concern for those still 'in denial' and our need to urgently bring these people 'on board', my concern is that, deep down, this applies to most of us. Are not most of us still in denial?

Our behaviour does not always align with our attitudes. While research indicates that the public's belief in climate change and its human cause are increasing over time (Milfont et al., 2017), for many of us the issue is still very distant (Stanley et al., 2018). We go about our everyday lives, "…driving the kids to school, heating our homes, putting food on the table", oblivious to the impact of our everyday behaviour (Marshall, 2014)[4]. Behaviour change leads to attitude change but not necessarily the other way around. Rather than changing our behaviour

4 See also Marshall, G (2014) in https://www.theguardian.com/commentisfree/2014/sep/23/why-our-brains-wired-ignore-climate-change-united-nations

we can modify our thinking to match what we do.

The problem is that we live in a culture that encourages our self-interest: our narcissism and our life as consumers (Weintrobe, 2013b). Narcissism normally involves our inability to tune into others but in this instance we are failing to tune into the very environment that supports us (MacDonald, 2014). As Randall (2013) has commented, as a culture we have become narcissistically entitled to consume, our liberalized markets "…well served by personalities who are alienated from the rest of the natural world and who are dependent on material satisfactions to sustain their sense of self-worth and identity." (p. 98). Supported by advertising (see Box 1) we give 'things' in our lives social and psychological meaning. We focus on buying so that we may be more attractive and our magical thinking deploys omnipotent fixes because we are 'worth it' (Weintrobe 2013a).

Box 1: Adverts for cosmetics and travel (absolute necessities!) bolstering our self-worth
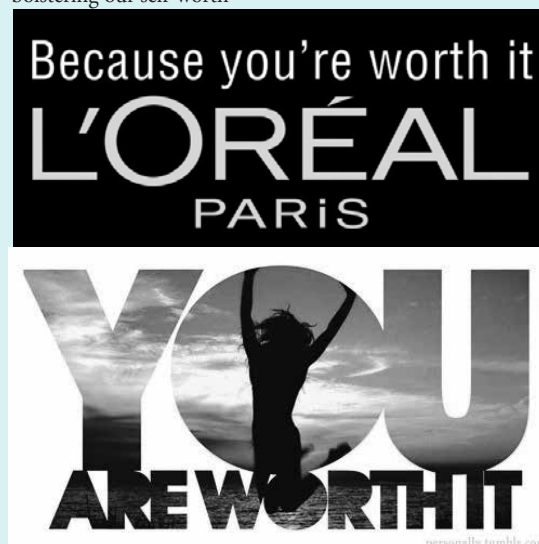
So, are we too constrained by the well-worn pathways of our everyday lives? Or is there something deeper that we still have to come to terms with? Some, alarmed at the lack of

response to climate change issues discuss the need to draw a distinction between denial and what they call *disavowal* - where we are unconsciously accepting that something is true while simultaneously finding ways to deny it, behaving in ways that suggest that the opposite is true (Weintrobe, 2013a)[5]. We are in conflict with ourselves and yet we fail to work through the dissonance. Any anxiety that surfaces is easy to deflect as we get on with our busy lives. Business as usual: Disavowing responsibility for both the problem and the solution (Hamilton, 2013).

So where and how should we psychologists focus our change efforts? We have for decades focused on the dysfunctional behaviour of individuals but is this still wise when evidence of greater systemic dysfunction becomes apparent? Will we be guilty of dealing with the symptoms rather than the 'disease'?

… a smaller study expanded on the notion of conservative, and linked right wing authoritarian and social dominance, particularly anti-egalitarian dimensions to climate change denial

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There is no doubt that while much of our focus will remain with the individual it has been seen as problematic. Over many years, government agencies have been keen to learn about individual behavioural change techniques and processes that engage people in pro-environmental behaviour. The focus of these campaigns has been an individualized climate change risk and responsibility. And while recent work by people like Wolske and Stern (2018) looks to encourage greater impact from this focus on individual and household behaviours, we are becoming increasingly aware that environmental deterioration is not just the result of poor individual choices.

What has occurred has been a powerful framing of the problem that shifts the locus of control from the political to the personal, from system and structural constraints to us as individuals. As Leonard (2013) writes though, this emphasis can distract "…us from identifying and demanding change from the real drivers of environmental decline. It also removes these issues from the political realm to the personal, implying that the solution is in our personal choices rather than in better policies, business practices, and structural context." (loc 5421).

It is clear that our absorption with the impact of worldviews reinforces this framing focus. Sociologist Brulle (2010)

has gone further arguing that expert communications developed to change the behaviour of individuals undermines collective change efforts and "…[weakens] the mobilization capacity over this issue of global warming." (p.1). A concern that would be shared by Bamburg and colleagues in their work of developing a psychology of collective climate action (Bamberg et al., 2015, 2018). It would seem in fact, that we are faced with systemic change requirements of a far greater magnitude than yet fully understood.

The reality is that we already know a lot about what is needed from a psychological perspective. Indeed, many of us are already working on the need to tackle psychological problems of a systemic nature, whether this be, for instance, in relation to cultural, income or gender inequality. The need posited here would indicate that we may also have a role not only in developing awareness of the environmental crisis that we face but also in dismantling the culture of consumerism, of building social capital… overcoming community fragmentation… and building connection… steps in a wider social transformation that has us flourishing in more aware and less materialistic ways (Jackson, 2009, Jackson, 2016). In these challenging times for humanity, psychologists have an ethical responsibility to support and encourage individuals, communities and our society to ensure the wellbeing of people and the sustainability of all life on Earth (Abraham et al., 2016).

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5 See also http://www.climatepsychologyalliance.org/explorations/blogs/290-bbc-coverage-of-global-climate-emergencywe-have-become-increasingly-troubled-by-how-the-bbc-covers-and-does-not-cover-climate-change-in-its-news-broadcasts

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One on One - with Tony

We invited prominent senior contributor to New on one contributors.

Tony was born in 1926 in the East End of London, with an outlook and career much influenced by the plight of the disadvantaged. He spent three years in the Royal Navy, before training as a social worker at the London School of Economics and Political Science, followed by probation officer training with the Home Office. He then emigrated to join the rejuvenated Probation Service in New Zealand. Further university studies led successively to appointments as a prison psychologist, lecturer in abnormal psychology, founder of the University Counselling Service, an Honorary Consultant in the Department of Psychiatry at Wellington Hospital, and Head of the Psychology Department (from which he retired in 1991).

To date Tony has over 300 publications, including five books, on topics ranging from the effects of imprisonment, evaluating group therapy with borstal girls, transvestism, Antarctic isolation, and disaster stress. More recently his attention has returned to prison reform and justice.

Tony lives with his partner on the waterfront in Paekakariki, with easy access to tributaries of families and friends which is a tonic. Trying to follow Quaker tenets is a challenge!

Taylor and Jade le Grice

Zealand psychology, Emeritus Professor Tony Taylor and Dr Jade Le Grice from The University of Auckland as our one

One aspect of your role(s) that you find really satisfying

Being touched by former probationers, prisoners, psychiatric patients and students who have overcome major obstacles in their lives and are helping others.

One event that changed the course of your career

Being asked by the headmaster to take a boy on probation into the Scout troop I was running.

One alternative career path you might have chosen

Accepting a permanent commission in the Royal Navy.

One learning experience that made a big difference to you

As a cockney kid, a 'gutter-snipe', ending up at the age of 19 as the leader's navigator of a mine-sweeping flotilla working off the Burma Coast.

One book that you think all psychologists should read

Viktor Frankl's *From Death Camp to Existentialism*.

One challenge that you think psychology faces

Easing the friction between many academics and practitioners over 'pure' and applied objectives – as I know to my cost!

One thing that psychology has achieved

Recognition, at last, that health and well-being depend on the interaction of many inter-related disciplines, rather than the arrogant assertions of a vociferous sector of any one.

One aspiration for psychology in Aotearoa

To get more academics attuned to 'real-life' problems, and practitioners more responsive in seeking their help in researching the dire effects of poverty, ill-health, poor housing, child welfare, resettlement of refugees, and all kinds of discrimination that breeds deep resentment.

One social justice issue psychology should focus on

Bringing justice into a framework of human needs, and obliging those who have attained the heights of 'self-actualisation' to help others overcome severe obstacles they face.

One big question

Is to remember that although psychology grew out of philosophy, morphing into science does not mean that it has to abandon its heritage, as some academics wrongly assert.

One regret

That it took seven years to overcome the opposition of staff before I could mount the interdisciplinary MA (Applied) in Clinical and Community Psychology for which the University Council had appointed me, (and it took barely a year for them to scrap it after I retired).

One proud moment

Not one but several – i.e. being told that the multi-component selection system for Volunteer Service Abroad retains its value, initiating the first University Student Counselling service, receiving the Police Commissioner's Award for organising a service for recovery personnel after the AirNZ DC10 crash on Mt Erebus, and a DHC (Reims) for my part in the International Bio-medical Research in the Antarctic.

One thing you would change about psychology

Oblige all academics to be of service to the community.

One piece of advice for aspiring psychologists

If you should be on the conveyor-belt of security and affluence, make sure that you take a spell to experience under-privilege: if you are not, beaver away and take opportunities to gain knowledge as they arise. There is nothing more satisfying than being of service to humankind.

Jade Le Grice is Ngai Tupoto hapū, Te Rarawa iwi, and Ngati Korokoro, Ngati Wharara, Te Pouka hapū, Ngāpuhi iwi. She currently resides on the north shore of Tāmaki Makaurau. She works as a lecturer in psychology at the University of Auckland, and her research focusses on Māori sexuality, reproduction, and whānau practices in contemporary contexts. She is currently a HRC Irihapeti Rehu Murchie Fellow, on a project exploring Hokianga mātauranga pertaining to sexual violence prevention.

One aspect of your role(s) that you find really satisfying

The dynamics of student responsiveness to teaching about mātauranga Māori and decolonisation in psychology, in the lecture theatre. Watching Māori (and Pasifika) students' eyes light up when you talk about something that relates to their lived realities in a mana-enhancing way. Hearing students reflect back upon what you have shared with them, expand, extend upon, and deepen those understandings. There are students who won't shift racist understandings about Māori (knowable through lecture evaluations!) and they can be slightly disruptive or dismissive in class. However, on the flip side is scope for stimulating possibilities for allyship and solidarity. It can be really thrilling listening to people tautoko the content, speak to their lived

experiences from positions of certainty or even ambiguity, and see the potential for leadership and solidarity emerge from the lecture theatre.

One event that changed the course of your career

Coming to the realisation that you don't have to be aged, Pākehā, or a man to be an academic – that I could be one, and that it would give me a platform to be heard on issues that matter to me.

One alternative career path you might have chosen

Being a stay at home mum, and equipping children with the flexibility and skill needed to navigate and survive in a racist, homophobic, sexist world.

One learning experience that made a big difference to you

Coming to appreciate human life as complicated, variable, diverse, contextual, and laden with cultural meaning. Learning to trust my intuition, rather than more restrictive notions of psychological processes and attendant outcomes.

One book that you think all psychologists should read

He Manu Kai i te Mātauranga!

One challenge that you think psychology faces

Recognising the myriad of ways that colonialism and racism has pervaded our understandings about psychology, unravelling that, and reassembling decolonised approaches to psychology. That requires us to understand ourselves as bearers of culture, and how we could (wittingly or) unwittingly perpetuate colonising approaches to psychology that harm Indigenous peoples.

One thing that psychology has achieved

Resistance to the medicalisation of distress, and the importance of listening to people's accounts – and ways of making meaning - of their experiences.

One aspiration for New Zealand psychology

Honouring the relationship between Pākehā and tangata whenua, as promised in te tiriti o Waitangi.

One social justice issue psychology should focus on

Intersectional marginalisation and resistance. Taking care not to unnecessarily pathologise people for divergent ways of being.

One big question

Are we going to be leaving the world a better place than were received it, for future generations?

One regret

Not learning te reo Māori earlier in life. Te reo Māori metaphorically stitches together a sophisticated ontology, scaffolding a mana enhancing approach to ourselves, others, and the world around us.

One proud moment

Watching my postgraduate students bravely step into new challenges, responsibilities, projects, and exceed their own expectations.

One thing you would change about psychology

Foreground and centre decolonising, discursive, and poststructuralist approaches to psychology.

### One piece of advice for aspiring psychologists

Take care of your health, wellbeing, and those you love.

We have something of a potpourri of reviews for this issue, although they all deal with reasonably common problems of living. Rebecca Sargisson comments on a book about the pressures to excel that young women now face, while Trish Hanlen introduces a text about responding to illness and disability. Included here are also two reviews that I have written, and one of these works deals with the fear of flying, and the other book is about sleeping difficulties.

Peter Stanley- Review Editor, pstanley18@outlook.com

Enough as she is: How to help girls move beyond impossible standards of success to live healthy, happy, and fulfilling lives
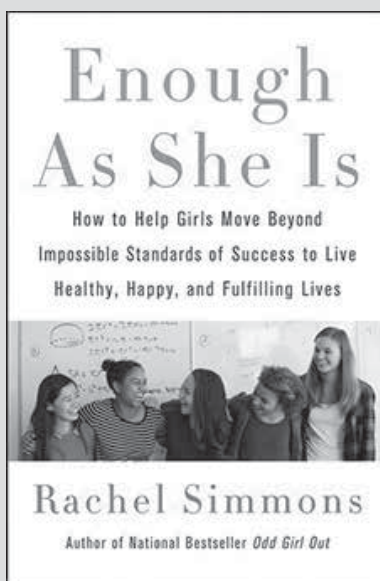
Reviewed by Dr Rebecca Sargisson, Lecturer and Researcher, Faculty of Social and Behavioural Sciences, University of Groningen.

I was excited to read *Enough as she is*, by Rachel Simmons, as I have two pre-teen girls in a world that seems increasingly complicated for girls and women. The topic is timely, and the book was informative in terms of modern issues faced by girls, such as the pressure of social media. The social media section was interesting as, not being a digital native, it is sometimes difficult to relate to the online world that teenagers inhabit today.

There was a good range of topics covered, including the extreme pressure placed on girls to succeed in all areas of their lives – academic, appearance, social life – and the impacts that pressure has on girls' confidence, self-esteem, and anxiety levels. A chapter on the continuing pressure on girls to be thin reminds us that this issue has not gone away despite increasing levels of obesity. Simmons also gives girls permission to make mistakes, to change their life course, and to be less-than-perfect, which is a message that everyone needs to hear.

To a non-American audience, the book began weakly, with a focus on the college application process. While girls in New Zealand share some of the generic problems mentioned here, our university enrolment system does not place as much pressure on girls and I found a great deal of this chapter irrelevant to those of us outside of the U.S. The focus of the entire book was clearly on wealthy, white, girls who are all expected to go to university. So, the audience was rather narrowly focused.

Simmons uses almost no citations to support statements of fact or research findings. She relies quite heavily on anecdotes, or personal stories, from girls she interviewed for the book. I realise the book is for a non-academic audience, but I would have liked a more rigorous academic base. Academic readers may struggle, as I did, with the lack of cited research evidence which inhibits the reader from fact-checking or exploring more deeply by reading the original research. Simmons likely wrote the discussion on growth and fixed mind-sets in Chapter 4 before the recent meta-analysis of Sisk et al. (2018) provided compelling evidence against this theory. The presentation of the idea of mind-sets as fact brought into doubt, for me, the evidence-base of the other chapters.

The book is advertised as a guide to "help girls move beyond impossible standard of success" but the focus seemed to be on the problems, rather than on the solutions. The problems made for sobering reading, but the solutions, when they did appear, were often rather weak, involving, for example, talking to your daughters about the problem (or in some cases, not talking about the problem). There was little mention of established and respected therapeutic approaches, such as Acceptance and Commitment Therapy, although mindfulness makes an appearance in Chapter 6 with self-compassion. It was often difficult to separate the recommended solutions from the general discourse about the problem.

The book as a whole seemed to

lack structure and came across as a bit undirected and repetitive. I found my interest flagging near the end. A clear chapter structure, for example, outlining the problem, then describing an example case, followed by suggested responses, might have provided the predictability I wanted, and enabled me to skip to the solutions when the problems came to seem overwhelming (as they did). I also found myself wanting to read about the girls whose teenage years had not been a problem. Positive psychologists would have us learn from those who navigate their lives and problems successfully, so that might have been a nice addition.

This book would be helpful to male and female parents, of both boys and girls, preferably whose children have not yet reached their teenage years. Educators, social workers, and psychologists may also find the book helpful in describing some of the issues faced by today's girls, and especially for those of us who did not grow up in a world dominated by social media. However, professionals will need to look beyond the information provided by Simmons when seeking solutions or therapies for girls facing these issues.

Overall, I was glad to have read this book as it reminded me of the difficult position girls are put in today. Awareness of these issues will change some of the things I say to my daughters and my female university students.

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Enough as she is: How to help girls move beyond impossible standards of success to live healthy, happy, and fulfilling lives.

Rachel Simmons (2018).

Harper Paperbacks. ISBN: 0062438425.

304 pp. Paperback. (Book Depository, $22.83)

Helping couples and families navigate illness and disability: An integrated approach.

Reviewed by Dr Trish Hanlen, MNZM, MANZASW, Registered Social Worker (semi-retired).
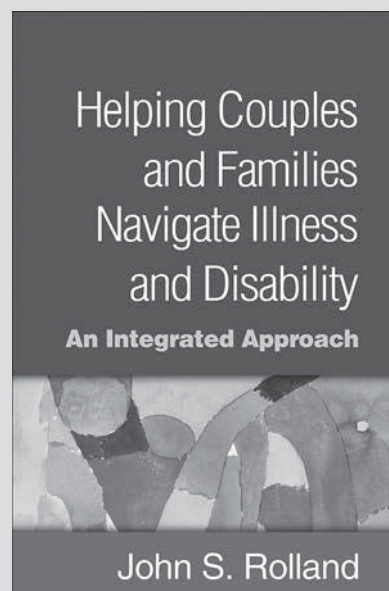
John S. Rolland is a Professor of Psychiatry and Behavioural Sciences and he is internationally recognised in family healthcare and family therapy. In this text he emphasises the importance of the psychosocial interplay of family, care-giving systems and community support, coupled with biomedical interventions, as important levels of influences on illness and disability, and on care and wellbeing. This systemic and process approach will be appreciated by those working in the helping professions who are involved with children, couples, adults, families, and for those clients with later life conditions. Another particular benefit of this valuable book is that it would also be useful for families themselves who are supporting family members with illness and disability.

The author recognises the importance of all family members in the assessment, intervention, support, and recovery of the person, and to the adaptions needed in family life. It aims to reduce marginalisation and exclusion of other family members, which may be seen in current medical models. The treatment and the amount of home-versus hospital-based care is acknowledged as varying among disorders. The visible, and invisible, signs of illness or disability (such as in Alzheimer's disease) are considered for the power and influence these may have on a family. A longitudinal perspective also considers the pattern of the illness over time and how this affects the family system and life cycle, how it is experienced subjectively, and the demands and challenges at different stages of illness. In addition, there are suggestions for linkages between the psychosocial and biomedical worlds.

Particular features of this book include a focus on the family system, family processes, and community support in the building of resilience. The family systems model

is applied in 18 chapters making this a book that can be 'dipped into and out of.' Illnesses and disabilities are considered by helpful categories that include type and degree, onset, course, outcome, and the level of uncertainty involved. Features are clustered on a grid, so the reader can think about the psychosocial demands of each condition. Case studies, vignettes, graphs, figures, tables, clinical guidelines and up-to-date theoretical and clinical research references are also provided to enhance the utility and accessibility of this text.

Some specific matters that are addressed in this comprehensive and useful work are the importance of multigenerational themes in illness and loss, transition points, the role of family belief systems, couples' relationship issues, anticipatory loss issues, and the challenges involved with the death of a loved one. Ethical issues in illness and disability are also given explicit consideration, as are chronic conditions in childhood and adolescence, and family challenges with mild and advanced dementia and in traumatic brain injury.

As a social worker I am especially grateful for this author's application of the family systems conceptual framework, and for his use of the genogram in particular. Psychologists would find this book a useful resource for any scope of practice. Moreover, the holistic framework that is utilised in *Helping Couples and Families Navigate Illness and Disability* is consistent with indigenous models of biopsychosocial case work in Aotearoa New Zealand.

Helping couples and families navigate illness and disability: An integrated approach.

John S. Rolland (2018)

The Guilford Press, ISBN: 1462534953

400 pp. Hardback. (Fishpond, $65.99)

Fear of flying workbook: Overcoming your anticipatory anxiety and develop skills for flying with confidence.

Reviewed by Dr Peter Stanley, Retired Counselling Psychologist, Tauranga.
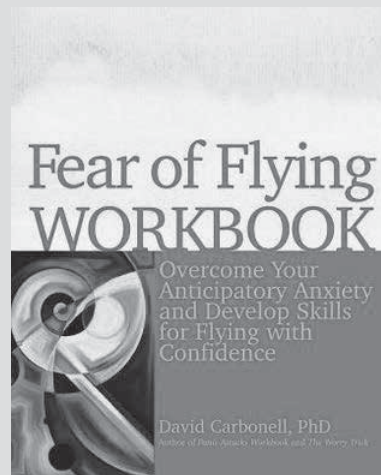
People who are afraid of flying do actually have a point. I made this note to myself earlier this year when I was in a plane midway across the Tasman Sea at an altitude of 12, 239 metres, with an airspeed of 843 kilometres per hour, and an outside temperature of minus 58 degrees centigrade. Moreover, if the plane were inexplicably to come down in the water (like Malaysian Airlines Flight 370) getting the inflight entertainment system to work as it should would obviously become the least of anyone's concerns. So, who's got the best grasp on reality here, the laid-back passengers with the designer head rests or the members of the white-knuckle brigade (as they are sometimes called) who can grip their seat with earnest apprehension (and raw courage) whenever they fly?

Actually, fearful fliers are probably not much more concerned about crashing than everyone else. As author David Carbonell explains, people who are afraid of flying have more developed, and more personal, fears which will not be allayed by being told that planes are made to fly and that commercial aircraft rarely crash. For the fearful flier, it is typically a fear of fear itself that is the problem; plus, consuming concerns that they will lose self-control and do something socially inappropriate and deeply humiliating. Fear-of-fear places fearful flying in the same category as all the other avoidance-based phobias and foibles; although fear of flying can combine a number of these states (e.g., claustrophobia, aversion to heights) in new and extreme ways. Interestingly, a fear of flying can develop in people who have had years of successful flying, and in other passengers it can fluctuate over time. These facts implicate the effects of other life circumstances on the fear, and they also suggest that aviophobia (as the diagnostically inclined can call it) is probably far more widespread than the 16 percent or so of people who will admit to it.

Carbonell's catch line is 'what we resist, persists.' This author and practitioner prioritises exposure and acceptance over the challenging of thoughts. He says that there are special complications with modifying cognitions, and he exemplifies this by analogy: When you change your clothes they "are not going to slither out of the hamper and crawl back onto your body" (p. 92). Nonetheless, nervous fliers can benefit from some reconceptualisations. Firstly, they may need to appreciate that anticipatory anxiety ('what if' thinking) invariably makes incorrect predictions about the future. Secondly, it can be important to recognise that they are passengers on planes and their only job is to experience fear and to let it pass. Thirdly, they should endeavour to observe their anxiety, rather than automatically respond to it as victims. Fearful fliers are also encouraged to discard their 'safety devices' (like distraction, looking for reassurance, and seeking a protector and manager) and, instead, to pay sustained attention to strategies (such as record keeping, relaxation responses, and belly breathing) that assist them to experience the flight. Fear of flying is "the mother of all counterintuitive problems" (p. 72) but it is not a disease. "It's an overgrown version of ordinary fear and anxiety that needs to be whittled down and retrained, not cured" (p. 114). Moreover, the author says that such a reorientation can be achieved in twelve months of progressively more demanding flying experiences.

Fear of flying might be seen as a metaphor for life, and an aspect of this is our prevailing responses to technology and modern living. Humankind was not really built to cope with high-rise apartments, advanced medical procedures, or weapons of mass destruction any more than we are naturally situated to be transported across the sky seated in a sealed tube. Nevertheless, as Carbonell makes clear, fearful fliers will likely pay a very high price for their reluctance with severely restricted career and leisure options. In addition, there is the inevitable shame, embarrassment, frustration, and regret whenever they turn away in the airport carpark or at the check-in. It's a quandary, but one that Carbonell's *Fear of flying workbook* can help to resolve. The tone of the book is optimistic from the outset, with the first line of the Introduction being "You can overcome the fear of flying" (p. 3). The author also makes clear that this anxiety is nobody's fault. It's just one of those things. As an addendum, it should be said that fearful fliers can develop a special sensitivity to the condescension of other travellers who do not have this particular problem and who (according to the seventeenth century poet Samuel Butler) compound the issues they are inclined to by damning those they have no mind to.

Treating sleep problems: A transdiagnostic approach.

Reviewed by Dr Peter Stanley, Retired Counselling Psychologist, Tauranga.
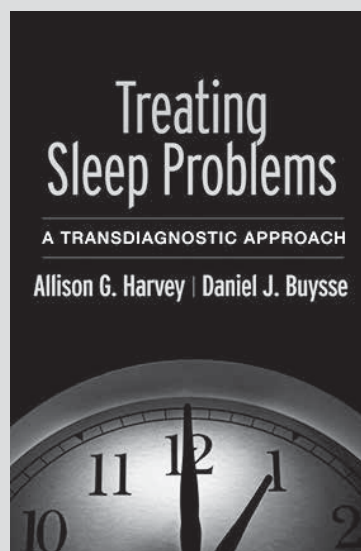
Sleeping well is the most sustained active thing that we do, and we do it involuntarily. In fact, good sleep does far more than knit up "the ravell'd sleeve of care" as Shakespeare suggested. Depending on the phase of sleep that we are experiencing, it performs such diverse functions as repair the immune system, maintain muscle memory, and contribute to our personal creativity. It is not especially surprising that adults who are good sleepers, and who average 7-8 hours, have longer lives. The many difficulties and dysfunctions that we can experience in relation to poor sleep can be catalogued according to the six dimensions of sleep, which are timing, regularity, duration, efficiency, satisfaction, and daytime alertness. For instance, poor sleep efficiency, (which is derived by dividing 'total sleep time' by 'total time in bed') is associated with metabolic syndrome, hypertension, coronary heart disease, and depression. Sleep, along with diet and exercise, is one of the pillars of our health, and its maintenance and improvement are definitely things to be taken seriously.

Professors Allison Harvey and Daniel Buysse, who are the authors of the present text, are committed to a health promotion perspective on sleep, and they offer the Transdiagnostic Sleep and Circadian Intervention (or

TranS-C), with its empirically-supported components, as a means to achieving this end. As the title of this intervention suggests, the circadian rhythm of 24 hours and 10 minutes is central to their model; as is the natural homeostatic process that increasingly drives our desire for sleep the longer that we are awake. These two physiological processes are key to understanding the sleep-wake cycle. Specifically, they help us appreciate the impact of light and dark, and the patterning of work, exercise, meals, and social activities, on our sleep characteristics. Hence, as the authors argue, it is necessary to understand what a person with sleeping difficulties is doing during the day, as well as at night. And this is also important because, as adult experience inevitably teaches us, daytime alertness is partially independent of having a good night's sleep.

Treating Sleep Problems is actually a treatment manual for a broad range of sleep problems and it contains three sets of modules. The four cross-cutting modules are case formulation, sleep education, behaviour change and motivation, and goal setting. The four core modules are establishing regular sleep-wake times, improving daytime functioning, correcting unhelpful sleep-related beliefs, and maintenance of behaviour change. And there are seven optional modules covering such topics as decreasing time in bed, assisting compliance with a CPAP machine, and reducing nightmares. This 'mix and match' system caters to the complexity of clinical presentations and it maximises usefulness for the client. TranS-C comes with a comprehensive array of downloadable resources, and this feature might also allow implementation by paraprofessionals with suitable training and supervision. To date, the treatment is supported by one small randomised control trial. Two larger RCTs are in progress. Available data indicate that this system impacts positively on both poor sleep and on the symptoms of comorbid problems.

TranS-C is part of a larger movement towards transdiagnostic treatments, and in the case of sleeping difficulties there are at least four important reasons why this should be so. Firstly, even with the imprecision of psychiatric disorders, comorbidity with insomnia is believed to be somewhere between 41-53 percent. Quite obviously, many if not most people who have problems of living do not sleep well at night. The second salient matter is that there is increasing evidence that problematic sleep is actually a significant cause of personal issues rather than simply being their frequent companion. Proof positive of this is the negative mood and diminished courage that any of us can feel after just one disturbed night. Thirdly, as indicated with the present treatment system, intervening with sleeping issues can do good things for comorbid

conditions as well. Such improvement has been found to apply to anxiety, depression, schizophrenia, PTSD, and even for cancer and renal disease. The fourth justification for a transdiagnostic approach is a corollary to the exorbitant comorbidity of mental health conditions, and this is the necessity to have an ever-expanding portfolio of particular evidence-based treatments. Wouldn't it be simpler, easier, and more efficient to address a principal issue first up?

Treating Sleep Problems is an excellent exposition and resource, and part of its strength is in the questions that it raises. Specifically, I wonder whether the authors might consider some additions to their next edition, such as some qualitative work on the misery of protracted sleep difficulties and on the client experience of becoming a good sleeper. I also wonder about the role of familiar fantasy states that people may utilise to transition "'twixt wake and sleep," in preference to therapist recommendations for savouring, giving gratitude, or positively-valenced imagery. Something else that I have wondered about is how an Acceptance and Commitment Therapy perspective would enhance this CBT text. The values component of ACT seems especially relevant as people need things to get up for, and to draw them through the swamp of sleeping difficulties. However, it is possible that Harvey and Buysse will have the same subvocal response that I can have to suggestions of reviewers on my work: 'Have you considered writing your own book or paper rather than trying to latch onto mine?' Nonetheless, as therapists and theorists we probably all need to give greater attention to the mechanisms of good sleep given its central importance to client wellbeing and to our own lives.

Treating sleep problems: A transdiagnostic approach.

Allison G. Harvey and Daniel J. Buysse (2018).

The Guilford Press. ISBN: 9781462531950.

192 pp. Paperback. (Fishpond, $43.57).

Kelly Scott
NZPsS Student Forum Editor

Tēnā koutou ngā tauira o matai hinengaro. Ngā mihi ki a koutou katoa. Nau mai, hoki mai ki te '*Psychology Aotearoa* Student Forum' i tēnei Whiringa-ā-rangi 2018.

As I write this, the dust has only just settled after the New Zealand Psychological Society's (NZPsS) Jubilee Conference in Auckland. I have come away with at least some renewed hope for the future of psychology in New Zealand (NZ). As a student, I have been raised in an ideological bubble about what psychology can and should look like for all New Zealanders. I have seen in my clinical placements however the reality and many shortcomings of systems in crisis. I have seen clients in distress turned away from services because they do not meet the severity threshold. This is in the knowledge that they will not receive adequate or any interventions elsewhere. I have learnt that despite our knowledge about the importance of early intervention, we have only three multidisciplinary teams for infants and toddlers in NZ with mental health needs (and all in Auckland). I have met more than one client who has died as a result of physical health complications due to

a system that breaks down when both physical and mental health needs are present. I have heard very experienced psychologists to whom I look up to and admire say that you could not pay them enough money to return to District Health Board work. Overall, I have begun to question the utility, efficacy and relevance of psychology as it is currently practised in Aotearoa.

I was heartened to hear at the NZPsS Conference however that those older, wiser, more experienced, more connected and influential than I have also seen the horrors and the reality of the worlds in which psychologists operate (and that they have some ideas for change). But it is time to do more than talk. It's time to get angry. It's time to get political. If you are a student reading this, you play a unique role. You are the future of this profession and our country needs you. If you are a Māori psychology student reading this, our profession needs you even more. It is heart-breaking that we need a Waitangi Tribunal claim to be filed because our profession has chronically failed again and again and again to adequately meet the psychology needs of Māori in NZ. If you do not know about this claim, you should.

This Jubilee *Psychology Aotearoa* Student Forum celebrates the work of our students; our future leaders and agitators in all sub-disciplines of psychology. The first article by Angus Craig, a clinical psychology doctoral student from the University of Auckland/Te Whare Wānanga o Tāmaki Makaurau is an amusing, but thought provoking reflection on Aotearoa's love affair with cognitive behavioural therapy. The next article is a reflection on the absence of disability in psychology by Amy Mauer, a Master's student from Massey University/Te Kunenga ki Purēhuroa. This is followed by an interview that I

conducted with clinical psychologist, Anton Ashcroft and social worker and therapist, Keith Tudor about personal therapy for psychologists.

The final three student pieces are diverse in their topics. Luke Sniewski who is completing his PhD at AUT University/Te Wānanga Aronui o Tāmaki Makaurau (and who was an author in the May edition of *Psychology Aotearoa*) reflects on the need for qualitative and quantitative data in academic research. Miriama Ketu-McKenzie who is completing her doctoral studies through Massey University/Te Kunenga ki Purēhuroa outlines her research on dysregulation in the stress response system, culturally enhanced mindfulness and adverse childhood experiences among Māori women. Katharine Jespersen, also a doctoral student at Massey University/Te Kunenga ki Purēhuroa describes her Honours project that examined whether mobile health apps help parents to establish children's oral hygiene routines. Linda Jones, her supervisor explains the difficulties they faced in getting this project published in a journal that paediatric dentists read and gives her reflection on this.

Thank you to our student contributors for sharing their mahi with us. If you are interested in contributing to Student Forum in the May 2019 issue of *Psychology Aotearoa*, or would like to write a response to one of the current articles (or to this editorial), please do not hesitate to get in touch.

Kia whakatōmuri te haere whakamua; our past is our present is our future. We walk backwards into the future with our eyes fixed on the past.

Mauri ora

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Aotearoa Psychology and CBT: A fraught love affair

Angus Craig

Angus is a Doctor of Clinical Psychology candidate at the University of Auckland and an Analyst in Training with the Australian Centre for Psychoanalysis, Melbourne, VIC. In his doctoral research, he is using data from two longitudinal cohort studies (Growing Up in New Zealand and the Auckland Birthweight Collaborative) to investigate the relationship between paternal involvement early in New Zealand children's lives (prior to 3 years of age), and their experience of behaviour and mood issues as they move through childhood into adolescence. Angus has a background in Youth Justice, where he spent time working as a residential youth worker and has completed clinical placements with regional forensic psychiatric services, and Clinical Services Oranga Tamariki. He is particularly interested in the intersection between psychology, politics and social discourse.

The story of Aotearoa Psychology and cognitive behavioural therapy (CBT) is one familiar to us all. We've heard it countless times across all kinds of media. It is a love story. In the 1970s, Aotearoa Psychology was coming of age, exiting what had been a troubling adolescence. Under the austere parenting of the psychiatric establishment they had only really ever been allowed to help out after school in the institutions. Now, however, they were free to expand their horizons in a community treatment model. Aotearoa Psychology was an attractive prospect, and many therapeutic models were showing their interest. Aotearoa Psychology had no desire to be tied down though, they were enjoying their new-found freedom to play the field. There was Psychoanalysis; always mysterious, hard to pin down, complicated and exciting. Such depth of character. They had no doubt that Psychoanalysis could "get" them, and there would be no shortage of good conversation, but could it be relied upon in the day-to-day workings of a relationship? The psychiatric establishment had known about Psychoanalysis a long time, seldom saying a kind word, and admittedly, sometimes when Psychoanalysis spoke, it made Aotearoa Psychology's head hurt. Family Therapy had made its way ashore, hot off the back of Minuchin's early work in the impoverished suburbs of Philadelphia. The anti-establishment rebel with a cause of the new psychotherapies, Family Therapy was training people off the streets in systems thinking. It challenged Aotearoa Psychology; to handle a room full of people, to juggle all sorts of complicated processes. Aotearoa Psychology was enamoured with its edginess, but wisely wary. They felt exhilarated with Family Therapy but who knew what it was going to do next. Would it get bored and simply move on? How would Aotearoa Psychology ever explain to the psychiatric establishment that they'd settled for such radical thinking?

Then there was CBT, the all-grown-up favourite nephew of Behaviourism, an old family friend to the psychiatric establishment. There would be a much greater chance of parental approval. CBT was kind, simple, and pragmatic. It knew how to play the courtship game. Every time it took Aotearoa Psychology out on a date, it let everybody know the agenda, and always returned on time. What's more, Beck and his army of graduate students were producing and disseminating research faster than Aotearoa Psychology could ever have believed. CBT was showing how far it was willing to go for love, and it all made such blissful sense. All apparent common knowledge in mental health, CBT took and put into succinct, aesthetically pleasing models that clinicians and clients alike could understand with ease. And the manuals... Oh the manuals. CBT intuitively understood Aotearoa Psychology's needs, particularly for something easy to teach, easy to roll out across all manner of services. CBT was the most conscientious therapy model Aotearoa Psychology had ever met.

By the end of the 1970s Aotearoa Psychology had a decision to make. It always had a stimulating time with Psychoanalysis, and the butterflies would always be there when Family Therapy walked into the room, but it was time to settle down. When Aotearoa Psychology looked at CBT, it saw a thriving upper-middle class kiwi future; a steady income, a place in a nice suburb, and, most importantly, legitimacy in the eyes of the psychiatric establishment. Aotearoa Psychology heard Psychoanalysis' voice in their ear; it is, in the end, a matter of living with regard to the expectations our parents have of us, consciously or otherwise. Aotearoa Psychology sighed,

resigned to agree. Sure, CBT didn't excite it in the way others had in the past, but this not a time to be hedonistic. CBT would be steady, and they could be happy together.

And so it happened. Aotearoa Psychology and CBT became exclusive. Psychoanalysis and Family Therapy stuck around in hope, and Aotearoa was not about to be impolite. It caught up with them for the odd coffee over the years but set clear boundaries: platonic relations only. Steadily, Aotearoa Psychology's two former lovers were pushed further and further to the fringes. Never completely gone of course, but largely irrelevant. CBT and Aotearoa Psychology began to build a life together. Their devotion was clear for all to see. When British Psychology, South African Psychology and even US Psychology came over to visit, they remarked constantly on the strength of exclusive commitment in the relationship (Thomas, 2018).

No one quite knows exactly when the difficulties started. Some say not long after the honeymoon, others, that things were fine for at least a few decades. What all can agree on is that this committed bliss eventually became an illusion. When CBT and Aotearoa Psychology went out with friends the couple made all the right noises, there was infidelity. Aotearoa Psychology felt bored, unsatisfied, turning up to work and doing the same thing each day. Caged, they wanted to flex their wings, to use their skills in putting together bespoke therapy plans. The sign on the door still read "CBT" but, inside… things were evolving. Suddenly the manuals stayed in bottom of the filing cabinet. "I call it CBT", confessed Aotearoa Psychology, "but I don't really follow the letter of the manual ya know… it's more of a… guideline", "Yea I mean every client is different and one simply has

to make adjustments here and there". The justifications were vehement. When CBT eventually got wind, it was confused, a little angry, but quickly reframed. Its relationship with Aotearoa Psychology had stagnated but there was still hope. Some quick problem solving produced an answer. Children.

When Dialectical Behavioural Therapy (DBT) and Acceptance and Commitment Therapy (ACT) were born, Aotearoa Psychology was overjoyed. The spark was back. The children were chips off the old block. They had CBT's eyes, the same core principles, and the same shaped nose, but were also new and interesting in their own way. Aotearoa Psychology skipped off to work each morning buoyed with new ideas. CBT felt it too. It changed its hair, modernised its wardrobe. Before long, however, old habits started to creep back in. Suddenly Aotearoa Psychology wasn't content with doing CBT, or DBT, or ACT as the evidence suggested, they were keen to do a combination of all of them. "Well pffft I mean the underlying assumptions are the same aren't they? Everyone knows that", remarked Aotearoa Psychology, "at a certain point one has to be allowed to use their clinical judgement, not every client will fit into a neat manualised box". The justifications had returned with equal vehemence… perhaps more. CBT was alarmed. Not angry this time… just disappointed. It had tried its best to keep Aotearoa Psychology happy, but to no avail. CBT took perspective. At least, it thought, this is an evidence-based family, what's the worst that can happen? And it's important that we stay together for the children. Although sometimes CBT wondered whether Aotearoa Psychology even remembered that DBT and ACT were its children. They seemed to be

considered almost separately these days. Aotearoa Psychology thought similarly. It seemed sometimes that they spent more time complaining about their partner and their kids than they did actually spending time with them. The unhappy couple continued in this malaise. All was certainly not well, but it was bearable.

Aotearoa Psychology endeavoured to make sure that the difficulties between them and CBT at home, weren't obviously affecting their work. They kept a careful eye on the national data. Soon, however, a few worrying trends started to creep in. People were getting stuck in the system for extended periods of time without getting any better, suicide rates were rising and people were generally more anxious and sad on average in any given year (Ministry of Health, 2018; Oakley-Browne, Wells, Scott, & McGee, 2006). Aotearoa Psychology felt ill. Surely this couldn't be because of what had happened between them and CBT? No of course not, defunding of services, the capitalism of mental health, systemic prejudices. Those were massive issues… Aotearoa Psychology took a deep breath, galvanised by rational thinking, but they couldn't quite shake the feeling that they were somehow also to blame.

As a responsible parent, the psychiatric establishment had always kept a close eye on CBT and Aotearoa Psychology's relationship. They were of course concerned with recent events. It seemed that the family's evidence-based values were all that was holding them together. The psychiatric establishment thought it better check. What they found was very troubling (Cuijpers, Cristea, Karyotaki, Reijnders, & Huibers, 2016; Leichsenring & Steinert, 2017). No parent wishes suffering on their child, reflected the psychiatric establishment, but it had to break

the news. Aotearoa Psychology could hardly believe what they read. Publication bias, small to moderate effect sizes, inconclusive meta-analytic findings…. No… Surely not… Waiting list control groups?! A bitter feud ensued. Aotearoa Psychology felt duped, CBT had made a mockery of their whole relationship. Aotearoa Psychology had spent all these years not tracking their own outcomes because they had blindly pedestalled CBT. How could they have been so stupid!? CBT tried to explain. The pressure of expectation from the psychiatric establishment had been immense, and it had so desperately wanted to earn favour. "Remember the discourse of consumer mental health!" implored CBT, "I make sense and am easy for everyone to practice and research… Surely that means we can all be happy and well!" Whatever CBT tried, Aotearoa Psychology could not be consoled. Their mind began to race. What if they'd made the wrong choice? Or worse, what if they'd never actually had to settle for monogamy in the first instance? (Leichsenring et al., 2015; Leichsenring, Leweke, Klein, & Steinert, 2015). The children thought Aotearoa Psychology… think of the children. DBT and ACT have their own evidence bases, they're different, and I pretty much just spend time with them these days anyway. Things might still be ok. But then they remembered… Same core principles, same nose! Aotearoa Psychology could be sure of nothing anymore. They needed time to think.

It seems that Aotearoa Psychology is still thinking, and the end of this story has yet to be written. Aotearoa Psychology's love affair with CBT has been a fraught one, and we find ourselves at an interesting point in the history of mental health in this country. We have two crises that we cannot ignore: one within the evidence base of something we have held blindly as a "gold standard" for such an extended period of time, and one within our mental health system itself, stretched to breaking point. With an active mental health inquiry, the political window has swung wide open, and the winds of meaningful change will hopefully blow in strongly. We can pre-empt the findings of any impending official report: Grim. The why is what must draw our focus. Perhaps it is merely a question of resourcing? If we could fund every mental health team to do what they're currently doing but do it better, would that provide complete relief? Alternatively, what if, in putting all of our eggs in the CBT basket, we have been blinded to the efficacy of other therapeutic models, and lost some vital flexibility in our practice? While resources, of course, will always be the key element, I think we need to hold the possibility that we have also contributed to our own

declining efficacy as a field.

And it's not as if we weren't already thinking this. In our training my classmates and I often joke about the fact that wherever we go for our clinical placements, the narrative in psychology teams is very much the same. The majority of Aotearoa psychologists practice the cognitive behavioural therapies in a bespoke way, adhering to the manuals reluctantly, sneakily changing treatment protocols and borrowing bits and pieces from everywhere. The real joke is that in doing that we aren't even aligned with the evidence base that we now see to be inherently flawed.

How do we get out of this odd quagmire we find ourselves in? We could radically critique the general concept of evidence-based practice; no one would blame us (Horton, 2015; Ioannidis, 2005). We could default, as we often do when it suits us, to the therapeutic relationship as the most important mechanism for change (Asay & Lambert, 1999; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Howe, 1999; Lambert & Barley, 2001), then rely on our clinical judgement to synthesise unique treatment plans for each client and see how that goes. It may go very well, but our mind set would have to change. It would require our training programmes to focus much more on teaching people to think, rather than teaching them to follow a manual, and match symptoms to diagnostic clusters. We would need to track our own outcomes meticulously (which we all need to be doing yesterday). It is now simply wrong to say, "we know it will work" and leave it at that). We would need to be sure on an individual basis, that each clinician is achieving meaningful outcomes through their unique clinical behaviour. This would be arduous for any system to fund, and it flies in the face of health economics in all western countries.

What about the other end of the spectrum? What if we simply picked models and stayed on them. Yes, we would still be nuanced and flexible in our interactions with our clients but if we are to pick an evidence-based protocol on the assumption that it works, it would be wise to practice with as much allegiance as possible. Perhaps where Aotearoa Psychology stumbled in their relationship with CBT, where perhaps South Africa Psychology and UK Psychology ran a little more smoothly, is where they limited themselves to a single paradigm, sulked in regret, then deviated in a clandestine way. Perhaps there is still a happy ending for Aotearoa Psychology and CBT, but it seems clear that the nature of the relationship needs to change. A more modern arrangement, where Aotearoa Psychology can spend time at home, with CBT and the children, but also explore other options may be the answer. The tarnishing of CBT's gold paint job need not be a negative for us. We now have an

opportunity to advocate for a variety of evidence-based models to be endorsed in our mental health system. I have no doubt that if Aotearoa Psychology plays the field now, as they once did, they will realise their potential.

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Disability - the elephant in the room

Amy Mauer

Amy Mauer is a 26-year-old Masters student at Massey University. Under the guidance of Professor Stuart Carr, she is exploring the psychological barriers to mainstream employment for individuals with intellectual disabilities. Her thesis is in line with Goal Eight of the United Nations Sustainable Development Goals, "promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all". When she is not working on her thesis, she coordinates social and adventure programmes for youth with intellectual disabilities at Recreate NZ. In her downtime, she can usually be found playing with dogs, hanging out with friends and family or catching up on sleep. Amy's aspiration for the future is to be an empowering figure who leads with compassion and gives a voice to every community that wants to be heard.

This year I was fortunate enough to attend my first New Zealand Psychological Society (NZPsS) Conference in which I assisted as a Master's student. It was a fascinating experience where every seminar presented incredible ideas that I have read about in online journals but have not had the chance to see in action. This finally confirmed for me that psychology is exactly what I want to be doing. The week ran effortlessly with no shortage of seminars, roundtables and keynote speakers. Our ideologies were in sync and our passions were evident, yet something was missing. Cultural competency was the buzzword. Tikanga Māori had a prominent place at the conference, and it was empowering to see women and Rainbow Youth have a respected voice among academics. However, there was one community whose voice was not present. I have a strong background in working with youth with intellectual disabilities. This is a group that are a minority in a larger community who identify with having a disability. During this conference, I did not feel that any part of this community had a voice or was recognised in a meaningful way.

During my undergraduate biomedical degree, I found it difficult to prescribe to the idea that you fix something only once it is

broken. That the system is under so much pressure there is no other way. My entry level psychology papers offered me an alternative view and so began my journey. Psychology gave me insight into how problems can be prevented rather than constantly reacted to. I felt enlightened and inspired to be among students and academics that were committed to solving problems, not just once they happened, but so they never happened.

Throughout my postgraduate studies, I developed critical thinking, was introduced to qualitative methodologies, and most of all, had the importance of being a culturally competent psychologist drilled into me. In my final Master's paper, I was taught about ethics and the need to continually strive towards competency. This meant training in areas I was unsure of, asking questions, and creating a dialogue with the communities I did not understand to ensure that my practice could be informed and fair. Yet in 2018, at the Jubilee NZPsS Conference, there was a painfully obvious voice missing. Not only was disability not being talked about, but the fact that it was missing was also not being discussed.

If I asked you, the budding or established psychologist reading this, how you would change your approach, your language, your practice for a person with an intellectual disability that needed your help? What would you do? The Special Olympics sports star, the employee of the month, the son dealing with the loss of a family member, or the young lady in the mainstream schooling system. How would you do this? Do you know the accepted terminology? Do you understand how they view their impairment? Do you understand how their impairment may have everything or nothing to do with the presenting problem? Would you know what to say? Is the solution to refer this person to "somebody else" or would you change nothing and continue your practice? I'm not sure which is worse, but I am pretty sure thinking back to my 100 level papers the former is called the bystander effect and both are examples of cultural competency failures.

The point I am making is disability; physical or intellectual (not including mental health) had little to no voice at the conference, yet disability permeates every walk of life. From poverty research to Tikanga Māori communities; from lower class to upper class; from Rainbow Youth to mental health clients to rising sports stars; people with disabilities are among every domain of psychology. Currently, the statistics state that 1 in 4 New Zealanders (Statistics NZ, 2013) have a disability yet the majority of people reading this article would probably not know how to approach a situation with a person who has an impairment.

This reflection is a call to action for all New Zealand (NZ) Psychologists to be aware that cultural competency includes disability too. As outlined by the NZPsS, "Cultural competence is defined as having the awareness, knowledge, and skill, necessary to perform a myriad of psychological tasks that recognises the diverse worldviews and practices of oneself and of clients from different ethnic/cultural backgrounds" (New Zealand Psychologists Board, 2011). Practising within your competence is knowing your limitations as a professional and making sure the clients get the best person for the job. But who is the best person for the job? When disability comes in so many shapes and forms and affects 1.1 million New Zealanders. Who is responsible? There is no such thing as a disability psychologist in NZ.

There is not a single specialisation within psychology that would not interact with the disability community. Many times, you may be unaware unless the client discloses it to you. But this is not an excuse. It is our job to make sure everyone is safely included no matter who they are or what they identify with. Disability is not a specialty, it's a majority and not a one size fits all. We need to inform our practice and develop our skills, so we are competent in helping all New Zealanders. My hope is that the next conference includes seminars acknowledging how their practice is inclusive for Tikanga Māori, Women, Rainbow Youth, and the Disability Community.

In the words of the NZPsS Cultural Competencies, I am raising the awareness in the hope I can empower you to seek the knowledge and gain the skill.

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Personal therapy for psychologists

Anton Ashcroft and Keith Tudor interviewed by Kelly Howard

Anton Ashcroft is a registered private practitioner psychologist consultant, who works predominantly in the arenas of leadership with Mantle and Forensic psychology for the Department of Corrections. Currently he supervises 18 practitioners from various psychological disciplines. He also has his own individual case load. Previously he set up the psychological services within Ko Hu Ora prison at Wiri, and developed substance management and sex offender programmes for the Department. He is committed to trying to improve clinical practice and is a strong advocate for integrating a more eclectic approach to therapy, as he feels all differing disciplines have something valuable to offer.

Keith Tudor is professor of psychotherapy and currently head of the School of Public Health & Psychosocial Studies at Auckland University of Technology. He is a qualified social worker and psychotherapist with many years' experience as a practitioner, supervisor, teacher/trainer, and academic. He has written over 300 peer-reviewed publications, including 15 books and is the editor of *Psychotherapy and Politics International* (Wiley-Blackwell). He is passionate about psychotherapy being a discipline (art and science) and a practice distinct from but related to psychology.

Many ideas are borne over the sharing of good food and wine, and so was the case with this article. It was over plates of dumplings at an Auckland Branch New Zealand Psychological Society (NZPsS) social event that a discussion about the importance of personal therapy for therapists arose. Anton Ashcroft, clinical psychologist, partook in this sharing and conversation and explained that this was something he and his colleague and friend, Keith Tudor, social worker and therapist had been discussing as an area that warrants further discussion in our professions. As a student and training clinical psychologist, this piqued my interest.

Whether or not to engage in personal therapy as a student is something that I have contemplated and in which I am now engaged. I have also experienced personal therapy in the past. However, on psychology courses in NZ, personal therapy is not something that is required or emphasised. This is somewhat concerning given that many students arrive to this work with their own history of psychological distress or mental health difficulties which may or may not be understood or processed sufficiently (Aina, 2015; Huynh & Rhodes, 2011). There might be a class or two on 'countertransference' or a therapist's reactions to their clients, but this is often an introduction to the concept and is not intended to be a time or space to explore a student's personal material that may arise in their work with clients. With this in mind, I was keen to talk to Anton and Keith about their views on this topic.

Kelly: I understand that you are both of the view that personal therapy is a topic that warrants further discussion in our profession today. Why is this?

Keith: Tēnā koutou, tēnā koutou, tēnā koutou katoa. Tēnā koe, Kelly, i tō pōwhiri mai ki a māua. Firstly, thank you, Kelly, for your interest in interviewing us for this article.

I am responding first as I want to clarify the first term of reference, that is, "our profession". I trained first as a social worker (1977–1979), in an era when social workers still did casework, informed by psychodynamic and humanistic psychology, and, later as a psychotherapist (1984/1985 in gestalt therapy, and 1987–1994 in transactional analysis). I come from and inhabit a critical tradition that sees the "psy" professions as encompassing counselling, clinical and counselling psychology, and

psychotherapy, as well as colleagues in nursing, psychiatry, and social work. However, there are a number of significant differences between these professions and even between clinical and counselling psychology. This is further complicated by the fact that in some countries, some of these professions are indistinguishable (and, for instance, where a formation in psychology includes a significant training in psychotherapy), while in other countries, these professions are very different and distinct from each other (and where a training in psychology would not lead to membership of a psychotherapy association, or recognition or registration as a psychotherapist).One of the differences I have experienced between psychotherapy and counselling on the one hand, and psychology on the other hand, is the assumption that for psychotherapists and counsellors' personal psychotherapy/counselling is an essential – and, indeed, often a required – part of training, whereas, by and large, this is not the case in psychology, even for clinical or counselling psychologists. This, for me, is why this topic warrants further discussion – precisely because there isn't a common or shared assumption that psychologists in training are in or (should) have some experience of personal therapy before, during, or after training.

Finally, in terms of our terms of reference, your readers will notice in the title of this article the generic word "therapy". For me, this is important, as it encompasses counselling, counselling psychology, psychotherapy, and therapeutic counselling, as well as other forms of personal, therapeutic help as well as spiritual direction.

Anton: Yes. My interest in this area was prompted when Keith and I were discussing the different and differing expectations regarding engagement in personal therapy during training, between, and indeed within, our two disciplines. This prompted some reflections on the possible benefits and risks of making personal therapy a requirement for anyone engaging in therapeutic training at some point in their journey. Our conclusion was there was no simple answer, as the issues were more complex than we had first thought – and hence our interest in researching and discussing this further.

Kelly: What have you been noticing about the reflective capabilities of students/new therapists?

Anton: In the last few years I have been supervising a number of psychologists coming through clinical, counselling, and forensic training pathways. Overall, I have been left feeling somewhat concerned by the lack of ability of some (though by no means all) recent psychology graduates, especially clinical, to engage in truly reflective practice. By that I mean, rather than focusing on the

effectiveness or otherwise of the "treatment" and the client's issues based on the techniques they have been taught, they naturally include consideration of themselves and their own historical/personal biases as part of their understanding of the therapeutic process, and their relationship with the client. Whilst it is clear that most have a conceptual understanding of transference and countertransference, it has been my observation that many have not worked on identifying their own transference processes, or the roots and functionality of these. As personal therapy is currently not a pre-requisite for practice for all psychologists in NZ, the vast majority of people have therefore graduated without having experienced therapy for themselves. Further, I have also noticed on average higher levels of this type of reflective practice amongst many group work facilitators I have supervised who have recently graduated from psychotherapy training, where personal therapy has been more strongly encouraged (if not required). However, I am not clear in my own thinking as to the extent to which engaging in personal therapy might ameliorate the lack of personal insight for some psychologists, or whether this observed lack of truly reflective practice could perhaps also be improved by changing the focus of the training itself.

Keith: I am interested that your question implies that therapists, and, in this context, specifically psychologists, should have some reflective capability. While, personally, I think that is – and/or would be – a good thing, clearly it is not necessarily or universally agreed. I link the argument for having some reflective capability to three aspects of education and practice.

The first concerns motivation. I think that it is important that those of us in the helping professions reflect on and understand our motivation for doing the work. I remember that, in the first week of my social work training, we had a class in which we reflected on our motivation for being social workers. I remember it as a particularly interesting and useful afternoon, and one which also brought our cohort together as a group. I also remember it as the only time on the two-year full-time course that we discussed this! The reason I think this is important is because if we know ourselves, we are less likely to act out our unexamined motives on others.

The second concerns the process of education/training which requires us to be reflective: literally, to be able to reflect on the knowledge and skills we are learning in order to understand and integrate them. So, I would say that we need to have reflective capabilities in order to be a student and, in this context, a new therapist. This is not new or unusual as such capabilities, capacities or qualities are often named in entry requirements, learning outcomes, and

graduate profiles.

The third concerns practice and whether our capability and/or capacity to be reflective constitutes our practice or at least a part of it. This brings us to ideas and debates about different theoretical orientations or therapeutic modalities, some of which promote reflective capability more than others. For instance, I know that some psychologists and therapists who practice cognitive behavioural therapy (CBT) and other manualised treatments would argue that they don't have to be particularly reflective or to have experienced their own therapy in order to deliver such therapies.

Kelly: What are the benefits of therapists engaging in their own personal therapy?

Keith: In one study, Murphy (2004) identified four processes by which personal therapy may be of use to trainee counsellors – and, by extension, others: reflexivity, growth, authenticity, and prolongation (for further discussion of which, also see Tudor, 2018). In the light of your previous question, I think it is interesting that the first of these processes is reflexivity as, clearly, this is enhanced through personal therapy. However, this raises the question of whether therapists and, again, in this current context, more particularly, psychology students want greater reflexivity.

Personally, and professionally, I see a big difference between those people who experience personal therapy and subsequently decide to train in one of the psy professions, and those who decide to train and are then faced with whether to engage in personal therapy or not. I myself was a client before I did any therapeutic training and I still value that experience. I think it is unfortunate that, for many students, especially those training in psychotherapy or counselling, personal

therapy becomes just another course requirement. For a long time, I have thought and argued that personal therapy is too important to make a course requirement, and, thus, prefer to see it as an entry requirement; in other words, that it is undertaken before education/training in one of the psy professions. It is also my experience that those who engage in personal therapy before training tend to "get it" and to continue in therapy during and after training.

Anton: What has struck me is the difference I have experienced in reflective practice between recent psychology graduates I have supervised who have engaged in some form of personal therapy versus those that have not. Talking with Keith, I see this as partly the difference in focus of reflective practice between education/training in psychology and psychotherapy. However, although only anecdotal, I have regularly also observed that those who have engaged in personal therapy have tended to show not only greater insights into their own processes within the therapeutic relationship, but also greater compassion for the process of therapy being experienced by their clients, than those who have not. As a result, I have seen the ability of many of these students and practitioners to remain working with clients by whom they feel challenged in a more reflexive and accepting manner, rather than feeling frustrated and tending to locate the "problem" only within the client, the therapy, or the training. When I have tried to explore the personal defensive processes of some practitioners who have not engaged in personal therapy in supervision, such as the imposter syndrome, or general fears of incompetence, several have found this a difficult focus. However, I have also noticed that some psychologists have not been helped by personal therapy, as they

have appeared then to become more focused on themselves than on their client. Personally, whilst I am unclear about the exact impact and role of personal psychotherapy with regard to these resultant behaviours, on balance and based on my own experiences (as detailed below), feel that the benefits of students engaging in personal therapy are likely to outweigh any risks.

Kelly: What modality of therapy would you promote or recommend for a student training to be a therapist?

Anton: I have mixed feelings about this. There's a part of me that feels it's helpful to have personal experience of the modality you are using with others, so that you can gain some insight into the potential benefits and pitfalls from a client's perspective. However, having experienced different modalities, orientations and styles of personal therapy myself, I have found it incredibly useful to be exposed to different methods and methodologies, not only academically but also personally. I have then used this "real world" experience to inform my own practice, taking on perspectives I didn't get purely from my training. On balance, therefore, I'd suggest that it can be helpful to have an experience as a client both of your own modality as well as that of others. I would also want to add that, for me, what has really worked for my own growth has been less about the modality (theoretical orientation) and more about the therapist (style and ability to relate). However, this then raises questions about what constitutes "helpful" therapy, and, in this context, how this could be evidenced within a training environment.

Keith: I agree with Anton. It seems to me rather obvious that a professional would want to have some experience of the approach in which they are training in which they

intend to practice, if only out of curiosity. Some might even see experiencing what they practice as demonstrating a "brand loyalty"! But even this argument seems to me to be the wrong way round. For those of us who experienced therapy first, we tended to choose to train in the modality or theoretical orientation we had experienced as clients, so we neither needed the requirement to be in therapy or in a particular modality of therapy. For me, that we have to require these matters, is both a failure of experience, as well as a sign of an increasing – and over – professionalisation of the psy professions (for further discussion of which, see Tudor, 2011, 2017).

However, as we are in what we might call a post-experiential professional environment, we now have the situation where some training institutes and professional associations do have particular requirements, for instance, that students/trainees are in therapy of the same theoretical orientation in which they are training and with the same frequency and duration as the therapy they intend to offer. Although this makes sense, there are wide variations in such requirements, for instance, with regard to what it is called, e.g., "training analysis", "personal psychotherapy", "experiential work", etc., and precisely how much therapy is required – for instance, within the different colleges of the United Kingdom Council for Psychotherapy, there is a wide variation between the amount of therapy required, from twice-weekly for four years to 50 hours over four years (for further details of which, see Tudor, 2018). Also, the requirement to undertake therapy in the modality in which you are training relies on there being a good number of therapists in that modality available to work with the number of students/trainees seeking therapy. This is less possible in countries with small populations such as New Zealand and smaller professional communities, a situation which has led at least one colleague I know to recommend that their students/trainees do not undertake therapy in the same modality in which they are training.

Finally on this point, with regard to therapeutic outcome, as evidence suggests that it is the nature of the therapeutic relationship that is more important than the therapeutic modality, then, in answer to your question, Kelly, I would promote and recommend that students choose a therapist with whom they can relate and who they think will be a good therapist for them.

Kelly: *What do or would you say to students who say, "But I don't have any problems"?*

Anton: I would say they are then missing the point on a number of counts. Firstly, to state they have no problems suggests a simplistic and dichotomous view of their own psychological functioning, that is, they feel that they either do or do not have problems. This raises concerns for me about how they then view the complexity of their clients' own psychological state and functioning. Secondly, in the context being discussed, for me, therapy is less about psychological distress, and much more about increasing awareness of the self, and building empathy for the process of therapy – from a client's perspective. Thirdly, this attitude suggests that the student may have an overly simplistic view of therapy as a purely task-focused, problem-solving process, rather than also a higher-level piecing together of internal processing to make better sense of ourselves, the world and others.

Keith: I would say three things. Firstly, I don't think that you need to have a "problem" to gain from therapy, because I don't see therapy as particularly or specifically concerned with problem-solving. Call me old-fashioned, but, to me, psychotherapy translates (from the Greek) as "soul healing", not "problem-solving". If anything, and here I'm influenced by the Brazilian educationalist and revolutionary, Paolo Freire, I would say that psychotherapy is problem-posing. Secondly, I haven't come across anybody who doesn't have problems, so for anyone to say, "I don't have problems", and especially a student/trainee psychologist, seems, as Anton puts it, somewhat dichotomous. Thirdly, I know, from my own experience as well as that of others, that working with people in distress can itself be distressing and that, as helpers, we need help. Some of what clients bring is traumatic and, for example, may evoke or provoke some of our own personal experiences and history. Although we may be able to deal with some of this in supervision, I think that therapy can help us to be better practitioners and to stay in the game – what Murphy (2004) referred to as prolongation.

Kelly: *What are the risks of students thinking that they don't need their own personal therapy?*

Anton: It concerns me to think that anyone undertaking psychological therapy as a career would consider having their own therapy as unnecessary, whether they actually undertook any or not, as this would suggest to me a lack of insight into the role of their own processes and life experiences in determining their process with their clients. It also demonstrates a possible avoidance of self-exploration, which, in turn, suggests that they may not wish to confront difficult aspects of themselves. Specifically, from my experience, the possible resultant risks for a student thinking this way could be a) missing out on the opportunity to experience therapy from a client's perspective, which could enhance empathy for their clients' process in practice, especially when the process feels stuck

in some way; and b) being somewhat more distant and less real or congruent with their clients' experience, as the student sees their own filtering processes as less relevant to therapeutic effectiveness, and hence are unwittingly overly influenced by it.

However, I have also worked with graduates who, while having had no personal experience of therapy, have still been able to demonstrate high levels of empathy and compassion for their clients, and others who appear to be able to make immediate use of supervision effectively to enhance their own reflective practice - which is why I don't see this question as having a simple answer.

Keith: I agree – and think that Anton has covered this well. Your question, however, sounds like one of those questions that has a statement behind it – it reads as if you think that psychology students do need to be in personal therapy. If you do, I think this raises – and confirms – the importance of peer feedback, that is, that students may be concerned about other students and their capacity for the work.

Anton and Keith: Thank you, Kelly, for inviting us to share our thoughts on what we hope will be of interest to your readers, and especially psychology students. For ourselves, we are continuing to research and reflect on this subject and are planning at least one journal article on the topic. We'll keep you posted! Best wishes in your work and continued training.

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The problem with problematic

Luke Sniewski

A former professional football player and Certified Public Accountant, Luke Sniewski found his passion for life diving into the diverse realms of healthy living. With credentials in personal training, soft tissue therapy, nutrition, and cooking, his client-centred approach empowers people to make productive changes in their life via movement, lifestyle and mindfulness strategies. He has over a decade of experience in the health and wellness industry working with a variety of clients and travelled around the world making a documentary series on healthy living in different cultures. Luke currently lives in Auckland, where he recently completed his Post Graduate Diploma in Health Science, with an emphasis in Drug and Alcohol Studies. He keeps himself busy balancing being a father and a PhD student at AUT, where he is examining the experiences and effectiveness of mindfulness meditation as an intervention for adult heterosexual men with self-perceived problematic pornography use.

I began my PhD journey exploring how meditation might work as an intervention for men with problematic pornography use at the Auckland University of Technology nearly two years ago. Quite quickly, it became the humbling experience I probably should have expected. What I thought was going to be a simple, straightforward project, turned into an important lesson in what it means to be a competent and capable researcher. My Postgraduate Diploma, Master's Degree, and cumulative life experiences did not stand a chance against the nuances, complexities, and the humanistic realities of the subject matter I was diving into. After all, when you consider the currently stigmatised and shame-ridden nature of problematic pornography use, the last thing I should have expected was simplicity. What I have learned during my study, and what will be discussed in this article, is the importance of contextualisation, and integrating quantitative and qualitative data in order to improve the validity and rigour of academic research.

Naïve confidence is often the seed of inspiration that fuels the brave souls that decide to venture down the path towards a

pornography use: A researcher's reflection

doctorate degree. I surely had plenty of it. And probably like every person reading this article, I wanted to help people that needed help. But it was pure naivety that made me think I already knew enough about pornography, about how men talk about and experience their use, about why men identify their use as problematic, and which interventions would work best. This PhD was going to be a breeze.

Over the last two years of my PhD, however, I have found myself continuously amazed by new, fresh, and thought-provoking perspectives; most of which have come directly from the first-hand experiences and insights offered by research participants. The research process has transformed my emotionally-charged, dogmatic beliefs about problematic pornography into a grounded, practical, and realistic worldview that takes into account the myriad of variables that make each case unique and different. Nothing is ever as simple as sensational media headlines can make it seem, especially problematic pornography use.

Self-perceived problematic pornography use (SPPPU) has become a heated topic within academic and clinical settings (Duffy, Dawson, & das Nair, 2016). SPPPU refers to the extent to which an individual feels they are unable to regulate their pornography use and relies overwhelmingly on the user's subjective self-perception and experiences (Grubbs et al., 2015). Individuals who perceive their relationship with pornography as problematic, however, classify their use as such for a myriad of reasons, including religious, moral or ethical, social and relationship, quantity of time spent viewing, or viewing in inappropriate contexts (Twohig & Crosby, 2009). Because of the variety of quantitative and qualitative factors that play a part in determining if and how pornography use is problematic, it would be unrealistic to assume that a single scale or questionnaire could accurately capture or assess each type of pornography user. This is why the main problem with SPPPU is likely the same problem that exists within most psychological contexts, fields, and phenomena: contextualisation.

Naïve confidence is often the seed of inspiration that fuels the brave souls that decide to venture down the path towards a doctorate degree. I surely had plenty of it.

In the clinical world, contextualisation and looking at the bigger picture is likely standard practice. Clinicians dig into the life of their client in order to understand their behaviours and circumstances. In the critical world of sexuality studies, the context of the individual is taken into

account as well as the broader social, cultural and economic context of a given society. Utilising both these approaches and applying them to problematic pornography research would greatly improve mainstream pornography research. It would allow researchers to understand pornography in a more nuanced manner; along with a greater degree of contextualising, both in terms of the person and in terms of society. In conducting my interviews, for example, it was surprising that this was the first time many of these men had ever spoken about pornography to anyone. Uncovering and exploring the reasons for the lack of communication and opening up would provide meaningful insights for the field of problematic pornography use.

One of the immediate takeaways (and definitely an unanticipated insight) from my research is that whether or not a man perceives his pornography use as problematic does not correlate well with the existent scores of scales and questionnaires related to porn use. One participant might watch porn very infrequently but consider their viewing to be extremely problematic, while another watches it every day and only feels he needs to tone it down a bit. Additionally, and not surprisingly, every participant identified very different and very specific reasons (i.e. specific content went against moral values, porn was the only coping mechanism for loneliness, violation of religious beliefs, felt unable to control the urge to watch, incapable of proper intimacy with real women, neglects childcare responsibilities in order to view) as to why they perceived their pornography use to be problematic. These first-hand experiences broke through some of the stereotypical myths and expectations around what is perceived as problematic pornography use. The continued challenge is the current lack of criteria for problematic pornography consumption, which means that determining whether or not consumption is problematic in a standardised way is difficult, and arguably impossible because of the many contextual layers involved. The raw numbers and questionnaire scores do not tell the full story.

On the surface, my own research seems fairly straightforward; examining meditation as an intervention for men with SPPPU. The research has been investigating the implications and experiences of an intervention which allows participants to practise sitting and observing their internal experience with non-reaction and acceptance, with the principal hypothesis that the consistent practice of 'being with self' will develop the participant's capacity to respond to cravings and urges to use pornography, and unwanted ruminating thoughts, in more productive ways. The research methods and methodology used,

however, had to be carefully selected and designed in order to adequately address contextualisation. Quantitative measures such as scales, questionnaires, and logging sheets were used to assess and analyse the effectiveness of meditation, but in-depth qualitative data in the form of pre- and post-study interviews provided the much-needed contextualisation.

In the critical world of sexuality studies, the context of the individual is taken into account as well as the broader social, cultural and economic context of a given society. Utilising both these approaches and applying them to problematic pornography research would greatly improve mainstream pornography research.

One of the primary reasons for using such a mixed methods approach was in large part due to previous research acknowledging that qualitative factors were often better indicators of problematic pornography use than quantitative factors (Sniewski, Farvid, & Carter 2018). Indeed, the frequency of pornography use is not always the underlying issue with pornography use as negative symptoms experienced by the individual more strongly predict the individual seeking treatment (Gola, Lewczuk, & Skorko, 2016). This made a mixed methods approach the most useful way forward for generating a thorough understanding of the issue.

The initial data from the participants' actual pornography use confirmed suspicions. Self-reported use was well below thresholds that would be classified as problematic within research settings. For example, the Pornography Craving Questionnaire (PCQ) attempts to predict the likelihood of relapse following therapy by measuring subjective craving for pornography (Kraus & Rosenberg, 2014), while the Problematic

Pornography Use Scale (PPCS) helps distinguish between non-problematic and problematic pornography use (Bőthe et al., 2018). Although both of these scales are scientifically validated, scores from neither would have categorised the majority of the participants' pornography use as problematic even though they identified themselves as having a problem for this research. Additionally, Cooper, Delmonico, and Burg (2000) quantified problematic pornography use as spending at least 11 hours viewing pornography per week; a threshold that no participant in my research came within 50% of reaching. While the quantitative data provided by the scales and questionnaires can provide some information, it was the in-depth qualitative exploration of each participant that provided a rich, detailed and contextualised account of what these numbers actually meant.

The initial data from the participants' actual pornography use confirmed suspicions. Self-reported use was well below thresholds that would be classified as problematic within research settings.

When you combine these methods to match the intention and aim of the study, you get richer data and a much clearer picture of what is actually going on in the lives of the respective participants, and certainly data that is less encumbered by research assumptions. This kind of data would help push the field forward. The results more closely resemble the participant and the many contexts that make him unique. There is more meaning behind the numbers. And this is why contextualisation matters.

In terms of pornography use, and likely many other psychological contexts, contextualisation further reinforces the notion of finding the uniqueness of the client's

experience and focusing on the bigger picture context of their life, and not just aspects, markers, scales, and quantitative assessments. The quantitative data is important, especially when the scales have been validated, but information needs to be contextualised with in-depth qualitative discussions. While the literature and data on pornography continues to mount, it will greatly benefit the field to integrate mixed methods that support and build a richer story beneath the scores. It is also this researcher's belief that much of the sensationalism, stigma, and shame would disintegrate if the participant's pornography use were viewed from the contextual reference point of their life.

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Dysregulation in the stress response system, culturally enhanced mindfulness and adverse childhood experiences among Māori women

Miriama Ketu-McKenzie

Miriama is a clinical psychologist of Ngati Raukawa and Ngati Tuwharetoa descent. Her whanau are located in the townships of Shannon and Morrinsville, however she currently resides in Dunedin with her husband and 3 small children where she works for Southern DHB. Miriama is completing her Doctoral studies through Massey University and was the 2017 recipient of the NZPsS Karahipi Tumuaki Scholarship. Miriama attributes her current success to the help of her family, friends and the generous support she has received from the New Zealand Psychological Society, Massey University, Te Rau Puawai and the Rose Hellaby Trust.

Introduction

This article presents an overview of my PhD research and the methods used to collect data. As the data is currently being analyzed, only preliminary results are presented. The foundation for this project was laid twenty years ago when my father was diagnosed with Cushing's Disease (CD). CD is a disorder characterized by excess levels of cortisol in the bloodstream, whose symptoms typically include weight gain (particularly around the middle of the body), type 2 diabetes, hypertension, mood and personality alterations, fatigue, concentration and memory difficulties, weakness in the bones and joints, as well as thinning skin (Newell-Price et al., 2006; Starkman, 2003). The physical and psychological changes observed in my father as a result of CD sparked a curiosity to understand the role(s) that stress hormones (especially cortisol) play in regulating almost every bodily system. To that end, the focus of this project has been upon measuring dysregulation in the stress response system, which typically presents as either hyper or hypo cortisolism and often follows adverse experiences in childhood and/or exposure to chronic stress (Fries et al., 2005).

Understanding the stress response

Cortisol is released by the adrenal glands following instruction from the hypothalamus and pituitary gland, which together comprise the hypothalamic pituitary adrenal (HPA) axis (Starkman, 2003). In healthy individuals, cortisol is released throughout the day in a pulsatile rhythm that consists of a steep rise immediately after waking, reaching a daily peak approximately 30-40 minutes later. This is known as the cortisol awakening response (CAR) (Steptoe & Serwinski, 2016). Cortisol levels then steadily decrease throughout the day, reaching their nadir around bedtime. This is known as the cortisol diurnal slope (Starkman, 2003). Cortisol levels also increase following exposure to an acute stressor and return to baseline levels when the stress has resolved (Rothschild, 2003). However, when an individual has been exposed to adverse childhood experiences and/or has been exposed to chronic stress (such as living with an abusive partner), the HPA axis can become dysregulated and chronically produce too much or too little cortisol (Panter-Brick & Worthman, 1999).

Cortisol exerts a profound influence over many of the body's functions, including blood pressure, cardiovascular functioning, inflammatory responses, the metabolism of proteins, and the balancing of insulin. Even slightly dysregulated cortisol levels are known to influence fat deposition (Dallman et al., 2003), eating behavior (Tomiyama et al., 2011), and levels of psychopathology (Newell-Price et al., 2003).

While the symptoms of extreme hyper-cortisolism (too much cortisol) are noted in the description of my father's illness, dysregulation in the form of extreme hypo-cortisolism (too little cortisol in the bloodstream), presents as Addison's Disease (AD) and is characterized by chronic fatigue, muscle weakness, nausea, vomiting and weight loss (Michels & Michels, 2014). Between those two extremes however, emerging research suggests that individuals exposed to adversity in childhood and/or

chronic stress can develop symptoms associated with sub-threshold CD or AD, characterized by weight gain around the middle (truncal obesity), psychopathology (especially mood, anxiety and trauma-related disorders), blunted cortisol awakening responses, flattening of the diurnal curve and a blunted response to acute stress (Fries et al., 2005).

…cultural enhancements were added, including tikanga Māori protocols such as opening and closing each session with karakia; stopping to share kai and say karakia halfway through the session; beginning the course with mihimihi and whakapapa sharing; using reo Māori to explain certain concepts and relating the theme of each week to concepts already embedded in Te Ao Māori – such as compassion…

My research

Given that cortisol dysregulation often follows exposure to adverse childhood events and that Māori women experience high levels of childhood trauma (Hirini et al., 2005), high levels of truncal obesity (Ministry of Health, 2015) and high levels of psychopathology (Oakley-Browne et al., 2006), the present research investigates the impact of Māori women's adverse childhood experiences on cortisol, obesity and psychopathology.

I developed a three-pronged investigation:

1. The first investigation examined whether a group of Māori women who had experienced adverse events in childhood, would also show HPA axis dysregulation, psychopathology, chronic stress and truncal obesity.

2. The second investigation sought to test whether a culturally enhanced Mindfulness Based

Stress Reduction Course (MBSR) would have any effect on their baseline scores.

3. The third investigation aimed to explore their individual reactions and responses to the course using interview data.

Method

Investigation One

To obtain accurate data regarding HPA axis functioning, eight Māori women with Adverse Childhood Experience scores ranging from 4-8 (indicative of significant childhood adversity) (see Felliti et al., 1998) were recruited using word of mouth and posters. To collect baseline data, each participant agreed to provide saliva samples at specified times, for three consecutive days, for two weeks. The mean measurement for each of those times was then calculated to provide an indication of their average cortisol awakening response and cortisol diurnal slope. To obtain their cortisol response to acute stress, each participant agreed to take part in a social stress test in which they were asked to present a small speech and answer math questions in front of two strangers. Each participant provided saliva samples throughout the test to give an indication of their overall cortisol output to an acute stressor. To measure psychopathology, the Depression, Anxiety, and Stress Scale (DASS; Lovibond, 1995) was used, as was the Post-Traumatic Stress Disorder Scale – Civilian Version (Weather et al., 1993). Both measures have adequate psychometric properties and are quick to administer. To measure chronic stress, the Perceived Stress Scale (Cohen, 1988) was used. To provide an indication of chronic stress, the Social Readjustment Rating Scale was administered (Holmes & Rahe, 1967). Waist-to-hip ratio (W-H-R) was calculated as an indicator of metabolic health. Each

person also completed an emotional eating scale (Dutch Eating Behaviour Questionnaire; Van Strien, 1986).

Investigation Two

To test the effects of a culturally enhanced MBSR course, several enhancements were made to the standardized 8-week MBSR programme developed by Kabat-Zinn (1979). By request of the developer, no changes were made to the content or overall structure of the course. However, cultural enhancements were added, including tikanga Māori protocols such as opening and closing each session with karakia; stopping to share kai and say karakia halfway through the session; beginning the course with mihimihi and whakapapa sharing; using reo Māori to explain certain concepts and relating the theme of each week to concepts already embedded in Te Ao Māori – such as compassion (which in the Māori world is known as atawhai). The course was also delivered in a bi-cultural manner, which involved having a Māori female clinical psychologist co-facilitate with a highly experienced mindfulness practitioner, who was a Pākehā male. The Māori female oversaw the cultural additions and ensured the cultural safety of the participants. The Pākehā male oversaw the delivery of the mindfulness content and led the practice components.

As expected, notable improvements in psychopathology, metabolic measures, self-reported stress scores and cortisol markers were found at post-treatment.

Investigation Three

Interviews were conducted before and after the course, to provide a comparison for how views of mindfulness changed for each woman as a function of attending the course.

The interviews were semi-structured and up to thirty-five minutes long.

The findings from the research are currently being analyzed and will be submitted for publication in an academic journal in early 2019. Overall, the results indicate that the culturally enhanced MBSR course was well received by the women in the study. Additionally, baseline measurements showed that most of the women had dysregulated CAR measurements, high W-H-R measurements and either underactive or overactive diurnal cortisol slopes. As expected, notable improvements in psychopathology, metabolic measures, self-reported stress scores and cortisol markers were found at post-treatment. More detailed findings will follow.

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Can mHealth "Apps" help parents to establish children's oral hygiene routines?

Katharine Jespersen

Katharine Jespersen (*right*) is a doctoral student at Massey University. Katharine's research interests centre on high and complex needs children and families within Aotearoa. Her doctoral research involves investigating the Impact of Training on Fidelity of 'The Ministry of Education Intensive Wraparound Service 'Te Kahu Tōī'. She has been a recipient of the Vic Davis Memorial Trust Postgraduate scholarship for the past three years and has a passion and commitment to return to the Eastern Bay of Plenty to work alongside tamariki, rangatahi and whānau within the Eastern Bay of Plenty.

Foreword: Linda Jones (*left*)

Dr Linda Jones is a Senior Lecturer in the School of Psychology at Massey University. Linda's research interests are in occupational health psychology and the role of the environment in wellbeing. She is the recipient of the International Stress and Anxiety Research Society "Lifetime Career Award" for 2018, for her work on children's dental anxiety; and a series of papers and books aimed to reduce dentists' occupational stress.

The study reported in the following article was a successful Bachelor of Arts (Honours) research exercise in psychology. The work was presented at an international paediatric dental conference and submitted to a journal that paediatric dentists may read. On receiving rejection, it became clear that for the reviewers, issues of ideology in dental practice were stronger than the consideration of the psychology themes arising from the study. With a critical health psychology focus, it can be seen that the project will meet publication resistance in dental journals because it is suggesting that parents can be empowered to manage (in this case) oral hygiene practices within their own families, without recourse to dental health professionals. mHealth apps may even deliver messages that dentists disagree with, as it transpired was the case of the commercial app used in the present study and may contradict the messages

dentists would want parents to hear. As the study found however, parents themselves found the app made a positive difference to their children's motivation to engage in oral hygiene practices and they were enthusiastic about generalising the benefits to a wider group. As the supervisor of the project, I think there are two key messages for postgraduate students. First, psychology can be applied to health behaviours to motivate and reward, and hence strengthen the rewarded actions. (You already knew that!) Second, there will be differences in ideology, knowledge and power between parents and professionals, so it can be helpful to find a balance between empowering parents who report the need for support or help, and who for whatever reason do not consult the appropriate professions for help, and an insistence that the help and support they receive is solely that which professionals promote. The

following paper on pre-schoolers' oral health care practices shows that there is space for some "good old" behavioural psychology operant conditioning: shaping and chaining, and the use of a token economy (aka star and sticker charts and the like) to motivate young children to want to brush their teeth routinely as part of parental action on tooth brushing. After reading the study and the dental journal reviewers' comments, my belief is that getting parents and children incorporating oral hygiene practices into a no-fuss daily routine is the step before considering how much toothpaste goes down the plughole, or whether the child spits or keeps the residue of the paste in their mouth, or whether a psychology paper need argue for an empirically established number of minutes of brushing and other similar ideological issues for dentists, that was the brunt of the dental critique. If an app helps with the routine, then the

technique can be fine-tuned as the child grows. There is a saying: practice makes perfect… well actually only perfect practice makes perfect. You can practise in mistakes too, but getting into the routine is a great start. For students undertaking Honours research projects, which are still about learning to research, not everyone is going to think you have found total solutions to real world problems, but there can be specks of gold to add to the gold standard, if the right audience looks. There is gold dust here.

Dr Linda Jones

Abstract

Children's poor oral health is a problem in economically disadvantaged regions of New Zealand. This paper discusses a successful study that aimed to have parents from one such community discuss and trial a smartphone app to encourage their children to want to brush their teeth. The study used a three-stage design: individual parent interviews; a three-week trial of a mobile phone app; and post intervention focus groups. Participants were 10 parents whose children attended one early childhood education centre (ECEC). While 14 children trialled the app, it was the parents who were the participants. Following thematic analysis, six themes arose from interview data. These indicated that the parents had not used mHealth apps before but were positive about the potential to create good tooth brushing habits. Eleven themes emerged post intervention: more positive than negative. Parents reported that the app created oral health awareness in their children, and they brushed their teeth for longer, without a battle. Focus groups suggested the inclusion of mHealth in the ECEC health curriculum; and the value of adapting the app for older children. The app increased pre-school children's motivation to brush without fuss, so parents reported that it was a beneficial tool for promoting oral hygiene.

The study used a three-stage design: individual parent interviews; a three-week trial of a mobile phone app; and post intervention focus groups.

Dental decay affects children worldwide and has increased in prevalence as people adopt a diet that includes fast food and sugar-laden drinks. Children with dental decay experience a range of negative health outcomes from pain, abscesses and oral infections, to loss of function; and depending on the age at which teeth are lost, malocclusion of permanent teeth, with attendant eating, speech, and appearance problems (Arora et al., 2012). Oral health promotion has historically had the ideology passed from dental practitioner to dental "patient". Twenty-first century mHealth (mobile health e.g. smartphone apps) and eHealth

(electronic health e.g. text appointment reminders) appear to offer new opportunities for families to learn about oral health and disease preventive strategies.

New Zealand (NZ) Ministry of Health (MoH) oral health statistics present a bleak picture particularly in areas where there is socio-economic disadvantage. In 2017, 3.5% of NZ children (approximately 29,000) had teeth extracted due to decay (MoH, 2018.) Hammam (2007) suggests that in disadvantaged regions oral health may take a back seat to other publically-funded child health initiatives. Schweitzer and Synowiec (2012) and Mechael (2009) suggest that mHealth initiatives are attractive in economically disadvantaged communities because they reduce the financial costs and time that families spend on professional services, but they caution against over-optimism for large scale benefits.

There is evidence of mHealth effectiveness. It was found to be effective in health promotion messages about alcohol misuse (Cohn, Hunter-Reel, Hagman, & Mitchell, 2011), reducing smoking during pregnancy (Gray, 2012), and improving the frequency of tooth brushing by 18-24 year olds receiving work and income support (Schluter, Lee, Hamilton, Coe, Messer-Perkins, & Smith, 2014).

Contemporary oral health practice information comes from professional dental personnel, but parents can have problems implementing their children's oral hygiene routines. A Google search on that phrase produced 1.3 million hits[1]; making finding the best information and support for parents daunting. In addition to oral health websites, parenting websites also offer advice. For example, under tooth brushing resistance on "Ask Dr Sears"[2] (paediatrician and parenting guru) a typical parent's question is:

> *"Q. It's such a struggle to get my 3-year-old to brush his teeth every night! I've tried using one of those kid toothbrushes that are supposed to make brushing fun, but every night it's the same tantrums and tears. Any tips on how to make the process easier?"* [3]

The present study explored NZ parents' experiences of using a mHealth app to promote oral hygiene routines. To achieve this aim, the objectives of the study were:

1. To establish a baseline of parents' knowledge of mHealth apps, and attitudes to oral health; then run a three-week trial of a mHealth app intervention;

2. To report parents' experiences of using the app with

1 December 2017.
2 https://en.wikipedia.org/wiki/William_Sears_(physician)
3 Ask Dr Sears http://www.parenting.com/article/ask-dr-sears-toothbrushing-resistance. Accessed 12 Dec., 2017.)

their children at home; and

3. To explore parents' views of having their ECEC implement an oral health programme based on a mHealth app.

Method

Participants

Participants were 10 parents (7 mothers and 3 fathers) who were recruited following an information evening at one ECEC in the Eastern Bay of Plenty, NZ. Collectively they had 14 children (mean age was three years, 8 months, range 1 - 11 years old). The children did not interact with the researcher but were involved by their parents who used the app. Participants received a pack containing a toothbrush, toothpaste and dental floss, for each of their children. The ECEC received a $100 in vouchers, as a token of appreciation.

Materials

The study used individual semi-structured interviews prior to participants downloading the app on their own mobile devices; with questions on parental knowledge of child oral health, dental service delivery and pre-existing knowledge of the smartphone app. The advance-reward pack ensured children all had toothbrushes.

The intervention was the free-to-download Nurdle Time App which uses behavioural modification techniques to elicit and strengthen tooth brushing: music and fun; the feel of clean teeth; accomplishment rewarded with a token economy of stars; and by the children's parents' approval. The app's central character is a Nurdle (see figure 1) that takes the child's name. It demonstrates tooth brushing techniques while dancing and singing for two minutes. Catchy song lyrics direct the child in placing toothpaste, "*the size of a pea*" on the

brush, a brushing pattern, rinsing and spitting "*with a silly sound*", while the time to completion flashes on the screen. The child earns stars which are redeemable in a virtual shop to dress and accessorise the Nurdle.

Figure 1. Screen shots of the Nurdle, reward stars, and the virtual store
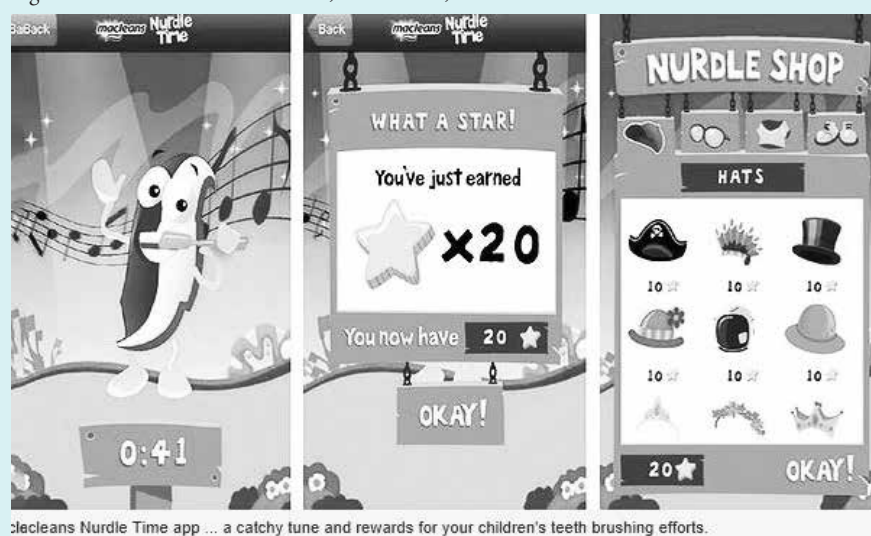
cleeans Nurdle Time app ... a catchy tune and rewards for your children's teeth brushing efforts.

Focus groups were conducted post intervention using trigger questions to elicit parental perceptions of the efficacy of the Nurdle Time App, and possible use in the ECEC.

Procedure

A pilot with a three-year-old demonstrated that she could quickly learn to find and initiate the app, brush and rinse with it running, and shop with the rewards, without an adult giving step by step directions.

Information about the study was discussed at a meeting held at an ECEC. Parents who had access to a smartphone capable of downloading an app, and had pre-school children, were asked to register their interest. A week later they were contacted to see if they were happy to participate and give written consent. The author conducted the pre-intervention interview, then showed how to download and run the Nurdle Time app. A three-week intervention period was specified. The two focus groups

were conducted after the intervention period. Only the mothers attended these groups.

Results and Discussion

Data was analysed using Braun and Clarke's (2006) thematic analysis. First, six themes identified from the parental pre-intervention interviews are reported with verbatim examples. Secondly, the post intervention focus group results are presented in two categories; positive and negative parental perceptions. Of the eleven themes, seven were positive perceptions and four were negative perceptions.

The study used individual semi-structured interviews prior to participants downloading the app on their own mobile devices; with questions on parental knowledge of child oral health, dental service delivery and pre-existing knowledge of the smartphone app.

Parents' experiences pre-intervention

1. There was general positivity in

relation to smartphone apps and health promotion. *The way technology is changing it's a good thing-whatever is accessible - it's easy and quick. As parents we need fun ways to entice kids to try different ways with health - they pick up technology so quickly.*

2. All parents were unaware of the Nurdle Time app and similar mHealth interventions.

3. Parents had high (and possibly unrealistic) expectations of their young children's competence at tooth brushing. There was an awareness that children's motor skills needed to be adequately developed before their children could brush their teeth with no help from their parents.

4. Parents reported a preference for their children to be independent in tooth brushing activity, feeling that they were the best judge as to when their child had adequate motor skills to brush independently.

5. Parents wanted knowledge of good oral hygiene for their children, and showed a willingness to try the app. They commented along the lines of: *If it's of some use that gives you extra information or awareness then for sure it's a good source.* Most knew that approximately two minutes was the recommended brushing.

6. Finally, parents discussed difficulties in accessing dental services, but this theme is not explored here.

Post Intervention focus groups

Eleven themes emerged from the post intervention data. These were seven positive perceptions and four negative perceptions that pertained to the triggers used in questioning.

Participants perceived that the app had a range of positive attributes in relation to aiding them, as parents, in creating good tooth brushing habits in their children, saying for example: *They really started remembering to do it themselves they were brushing their teeth on their own initiative.*

Themes were: (1) that the app created an extra awareness of oral hygiene; (2) that it elicited independence and autonomy; (3) that it facilitated an easy compromise over who performed the tooth brushing; (4) that it created positivity around oral hygiene generally; (5) that children and parents wanted to continue to use the Nurdle Time app after the intervention period; (6) that apps were now perceived as having a general benefit for parents in health promotion; and (7) value was seen in using positive reinforcement through rewards to strengthen healthy behaviours.

Parents had a good knowledge of what their children

"should be doing" about tooth brushing, but no experience with mHealth. They all had a positive attitude towards apps in education, saying it was, "*how their children would most likely be learning in the future*". With the app, children became extra-aware of brushing their teeth and had become more autonomous over their teeth brushing routines. Six of the seven parents agreed that children brushed for longer, after exposure to the app. Some parents reported letting their children brush their teeth first and then helping finish the job off. This compromise allowed for the parents to respect their child's need for independence and autonomy, whilst ensuring that their teeth were cleaned effectively.

Nurdle Time stars and shopping rewards definitely were a positive aspect to the app. Those with older children reported that the app also engaged their older children but needed modifications pitched to their cognitive level, such as making rewards build towards unlocking different levels with new rewards to keep older children engaged. Indications were that smartphone apps would be of benefit to parents to promote other aspects of health too, such as nutrition.

A pilot with a three-year-old demonstrated that she could quickly learn to find and initiate the app, brush and rinse with it running, and shop with the rewards, without an adult giving step by step directions.

Several negative perceptions flowed through from analysis, and four themes were identified as follows: (1) that it could detract from brushing properly; (2) that it could undermine parental input; (3) that there was not enough educative material; and (4) that an app cannot address service delivery issues from the dental profession. These concerns could be resolved by redesigning this particular app to include a step for a parent to have a helping turn too and to include more information from paediatric dentists such as how much toothpaste to use, or if the child should spit or rinse.

Limitations included selection bias as volunteers had to already own a suitable device to download the Nurdle Time app. Also, the ECEC teachers were not included and could have been as key-informants. It makes it difficult to address the third objective – whether the app would work in the pre-school setting. A Japanese study evaluated 3-5-year-old children in a nursery environment who brushed and rinsed their own teeth. Significantly fewer bacteria were on tooth surfaces after children had used their own toothbrushes (Hohashi & Nakagami, 2007) suggesting ECEC are a possible target. Parents reported that the technology is in place in ECECs in NZ, and health promotion is part of the curriculum, so an oral health trial could, in principle, be

undertaken.

Parents found using the Nurdle Time App motivating for all the family. This might theoretically have been expected given the use of reinforcement and the shaping that the desired behaviour received (Prochaska, & Norcross, 2010). By placing an emphasis on self-direction, freedom of choice, and control over learning, Krause, Bochner and Duschesne (2003) suggest that optimum learning will occur. However, in order for mHealth interventions to be adopted by the target audience, and elicit behavioural change, they need to be seen as effective and useful, and easy to implement (Abraham, Conner, Jones, & O'Connor, 2008) and for the participating families this was true.

Key messages

- mHealth/smartphone apps can be an efficacious way to teach oral health behaviours when embedded with principles of psychology.

- Apps have a role where parents need young children to be independently motivated to initiate tooth brushing, while still allowing for parental involvement and oversight.

- Star rewards promoted improvements in tooth brushing behaviour for pre-schoolers, but the limited range of shopping options was less motivating for older children.

- There is a potential to use apps to support tooth brushing in ECEC routines, along with hand washing or sun safety.

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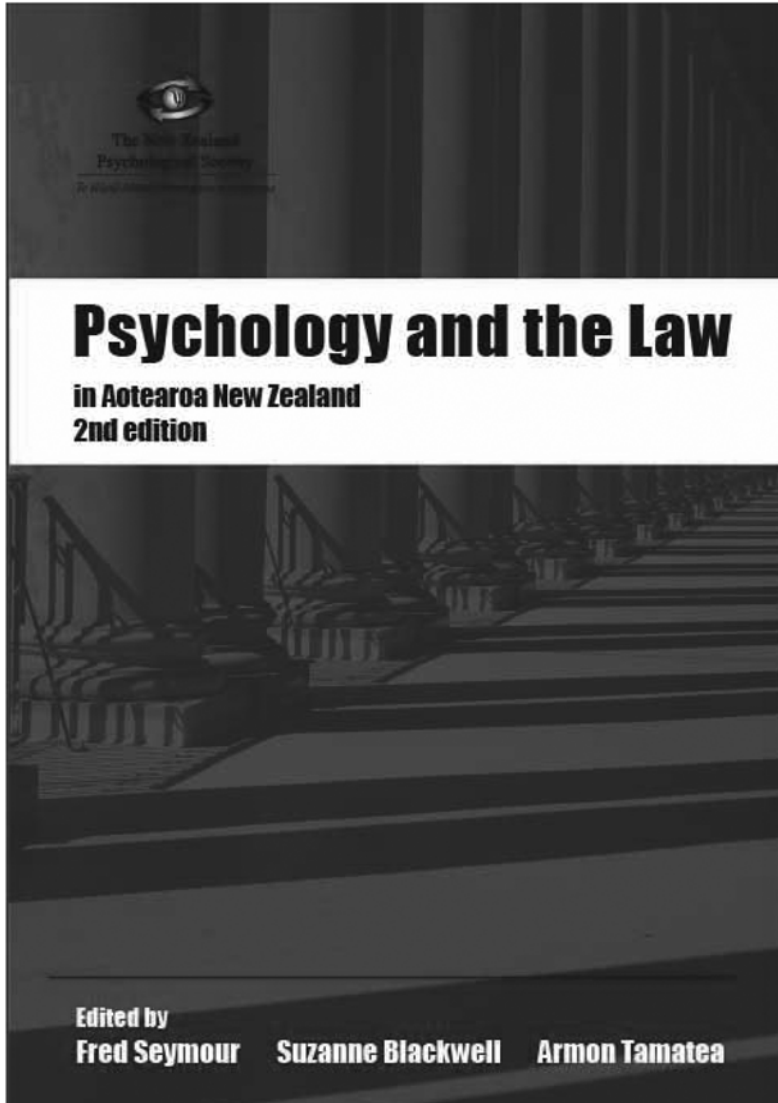
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