

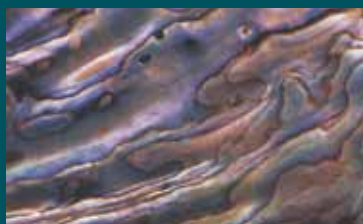


The New Zealand
Psychological Society

Te Rōpū Mātai Hinengaro o Aotearoa

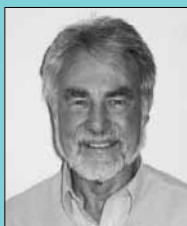
Psychology Aotearoa

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Tēnā koutou ngā kaiwhakamatau hinengaro

I attended the Australian Psychological Society (APS) conference in Melbourne in my first duty as your President. I joined a panel with Susan McDaniel (President of the American Psychological Association, APA)

and Mike Kyrios (President of the Australian Psychological Association, APS) to discuss some of our organisations' respective concerns.

I spoke to five key themes about psychology in Aotearoa/New Zealand. (1) Rigor – maintaining the quality of evidence with the pressure to publish, the falsification and massaging of social science research and the risk of watering down the delivery of psychology to homeopathic levels with schemes similar to the Increasing Access to Psychological Practice (IAPT). (2) Relevance – meeting the huge public appetite for psychology. How do we ensure our work is well disseminated so that it makes a difference? (3) Representation – can we uphold our Treaty, to enter into a power sharing relationship in good faith with the first people of our country. Who asks the research questions and who delivers our psychology? (4) Reality – how does our psychology meet with the lives of our clients and communities who often live with poverty, homelessness, violence, displacement and increasing environmental risks. What do we do to challenge existing power structures? (5) Re-emergence – our psychology does not stay static with an increasing focus on neuropsychology; health psychology, coaching psychology and Indigenous psychology/psychologies. What are the threats and opportunities for psychology?

I was struck by the vitality of the Psychologists for Peace Interest group at the APS conference. They co-opted a creative mix of diverse psychologists to address research, work with individual, whole group, national and international conflicts. They have been outspoken about misguided initiatives to counter extreme violence and then offering evidence based alternatives.¹ In Aotearoa New Zealand we have a strong tradition of work in peace and restorative justice. Our membership cares deeply about these matters. At this year's NZPsS Annual General Meeting, after a symposium addressing issues of concern to 1 APS. (2016 23 August). Why do people join violent extremist groups. Psychopaedia [Blog], 23 August. Retrieved from <https://psychopaedia.org/society/people-join-violent-extremist-groups/>

refugees, a new remit was suggested. The remit proposed that we urge our government to use its influence during our remaining period on the United Nations Security Council to halt the supply of weapons that are being used to victimise their citizens in their own, and neighbouring countries. A significant reason to be part of the New Zealand Psychological Society (NZPsS) is to use our collective efforts to bring about changes at a national level and international level.²

The APS Psychologists for Peace group planned a stimulating debate arguing for and against the assertion that "Individual happiness is the path to world peace." Most people in the audience agreed that when we are happy we are more inclined to making love than war; that unhappy individuals are often responsible for extreme acts of violence; and that individual happiness can be a building block towards reducing violence. However, the majority questioned if happiness alone was a sufficient precursor for peace. Can the benign contentment of individuals guarantee social justice?

A connection could be made with the formal apology made by the Australian Psychological Society to Aboriginal and Torres Strait Islander people at their annual conference.³ The APS acknowledged their silence and complicity as a profession in the forced removal of children from their communities and the consequent Stolen Generation. They acknowledged the inappropriate use of assessment techniques that gave misleading and inaccurate information about the abilities of Aboriginal and Torres Strait Islander people; their role in justifying practices of assimilation and oppression; and the implicit and explicit dismissal of the importance of culture in understanding and promoting social and emotional wellbeing. At the time, many of the Australian settlers would have been "happy" and content. Indeed, some are likely to have had good intentions in bringing Christianity and civilisation to this country.

Representing Aotearoa/New Zealand at the APS, I received many positive comments about our settler relationship with the first people of our land. We can be proud of

2 Abraham, Q., Feather, J., & Harre, N. (2016). Bigger than Self Issues Implications for Psychological Practice in Aotearoa New Zealand. In Waikaremoana W. Waitoki, J. S. Feather, N. R. Robertson, & J. J. Rucklidge (Eds.), *Professional Practice of Psychology in Aotearoa New Zealand* (3rd ed.). Wellington: New Zealand Psychological Society.

3 APS. (2016). The Australian Psychological Society apologises to Aboriginal and Torres Strait Islander People. APS Media Statement: Thursday 15th September. Retrieved from http://www.psychology.org.au/news/media_releases/15September2016/

our attempts to put right some of the wrongs of the past and the ongoing commitment to challenging inequity and discrimination. The NZPsS has a subcommittee, the National Standing Committee for Bicultural Issues (NSCBI) and their representatives, Dr Waikaremoana Waitoki and Dr Julie Wharewera-Mika sit on our Executive. The Executive are fortunate to be advised by our Kaihautū, Professor Angus Hikairo MacFarlane. However, we still have plenty of work to do. Only 3% of registered psychologists identify as Māori compared to 44% and 19% that identify as New Zealander or European respectively?⁴ We need to redouble our efforts to work towards collectively creating structures that make psychology an attractive profession for the first people/s of our country?

Finally, the American Psychological Association are still reeling from the Hoffman report⁵ which found that the APA colluded with the Department of Defense to interrogate terrorist suspects in order to “curry favor” with government organisations. There are important lessons for us all about the safeguards required for governance so that our psychological organisations uphold our ethical standards. Afterwards, our panel, Susan McDaniel drew my attention to the recent APA keynote by John Haidt.⁶ Although, there is much in his presentation I would question, he does urge us to consider our own biases and create a place for diverse conversations. Our passionate beliefs may have unintended consequences that can alienate and polarise opinions. This would be contrary to our aspiration for better psychology and a better world.

He pūkai tō Tū, he pūkai tō Rongo.⁷
Mauri ora

⁴ New Zealand Psychologist Board, electronic communication, 25 August 2016. A total of 3229 registered psychologists, with 1418 NZ; 620 European; 100 Māori. Note data is missing or no ethnicity data recorded for 392

⁵ Hoffman, D., Carter, D., Lopez, C., Benzmliller, H., Guo, A., Latifi, S., & Craig, D. (2015). Report to the Special Committee of the Board of Directors of the American Psychological Association: Independent Review Relating to APA Ethics Guidelines, National Security Interrogations, and Torture. July 2, 2015. Retrieved from <https://www.apa.org/independent-review/APA-FINAL-Report-7.2.15.pdf>.

⁶ Haidt, J. (2016). What Is Happening to Our Country? How Psychology Can Respond to Political Polarization, Incivility and Intolerance. <https://www.youtube.com/watch?v=vAE-gxKs6gM&feature=youtu.be>

⁷ A whakatauki referring to the pile of bodies left by Tū and the heap of kumara left by Rongo

Editorial

Tēnā koutou colleagues,



It is just one month since the national NZPsS Conference and those of us who were able to attend were served up an enticing menu which was varied, challenging and stimulating. The keynote speakers ranged from clinical, health, educational

to academic and delivered us a feast of topics such as social justice, non-suicidal self-harm, rape culture, ethics, Acceptance and Commitment Therapy, culturally responsive educational psychology, and controversies in the scientific realm. We were also treated to presentations on “The importance of innovative qualitative research in Psychology: Young people, social networking and alcohol”; “On Advice for Psychologists Working with Media”; “Succeeding in the short-term: Some factors that contribute to desistance in high-risk prisoners on parole” and “Nutritional Therapies for Psychological Symptoms: What is the evidence to date?” Some of these will be presented in this edition and the next.

In keeping with the strong social justice theme at the conference, we have added a new content area entitled ‘Social Justice Issues’ to give voice to the Society’s interest in reflecting the social contexts and often inequalities which impact on the lives of the clients our members work with. First up, Innes Asher, Professor of Paediatrics and passionate voice for our children’s health and wellbeing provides a timely account of our child poverty statistics – illustrating the different measures used in the field. Innes explains the interconnection between poverty, inadequate basic healthcare and unhealthy housing. Innes serves on the Steering Group of the National Child and Youth Epidemiology Service, and the Management Committee of the Child Poverty Action group. These issues are relevant for us all, and are in need of urgent policy reform.

Issues encountered in working with refugees also had a strong presence at the conference and our international article in this edition also features this topic. It is written by a young psychologist from the Czech Republic who is now practicing in Switzerland. She shares a migrant status with her clients whom are predominantly refugees and migrants. Štěpánka spent some time in New Zealand and conducted her Masters research on a comparison of social capital between New Zealand, Indian and Czech populations. I attended the Second Czech Positive Psychology conference

where I met her. Another young psychologist has written a reflective piece on her journey as a new graduate expressing the gratitude for the support and encouragement she experienced from her more experienced colleagues during her first few months out. Naomi White writes from her beach village in Mexico where she has followed her passion to pursue a yoga and meditation teacher training course. Perhaps a different passion to Štěpánka, but her essential message is to follow one's passion especially in the face of the imposter syndrome.

David Semp, an innovative clinical psychologist from Auckland presents a follow-up piece on his article in a previous edition, "How to Survive and thrive in a public mental health service". This article is entitled "A short course of Panadol - for everything" and charts a course for psychologists to use the bio-medical discourse and DBT strategies to argue for psychological treatment for their clients. This is a useful article for those working in health who wish to strengthen their role.

Leena St Martin and Liz Painter, also psychologists from Auckland, present their approach to practicing psychology in physical health settings. It is entitled "By the hospital bedside: Adapting psychological practice". This is an interesting insight for those who work in other settings and who might want to consider making a shift in their employment. The seeking out of new or as yet underserved areas of employment for psychologists has been discussed at many of the Future of Psychology Initiative meetings.

Dryden Badenoch is also helping to prepare us for the future in his piece entitled "Psychology on the Web". This UK-trained clinical psychologist, articulates a few 'how-to's' of the Web in the hope that we can promote ourselves better for the sake of improving the public perception of psychologists. This will be welcomed by many I suspect, especially those whose training pre-dates the Web like me. We may need a follow-up piece from Dryden, perhaps given the rate of change in this area, a regular slot!

In relation to the Web, Joyce Fennel has written a review of an on-line course on "Act and Mindfulness for Trauma" by Russ Harris. As more and more of these are offered enabling us to take up training opportunities that would otherwise be hard to attend, it is important for us to provide feedback where we can on useful courses or resources, just as we would do with book reviews. Also in the vein of educating the public and promoting the role of the psychologist, Angela Arnold-Saritepe begins her piece on what ABA psychologists do with a quote from many well-known figures, 'the measure of society is how we treat those most vulnerable'. This will ring a bell with many and it is clear that Angela carries a passion for her work and that

of the field of applied behavior analysis. She describes the breadth and depth of the work which will help challenge misconceptions and confront stereotypes.

These articles are all featuring psychologists who are in some way working at the top of their scope, in that they are presenting new or innovative ways of working. This challenge to be working at the top of our scopes has been a challenge put to us and has since been a topic of discussion. Mike Butcher is one psychologist who has pursued leadership within the health sector, and is now an Allied Health Director for Mental Health and Addictions at Auckland DHB. Mike has answered the call to write about his take on working at the top of our scope. If you would like to present your version, we welcome a submission!

Barry Parsonson presents a response to Peter Stanley's "Point of View" about 'Fetal Alcohol Spectrum Disorder: What we know and what can be done about it'. He writes a caution to throwing the baby out with the bathwater with regard to this challenging disorder. Peter Stanley has written a response to Barry's contribution.

Finally, we have our student forum section which is headed up by two new editors, Ariana Krynen of Auckland and Anna Kurek of Wellington. These two have assembled an interesting array of contributions from Māori women's leadership by Stacey Ruru, (recipient of the 2015 Karahipi Tumuaki President's Scholarship) to academic outcomes of children born to opioid-dependent women by Samantha Lee et al. There is also a visionary piece about how psychology can become 'an integrated, culturally sensitive and ethically informed science of human psychology' by Nick Laurence. There is also a contribution touching on urban design and flourishing from Walter Hamer as well as the experience of being an international student by Sandila Tanveer. Ariana and Anna have themselves written an informative piece about the transferability of our qualifications internationally. This is a must read for those of us in the education sector. Well done to all the student contributors, these are interesting readings for us all.

This is a rich set of articles to add to your bedside stack! We welcome contributions from far and wide, so please email us if you have a report of your practice, a piece of research, a book or course review or an opinion piece. Remember we have the new section on 'Social Justice Issues' in which we can spotlight certain issues, so if you are engaged in an area and have something to say, please email us! We look forward to your future contributions.

Kia kaha,
Hei konā mai,
Fiona

NZPsS News

Our warm congratulations to new NZPsS Fellows

Congratulations to our new Fellows of the Society whose careers and work are reflected in the items below



Stuart Carr

EPIC (End Poverty & Inequality Cluster), Massey University

A Career in Psychology without Borders

This year's conference theme *Psychology without borders* is hugely relevant to the challenges and opportunities facing

humanity today. As we heard at the conference, psychology has an active responsibility, and the capability, to step up to these global and local issues – from forced displacement to child poverty, to working poverty, climate change, peace and inclusion, Indigenous rights... In that sense there are no borders that a psychology which is respectful and invested in social justice, cannot cross.

Crossing borders is a leitmotiv in the awarding of this fellowship, for which I am extremely grateful and of which I am extremely proud and humbled at the same time. Humbled because these things can only happen through teamwork and collaboration – across borders. Those borders are not only geographic but also inter-disciplinary, across not only space but also time. My first job was at the National University of Malawi, where traditional wisdom observed that “one head does not carry the roof.” Teamwork. It was also said that the two worst days in Malawi are the first and the last – the first because of the realization that much of what is held as true proves culture-centric and does *not* actually cross borders very well, and the last (4 years later in this case) because of the borders that have come down as we say goodbye to so many friends.

“Visitors are as the dew,” here today and gone tomorrow – and in our case gone to Newcastle Australia (5 years) and then Darwin in the Northern Territory (3 years). Many friendly collaborations and projects again - this time across borders in the South Pacific, Southern, South East Asia and with friends from Malawi now in Western Europe. By this time, it was beginning to dawn that what we had seen in

sub-Saharan Africa – the inherent agency of people despite much poverty of opportunities – was not going to leave me alone, and was too cross border. One Hawaii-based mentor told me one day, “Your focus is poverty.” I hadn't realised it was, but it was, it still is, and will always be. It only took 15 years to realise!

Across the sea to Aotearoa/New Zealand in 2001, and this country is now home. My colleagues in the School of Psychology, the School support, and the College and University have helped hugely to make it so. Hence our focus today, in EPIC, is for me the culmination of years of psychology without borders. The newest incantation of the borderless mantra is the set of United Nations Sustainable Development Goals, or “SDGs.” The latter came into force this year and they run for 15 more years, across the whole planet. With their primary focus on eradicating poverty in all its forms everywhere, they are a call to arms for psychology to flex its voice on poverty of opportunities in health, education, gender equity, social inclusion, decent work, sustainable livelihood and living wages, access to safe and clean environments; and to enact a capstone process of partnership to enable the goals to be met.

Looking to the future, we have a role to play in operationalizing how these “macro” level SDGs are enabled and achieved by people, in everyday life. That's what we do best. At the end of the day, psychology without borders is actually, for me, all about crossing borders.



Suzanne Blackwell

I am very grateful that I chose psychology as a profession or rather, that it chose me. It has been a wonderful and fulfilling career with supportive colleagues and amazing experiences. I would like to be able to say this was a carefully

planned ambition realised, but it was not. It just seemed to happen. I have had very good luck and marvellous opportunities over the years.

I enrolled in psychology at Auckland University with absolutely no notion of what a psychologist was, or the subject matter of psychology. However, I found it fascinating and it became my major.

Having been put off postgraduate studies by the unwanted attentions of the American, then Professor of Clinical Psychology, (we didn't know the term sexual harassment in those days) I found a job at Tokanui Hospital. That was

a unique experience (think *One Flew over the Cuckoo's Nest*).

The next year, it was my very good luck that Waikato University began a postgraduate clinical course run by Gerry Rosser, Barry Parsonson and Bill Temple. I was accepted into this (the only female - how things have changed). Although rabidly behavioural, it was an excellent course and my internship at the then Waikeria Borstal, was an eye-opener which ultimately set me on a course of working within the criminal justice system.

After qualifying, I moved back to Auckland, and was a psychologist at the Auckland Maximum Security Prison (Paremoremo). It was probably a dangerous place for a young woman but my youthful sense of invincibility seemed to be protective of me. I also worked within the probation setting and had the enormous good fortune to work under the guidance of the Regional Senior Psychologist, Fred Masters. He was a wonderful person and he championed women in the office because he believed we worked hard. Later, I was promoted to Senior Psychologist.

I left in 1980 to take maternity leave and returned in 1983 as a consultant working two to four tenths until 1995, when I decided I had done several prison terms. After 1980, I began private practice and enjoyed a combination of private clinical practice and forensic work. I was also co-opted to conduct Family Court assessments by the brilliant Lynn Beatson who was the "boss" of the Auckland Family Court. I also began to undertake expert witness work in criminal trials. All of this was interspersed with periods of maternity leave.

I have had a long association with the University of Auckland as a student, a supervisor of interns, external examiner and, more recently, as an Honorary Research Fellow. I have worked with Fred Seymour and enjoyed the fascinating research (including the jury research project) we have worked on together, and have greatly valued the supportive collegiality of that relationship. As I approach retirement in the next few years, I look back on working with marvellous people, both colleagues and clients. The love and support of my husband and three sons has been an integral part of any successes I may have had.



Frank O'Connor

An accidental psychologist

Two roads diverged in a yellow wood. And I ... I took the one less travelled by. It seemed just as good.

Robert Frost's advice to travellers got me into

psychology at an intriguing time. No one I knew had studied it, and I was looking for another subject to fill out 1977, my first year at university. I was at Canterbury, then a supposed den of behaviourists, quantitative psychologists and more than a few Society members.

It took a while to finish my Masters, fending off the distractions of new-fangled ideas that people might process information as computers seemed to, and that meaning might be encoded in language in ways that brains were peculiarly suited to. Both of these notions have received publicity in the current fad of neuroanything, yet they remain firmly discoverable by those prepared to take a dose of doubt with their science. Rob Hughes helped me realise there was the possibility of science as robust as my friends in geology pursued, and that the Society gave a place to gather for people interested in this way. This stimulation of grounded research, carefully considered research questions and access to a body of experience worth more than the books in the library, combined attractively with things I learned in my philosophy, linguistics and life sciences courses. Together, these people and doubts kept me from the deeper temptations of neurolinguistics programming, learning styles and brain gymnastics. These seductive practices are, it seemed to me then as now, explicable by other processes than their founders suggest, if one holds the doubt and does the science. Preferences are not constants, I recall learning, and have pondered many times since about the boundary between evidence that distinguishes earnest personal beliefs from constant shared truth or reliable facts in the world. I straggled out of university and away from participation in Society activities for a year or two. Once I found my work supervisor serious about my registration as a psychologist, I thought I'd better find out what these people did. I really didn't know, and certainly didn't see myself as one. Murray Dobson was kind enough to let me annoy a few of his professional colleagues and hear what they did. The application of basic science to the way people worked, played and lived was the bit that appealed to me.

I regularly joined Society branch meetings after I moved to Wellington in 1988. A mix of town and gown characterised gatherings, in presenting work of all psychological sorts and

discussing some of the issues it raised. I was given what I still regard as my strangest Society duty: explaining to the panel reviewing the performance of Victoria's Psychology Department that the Society held concerns that graduates produced were not fully able to do the work expected of their profession. The Dean of Science looked mildly startled at this, but as the examples were outlined, the need for change was grasped. Christina Rush and Peter Priest inveigled me into organising a few things – and when that list included the 1992 Society Annual Conference, I thought I'd better go to the Knox College one of 1991 and find out what was expected. I sensed uncertainty in the establishment when I responded "I'm sure we can do that!" or similar to the question of whether Wellington Branch would be up to hosting. My Knox room-mate Ray Nairn had made a start on my understanding of the need for a big push away from monocultural academe that (some felt) had constrained the Society's growth. Richard Sawrey took my invitation to open proceedings differently, and we front-footed on the less comfortable lives of people who were poor, Māori or Pasifika. A few startled faces at the challenge to look at the imbalance, but we have progressed together. Another reason for feeling challenged was the icy division then piecing our profession — another experience for me of how people naturally organise their worlds to accord with beliefs, and forget the likelihood of validity in other beliefs also. While the frost has never thawed, more than two decades later, I had the honour of working alongside John Bushnell to suggest to our professional regulator some more effective ways of meeting the need for practice-risk mitigation without undue practitioner workload. That must be seen as a work in progress: my work in other fields makes it obvious to me that focus on input quality rarely assures output quality, especially where public safety is the bottom line.

Psychologists and the broader research and practice of psychology provided some much needed relief for me. My work as an organisational consultant took me up and down New Zealand and out into the Pacific and Asia. I realised how vital it was to share professional tools and insights. I had found my way onto the internet, and saw the opportunity for a Massey-hosted chat group to provide a means of exchanging experience, readings and tactics. I/O Net was not my invention – all I did was encourage people to post questions, information and considered responses. Similarly, I didn't establish the I/O gatherings, which continue in Auckland, Wellington and Christchurch, but brought them into the fold of Society business.

During this time, I began to refer to myself as a psychologist. Until then, I had been a person who knew

about many aspects of getting the best out of people at work. The change in title was minor, perhaps precipitated by the move to protect the title's use for those who were officially regulated, rather than those who had studied the body of work and contributed more to it than I ever could. More likely, my work in other jurisdictions showed me a way that was less officious and more helpful. And the word fills all the boxes in the arrival card at the border. In Sri Lanka and Malaysia and the Philippines, I was tested heavily. My careful tuning of systems, advice and encouragement to people of dozens of different nationalities were vital to the acceptance of a different way of sharing work and gauging effect. I sought out motives, and made channels to allow them to flow in the desired directions. Many moments of seeking guidance from within this culture or that. It worked, more or less. A dozen years later, it ticks over quietly, fitting the world views of people from all of the globe and allowing them coexistence so the shared goal can draw nearer. A very senior Japanese in Manila, who shared my interest in the way proverbs spoke deeply of culture, sent me homeward with, "In English, you have a saying. 'You can lead a horse to water, but you cannot make him drink.' But you. You have a way of making horses thirsty."

I was trusted with the Presidency and I hope I did all right – it was a challenging period on personal fronts with squabbles in families, noises in my head and too much experience of the distortions of reason and affect that come with major overload. We regularised a few unsatisfactory arrangements, learned some surprising things about where our money comes from and goes to, and thought ahead to how the profession would be in another two decades. Trying to preside while hopping among Vanuatu, Kiribati, Tonga and Samoa didn't help. It probably did help the Executive do things together without waiting for someone to lead, but they didn't need me to work that out. We're lucky with our Executive, and with the national office staff. Very lucky.

I did what I believed necessary in our Conferences, as they came and went. A few all-too-human things continued in the mix of workplaces and I found my Society colleagues useful as sounding boards on sticky topics. We produced words and pictures on many things: bullying: loss of mental fitness for work: breaking silence when harm happens: standards of evidence for claimed improvements: why so much effort goes into avoiding evaluating the gains from interventions: the weakness of self-report as a predictor of action: duty of care in a multi-client situation: seeking cultural advice before the moment of ignorance matters. Guidance came freely. Freda Walker. Huata Holmes.

Neville and Ray, again. Fred Seymour. Jack Austin. Moana Waitoki. Angus Macfarlane. I will stop before it looks like I can recall all the collaborators... Without your responses to my queries, I would not have made it as a professional, or as a person. Thank you for being there. That, surely, is Fellowship.



Bruce Jamieson

Bruce Jamieson headed up the Industrial and Organisational Psychology programme at Canterbury University from 1966 until 1999 when he became the HR Director at the University. During his tenure Bruce was responsible for approximately 400 graduates

from the Masters programme. In 1970 he increased the Masterate programme from the single paper occupational psychology, which had been available at the university for many years, to three masters level papers (organisational psychology, personnel psychology and human engineering) and some years later two additional papers completed in the second year concurrently with a thesis. In 1986 he introduced the Post Graduate Diploma in Industrial and Organisational Psychology which facilitated IO graduates becoming registered psychologists. In 1993 Bruce formed the current Masters in Applied Psychology programme which had produced 90 graduates before his retirement from the programme.

He has been a member of the Society since 1966 and served on the NZPsS Council as well as two terms as treasurer. Bruce founded the Society's Jamieson award for contribution to Industrial/Organisational Psychology. He was also a member of the foundation Psychologists Board.

Bruce is enjoying retirement with more time to read the things he enjoys than the things he felt he should read while he ran the programme. He has a number of grandchildren to keep up with including a grandson who has recently graduated with the Masters in Applied Psychology from Canterbury! He still keeps tabs on his graduates and enjoys hearing from them on a frequent basis. They have gone far and wide, and include the current CEO of Tait Technology (Garry Diack), former Head of the Christchurch School of Medicine (Andrew Hornblow) and numerous GM HRs, HR managers and consultants in New Zealand, Australia and as far away as Switzerland, London and Dubai, as well as many who have completed further degrees and have pursued academic careers.

A summary of the 49th NZPsS Annual General Meeting

The following is a brief summary of the NZPsS AGM 2016 held 3 September, 2016 at the Annual Conference at Massey University, Wellington.

Thirty-three members and five students attended the meeting. There were seven apologies.

Minutes and Reports

The 2015 minutes were accepted without amendment and there were no matters arising. President Kerry Gibson spoke to a Powerpoint presentation on the work of the Society in the last year and thanked all Executive members including Michele Blick for her excellent work in engaging students, Director of Professional Issues John Eatwell for his development of the Institute of Organisational Psychology (IOP) and for his work in organizing the IOP stream at the conference. Kerry noted the NZPsS has strong financial reserves which allowed for a nil increase in member subscriptions this year. Jackie Feather was thanked for her work on *Psychology Week*, John Fitzgerald for his editorship of the *New Zealand Journal of Psychology* and Fiona Howard for her co-editorship of *Psychology Aotearoa*.

Kerry noted the support of the Society for members dealing with ethical matters and acknowledged Jack Austin and those members of the Ethical Issues Committee who have contributed to the work of the Ethics Help Desk. She also thanked Elizabeth du Preez for her excellent ethics columns in *Connections*. She reported on the advocacy matters the Society had been involved in and the submissions presented and feature on the Society's website.

Kerry also reported on the recent MOU with the BPS and commented on the continued development of the MOU relationships with the APS and APA. She noted the importance of being involved in the international arena and reported on Waikaremoana Waitoki's active role in the international competencies project and the declaration at the Asia Pacific Leadership Forum in Yokohama.

Neville Blampied expressed a vote of thanks for Kerry and the Executive for their work at an international level. Barry Parsonson expressed support for Neville's comment, noting the importance of an international role and thanked the Executive. Richard Smith thanked Kerry and noted the achievements under Kerry's leadership as President. Kerry acknowledged the team effort of Executive, national office, branches and institutes.

Thanks and farewells were expressed to Erana Cooper, Bridgette Masters-Awatere and Jackie Feather for their

contributions on the Executive and Quentin Abraham was welcomed to the role of President.

Executive Director, Pamela Hyde proposed a remit for approval to implement a secure and effective method of conducting NZPsS elections for the Executive, electronically and the remit was carried.

Another remit was proposed arising from the symposium on behalf of participants in the refugee issues symposium at the 2016 NZPsS conference. The remit was proposed by Brian Dixon and seconded by JaneMary Castelfranc-Allen and was carried.

The New Zealand Psychological Society declares its abhorrence of armed violence by those in nation states who use weapons to suppress the human rights of citizens AND agrees to make representations (through appropriate channels) to seek NZ Government action to request a ruling by the UN Security Council or the UN itself requiring that its members implement effective measures to halt the supply of weapons to those victimising citizens in their own and neighbouring countries and detect, seize and destroy weapons already being used for such purposes.

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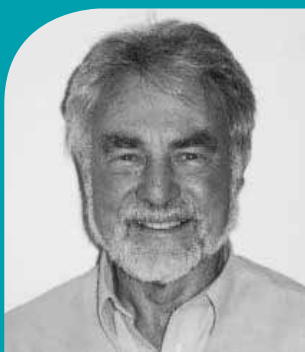
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Foetal Alcohol Spectrum Disorder: What we know and what can be done about it: A response to Peter Stanley's "Point of View"

Barry S Parsonson



Barry graduated from University of Canterbury in clinical psychology and obtained his PhD in Developmental and Child Psychology, from the University of Kansas. He was an Associate Professor in Psychology at University of Waikato and had terms as Chair of the Psychology Department and Dean of the Faculty of Social Sciences. Barry is a Fellow and Past President of the New Zealand Psychological Society and former chair of the NZ Psychologists Board. He currently works part-time as a clinical psychologist with Explore Specialist Advice providing behaviour support services for persons with ID and Developmental Disabilities.

Introduction: Peter Stanley raises a number of important issues relation to diagnostic labeling and its potential to stigmatize those so identified and their mothers in his "point of view" article (*Psychology Aotearoa*, 8(1), 2016). While many of these points are valid and important to consider, the underlying argument that foetal alcohol spectrum disorder (FASD) is somehow an invalid construct is not. Despite the fact that DSM 5 (American Psychiatric Association, 2014) does not include it in the main body of its diagnostic categories, there is a long history of researching and developing an approach to the identification and classification of the variety of effects of prenatal exposure to alcohol.

Jones, Smith, Ulleland and Streissguth identified foetal alcohol syndrome (FAS), which includes the physiological features of growth deficiency, facial anomalies and evidence of structural and/or functional central nervous system damage as a disorder in 1973. Stanley (2016) cites Armstrong (2008) who argues that this diagnosis, along with that of the broader FASD classification, is essentially a consequence of social concerns and technological developments in the 1960s and 70s and imposition of moral judgments by the medical profession. Armstrong concluded that this was a strategy to place the responsibility for the children's "disorders" on women, especially African-American women, rather than on the circumstances imposed on them by low educational achievement, age and poverty.

While elements of Armstrong's (2008) argument are extreme, those that identify social and environmental factors that may

function as confounding variables in determining the behaviour of children diagnosed with FASD are relevant and worthy of consideration. However, this has also to be tempered by the fact that the neurodevelopmental effects of alcohol on the foetal brain are undeniable. This latter fact is not evident in Stanley's (2016) "point of view" as he fails to review any of the FASD literature and it needs to be addressed.

There is extensive evidence from brain imaging and neurological investigation that alcohol has teratogenic effects on the developing foetal brain. These teratogenic effects are observed in both the cortex and the cerebellum (Astley, Aylward, Brooks, et al. 2009; Riley & McGee, 2005; Riley, McGee & Sowell, 2005; Sampson, Streissguth, Bookstein, & Barr, 2000; Sowell, Jernigan, Mattson et al. 1996). Consequently, in those diagnosed with FASD, some of the frequently encountered effects on cognitive functioning, communication, emotional dysregulation and problems with balance can reasonably be attributed to neurodevelopmental factors.

This is not to say that all of the identified deficits in cognitive and behavioural functioning are due to maternal prenatal alcohol consumption. The attribution of cause to alcohol is confounded in many instances by the environmental impacts of poverty, low maternal education, living with domestic violence and family dysfunction along with parental alcohol and drug abuse that many of these children experience (Malone & Koren, 2012; Sood, Delaney-Black, Covington et al., 2001;

Victor, Wozniak, & Chang, 2008).

These effects can be compounded by the intervention of social agencies that result in multiple foster care placements (Brown, Bednar, & Sigvaldason, 2007; Carpenter, 2011, Westrup, 2013) as well as the child's own experience of learning, behaviour and social challenges, often resulting in suspension, exclusion or dropping out from school (Streissguth, Barr, Kogan, & Bookstein, 1996). As is the case with many behaviour disorders whose diagnostic attributions include both neurodevelopmental and environmental components (e.g., ADHD, ASD, childhood trauma), in FASD it is difficult to precisely partial out the effects of neurological dysfunction and the environmental impacts resulting from any resultant individual neurological deficits or dysfunctions from those also generated by the challenging social contexts in which the child finds her or himself.

Stanley (2016) presents FASD diagnosis as a 'mother blaming' label, possibly because confirmation of the condition relies on evidence that prenatal consumption of alcohol is acknowledged. For the very reason that mothers of children with FASD diagnoses report guilt and self-blame, those involved in the diagnostic and family support services typically make every effort to avoid attribution of blame or guilt-inducement because they want to be able to continue to work with and support these families and the children involved (Whitehead, 2011; Wilton & Plane, 2006).

Intervention: Stanley (2016) also refers to local resources promoting interventions for various forms of challenging behaviour (i.e., Bissett, Church; Fergusson, Lambie et al., 2000; Church, 2003; Meyer & Evans, 2006; Mudford, Blampied, Phillips, Harper et al.; 2009) as relevant to intervention for the behaviours

attributed to FASD. The problem is that those reviewers, in promoting various interventions, neither drew on any of the FASD literature nor referenced FASD as a potential causal factor in relation to the challenging behaviours as their primary focus was on either conduct disorder or autism. Given that FASD is associated with a spectrum of cognitive, behavioural and social deficits and that these express themselves differently in each affected individual (as is the case with the autistic spectrum). These individual differences are deemed to possibly be a result of the timing and the amount of alcohol consumed during prenatal development and subsequent life experiences. Consequently, any given child diagnosed with FASD and his or her family may need a range of intervention approaches attuned to their specific support needs and across a variety of settings, e.g., home, school, community.

There is extensive evidence from brain imaging and neurological investigation that alcohol has teratogenic effects on the developing foetal brain.

Currently, the literature on effective interventions is sparse. The intervention studies that are reported in the literature fall generally into three categories: early intervention; learning and life skills; and, wraparound family support. Some examples of this research are provided below as reviewing all of extant research is beyond the scope of this response.

Early Intervention: A literature search by the author in 2015 produced only two early intervention studies. Yazdani, Motz and Koren (2009) compared two samples of children aged less than 3 years. One sample comprised of 28 alcohol-

exposed children whose mothers had used alcohol at a level defined as "problem drinking" in pregnancy and the other of 15 non-alcohol exposed children whose mothers had misused other drugs (most often cocaine) in pregnancy. All mothers had low educational achievement and low-income backgrounds. The mother-child dyads participated in a programme offering significant child and maternal health, welfare and educational support. Testing between ages 2-3 years showed no significant differences between the two groups of children on IQ and developmental assessments and all scoring in the average range. Maternal parenting skills, personal health and welfare also improved.

McConnell, Rush, McEvoy, and Carta (2002) undertook a single-subject multiple-baseline design study across two toddlers. The children's caregivers were consecutively trained to enhance the frequency and content of their verbal communication with the children. The outcome demonstrated enhanced verbal competence of the children over baseline levels. The authors argued that by enhancing each child's verbal skills, some of the communication and social deficits of FASD could be mitigated.

While these two studies show some promise of benefits from early intervention, the samples are small and initial assessment at their age is unlikely to identify specific FASD effects, which could mean that the child participants differed little, if at all, from children not exposed prenatally to alcohol. Also, there were no long-term follow-up data to evaluate any benefits or effects that might appear later in childhood. Because FASD effects often are not evident until school-age, early diagnosis and intervention, which could possibly increase synaptic

diversity and reduce brain dysfunction, is uncommon.

Learning & Life Skills: Gunn (2013) reviewed 11 of 47 studies meeting her criteria for inclusion that examined the efficacy of interventions intended to enhance academic skills, including learning, numeracy, literacy and language and cognitive skills. Gunn concluded that five focused more on parents and children (e.g., homework) than on classroom application and that the remaining six had a variety of flaws, including small samples and/or poor design, including confounding variables, inadequate control groups, reliance on parental report, and lack of follow-up or assessment of generalization from training setting to classroom.

Many families containing children with an FASD diagnosis report finding themselves bereft of information, support and therapeutic intervention in home, school or community settings.

One large sample control-group study evaluated a classroom-based language and literacy programme that ran over 9 months. Forty FASD-diagnosed 9-year-olds were randomly assigned to the language and literacy training or to an FASD control group. 25 non-alcohol affected peers served as normal controls (Adnams, Suroua, Kalberg, Kodituwakku et al., 2007). Initial, pre-intervention data showed the children in the FASD sample to be functioning well below the controls in a range of academic and cognitive areas, including reading, spelling, arithmetic and phonological awareness. While the literacy and language programme did not produce significant general academic benefits compared with FASD controls, there were significant gains for the participants in language

and early literacy skills that benefited reading and spelling. The study demonstrated that specific skills can be enhanced through intensive, targeted learning programmes. The question remains as to how practical this approach is in the context of schools with small numbers of pupils diagnosed with FASD.

Kerns, Macsween, Vander Wekken, & Grupusso (2010) used a 16-hour long computer-based attention training programme spread over a period of 9 weeks to enhance the ability of a small group (n= 10) of children aged 6-15 years to sustainably and selectively attend to the presented tasks. They found that in addition to improvements in attention, the children showed significant post-test increases on measures of spatial working memory and of maths and reading fluency. Again, while the findings showed promise, the absence of a control group and a small sample made generalizations from the study difficult.

Coles, Strickland, Padgett, and Bellmoff (2007) also used computer technology in the form of “games” to train fire and road safety skills to 32 children diagnosed with FAS and FASD aged from 4 to 10 years. Having learned the skills to mastery on the computer games, post-tests showed 72% of the participants were able to generalize the skills to a behavioural setting. This raises the question of whether children diagnosed FASD learn more effectively when visual stimuli are used, if so, video-modelling strategies (Dowrick, 2012) could prove effective in assisting learning and behaviour.

Parental & Community Support:

Many families containing children with an FASD diagnosis report finding themselves bereft of information, support and therapeutic intervention in home, school or community

settings (Duquette, Stodel, Fullarton, & Haglund, 2011; Sanders & Buck, 2010; Whitehurst, 2011).

Several factors contribute. A major problem is a lack of access to skilled diagnostic services and the fact that diagnosis is often not made until the child is at school, when cognitive and behavioural challenges are identified. Also, for many it is a consequence of adopting or fostering a child who is subsequently diagnosed with FASD. It is estimated that up to 85% of children with FAS/FASD diagnoses are in care (Carpenter, 2011) and placement breakdown is both common and, for many children, repeated (Brown, Bednar & Sigvaldason, 2007; Westrup, 2013; Whitehurst, 2011). Schools have been found to be unwelcoming of children with FASD and the multiple challenges they present (Duquette et al.; Timler & Olswang, 2001). It is hardly surprising that an estimated 60% of diagnosed children aged 11-years or more experience disrupted schooling through suspension, exclusion and dropping out (Blackburn, Carpenter, & Egerton, 2010).

A long-standing initiative in community support programme is the “Family Empowerment Network”, a Wisconsin-based service that, since 1992, has provided a range of specialist information sources and resources to parents and professionals involved with children diagnosed with FASD (Wilton & Plane, 2006). However, while addressing the information gap is important, there is also a need for active professional support for families. On recent study is worthy of note. A Manitoba-based programme (Hanlon-Dearman, Edwards, Schwab, Miller, & Longstaffe, 2014) provided a telehealth support service to families in remote areas of the province who would otherwise had to travel significant distances to access services. The

programme not only provided families with information and access to professional support, it also assisted in setting up local support groups. Evaluations revealed that, while many felt that face-to-face support was most desirable, the telehealth option and the support groups were a valuable alternative. Given that there are likely to be numbers of such families in Aotearoa/New Zealand who live in isolated communities, such a model could be applied in this country.

Conclusion: Although Stanley (2016) raised a number of points worthy of consideration, in this writer's opinion his point of view was too critical and relied too little on an actual evaluation of the FASD literature on diagnosis, neurological and cognitive challenges posed, the problems faced by families and educators and the efforts at ameliorating these effects and providing effective support.

This author's viewpoint is that while there are many issues to resolve in terms of the diagnostic model; the confounds between neurological and environmental factors contributing to the observed "deficits"; and the inadequacy of many of the intervention studies, it is pointless in throwing the baby out with the somewhat murky bathwater. Understanding what the FASD literature is trying to say and extending the research endeavour is much more likely to contribute to the benefit of these children and their families than simply implying that FASD is some sort of hoax and that we should treat it with considerable suspicion.

References

- Adnams, C.M., Sorour, P., Kalburg, W.O., Kodituwakku, P., Perold, M.D., et al. (2007) Language and literacy outcomes from a pilot intervention study for children with fetal alcohol spectrum disorder in South Africa. *Alcohol*, 41, 403-414.
- American Psychiatric Association (2014) *Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM 5)*. Washington D.C.: Author.
- Armstrong, E.M. (2008). *Conceiving risk, bearing responsibility: Fetal Alcohol Syndrome & the diagnosis of moral disorder*. Baltimore MD: Johns Hopkins University Press. Cited in Stanley, P. (2016).
- Astley, S.J., Aylward, E., Brooks, A., et al. (2009). Magnetic resonance imaging outcomes from a comprehensive magnetic resonance study of children with fetal alcohol spectrum disorders. 21. *Alcohol Clinical & Experimental Research*, 33:1-19.
- Blackburn, C., Carpenter, B., & Egerton, J. (2010) Shaping the future for children with foetal alcohol spectrum disorders. *Support for Learning*, 25(3), 139-145.
- Brown, J.D., Bednar, L.M., Sigvaldason, N. (2007). Causes of placement breakdown for foster children affected by alcohol. *Child & Adolescent Social Work Journal*, 24(4), 313-332.
- Carpenter, B. (2011). Pedagogically bereft! Improving learning outcomes for children with foetal alcohol spectrum disorder. *British Journal of Special Education*, 38(1), 37-43.
- Duquette, C., Stodel, E.J., Fullaron, S., & Haglund, K. (2011). Educational advocacy among adoptive parents of adolescents with fetal alcohol spectrum disorder. *International Journal of Inclusive Education*, 16(11), 1203-1221. Retrieved from: <http://dx.doi.org/10.1080/13603116.2011.557445>
- Gunn, J. (2013). Meeting the needs of children with foetal alcohol spectrum disorder through research-based interventions. *New Zealand Journal of Teachers' Work*. 10(1). Retrieved from: http://www.teacherswork.ac.nz/journal/volume10_issue1/gunn.pdf
- Hanlon-Dearman, A., Edwards, C., Schwab, D., Miller, D.C., & Longstaffe, S. (2014). "Giving Voice": Evaluation of an integrated telehealth community care model by parents/caregivers of children diagnosed with Fetal Alcohol Spectrum Disorder in Manitoba. *Telemedicine & e-Health*, 20(5), 478-484.
- Jones, K.L., Smith, D.W., Ulleland, C.N., & Streissguth, A.P. (1973). The pattern of malformation in offspring of chronic alcoholic mothers. *Lancet*, 7815, 1267-1271
- Kerns, K.A., Macsween, J., Vander Wekken, S., & Gruppuso, V. (2010). Investigating the efficacy of an attention training program in children with fetal alcohol spectrum disorder. *Developmental Neuropsychology*, 13 (6), 413-422.
- McConnell, S. R., Rush, K. L., McEvoy, M. A., Carta, J. J., Atwater, J., & Williams, R. (2002). Descriptive and experimental analysis of child-caregiver interactions that promote development of young children exposed prenatally to drugs and alcohol. *Journal of Behavioral Education*, 11, 131-161.
- Malone, M., & Koren, G. (2012). Alcohol-induced behavioral problems in fetal alcohol spectrum disorder versus confounding behavioral problems. *Journal of Population Therapeutics & Clinical Pharmacology*, 19(1), e32-e40. Retrieved from <http://www.jptcp.com>
- Riley, E. P., & McGee, C. L. (2005). Fetal alcohol spectrum disorders: An overview with emphasis on changes in brain and behavior. *Experimental Biology and Medicine*, 230, 357-365.
- Riley, E. P., McGee, C. L., & Sowell, E. R. (2004). Teratogenic effects of alcohol: A decade of brain imaging. *American Journal of Medical Genetics Part C: Seminars in Medical Genetics*, 127C, 35-41.
- Sampson, P. D., Streissguth, A. P., Bookstein, F. L., & Barr, H. (2000). On categorizations in analyses of alcohol teratogenesis. *Environmental Health Perspectives*, 108(Suppl. 3), 421-428.
- Sanders, J.L., & Buck, G. (2010). The long journey: Biological and non-biological parents' experiences of raising children with FASD. *Journal of Population Therapeutics & Clinical Pharmacology*, 17(2), e308 - e322. Retrieved from <http://www.jptcp.com>
- Sood, B., Delaney-Black, V., Covington, C., Nordstrom-Klee, B., et al., Prenatal alcohol exposure and childhood behavior at age 6-7 years: 1. Dose-Response Effect. *Pediatrics*, 108(2), 1-9. Retrieved from <http://www.pediatrics.org/cgi/content/full/108/2/e34>
- Sowell, E.R., Jernigan, T.L., Mattson, S.N., Riley, E.P., Sobel, D.F., & Jones, K.L., (1996). Abnormal development of the cerebellar vermis in children prenatally exposed to alcohol: Size reduction in lobules I-V. *Alcohol Clinical & Experimental Research*, 20, 31-34.
- Stanley, P. (2016). 'Oh dear, let's not go there': A response to the Ministry of Health's discussion document on Foetal Alcohol Spectrum Disorder. *Psychology Aotearoa*, 8(1), 7-13.
- Streissguth, A., Barr, H., Kogan, J., & Bookstein, F. (1996). *Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE): Final Report for Centre for Disease Control & Prevention*. Seattle: University of Washington.
- Timler, G.R., & Olswang, L.B. (2001). Variable structure/variable performance: Parent and teacher perspectives on a school-age child with FAS. *Journal of Positive Behavior Interventions*, 3(1), 48-56.
- Victor, A., Wozniak, J.R., & Chang, P.-N. (2008). Environmental correlates of cognition and behavior in children with Fetal Alcohol Spectrum Disorders. *Journal of Human Behavior in the Social Environment*, 18(3), 288-300.
- Westrup, S. (2013). Foetal Alcohol Spectrum Disorders: As prevalent as Autism? *Educational Psychology in Practice*, 29(3), 309-325.
- Whitehurst, T. (2011). Raising a child with fetal alcohol syndrome: Hearing the parent voice. *British Journal of Learning Disabilities*, 40, 187-183.
- Wilton, G., & Plane, M.B. (2006). The Family Empowerment Network: A Service Model to Address the Needs of Children and Families Affected by Fetal Alcohol Spectrum Disorders. *Pediatric Nursing*, 32(4), 299-306.
- Yadzani, P., Motz, M., & Koren, G. (2009). Estimating the neurocognitive effects of an early intervention program for children with pre-natal alcohol exposure. *Canadian Journal of Clinical Pharmacology*, 16(3), e453-e459. Retrieved from: <http://www.jptcp.com>

Peter Stanley's Response

Fetal alcohol spectrum disorder: A road paved with good intentions?

Peter Stanley PhD, Counselling Psychologist, Tauranga

I am grateful to have this opportunity to reply to Barry Parsonson's critique of my paper on fetal alcohol spectrum disorder (FASD) (Stanley, 2016). The pivotal argument in his paper contains logic that may typically be associated with FASD: (i) alcohol has teratogenic effects on the developing brain, (ii) some problems with balance, cognitive functioning, communication, and emotional regulation in children and young people diagnosed with FASD regularly reoccur and, (iii) these problems "can reasonably be attributed to neurodevelopmental factors" (Parsonson, 2016, this issue). Barry also says that the categorisation is "somewhat murky" because of confounds of neurological and environmental influences and the inadequacy of intervention studies. Equally, official Ministry of Health statements about FASD do not communicate a certainty that might otherwise be presumed. For instance, the Discussion Document (Ministry of Health, 2015) admits that there are actually "really big holes" (p. 24) in the relevant knowledge. And in the recently released Action Plan there is this statement:

While some people present with visible signs of alcohol exposure, others present with a range of neurodevelopmental impairments that can be difficult to attribute to a specific cause. Sometimes the issues people present with are common to a number of disorders as well as FASD; some people will meet the criteria for multiple diagnoses. (FASD Working Group, p. 15)

The Action Plan reports that systems are to be developed for the diagnosis of FASD but, in less careful situations at least, a designation of neurodevelopmental damage is easy to make, and similarly it can be difficult to disprove. As Kauffman and Landrum (2013) observe, almost all instances of serious emotional and behavioural problems are, at some level, the consequence of structural or chemical changes in the brain.

My first concern is the expansionism that is inherent in the FASD categorisation. As I indicated in my first paper,

those of us who have had careers in the social services have previously witnessed 'epidemics of discovery'. In the 1990s attention deficit hyperactivity disorder (AD/HD) ran hot, largely as a consequence of a book publication (Stanley, 2006a). Successions of parents consulted psychologists declaring that their child was suffering from this 'hidden handicap' and attesting that the condition accounted for both the young person's unruly behaviour and their parenting difficulties. AD/HD was then lapped by autism; a descriptor and attribution which Liu, King, and Bearman (2010) conclude is significantly impacted by social influence, such as through conversations among parents of young children at schools, shops, and playgrounds. Meanwhile, other commentators were contending that the over use ('diagnostic generosity' as it was also termed) of the Aspergers category could lead to professional conflicts and ethical dilemmas (Stiefel, Shields, Swain, & Innes, 2008). The strength of these diagnostic fashions really needs to be experienced to be appreciated. For example, Horrocks (2006), in a critique of the medical interpretation of children's issues, chides that if he had been paid for every time he had heard someone's child described as dyslexic, Aspergers, gifted Aspergers, AD/HD, ADD, or borderline personality disorder, he would be a rich man.

It should be noted that FASD is on a different plane altogether to AD/HD and autistic spectrum disorder (ASD) in the potential for expansionism and the medicalisation of the problem behaviours of children and youth. The goal of the FASD Action Plan (FASD Working Group, 2016) is to have a coordinated multiagency pathway of care in this country for people who are affected by FASD, and this should be available across the lifespan. A "neurodisabilities lens" is to be applied to (amongst other activities) the revision of special education, to the interactions of classroom teachers with children, to what occurs in youth justice settings, and to the work of Children's Teams (and 50 percent of children and young people in care are now believed to have FASD). Special tools are to be developed, and facial screening software for FASD is to be tested with a local cohort. There is to be an audit of the skills and knowledge of all health and allied staff for preventing, identifying, and responding to FASD; and an e-learning and other training packages on FASD are to be developed for different professions. The aim is "to ensure that all frontline professionals have the same knowledge, use the same language and give the same advice about FASD" (p. 14). This is important, not least, because what is also sought is "a standardised cross-agency data protocol for recording and reporting FASD diagnoses" (p. 7).

The second point that I would like to reiterate is that,

even if FASD is an incontestable condition that can be consistently applied, a diagnosis is largely irrelevant to the design and implementation of behavioural interventions in response to it (Meyer & Evans, 2006). Having a diagnosis can fulfil functions for parents, but they are typically superfluous to the work of psychologists in schools and elsewhere who instigate programmes for children and young people in relation to their presenting behaviours and the availability of contextual supports. Similarly, the search for special pedagogies and treatments for particular categories of special needs can contribute very little; and they can also use up time, financial resources, and therapeutic opportunities (Foxy & Mulick, 2016; Stanley, 2006b). Furthermore, the Ministry of Education has shown with the needs-based categories of the Ongoing Resourcing Scheme that the administrative justification for diagnosis ('kids need a label to get services') is unnecessary (Ministry of Education, 2015). Of course, these programming considerations are irrespective of the stigmatising potential of FASD which is inseparable from diagnosis.

There is no question that alcohol is a teratogen and that it can be a threat to prenatal development, but this does not mean that FASD is necessarily a reliable or required categorisation for useful professional engagements. Barry Parsonson argues that additional work in this area will benefit children and families. More probably, FASD with its assessment emphasis, will prove to be a distraction from useful community-based interventions and programmes for children and youth with learning, emotional, and behavioural difficulties. And as an 'invisible' and 'hidden' spectrum/continuum diagnosis, that is receiving

multi-ministry government money and support, FASD has an extraordinary potential for expansionism. As indicated in my first paper, the recent evaluation of the FASD assessment pathway in the Hawke's Bay (Health Promotion Agency, 2015) suggests that the burden of diagnoses will likely fall on Māori boys and their mothers. The situation that is developing before us with FASD demands that psychologists ask questions, and that we closely consider the implications for all of the children and young people that we intend to serve, for our profession, and for the social services in this country.

References

- FASD Working Group (2016). *Taking action on fetal alcohol spectrum disorder, 2016-2019: An action plan*. Wellington: Ministry of Health.
- Foxy, R. M., & Mulick, J. A. (2016). *Controversial therapies for autism and intellectual difficulties: Fads, fashion, and science in professional practice* (2nd ed.). New York: Routledge.
- Health Promotion Agency. (2015). *Hawkes Bay District Health Board Developmental Assessment Programme FASD Assessment Pathway: Process Evaluation*. Retrieved from <http://alcohol.org.nz/sites/default/files/documents/HBDHB%20Development%20Assessment%20Programme%20FASD%20Assessment%20Pathway%20-%20Process%20Evaluation%20Report%20August%202015.pdf>
- Horrocks, J. (2006, September 29). Bad behaviour: is "therapism" the answer? *Education Review*, 11, 7.
- Kauffman, J. M., & Landrum, T. J. (2013). *Characteristics of emotional and behavioural disorders of children and youth* (10th ed.). Upper Saddle River, NJ: Pearson.
- Liu, K.-Y., King, M., & Bearman, P. S. (2010). Social influence and the autism epidemic. *American Journal of Sociology*, 115, 1387-1434.
- Meyer, L. H., & Evans, I. M. (2006). Literature review on intervention with challenging behaviour in children and youth with developmental disabilities. Wellington: Victoria University.
- Ministry of Education (2015). Ongoing Resourcing Scheme. Retrieved from <http://www.education.govt.nz/school/student-support/special-education/ors/>
- Ministry of Health. (2015). *Taking action on Fetal Alcohol Spectrum Disorder (FASD): A discussion document*. Retrieved from <https://www.health.govt.nz/system/files/documents/publications/taking-action-fetal-alcohol-spectrum-disorder-discussion-document-dec15.pdf>
- Stanley, P. (2016). 'Oh dear, let's not go there': A response to the Ministry of Health's discussion document on Foetal Alcohol Spectrum Disorder. A submission to the Ministry of Health. *Psychology Aotearoa*, 8(1), 7-13.
- Stanley, P. (2006a). A case against the categorisation of children and youth. Part 1: Theoretical perspectives. *Kairaranga*, 7(1), 36-41.
- Stanley, P. (2006b). A case against the categorisation of children and youth. Part 2: Professional perspectives. *Kairaranga*, 7(2), 36-40.
- Stiefel, I., Shields, A. K., Swain, M. A., & Innes, W. R. (2008). Asperger's coming out of our ears: Making sense of a modern epidemic. *Australian and New Zealand Journal of Family Therapy*, 29(1), 1-9.

PsychDirect is a referral search facility that allows NZPsS members to have their practice details accessed by members of the public looking for a psychologist in private practice in New Zealand. PsychDirect is linked directly from the NZPsS Home page via the menu item "Find a Psychologist". The listings on PsychDirect are available to NZ registered, Full Members of the Society with a current APC, offering private psychology services in New Zealand. PsychDirect is searchable by psychology work area, geographic location, and client type and/or psychologist surname. "Additional languages spoken" is a further option which is very helpful when looking for help with specific cultural requirements. PsychDirect is now offered free of charge to all existing and new members.

A short course of Panadol, for everything!

Using the bio-medical discourse and DBT strategies to support

David Semp



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

As a psychologist working in adult public mental health services for 20 years I've become aware of a peculiar dialectic. On the one hand, compared to some other disciplines, psychologists are generally regarded as specialists and privileged. We are more likely to be employed to do 'psychology' versus generic keyworker/mental health roles. We're also likely to have smaller caseloads than our non-psychology colleagues, in acknowledgment of the frequency and intensity of the work we do¹.

At the same time there are many ways in which psychology is marginalised in relation to the bio-medical discourse of psychiatry. 'Treatment as usual' often begins with a psychiatrist prescribing medication, generally doctors are viewed as the 'responsible clinician', and the number of psychologists employed is considerably less than required to provide therapy to the large percentage of clients who could significantly benefit from it. Additionally, there are ways of talking about psychology which further marginalise it. As one manager said

of therapy, in a service planning meeting I attended, "It's a luxury we can't afford". I wondered, do we hear surgery or evidence based medications described in a similar way?

My aim here is not to complain about how things should be different, rather it is to prompt conversations about common discourses that circulate within public mental health services, and which affect the provision of psychological treatments, and those who provide them. From a Dialectical Behaviour Therapy (DBT) perspective I see one benefit of describing these discourses, as a form of radical acceptance i.e. if we accept these are common ways of thinking and talking about mental health and psychology, then we can 'let go of fighting reality' and focus on how we can most effectively deal with the situation we find ourselves in. 'Effectiveness' is a key principle of mindfulness and improving quality of life, within DBT. This doesn't mean we can't hope for and work towards systemic change, but it involves accepting its unlikely to happen any time soon.

In this paper, I illustrate ways in which dominant discourses describe bio-medical and psychiatric treatments compared to psychological treatments.

I suggest strategies for using dominant bio-medical discourses to support the provision of psychological treatments in services, and to validate those who provide them. At the outset, it is important to clarify I do not assume particular people, or disciplines e.g. psychologists, psychiatrists, or managers, speak the language of any particular discourse, in any particular situation. For example, sometimes psychologists (knowingly or not) use assumptions from the medical discourse to describe and think about their practice. Similarly, sometimes psychiatrists talk, think and practice psychiatry from a more psychological perspective. Discourses are just ways of thinking, talking, and 'doing' associated with particular topics (Willig, 2001). They develop and circulate in particular sociohistorical contexts and vie for our attention and loyalty.

Let us turn to some of the various ways the bio-medical discourse is used to describe psychiatric and physical health treatments vs psychological treatments.

While often claiming a biopsychosocial model, the primary focus of treatment from a bio-medical discourse is viewed from a biological 'illness' model, or as 'diathesis/stress'. Thus medication or other biological intervention is assumed. From this perspective therapy can be considered of limited value and not an essential part of treatment. Therapy becomes an 'optional add on'². However, considerable research points to the efficacy of psychological treatments

¹ This is not consistent across DHBs or services and in some places there is pressure for psychologists to undertake more generic roles.

² It is relevant to note that this is generally not the case in Child and Adolescent mental health services where 'treatment as usual' is a psychological and systemic approach.

psychological treatment in adult public mental health services

for various major psychiatric conditions such as anxiety and depression (Keefe, McCarthy, Dinger, Zilcha-Mano, & Barber, 2014; Solomonov & Barber, 2016; Watts, Turnell, Kladnitski, Newby, & Andrews, 2015), borderline personality disorder (DeVylder, 2010; Stoffers JM, 2012), and psychosis (Peters et al., 2015; van der Gaag, Valmaggia, & Smit, 2014).

The duration and cost of treatment is another area in which psychology is often assessed by different standards than biomedical treatments. 'Mental illness' is often seen as chronic, episodic, and requiring ongoing treatment and monitoring. Psychiatric medications are trialled, reviewed, and repeated, at significant expense, with often considerable side effects, over a long period of time. Examples include Clozapine or Relprev. All this is seen as 'necessary', 'first line', treatment. In contrast therapy is commonly described as 'expensive', 'slow', or a 'luxury'. Further, there is an increasing expectation that therapy be 'brief' or 'provide a short course of skills', often regardless of the nature or complexity of the mental health issues the patient has. Likewise, when the initial prescribed psychiatric medication does not work, it is usual practice to trial various alternatives, over a considerable period of time. However, if therapy doesn't work quickly, the client may be inaccurately judged as 'resistant', 'entitled', or 'not psychologically minded'. Or, it might be assumed that 'therapy doesn't work' or the psychologist is 'holding onto clients'. Unlike with medication, there is less likely to be a consideration that other factors are at play, or that another form of therapy is worth trying.

...there are many ways in which psychology is marginalised in relation to the bio-medical discourse of psychiatry.

Using medical analogies can be useful to highlight these biased critiques of psychological treatments. For example, "sometimes a short course of CBT is indicated, but in this case it would be like prescribing a short course of antibiotics for a serious infection", i.e. 'antibiotics are potentially useful, but only if prescribed for long enough and if the right antibiotic is used'.

Another analogy expounds the idea that with both therapy and medication we need the right treatment for the problem. For example, "we don't prescribe anti-depressants

for mania as it might actually make the mania worse" and 'we don't prescribe a short course of Panadol for everyone with pain'.

There is growing evidence that longer term psychotherapy is safer, more effective and cheaper than medications in the long run for major psychiatric diagnoses including schizophrenia, anxiety disorders (including posttraumatic stress disorder), depression, and substance abuse (Lazar, 2014). One apt analogy is that 'surgery and rehab following strokes and other brain injuries are expensive, but reduce health costs in the long run. Therapy for complex psychological problems is the psychological equivalent of both'.

Often when non-psychological colleagues make recommendations about psychology, it is based on insufficient information and assumptions about psychology. One of the challenges of promoting psychological treatments in mental health services is that many clinicians and managers have not had, and do not understand, what therapy involves, the process of change, or the wide variety of psychological interventions available. One way we can help our colleagues (and thus ourselves) here, is to explain psychological formulations, treatment plans, and the process of therapy, in plain language in our teams e.g. "Susan is so scared of trusting anyone due to her extensive history of abuse, so first I'm working mainly on building trust and safety". We can also enhance the understanding and valuing of psychology and psychologists by offering to help our colleagues, even when we can't see their client. This might be via facilitating complex case reviews, team discussions, or consultations with individual staff about their clients.

Related to common misunderstandings about therapy, psychology waitlists are often discussed very differently to surgery and other medical waitlists. When there are media discussions about waitlists for medical treatments, such as surgery, funding is seen as the primary issue. Yet in mental health services it is not uncommon for people to talk of psychology waitlists being due to psychologists "seeing people for too long" rather than as a result of therapy for complex problems being a complex treatment which takes time and which is structurally underfunded. I've never heard anyone suggest surgery waitlists are because doctors spend too long doing surgery, or do surgery when people

don't need it³.

In this context of structural and discursive bias against psychological treatments, psychologists are (implicitly or explicitly), invited to feel guilty about waitlists and to offer brief treatments, even when there is no evidence base to support their efficacy for the clients we commonly treat in public mental health services. I argue that it is not effective for us to take personal responsibility for psychology waitlists as we didn't cause them. Instead, it is both factual and ethical to remind colleagues and managers that psychological treatments are evidence-based specialist treatments which are effective, yet often take considerable time for many of our clients who have chronic, multi-diagnostic and difficult to treat problems. It is generally the case that brief therapies (including brief CBT) do not have a strong evidence base for the complex presentations which are frequently seen at public mental health services.

I argue that it is not effective for us to take personal responsibility for psychology waitlists as we didn't cause them.

One of the challenges then facing psychologists is how do we clearly explain the evidence-base for longer term treatments as necessary for many of the clients we typically see in public mental health services? One way to do this is to describe the emerging evidence that via neuroplasticity, long term psychotherapy produces permanent changes in the brain

3 It is notable that due to stigma, psychiatric services are also marginalised as the 'poor cousin' of physical health. While funding and waitlists for surgery are often debated in the media, waitlists for psychiatric treatment appear to be politically and systemically unacceptable. This helps account for psychiatrists' and keyworkers' huge caseloads.

(Cozolino, 2010; Horwitz, Gilmore, Horwitz, McConnell, & Johnson, 2013; Schore, 2014). This evidence also disrupts the physiological-psychological dialectic regarding treatments; therapy changes the brain.

One of the challenges then facing psychologists is how do we clearly explain the evidence-base for longer term treatments as necessary for many of the clients we typically see in public mental health services?

Further, for the complex clinical presentations our clients in public mental health services often have, in order to develop an effective psychological treatment, like doctors we need to assess a broad range of factors and select from a wide range of possible courses of therapy (or other interventions) to determine the 'right' evidence-based treatment for each client.

Ensuing from the dominance of the bio-medical discourse in public mental health services, it is not surprising that in many ways doctors and bio-medical treatments are usually given structural power within mental health services. For example, organisational 'lead clinicians' are often required to be psychiatrists and psychiatrists often assume leadership in multidisciplinary teams. In response to this environment, psychologists can easily end up in a passive (and hopeless), or defiant relationship to psychiatrists and the wider system.

If, however, we radically accept this is the situation we find ourselves in, (which doesn't mean we can't work to change it), we can choose to find ways to be neither passive nor combative. We can focus on being effective at providing and promoting psychology for our clients, while supporting our colleagues and sustaining ourselves. Both I, and many

other psychologists have found it useful to use our psychological skills to foster relationships which develop our influence in teams and the wider system. It is often especially helpful to do this with colleagues whose views differ markedly from our own on clinical issues. Some DBT strategies which can help with this are finding commonality with our colleagues, validating what is valid in others' points of view, offering to be helpful whenever we can, and acting opposite to our emotions (when acting on our emotions is not likely to be effective)⁴.

I hope that this paper invites psychologists to reflect on how we relate to common discourses which circulate within public mental health services, and how we might to utilise the power of the medical discourse to make analogies which enhance understanding and valuing of psychological treatments and psychologists. Through this we are likely to enhance service provision for clients of mental health services, and sustain ourselves within the complex discursive and structural practices which constitute public mental health services in New Zealand.

References

- Cozolino, L. (2010). *The neuroscience of psychotherapy: Healing the social brain* (2nd ed.). New York, NY: W W Norton & Co; US.
- DeVylder, J. E. (2010). Dialectical Behavior Therapy for the Treatment of Borderline Personality Disorder: An Evaluation of the Evidence *International Journal of Psychosocial Rehabilitation*, 15(1), 61-70.
- Horwitz, J., Gilmore, E., Horwitz, N., McConnell, J., & Johnson, R. (2013). The psychopathology and functional neuroanatomy of psychotherapy *The neuropsychology of psychopathology* (pp. 495-505). New York, NY: Springer Publishing Co; US.
- Keefe, J. R., McCarthy, K. S., Dinger, U., Zilcha-Mano, S., & Barber, J. P. (2014). A meta-analytic review of psychodynamic therapies for anxiety disorders. *Clinical Psychology Review*, 34(4), 309-323. doi:http://dx.doi.org/10.1016/j.cpr.2014.03.004
- Lazar, S. G. (2014). The cost-effectiveness

4 For more ideas on how to use DBT principles and strategies to increase our effectiveness in teams and systems, see Semp (2015).

of psychotherapy for the major psychiatric diagnoses. *Psychodynamic Psychiatry*, 42(3), 423-458. doi:<http://dx.doi.org/10.1521/pdps.2014.42.3.423>

Peters, E., Crombie, T., Agbedjro, D., Johns, L. C., Stahl, D., Greenwood, K., . . . Kuipers, E. (2015). The long-term effectiveness of cognitive behavior therapy for psychosis within a routine psychological therapies service. *Frontiers in Psychology* Vol 6 Oct 2015, ArtID 1658, 6.

Schore, A. N. (2014). The right brain is dominant in psychotherapy. *Psychotherapy*, 51(3), 388-397. doi:<http://dx.doi.org/10.1037/a0037083>

Semp, D. (2015). How to survive and thrive in public mental health services: Mindful dialectics in action. *Psychology Aotearoa*, 7(1), 12-15.

Solomonov, N., & Barber, J. (2016). What we know, what we do not know, and where are we heading? Efficacy and acceptability of psychological interventions for depression. *Epidemiology and Psychiatric Sciences*, 25(4), 301-308. doi:<http://dx.doi.org/10.1017/S2045796015000815>

Stoffers JM, V. B., Rücker G, Timmer A, Huband N, Lieb K. (2012). Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews*, 2012(8). doi:10.1002/14651858.CD005652.pub2

van der Gaag, M., Valmaggia, L. R., & Smit, F. (2014). The effects of individually tailored formulation-based cognitive behavioural therapy in auditory hallucinations and delusions: A meta-analysis. *Schizophrenia Research*, 156(1), 30-37. doi:<http://dx.doi.org/10.1016/j.schres.2014.03.016>

Watts, S. E., Turnell, A., Kladnitski, N., Newby, J. M., & Andrews, G. (2015). Treatment-as-usual (TAU) is anything but usual: A meta-analysis of CBT versus TAU for anxiety and depression. *Journal of Affective Disorders*, 175, 152-167. doi:<http://dx.doi.org/10.1016/j.jad.2014.12.025>

Willig, C. (2001). *Introducing qualitative research in Psychology: Adventures in theory and method*. Buckinghamshire: Open University Press.

Climate Psychology Update

Marg O'Brien & Jackie Feather



Marg can be found working either as a Nelson based social ecologist (concerned with the relations between humans and their environments) or on her lifestyle block out in the Kenepuru Sound. In the last few years she has led government funded research on the development of sustainable settlements and particularly the networks that create community resilience. She's also been involved in research on collaborative governance in the management of freshwater; the use of Mātauranga Māori in the Resource Management Act process; and the 'people' side of marine biosecurity. Prior to this, Marg taught on human behaviour, counselling and environmental studies courses; spent some years on conservation research and became involved in organic farming. Initially trained as a clinical and social psychologist at Canterbury and then London University she transferred her psychological skills to the people-environment context in the late 80s. She is now helping progress the work of the NZPsS think tank on climate change and sustainability psychology.



Jackie is a clinical and counselling psychologist who teaches on the postgraduate counselling psychology programme at Auckland University of Technology. She is a member of the Society's climate change think tank and her interests include psychological contributions to 'bigger-than-self' issues.

As a result of the 2014 climate change/sustainability remit passed at the 2014 AGM, a small group of NZPsS members formed as a working party to explore how psychologists could contribute to the climate change issue. This group comprised Marg O'Brien and Brian Dixon, who proposed the remit, Jackie Feather, who joined as part of her (then) role on the Executive and Jane Furness, representing community psychology. We all shared a personal concern about climate change and wondered how as psychologists we could contribute in our professional roles. As we were initially focused on thinking and talking about climate change and psychology, we were named the 'Climate Change Think Tank'.

Since then we have been busy gathering resources, writing up our ideas, and liaising with colleagues locally and internationally to understand the state of the art and science in this area. We are now expanding into an action phase, with new members Neville Blampied, Marc Wilson and student, Nick Laurence who will bring a wealth of experience to the group. In this brief update we reflect on some of the global

and personal events that have occurred since we began our work, and highlight some key questions around how we deal with the 'long slow emergency' of climate change, and how psychology could be more relevant. We invite others to dialogue with us and welcome responses to this article.

A great deal has happened since the climate change/sustainability remit was passed at the 2014 AGM. The most "momentous, world-changing event"¹ occurred at the UN climate talks in Paris last December when 195 countries agreed to coordinate action on climate change. This is to anticipate and forestall the worst effects of climate destabilization across generations and stay below 2°C warming above pre-industrial levels – thought to be the threshold of civilization-altering catastrophe – while working towards limiting temperature to 1.5°C.

Of interest was the global upwelling of grass root organizations prior to the December meeting (including NGOs, professional networks and citizen groups) and the success of the highly publicised divestment campaigns led by the NGO 350.org targeting bank and church investments in fossil fuel companies both here and in the UK²; the success of the world's first climate liability suit for Dutch campaigners with their court ordering the state to reduce emissions by 25% within 5 years to protect its citizens from climate change; and the Pope's views on climate change expressed through a 'letter to the world' (the Papal Encyclical).

1 <http://theconversation.com/five-things-you-need-to-know-about-the-paris-climate-deal-52256>

2 <http://www.christiantoday.com/article/church.of.england.fossil.fuel.divestment.could.have.huge.impact.on.business/53159.htm?email=1>

At the Paris climate talks we found, for one of the first times, that the change demanded by these grass root networks with their civil protests and environmental activism was understood. Not as a security risk but as a "right to speak out"³. This represented a turning point in the drive for ordinary people to demand change. As David Orr, long time environmental educator discusses, people working together on a myriad of sustainability issues are beginning to reshape the future: "...an effective planetary immune system is already emerging in the form of networks"⁴.

So what next? The Paris agreement now ratified by more than 55 countries (including New Zealand as of last week⁵) and covering over 55% of global greenhouse emissions will come into force next month. This will legally bind countries, to act on the pledges made last year - a commitment to prepare increasingly ambitious pledges to tackle greenhouse gas emissions every 5 years - with developed countries expected to take a lead on emission reduction targets. But rather than establish top down controls each country is left to decide how best to address this reduction. Essentially, we are tasked with rapidly finding a new way to live - our dependence on fossil fuels has to go...

While this momentous event has taken

3 http://static1.1.sqspcdn.com/static/f/551504/26761472/1451508306667/World+finally+grasps+climate+change+threat_RG_12_24_15.pdf?token=fiOFbZs7iDrzxSdD9WnKiVUxh8%3D

4 David Orr (2013) *Governance in the Long Emergency*, in *State of the World 2013: Is Sustainability still possible?* L. Starke (Ed.), Worldwatch Institute... commenting on the work of Paul Hawken (2007) *Blessed Unrest*. Penguin: New York

5 <https://www.beehive.govt.nz/release/nz-ratifies-paris-agreement-climate-change> and <http://www.stuff.co.nz/environment/climate-news/84985561/new-zealand-ratifies-paris-agreement-to-combat-climate-change>

place on the international scene we in the Climate Change Think Tank have been caught up in unexpected life changes that have stalled our work... the injured partner needing nursing, the newborn child requiring an urgent operation, the neighbour who has just lost her husband... all have required our attention and we give it without question - our responsibility being firmly to our family and our community. It has been a learning experience for all of us as we wrestle with the issues of priority. Milfont and colleagues⁶ found that over half of us believe in the reality of climate change and its cause by human activity and yet it is difficult for us to prioritize the work this demands when there are so many other worrying, competing and, dare we say it, more manageable concerns.

So our question is: Can we [psychologists] be more relevant? Over the next months as we search for answers to many of these questions we hope to hear from many of you.

We are all part of what Kunstler and others have since called a slow crisis... a long emergency⁷. We've not evolved to deal with this sort of crisis! The story of the frog comes to mind... if put in cold water it will not stir if the water is heated up slowly and gradually it will in the end be boiled alive! It is too comfortable with continuity to realize that continuous change at some point becomes discontinuous and demand a change in behaviour...⁸

6 From a survey of over 6,000 of us: See MILFONT, T. L., MILOJEV, P., GREAVES, L. M. & SIBLEY, C. G. 2015. Socio-structural and psychological foundations of climate change beliefs. *New Zealand Journal of Psychology*, 44, 18.

7 <http://www.resilience.org/stories/2015-03-09/a-review-of-james-kunstler-s-the-long-emergency-10-years-later>

8 From Handy, C. (1990) *The Age of Unreason*, Arrow Books: London. Pp 7-8

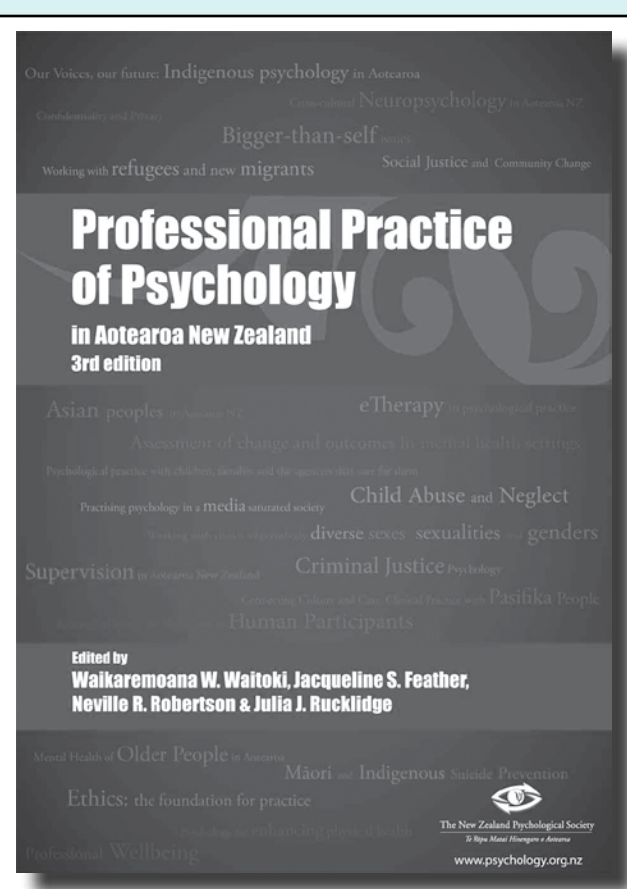
While discredited by biologists the anecdote is a colourful reminder: If we want to avoid such a fate we must learn to look for and embrace discontinuous change. To do this we will need to completely rethink the way forward - the ways followed so far will not be those that take us into the future.

The “long emergency” represents a convergence of worsening ecological, social, and economic problems, including in this country the increasing discrepancy between the wealthy and poor, child poverty and abuse, increasing alienation... with drought, flooding and resulting food security issues beginning to impact. And yet, what does this offer us as psychologists? Where do we want to stand to most effectively address this crisis of crises? We could all ask why our own expectations are not more thoroughly challenged: Are we too entrenched in our current structures? If we seriously considered climate change a priority would we still be living and working as we do now? Would we measure our own success in the same way? What preparation for what challenges would we give students? What indeed would we do to prepare students for turbulent times?

So our question is: Can we be more relevant? Over the next months as we search for answers to many of these questions we hope to hear from many of you. The transition through the long emergency to more sustainable lifestyles is not clear cut. And, as with the grass root networks mentioned before, we too will need to network, to better communicate our ideas, to work together, to develop the collective action for political and structural change and chart a course forward that gives us the power to demand change.

“The plain fact is that the planet does not need more successful people. But it does desperately need more peacemakers, healers, restorers, storytellers, and lovers of every kind. It needs people who live well in their places. It needs people of moral courage willing to join the fight to make the world habitable and humane. And these qualities have little to do with success as we have defined it.”

David W. Orr, Ecological Literacy: Educating Our Children for a Sustainable World



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Child poverty and health in Aotearoa – the way forward

Innes Asher



Innes is Professor of Paediatrics in the University of Auckland's Department of Paediatrics: Child and Youth Health, and Respiratory Paediatrician, Starship Children's Health. In 2003 she was awarded the Officer of the New Zealand Order of Merit for services to Paediatrics, and in 2007 the Health Research Council Liley Medal for her research leadership. She has been the chair of worldwide research studies for more than 20 years - since 2012 the Chair of the Global Asthma Network. Her passion to see all New Zealand children enabled to reach their potential has led her to actively promote evidence-based policies to improve child health, and she serves on the Steering Group of the National Child and Youth Epidemiology Service, and on the Management Committee of the Child Poverty Action Group.

*Take care of our children
Take care of what they hear
Take care of what they feel
For how the children grow
So will be the shape of Aotearoa*

Dame Whina Cooper

The Minister of Health Jonathan Coleman told the Perinatal and Maternal Mortality Review Committee's annual conference on 28 June 2016 that the government's aim is that "every child should have a healthy start". However, for more than two and a half decades some of the decisions of our policy-makers have adversely affected some of our most vulnerable and disadvantaged children and their families in New Zealand (NZ), and continue to do so, leading to poor mental and physical health and a range of other adverse outcomes for many.

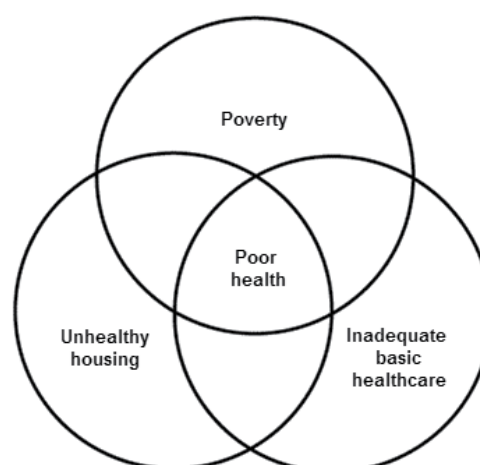
We have choices about how we allocate our resources in our affluent country and these choices are underpinned by our values. Therefore, it is concerning that recent government budgets prioritise the well off, and leave many children with little opportunity to reach their potential.

Early childhood adversity, including poverty, housing stress, racism and family violence which may co-exist [1], can result in lifelong impairments in learning, behaviour and both physical and mental health. Such adversity can result in adoption of unhealthy lifestyles as a coping mechanism – tobacco use, illicit drug use, obesity, promiscuity, gambling [2]. That there has been a 21% increase over the last five years in demand for Mental Health and Addiction Services

[3], is no surprise given our recent history.

Early childhood adversity can be worsened by bad policies and lessened by good policies. In NZ we have created a triple jeopardy for poor health [4]. Poverty, unhealthy housing and inadequate basic health care, each alone, puts health at risk, but when the three are combined, poor mental or physical health is almost inevitable (Figure 1) – as in Dickens' times. In NZ we have 40,000 hospital admissions per year for children under 18 years because of serious, potentially preventable diseases, many brought on by these factors. Education, too, is vital and weaves through all parts of people's lives.

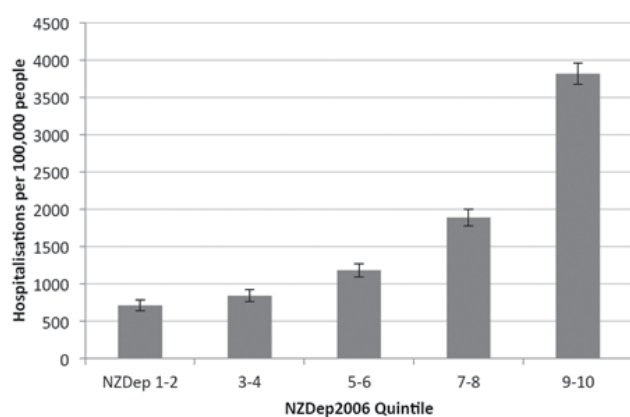
Figure 1. New Zealand's triple jeopardy for child health [4]



We have a good understanding of the relationship between these factors and poor physical health among NZ children, but we have inadequate understanding of the effects on mental health, which is a field for future collaborative research.

In childhood the adverse relationship between deprivation and disease can be marked, as shown below for childhood admissions to hospital with bronchiolitis a serious chest infection, and one of the commonest reasons for babies to be admitted to hospital [5].

Figure 2. Childhood admissions to hospital with bronchiolitis, age-adjusted, by quintile of deprivation (9-10 the most deprived neighbourhoods) [5]



Our rates of admission for bronchiolitis have increased from about 1400 in 2000 to about 1700 in 2013 [5]. Our rates in NZ are higher than ‘similar’ countries, and are going up – the opposite of what you might expect in an affluent country. This disease is more likely where poverty and substandard housing are present.

In August 2014 Emma-Lita Bourne died at the age of two years from complications of pneumonia. Coroner Brandt Shortland reported that “*It is entirely possible the condition of the house [very cold and damp and had a leaking ceiling when it rained] contributed to the pneumonia-like illness that [she] was suffering from the time of her death*”. The landlord was Housing NZ, and the family had repeatedly asked for the cold and damp to be remedied, but they were not. Following Emma-Lita’s death the family were rehoused in a better home [6].

Each year in NZ about 11 children die from pneumonia, with the ‘most deprived’ quintile having rates about 10 times the ‘least deprived’ quintile [5]. Most of these deaths are Māori or Pacific children, which reflects the huge inequities by ethnicity in most measures of health. It doesn’t

have to be this way. If, hypothetically, European children had hospital admissions many times higher than the rate of Māori and Pacific children would more be done? If the answer is yes, then there is some racism in our society and systems, and perhaps in ourselves – these are things we can actively address.

Poverty

Child poverty rates increased dramatically after the Budget in 1991 when benefits were cut by more than 20%. Although the poverty rate in the whole population was affected, children were disproportionately affected. Poverty rates have remained high under both National and Labour governments, and in times of good economic growth, and after tax cuts. The Prime Minister’s promise, after the last election, of reducing child poverty has yet to be realised, as there have been no significant policy changes which would help.

Poverty is measured according to income and by material hardship. The table shows three income measures of poverty – less than 60%, 50% and 40% of the 2015 median disposable household income, after housing costs [7]. Theoretically it is possible that no-one would be below these thresholds [8]. Material hardship is the other measure we use [7]. By any assessment we have a large proportion of children in income poverty and hardship, and alarmingly high numbers at more severe levels.

(See Table overleaf)

Early childhood adversity can be worsened by bad policies and lessened by good policies.

Our leaders repeatedly state that “paid work is the way out of poverty”, and our recent welfare ‘reforms’ are based on this approach. However, among the children in poverty, about 40% are supported by an adult in full-time paid work, and about 60% are supported by an income-support benefit. Thus the data suggest that for some low income families, the ‘paid work’ mantra is not true, and higher incomes are required.

Policy changes are the most rapid and effective ways of influencing poverty within a population. Following the benefit cuts in 1991 the percentage of children in poverty in ‘beneficiary’ families increased from 25% to 75% and has remained at that level since - a ‘bad’ policy. In 2004 the Working for Families package was introduced, helping particularly children in families supported by paid work – the percentage of those children in poverty halved from 21% to 11% - a ‘good’ policy for that group. The Working for Families package of tax credits is the main government

Table: Children 0-17 years in poverty in NZ 2015 using different measures [7]

Child poverty figures in NZ	No. of children	% of children
Total children	1,060,000	100%
Income poverty (<60% 2015 median after housing costs)	295,000	28%
Severe income poverty (< 50% 2015 median after housing costs)	210,000	20%
Very severe income poverty (<40% 2015 median after housing costs)	125,000	12%
Material hardship (EU standard threshold)	155,000	14%
Severe material hardship (EU severe threshold)	85,000	8%
Severe income poverty and material hardship	82,000	8%

policy to help low and middle income families with children. However, it was designed so that 'beneficiary' families do not get a key child-related tax credit - the 'In Work Tax Credit' currently worth \$72.50/week, contributing to their high poverty rates since 1991. In 2013 the Child Poverty Action Group took a Human Rights case against the Crown, and the Courts found children of beneficiaries were discriminated against by this policy [9] - a 'bad' policy for them. The safety net for children in NZ is inadequate and there are clear steps

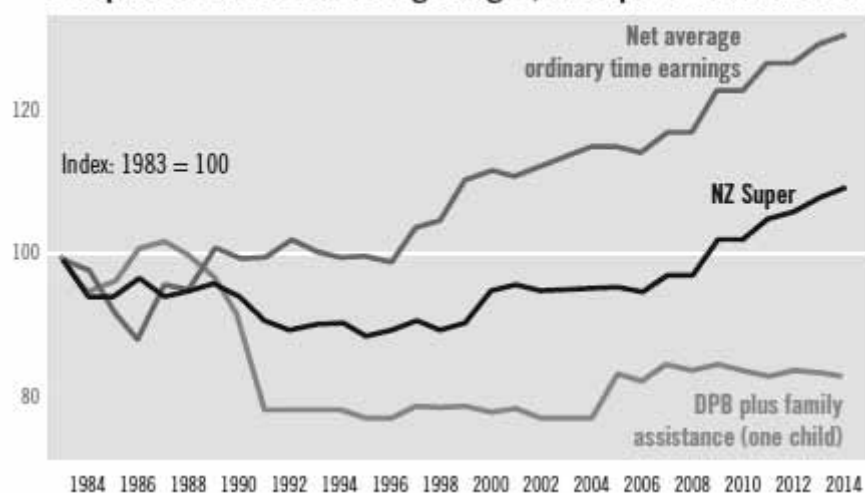
which could be taken to rectify this [10].

In Figure 3 the dramatic differences are shown between net average wages, NZ Superannuation, and the 'DPB' income support benefit (now called the 'Sole Parent Support'). NZ Superannuation is an income support benefit, and it is fully indexed (is not allowed to fall below 66% of the net average wage). However, family income support benefits which assist with the costs of raising children are not similarly indexed and have fallen behind, hugely, as illustrated by the

bottom line. The country has saved billions of dollars by not allowing these benefits to keep up with other income levels, and the tax cuts of 2010 did not help family poverty at all.

It is not widely known that about 15,000 (25%) of the babies born each year miss out on vital extra tax payer support. Parents on a benefit with a new baby don't get Paid Parental Leave worth up to \$8,396 or even the lesser alternative, the Parental Tax Credit \$2,200. Their parents do not get the 'In Work Tax Credit' worth \$3,770 a year either because looking after children is not counted as work [12].

We have an unusual paradox in NZ where we treat two vulnerable age groups differently. Income support benefits for those 65 and over are more adequate, and result in low poverty rates for them. However, income support benefits for families with children are less adequate, so they have high poverty rates. Their benefits are not universal, are not indexed to wages, are complicated, they reduce in hard times (such as death of the breadwinner, loss of work in an earthquake, parents stop work because their child is slowly dying), and they can be cut (sanctioned)

Comparisons between average wages, NZ super & benefit levels**Figure 3. Comparisons between average wages, NZ superannuation and benefit levels [11]**

for not meeting social or job-seeking obligations [13]. Furthermore, they are based on relationships status (the state zealously watches in case a single parent has established an undeclared new relationship [14, 15]), and society has a negative judgement of people receiving this form of income support. In contrast, for those receiving NZ Superannuation these adverse judgements do not apply.

Child poverty rates increased dramatically after the Budget in 1991 when benefits were cut by more than 20%.

The solutions to child income poverty for those on income support benefits is to do the same for them as we do for those aged 65 and over, that is, make a simple system, fully index the benefits and tax credits, do not cut the amount in hard times or for not meeting obligations, and base it on the parent as an individual, not their relationship status. This will require money. Remember that for years we have already saved billions by not giving this money to low income families with children [12]. Designing policies which ensure that families have adequate resources for their children's basic needs, such as enough healthy food to thrive, grow, and learn, is the responsibility of government [16]. We should not have tax cuts; we actually need to increase our tax revenue.

Inadequate basic health care

Inadequate basic health care includes lacking any of these: basic hygiene in the home, health literacy, access to primary health care, including doctor visits, medicines, dental care and optometry care, enrolment with health providers from pregnancy, regular assessment and coordination. Recently the government prioritised increasing immunisation rates in all children through a Better Public Service target set in 2012. This has been highly successful, and the inequities in immunisation have dramatically lessened. This inclusive comprehensive approach should be extended to other areas of basic health care. All pregnant women should be enrolled with antenatal care from early pregnancy; all children enrolled at birth with a general practitioner (GP), the National Immunisation Register, Well Child /Tamariki Ora and Dental services; and all primary care services should be free for all children from last 3 months of pregnancy up to age 18, including GP services, prescriptions, hearing assessment and management, dental and optometry care.

Unhealthy housing

Stress and diseases flourish with unhealthy housing. In NZ some families with children live in cold, damp, mouldy crowded homes [17], some live in garages [18], some live

in cars [19, 20], and some are homeless [21]. On 19 May this year Te Puea Marae opened its doors to families living in cars. The mother of a two-week old baby at the Marae said "I want her to be able to grow and to have somewhere to belong." In Whakatane their car was impounded so the family camped in a tent. The family approached Housing NZ but did not inform the agency of baby Mereana, fearing she would be taken away by CYF [22]. Is this the 'healthy start' intended by the government?

The key housing issues affecting health are crowding (because private rentals are too expensive or houses are unavailable), poor quality houses which are cold, damp and mouldy, and unaffordable or unhealthy fuel. We know that making NZ homes healthy improves health, such as fewer days off school and work, fewer visits to GPs, fewer hospital admissions [23-25]. The number of state houses per population has fallen over the last 2 decades. After more than 10 years of neglect of the increasing need for healthy housing, it will take 10 years to rectify it, and a cross-political party accord is needed for such an important and complex issue.

A comprehensive plan needs to be made and implemented now, and families housed in healthy homes so that their mental and physical health and well-being can improve [26]. When speaking in May 2016 about families living in cars or otherwise homeless, John Key said "*That's not the NZ we want and it's not acceptable*" [27]. Of course we all agree with that. However, six months later no adequate solutions have been proposed by the government to meet the immediacy and extent of need.

The key housing issues affecting health are crowding (because private rentals are too expensive or houses are unavailable), poor quality houses which are cold, damp and mouldy, and unaffordable or unhealthy fuel.

To start to remedy the unhealthy housing issues, several steps are needed. Firstly, pass The Healthy Homes Guarantee Bill 2016 so that every rental home in NZ would meet up to date standards of insulation, heating and ventilation; secondly increase the number of state houses and social housing by 1000 units per year; thirdly increase emergency housing to provide for about 5,100 people [28]; on Housing NZ Priority A list (those with immediate risk to health and safety); and fourthly provide greater tenure and rent protection for tenants.

What we need to do

We do know what to do. We need the policies recommended in the following three recent reports, each

of which makes many similar recommendations. Children's Commissioner's Report 2012 made 75 recommendations [29], but the main solutions to lessen income poverty and increase healthy housing have not been implemented [30]. The report of Health Committee Nov 2013 "*Inquiry into improving child health outcomes and preventing child abuse, with a focus on pre-conception until 3 years of age*" included 125 recommendations [31]. Child Poverty Action Group's Sept 2014 publication *Our Children Our choice* had 47 recommendations [10]. For the health of all our children and families, communities and our society, NZ needs these better policies now.

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References

- Wynd D, *Child Abuse: What role does poverty play?* 2013, Auckland: Child Poverty Action Group.
- Shonkoff JP, et al., *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*. Pediatrics, 2012. 129: p. e232-246.
- Coleman, J. *Mental Health and Addiction Services*. 2016 16 May 2016]; Available from: <https://www.beehive.govt.nz/release/access-mental-health-addiction-services>.
- Turner N and Asher I, Child Poverty and Health in *Our children, our choice: priorities for policy*, Dale MC, O'Brien M, and St John S, Editors. 2014, Child Poverty Action Group: Auckland. p. 14.
- Telfar Barnard L, et al., *The impact of respiratory disease in New Zealand: 2014 update*. 2015, Wellington: The Asthma Foundation.
- Coroner HB Shortland, *Emma-Lita Pepe Quintanella Bourne*.
- Perry B, *Household incomes in New Zealand: Trends in indicators of inequality and hardship 1982 to 2015*. 2016, Wellington: Ministry of Social Development.
- Boston J and Chapple S, *Child Poverty in NZ*. 2014.
- Child Poverty Action Group. *CPAG in the Court of Appeal*. 2013 27 September 2016]; Available from: <http://www.cpag.org.nz/campaigns/cpag-in-the-court-of-appeal-4/>.
- Dale MC, O'Brien M, and St John S, *Our children: our choice: priorities for policy*. 2014, Auckland: Child Poverty Action Group.
- Perry B, *Household incomes in New Zealand: Trends in indicators of inequality and hardship 1982 to 2013*. 2014, Ministry of Social Development: Wellington.
- Child Poverty Action Group. *Fix Working For Families Campaign*. 2016; Available from: <http://www.cpag.org.nz/campaigns/fix-working-for-families-fwff-campaign/>.
- Wynd D, *Benefit sanctions and children: an urgent need for greater clarity*. 2014, Auckland: Child Poverty Action Group.
- MacLennan C, Kathryn's story. *How the Government spent well over \$100,000 and 15 years pursuing a chronically-ill beneficiary mother for a debt she should not have*. 2016, Auckland: Child Poverty Action Group.
- St John S, et al., *The complexities of relationship in the welfare system and the consequences for children*. 2014, Auckland: Child Poverty Action Group.
- United Nations, *United Nations Convention on the Rights of the Child*. 1989, Geneva: United Nations.
- Carville O, *Toddlers sick in damp mouldy home*. 2013, The Press.
- Tischler M, *Garage life for two years*, in Western Leader. 2013.
- Collins S, *More living in cars as rents go through roof*, in NZ Herald. 2014.
- Wesley-Smith M, *Auckland's hidden homeless*. 2016.
- K, A. *Most homeless people working or studying*. University of Otago 2016; Available from: <http://www.otago.ac.nz/news/news/otago619718.html>.
- TV One. *Homeless premature 15 day-old baby found living at Te Puea Marae*. 2016; Available from: <https://www.tvnz.co.nz/one-news/new-zealand/exclusive-homeless-premature-15-day-old-baby-found-living-auckland-marae>.
- Jackson, G., et al., Reduced acute hospitalisation with the healthy housing programme. *Journal of Epidemiology and Community Health*, 2011. 65(7): p. 588-593.
- Chapman R, et al., Retrofitting houses with insulation: a cost-benefit analysis of a randomised community trial. *Journal of Epidemiol Community Health* 2009. 63: p. 271-277.
- Howden-Chapman, P., et al., Effect of insulating existing houses on health inequality: cluster randomised study in the community.[Erratum appears in BMJ. 2007 Jun 23;334(7607). doi: 10.1136/bmj.39246.620486.AE]. *British Medical Journal*, 2007. 334(7591): p. 460.
- Howden-Chapman P, Baker MG, and Bierre S, The houses children live in. Policies to improve housing quality. *Policy Quarterly*, 2013. 9(2): p. 35-39.
- Radio New Zealand. *Plea for budget to deliver on Auckland housing*. 2016; Available from: <http://www.radionz.co.nz/news/national/303946/auckland-housing-%27we%27ve-lost-the-plot%27>.
- Scoop Independent News. *The Nation: Lisa Owen interviews Paula Bennet*. 2016; Available from: <http://www.scoop.co.nz/stories/PO1609/S00111/the-nation-lisa-owen-interviews-paula-bennet.htm>.
- Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty, *Solutions to Child Poverty in New Zealand: Evidence for Action*. 2012: Office of the Commissioner for Children.
- Wills R. *Are we there yet? Five years on the road to addressing child poverty*. 2016; Available from: <http://www.occ.org.nz/publications/expert-advisory-group/>.
- Health Committee, *Inquiry into improving child health outcomes and preventing child abuse, with a focus on pre-conception until 3 years of age*. 2013, Wellington: New Zealand Government.

By the hospital bedside: Adapting psychological practice

Leena St Martin and Liz Painter



Leena St Martin is a clinical psychologist and also the Professional Leader for psychologists working in physical health settings at Auckland District Health Board (currently 35 psychologists). She completed her academic degrees at the University of Auckland in 1996. After six years working in community mental health,

Leena was drawn to women's health and has been with Gynaecology Outpatients, ADHB since 2001 as well as spending 3 years at Fertility Associates Auckland. She has also been in private practice since 2001, covering employment-related concerns as well as health and relationship issues.



Liz Painter has been a clinical psychologist employed by ADHB for over 30 years in physical health/medical services with extensive experience in the delivery of psychological services in a variety of settings including cardiac, paediatric, intensive care and women's health. Liz's current specialist area is with cardiac and

respiratory patients, in particular those adjusting to organ transplantation and critical health event trauma. Liz has an Honorary Senior Lecturer position at the University of Auckland Medical School.

Psychologists in New Zealand are increasingly working in physical health settings such as hospital wards, outpatient clinics, specialist services, primary care, and NGOs. According to Ministry of Health statistics, the leading causes of death in New Zealand are ischaemic heart disease, followed by cancer, cerebrovascular disease (strokes), and suicide, with variations across gender and Māori versus non-Māori (Ministry of Health, 2015). This suggests that chronic disease morbidity dominates healthcare use and lends support to the presence of psychologists in improving population health as illustrated by the diagram below.

Translating scientific evidence into clinical practice



This article is inspired by the Future of Psychology Initiative (Du Villier et al, 2015), Stepped Care (Earl, 2010), and the recognition and expansion of psychology roles in healthcare (Stewart et al, 2014). It was also prompted by findings discussed within a strategic plan of the NZ College of Clinical Psychologists which led to an earlier edition of this article (St Martin, Painter 2015). The Future Psychology Initiative was formed to ensure that psychology remains “a robust, resilient and relevant profession” and identified five areas for action. These include “enhancing professional identity and practice” “building advocacy and the profile of

psychology” “psychology’s response to cultural factors” “increasing leadership by psychologists” and lastly, “improving training and professional development” (Du Villier et al, 2015). We suggest that physical health settings require psychologists to routinely manifest these five areas of action, in particular the requirement to be innovative and flexible in their clinical interventions and consultations.

Psychologists working in health will usually find themselves as the only representative of the mental health professions in their service, engendering a sense of professional isolation.

Our goal is to illustrate some of the professional skills required for working in physical health settings by addressing the following questions:

- How do you create a positive identity in a strongly biomedical work environment?
- How do you relate to a bedridden patient, very likely from another culture, who is reluctant to meet you?
- What sort of clinical information can be usefully shared with colleagues?
- How do you document your findings safely?
- Who can you go to for useful supervision?
- Who are your allies going to be?

Professional Identity

Psychologists working in health will usually find themselves as the only representative of the mental health professions in their service, engendering a sense of professional isolation. Identifying a clinical supervisor who can respect and

support this emerging professional identity is therefore an early task.

Job opportunities are often available only as a small FTE (full-time equivalent). The incumbent is therefore regarded as a consultant to the medical team and positioned in the hierarchy alongside medical consultants. Timely self-marketing of the psychologist as an approachable person and competent professional is key. Rather than waiting for referrals to arrive, professional traction can be gained by targeting familiar areas to make a difference. For example, unfinished research projects within the service, or developing a methodology for managing acute anxiety/distress or developing a model for addressing challenging patient behaviours which are affecting staff morale. This has the benefit of immediately increasing visibility through one’s work.

Other valued interventions include advising on the management of “frequent fliers” with the goal of reducing length of hospital stays and inappropriate use of medical treatments and medications (St Martin, 2006). Non-compliance, or the term “adherence” as it is used in physical health, has come into sharp focus in health care, for example in the UK (NHS, 2015) and in New Zealand (New Zealand’s Medicines Landscape, 2015). Psychologists are increasingly called upon to provide formulations and guidance to colleagues regarding intentional rather than unintentional non-adherence, also known as “forgetting” (Horne, 2013). Psychologists have also demonstrated the effectiveness of the “necessity versus concerns” framework, targeting patients with specific individualised interventions to improve adherence (Petrie, Perry, Broadbent, Weinman, 2012). If no formal psychological academic study in health or a relevant placement has

been undertaken, we suggest reviewing the competencies for psychologists working in physical health from overseas sources. For example, the British Psychological Society lists the following competencies:

- adopting a biopsychosocial perspective of health
- developing an understanding of the culture and working practices of medical systems
- having specialty-relevant medical knowledge (which quickly develops in the workplace)
- understanding acute and chronic illness and injury and their specific psychological consequences including socio-political context
- working with patients with impaired function or consciousness, and addressing impacts on communication
- being able to assess complex medical and psychological risk (e.g. non-adherence)
- the delivery of difficult or unwelcome communications in a sensitive and effective way
- applying strength and resilience models of psychological therapy

(The British Psychological Society, 2008).

Dobmeyer and Rowan (2014) suggest additionally, that the physical health setting requires the psychologist to be an advocate for patients’ needs, and to be capable of educating medical colleagues in a biopsychosocial understanding of illness. They also highlight the importance of the psychologist having personal resilience to tolerate working with populations in which physical disease, disability, or terminal illness are prevalent features. This latter point should not be minimised, as most of us will have personal experience of family

and friends being medically treated and perhaps dying in general hospital settings.

Patient Diversity

In contrast to a private practice or mental health service psychology setting where the client actively seeks your services, the bedridden patient may be in any variety of hospital settings and may not be expecting to see a psychologist or know of your role when you first meet them. A typical response is “why am I seeing a psychologist when I have a physical condition? It’s not in my head” or the patient fears that you are going to admit them to a mental health unit. They may be within an intensive care unit surrounded by bleeping machines and other staff, or in medical isolation (which means you need to “gown up” before entering). They may be in a multi-bedded ward, curtained off from their neighbour a mere metre away or they may be alone in a large vacant ward. Negotiating privacy and confidentiality when seeing patients by the bedside in a shared ward can be a challenge for psychologists who uphold the importance of a therapeutic space.

As a first step, we suggest that you talk with the staff in the setting as to the patient’s current medical and psychological state, read the medical notes and check for psychoactive medications. It can be useful to knock first or to call out a greeting to alert the patient of your presence and ask permission to speak to them. They are after all in a disempowered position and cannot walk away from you. They may dismiss you by saying they are “ok” or are too nauseous or too tired. They may request your help with a vomit bucket or a glass of water, or ask you to call for a nurse who can take them to the toilet. You may have to return later.

... the physical health setting requires the psychologist to be an advocate for patients’ needs, and to be capable of educating medical colleagues in a biopsychosocial understanding of illness.

It is hard to ignore the presence of the body in such settings as you are confronted with the sensory experience of electronic beeps, tubes and drains, and the image of a patient with bodily distortion brought about by their medical condition or by treatment. There may also be the smell/stench of bodily discharges. If you are prone to blood or hospital phobia, this will make itself evident. If you have personal history of visiting loved ones in similar situations, this may retrigger an unexpected recollection and/or grief reaction. Clinical supervision and self-care practices play an

invaluable part to enable processing of such experiences.

If the patient is willing to engage, we suggest that inquiring about their physical comfort is a useful rapport builder. Gathering information about their patient experience, including any tensions with staff, will assist your formulation. It is useful to ask if they knew your involvement had been requested as often a referral is made when the patient is semi-conscious or confused. This gives you a chance to explain your role, discuss the referral question and then to clarify whether this is a priority for them. Asking the patient what they would have been doing if they were not hospitalised, can signal important areas of grief and adjustment for future therapeutic conversations and also give an immediate insight into the patient’s lifestyle.

Professional Practice

Assessment

Bedside psychology requires you to move away from expectations of conducting an uninterrupted standardised assessment. Your “assessment” is likely to be interrupted by medical rounds, nursing interventions, menu requests, scans, and visitors. You may also be limited by the patient’s ability to concentrate and engage in conversation and it may not be possible to achieve more than a brief sense of where the patient is at psychologically. The priority is to address the immediate referral concern, especially its relevance to medical care (Ernst et al, 2014). This is in contrast to psychodynamically-oriented descriptions of suggested patient themes to explore such as “denial of illness, loss of control, dependency and regression, fear of abandonment, loss of identity, fear of death, survivor guilt” (Lolak, 2004). Ernst et al (2014) suggest that assessment of biopsychosocial areas most directly related to referral are the most relevant to prioritise such as medical or disease-specific factors impacting presentation, pre-morbid emotional functioning, and identification of coping strategies. You may be side-tracked into their other concerns which have to be addressed if you are to develop their trust for any further therapy. Such topics may include the patient’s worry about the wellbeing of their family or pets and plants whilst they are in hospital, or fear of falling behind with academic or work commitments. Your recommendation may be that liaison psychiatry assessment is warranted. A close working relationship with this service is therefore essential.

Therapeutic interventions

You may only have one opportunity to make a difference to the patient, so it is important to have a repertoire of brief, effective strategies at your fingertips which alleviate

symptoms or enable them to cope with an impending medical procedure. For example, eliciting health beliefs which are impacting on treatment adherence, coaching the patient in distraction using the five senses as they succumb to anaesthesia, breathing techniques to enable them to cope with a tracheostomy, mental imagery to prepare for their first post-operative shower when there are missing body parts, or rehearsing a conversation they anticipate will involve some difficulty. Such one-off interventions do not allow the luxury of time so creativity is called for.

Mindfulness based interventions have been shown to be extremely useful in some medical settings such as chronic pain management (Wright and Schutte, 2014), improving wellbeing with breast cancer patients (Hoffman et al, 2012) and general cardiac patients (Loucks et al, 2015). However, applying body awareness techniques with patients experiencing acute somatic distress is not recommended, as many are already hypervigilant regarding their bodily sensations. For example, mindfulness techniques have been shown to exacerbate symptom awareness and consequently increase distress in cancer patients receiving chemotherapy (Reynolds et al, 2014).

Less urgent interventions may include a conversation about adjusting to change, facing mortality, or planning for return to work. Ongoing outpatient therapy might address adjustment disorder or a delayed post-trauma reaction to medical intervention or surgery. If there are complaints, litigation, and the involvement of third parties in the patient's medical picture, the psychologist may have a role with regard to coaching the patient and encouraging resilience as they navigate these new systems.

Traditional cognitive behaviour therapy is well supported as a model in physical health settings (Ernst et al, 2014) and can be applied to address a wide range of scenarios such as dysfunctional beliefs about illness, treatment, or self-image. As described above, CBT can also help patients manage immediate distress related to their medical care such as shortness of breath while being weaned from a ventilator or anxiety related to procedures. Breathing, progressive muscle relaxation and guided imagery can be effectively taught at the bedside. Acceptance and Commitment Therapy (ACT) has been applied to health-related concerns, with efficacy reported for diabetes self-management, chronic pain, epilepsy, and smoking cessation (Ernst et al, 2014). These authors note that application of ACT to an inpatient hospital setting has not yet been documented but suggest that the focus on engaging in meaningful activities even while having unpleasant experiences may be particularly relevant for hospitalised medical patients where avoidance is not possible.

You may only have one opportunity to make a difference to the patient, so it is important to have a repertoire of brief, effective strategies at your fingertips which alleviate symptoms or enable them to cope with an impending medical procedure.

Documentation

The question of what a psychologist should document, and where, is often raised in physical health settings. This is because the general medical record is accessed by a wide range of medical personnel on the ward, and even when electronically stored, offers fewer protections than the typical mental health record. As a conservative guide, we suggest that documentation should be written with the expectation that the patient and their whanau/family will read the notes, and health care

providers will communicate findings to the patient/whanau without fully understanding the context/ramifications of the information. When more sensitive information needs to be included, general terms such as “past history of trauma” or “significant psychosocial stressors” are used to indicate complexity. Ernst et al (2014) note that while some services document all information that was obtained, other services will record only the pertinent “need to know” information particularly salient to the referral question, the conceptualisation, and the care plan. These authors suggest that impressions/recommendations section is the most important as it potentially can guide other medical colleagues to provide more empathetic and effective care. When appropriate or necessary, assessments can include a diagnostic impression. However, many patents do not meet criteria for a significant psychiatric disorder and are instead typically functioning individuals who are now in a highly stressful situation that is exceeding their coping resources so “adjustment disorder”

or “psychological factors affecting medical condition” may be the most appropriate diagnostic descriptors to use.

The psychologist should note that “secondary psychology notes exist” to indicate there are separate, more detailed notes stored elsewhere. However, this practice can be challenged as being counterproductive to multidisciplinary collaborative care. Thus many psychologists in the hospital will choose to place their consultation reports among the general

medical progress notes to maximise usefulness to health care providers, but amend their documentation accordingly.

Summary

If we return to a consideration of the five areas of action outlined by the Future Psychology Initiative (Du Villier et al, 2015) we believe that working in physical health settings offers psychologists the opportunity to enhance their professional identity through being innovative and flexible in their interventions, which are both valued and visible to the rest of the medical team. This is exemplified by a recent informal survey of ward staff regarding our roles which indicated that we have an impact on:

Direct patient care: “Patients more relaxed when you have seen them”, “They are able to understand and take on board what we are asking them to do”

Improving health care outcomes by supporting staff to develop biopsychosocial conceptualisations of patient’s behaviour: “You have explained so clearly to us (nurses) why they are behaving like they are so we can help them better”

Providing effective strategies to reduce burden of cost to District Health Board by supporting medical treatments and improving poor treatment outcomes: “They are taking their drugs now so they are much better and aren’t coming back into hospital so often”

Psychologists in physical health therefore have an opportunity to become ambassadors for the wider psychology profession. By virtue of often being the sole psychologist in a service, there are opportunities for informal leadership opportunities which can develop into more formal leadership roles.

We suggest that if you are considering a foray into physical health settings, especially inpatient work, in addition to your clinical competencies, you will need the following:

A flexible attitude

An approachable demeanour

Be able to develop effective rapport with diverse patients and their supporters/whanau

Combine assessment with therapy – often creative and innovative “off the hoof” interventions

Collaboratively work with colleagues who are not psychologically-minded – and be prepared to keep working at this due to constantly changing team make-up (e.g. three or six monthly rotations of House Officers and Registrars and nursing shifts/use of casual nurses)

Maintain your own resilience

Keep abreast of scientific knowledge, both within your medical speciality and with psychology models and research.

References

- British Psychological Society (2008). *Briefing Paper No. 27 Clinical Health Psychologists in the NHS*.
- Dobmeyer, A.C., Rowan, A.B. (2014). Core Competencies for Psychologists: How To Succeed in Medical Settings. In C.M. Hunter et al (eds.). *Handbook of Clinical Psychology in Medical Settings*, Springer Science & Business Medical: NY.
- DuVillier, T., Earl, T., Feather, J., Howard, F., Lambrecht, I., Soldatovic, M., Stewart, M. & Verhoeven, M. (2015) Strengthening the Future of Psychology in Aotearoa: A Call to Action. *Psychology Aotearoa*, 7(2), xx-xx.
- Earl, T. (2010). Talking therapies and the stepped care model. *Journal of the New Zealand College of Clinical Psychologists*, 20(2), 13-16.
- Ernst, M., Piazza-Waggoner, C., Chabon, B., Murphy, M., Carey, J., Roddenberry, A. The Hospital-Based Consultation and Liaison Service. (2014). In C.M. Hunter et al (eds.). *Handbook of Clinical Psychology in Medical Settings*, Springer Science & Business Medical: NY.
- Hoffman, C.J., Ersner, S.J., Hopkinson, J.B., Nicholls, P.G., Harrington, J.E., Thomas, P.W. (2012). Effectiveness of Mindfulness-Based Stress Reduction in Mood, Breast- and Endocrine-Related Quality of Life, and Well-Being in Stage 0 to III Breast Cancer: A Randomized, Controlled Trial. *J Clin. Oncol.* 30:1335-1342.
- Horne, R. (2005). Concordance, adherence and compliance in medicine taking. *Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation, R&D (NCCSDO)*.
- Horne, R., Chapman, S.C., Parham, R., Freemantle, N., Forbes, A., Cooper, V. (2013) Understanding patients’ adherence-related beliefs about medicines prescribed for long-term conditions: a meta-analytic review of the Necessity-Concerns Framework. *PLoS ONE [Electronic Resource]*. 8(12):e80633.
- Lolak, S. (2004) Bedside psychotherapy. *Current Psychiatry* 3 (8):11-20.
- Loucks, E.B., Britton, W.B., Howe, C.J., Eaton, C.B., Buka, S.L. (2015): Positive Associations of Dispositional Mindfulness with Cardiovascular Health: the New England Family Study. *Int. J. Behav. Med.* 22(4): 540–550.
- Ministry of Health (2015). Major Causes of Death. Wellington
- New Zealand’s Medicines Landscape 2015 retrieved from <http://www.medicinesnz.co.nz/assets/Documents/New-Zealands-Medicines-Landscape-2017.pdf>.
- NHS (2015) Pharmaceutical waste reduction in the NHS retrieved from <https://www.england.nhs.uk/wp-content/uploads/2015/06/pharmaceutical-waste-reduction.pdf>.
- Petrie, K.J., Perry, K., Broadbent, E., Weinman, J. (2012) A text message programme designed to modify patients’ illness and treatment beliefs improves self-reported adherence to asthma preventer medication. *Br. J. Health Psychol.* 2012 Feb;17(1):74-84.
- Reynolds, L., Bissett, I., Porter, D., Considine, N. (2014). Eyes wide open: tread carefully with Mindfulness Training during Chemotherapy. *Psycho-oncology* 23 Sup. 3.
- St Martin, L. (2006) Chronic pelvic pain and complex pain behaviours. *O&G Magazine*, 8(3) Royal Australian and New Zealand College of Obstetricians & Gynaecologists.
- St Martin, L. and Painter, L. (2015) Bedside Psychological Interventions. *Journal of the NZ College of Clinical Psychologists* (25)1.
- Stewart, M., Bushnell, J., Hauraki, J., Roberts, M. (2014) Evidence and Wisdom: The role and value of psychologists in healthcare. *Journal of the New Zealand College of Clinical Psychologists* 24(1)3-14.
- Wright, C.J., Schutte, N.S. (2014). The relationship between greater mindfulness and less subjective experience of chronic pain: Mediating functions of pain management self-efficacy and emotional intelligence. *Aus. J. Psychol.* 66(3) 181–186.

Psychology on the Web

Dryden Badenoch



Dryden Badenoch is a UK-trained clinical psychologist who was born at much the same time as the internet, trained while the World Wide Web was created and came to New Zealand as the mobile Web took off. When he's not being Consultant Clinical Psychologist for Whanganui DHB's Assessment, Treatment & Rehabilitation service, he preaches about web design to psychologists and about psychology to web designers.

"Why do they need a website? Why can't they just use Facebook?"

A senior psychologist asked me this question recently. I was taken aback: I'd thought the answer was obvious. Then again, I'd thought it obvious that psychologists should be involved in the national dementia strategy, but the Ministry of Health's Senior Advisor said our perspective could be represented by nurses.

It seems psychologists understand and value the World Wide Web no more than non-psychologists value and understand our discipline. Improving our Web literacy can help us improve public perceptions of psychology.

The World Wide Web

In the 1980s, collaborating on a paper was even more painful than today. To indicate the styling and layout — headline, italic, boldface — each word-processing program inserted a different, incompatible set of invisible markers into the viewable text of a document.

Translating one author's WordPerfect file for another's WordStar program was the worst part of Tim Berners-Lee's job. Instead, he created Hypertext Markup Language: HTML styles text with 'tags' typed by, and

visible to, the author and their editors. `<h1>` indicates that the subsequent text should be considered the topmost headline, `` that the following text should be *emphasised*, etc. HTML makes documents accessible not just to any computer — Mac, Windows or Unix — but to any reader. HTML documents can be rendered in print, on a screen, by a speech synthesiser, or in Braille with no additional effort by either author or reader. In print or on screen, `` might cause text to be shown in italics, while a speech synthesiser would *stress* the word or phrase and a Braille display might ignore the tag (Braille eschews emphasis). A browser's conventions — headlines are large and bold, emphasised text is italic — can be reprogrammed. A single HTML document can be presented in any number of layouts and styles without altering the original text. This has made the World Wide Web, Sir Tim Berners-Lee's system for sharing HTML documents via the internet, enormously appealing to publishers of all types. It is now the dominant publishing medium.

Web generations

People who completed their professional education and raised their

children before Sir Tim introduced the Web are now the majority of the retirement community. If you work with older adults, few of your clients may think to access information about you and your services on the Web, though the same will not be true of their children. People who were beginning their careers and families when the Web was introduced have seen their workplaces and home routines change to accommodate it. If you work with adults, they will be looking to the Web for information and advice about their work, their children, and themselves. For people born after the introduction of the Web, it is as basic an amenity as tap-water and electric light: they notice when it *isn't* available. If you work with adolescents and young adults, they will expect to find you on the Web, and think it strange if they can't. As each group ages, habitual Web users will become the majority across the age range, including older adults. What will the Web tell them about us?

Public perceptions

The public has many misconceptions of psychology: that we are "shrinks", that we read minds. Our discipline is often lumped in with pseudoscience and quackery. There is great interest

in psychology, but less understanding. Our highest-profile representatives, clinical and educational psychologists, work behind closed doors. Unlike medics and vets, our work doesn't lend itself to humorous and heart-warming semi-autobiographical stories about the 'funny' people we see. Our ethical codes prioritise confidentiality; our therapeutic approaches steer us away from self-disclosure. We're hard to publicise. Few professions are, as yet, making good use of the Web. We have an opportunity to use this nascent medium to sidestep the prejudices of TV, radio and other established media, to raise and enhance our public profile.

... I'd thought it obvious that psychologists should be involved in the national dementia strategy, but the Ministry of Health's Senior Advisor said our perspective could be represented by nurses.

Writing for the Web

Five years after Sir Tim introduced the Web, most users were still academics. Larry Page's PhD supervisor noted that journals had citation indexes, but the Web did not. With fellow postgrad Sergey Brin, Larry created the PageRank. This algorithm calculates the authority of a web page from the authority of the pages which link to it, much as being cited in *Science* or *Nature* is more impressive than citation in a small circulation, narrow focus journal. The PageRank is the heart of the Google search engine, which has been so successful that 'google' is now a verb. Your clients and their whanau will google your service. Have you? Do you know what they will be told about the work that you do? Are the top search results for helpful information or negative stories about years-old scandals? They will google your therapeutic techniques. Have you? Do you know what your clients will be led to expect of your interventions? If your explanations and instructions won't match their search results, how will you reconcile these? And they, your colleagues, potential employers, and collaborators will most certainly google you. If you have a Facebook or similar account, that's likely to be the top search result, reflecting the size and popularity of social media sites. Will the search results match and enhance your c.v. or detract from your professional image?

The best way to improve the results of clients' and colleagues' searches is to create useful web content. This is where most people and services go wrong. Their web sites feature what they want people to know, rather than what people want to know. So few people visit or link and the site moulders in obscurity.

Ideas for sites

Think of your website not as a journal or magazine but as a

service. Consider:

1. what is the service your site is providing?
2. for whom is the service intended?
3. who will be providing the content?

A good example is the website of the New Zealand Psychologists Board. The site is actually four distinct services provided by the Board's staff, each of which could be a stand-alone website:

- our standards and how to make a complaint, for the public
- how to register and stay competent, for practitioners
- access to training, for would-be psychologists
- how to check someone is a psychologist, for employers and clients

Let's say you want to point the media towards positive stories about psychologists. Your service could be in-depth information about the work of a particular psychologist or type of psychologist (the service) for journalists and their readers (the target audience) written and collated by members of your workgroup (who each commit to a certain amount of research or writing). You might aim to offer print-ready resources — photos, quotes, illustrations — for one feature-sized article per month, building over time into a directory of positive stories about our profession in NZ. This would be a treasure trove for journalists with pages to fill, or wanting to add a sidebar to an existing article. Or your site could be more of a service to members of your workgroup, collating minutes and other information to keep track of the various discussions and allowing people who couldn't attend meetings to comment and contribute in a more organised and permanent way than relying on email.

If you work with adults, they will be looking to the Web for information and advice about their work, their children, and themselves.

It's easy to begin with good intentions, then post nothing to your site after an initial flurry of activity. If the content is relatively timeless, that may be fine; if not, a website which hasn't been updated for months can give the impression that your workgroup has stalled or even dissolved. Best to agree at the outset what will be posted, how often and by whom.

Making a site

Creating a website can be a daunting prospect: many people

delegate the task to a professional web designer. This risks ending up with a beautiful but expensive site you don't understand: small and simple is usually the best starting point. WordPress.com is one of many easy entry website creation services. They stand out for their commitment to [free speech](#) and to [your ownership of your content](#). Creating a free WordPress.com website is no more challenging than signing up to Facebook. But you get what you pay for: you're stuck with their standard designs, the address will be "yoursitesname.wordpress.com", and ads may be placed on your pages. For a yearly fee of NZ\$50, they will remove the ads and the address can be "yoursitesname.com". An additional NZ\$100 per year permits you to customise the site's design and, if you're so inclined, to earn money from any ads you allow on your pages. For most people, and many projects, this will be all they ever need.

Web designers often use the stand-alone WordPress program as the base for the sites they'll create for you: starting small with WordPress.com allows easy transfer of your content to either a custom site or to another service, if and when you're sure the extra expense is warranted.

The mobile Web

In the early years of the Web, sites were usually accessed with a desktop PC. This encouraged bad habits: presenting information not as HTML-formatted text, but as downloadable Word files — because 'everyone' uses Microsoft Office — or PDFs.

The Portable Document Format was developed at the same time as the World Wide Web to solve the same problem of document sharing, but for publishers, not cash-strapped academics. PDFs look exactly the same onscreen or when printed, on a Mac or a PC, but are many times larger than

their HTML equivalent and cannot be re-formatted or edited without expensive proprietary software.

Fifteen years after the launch of the Web, Steve Jobs unveiled the iPhone, possibly the most successful tech product ever. One of the iPhone's many innovations was direct access to the World Wide Web. Today, the majority of Web users' access is primarily, if not exclusively, with their smartphones.

We have an opportunity to use this nascent medium to sidestep the prejudices of TV, radio and other established media, to raise and enhance our public profile.

Ever tried to view a journal article on a smartphone? A4 sized PDFs can be frustrating, bordering on impossible, to read on a pocket-sized screen. Web designers are rediscovering the flexibility and accessibility of simple HTML, but many of us continue to frustrate, and even exclude, readers by posting Word and PDF documents on our websites.

Writing for the future

The iPhone is unlikely to be the last revolution in Web use. The World Wide Web is now 25 years old: after their first quarter century, movies were still silent and monochrome, airliners were still made of canvas and wood, and computers still filled an entire room. The lesson of the smartphone is that we shouldn't lock our content into rigid proprietary formats: using HTML can make our documents more accessible now *and* keep them accessible in the future.

Using HTML needn't mean *writing* in Hypertext Markup Language. John Gruber created an author's shorthand called *Markdown*. An octothorp (#) indicates that the subsequent text should be considered the topmost

headline, an asterisk or underline (* or _) that the following text should be emphasised, etc.

Which would you rather write: HTML?

```
<h2>Introduction</h2>
```

```
<p>It was the <em>first</em> time for both of us. That said, it would <strong>not</strong> be the last.</p>
```

or Markdown?

```
## Introduction
```

```
It was the *first* time for both of us. That said, it would **not** be the last.
```

Markdown is much easier to write, read, and edit than HTML, but can be converted into HTML automatically by WordPress.com, as well as by a range of [Mac](#) and [Windows](#) programs. Many are free, and some can also convert Markdown to Rich Text, Word, or PDF as required. Write once in Markdown, publish to anything, now and in the future.

Progressive enhancement

Images, sound and, increasingly, video are important on the Web but they decrease the accessibility and future-proofing of our work. Smartphones are often the only access to the Web for people on low incomes: the people most likely to be accessing your website on a smartphone are also the least likely to be able to afford to waste bandwidth.

A picture may be "worth a thousand words", but the logo on the New Zealand Psychologists Board site uses as much bandwidth as *two* thousand words and is useless to non-sighted users, unlike two thousand actual words in HTML, which can also be experienced as speech or Braille. Watching thirty seconds of video can use as much bandwidth as downloading an entire text book.

Use photos, audio and video to

enhance your text, but ensure their value in clarity justifies their cost in bandwidth, and in the time required to download and to view. If you're out in the wilds with a poor connection and you've just been bitten by a snake, would you rather download a page of instructions in seconds, or spend ten minutes waiting for a thirty second instructional video?

Facebook

Facebook is one of the three most used websites in the world, and the most popular social network. More than two million New Zealanders use it every day, including 80% of students, 81% of young adults and 82% of mothers. So why bother with a website? Why *not* “just use Facebook”?

Facebook doesn't charge for accounts or pages but, as a publicly traded company, needs to make a profit. They make money by helping advertisers target their ads more effectively, by keeping track of individual users' interests and where they spend their time on the Web. Ad targeting without such data can be laughably imprecise. As an atheist, I was surprised to find my free WordPress film review site festooned with ads for Bible Study classes. I eventually realised that I'd reviewed the fourth Terminator film, *Terminator: Salvation*. It's easy to imagine how ads generated automatically from key words on a psychologist's site might be highly inappropriate.

Facebook needs their users to be as identifiable and as trackable as possible, ideally by using their real names and spending most of their time on Facebook. They achieve the former by banning anyone not using their real name and the latter by removing content which users might find aversive.

Why not Facebook?

Facebook's strategy has resulted in multiple charges of discrimination:

- against ethnic minorities e.g. Robin Kills The Enemy, of the Sioux nation, was considered to be using a “fake name”
- against the LGBT community e.g. drag kings and queens were not permitted to use their stage names
- against breast feeding women: Facebook removes photos of women's nipples, regardless of the nature of the photo

Most recently, an iconic photo from the Vietnam War was deleted from an author's Facebook page because it includes a naked child. The photo has now been reinstated, but not without the intervention of a Prime Minister.

Facebook filters individual users' feeds, so news which is rarely 'liked' will become less prominent. Members of, say, Amnesty International may find news of oppression and torture disappearing from their feeds unless they 'like' such news. If a user's audience becomes too big, Facebook will hide that user's posts from all but a fraction of their 'friends' until the user pays to reach the rest of the audience they've built.

This might explain why 79% of New Zealanders on Facebook use it to stay connected to their friends and family, but only 33% use it to keep up with news and events.

“Why not just use Facebook?” Because:

- your readers may have unusual names, or need anonymity
- your content may be controversial, at least in Facebook's eyes
- most people get their news and information elsewhere anyway
- unless your content elicits 'likes', your readers will see less of it over time

Creative Commons

Some worry that putting their hard work on the open Web invites plagiarism and outright theft. Others worry that their work won't find an audience if locked behind a paywall. Copyright is a blunt instrument which requires the author's permission for any reuse, while putting work in the public domain is to lose all control.

Use photos, audio and video to enhance your text, but ensure their value in clarity justifies their cost in bandwidth, and in the time required to download and to view.

Creative Commons licences are a middle ground, permitting creators to specify how their work may be reused whilst retaining copyright. Most of my work has an “Attribution Non-Commercial Share-Alike” licence. You don't need to ask my permission to copy and adapt my words, so long as you credit me (Attribution), don't charge for your product (Non-Commercial) and, if you adapt my work, you make your product available under the same licence (Share-Alike).

Conclusion

Psychology is an often under-valued and misunderstood discipline, usually portrayed stereotypically by TV,

newspapers and other ‘old’ media. The World Wide Web offers us the opportunity to sidestep the biases of traditional media, to communicate directly with the public.

With minimal expense and effort, we can create web services for people seeking psychological information and opinion. With similarly little effort and expense, we can make our writing future-proof, accessible through print, screen, speech synthesiser, Braille reader and interfaces yet to be invented.

We have stories people would benefit from hearing, handouts people would benefit from reading, findings which could inform future research and more. Actively sharing on the open Web can only raise our public profile and enhance general understanding of our discipline.

References?

I wrote the references (and the article) in Markdown in the TextEdit app free with every Mac. An NZ\$15 app called Marked converted it instantly to HTML. I opened a new page on my WordPress site, copied in the HTML, and clicked ‘publish’. It’s that simple.

For Windows users, an NZ\$20 app called MarkdownPad will substitute for TextEdit and Marked.

You can find the references at <http://relaxedtherapy.com/web>

Working at the top of your scope

Mike Butcher



Mike has been a clinical psychologist for over 30 years, training at Auckland University. He has worked within public mental health services in Auckland for over 25 years, specialising in child and adolescent mental health. Mike was the Clinical Director of the Kari Centre (CAMHS, ADHB) for 18 years until 2014, and currently is the Allied Health Director, Mental Health and Addictions, Auckland DHB. Mike maintains a small private practice focussed on the Family Court arena, and had a short period as a Specialist Assessor under the IDCCR Act.

I have been asked to write a piece on “working at the top of your scope”, which is a common phrase these days in DHBs and other large organizations employing psychologists. And though the phrase is common, I was not sure what the technical meaning was. The Te Pou (2015)¹ report on this topic helpfully defined “top of scope” as:

At a systems-level, working to top of scope means optimising workforce capacity and effectiveness through:

- *validating and maintaining current best practice*
- *developing new roles and new ways of practising*
- *ensuring that policy, provider, and service environments support these new roles and practices to succeed.*

At an individual and practice level, working to top of scope means enhanced opportunities and capacity to utilise specialised knowledge and expertise in a way that is efficient,

adaptive, collaborative, holistic and ethical, and fundamentally supports the service user and their wider family and whānau. (p.6)

With the above definition in mind, and in the context of significant changes within the delivery of mental health and addiction services in New Zealand and overseas, particularly the National Health Service (NHS) in Britain with their “New Ways of Working” approach (UK Department of Health, 2007), what does this mean for psychologists? While the Te Pou report speaks about the importance of clarity of roles to achieve “top of scope”, at the same time it talks about the significant and ongoing changes in roles for professional and para-professional groups, with the “shifting” of tasks from traditional expectations for particular professions, with roles “enhanced”, “enlarged”, “substituted” or “delegated”. This process is one which is important for psychologists who seek to define their roles in a changing landscape, which includes the movement of other professionals into areas of practice that have traditionally been inhabited by psychologists. If we spend our time resisting the tide, we are likely to be

¹ <http://www.tepou.co.nz/uploads/files/resource-assets/scope-it-right-literature-review.pdf>

swept away by it. However, I think that we have significant opportunities as a profession to embrace the changes and make (more) difference to the service users and services that we work with. When I think about the personal meaning of “top of scope”, I take this phrase to mean taking on extended responsibilities within your area of practice. And for psychologists, and clinical psychologists in particular in a DHB environment, it means moving away from the traditional roles that we are very good at, of seeing individual clients or families, and providing assessment and intervention which is aimed at single service users.

I think that psychologists have excellent background training for leadership, though this is not something that is emphasised or generally referred to in professional training courses...

In terms of working at the top of your scope, there are two aspects which I have been significantly involved. The first of these is in leadership and service development, and the second is the interface between psychology and the law. In terms of the law, psychologists are in quite a privileged position in that our profession is mentioned in 20 acts of parliament, usually privileging psychology with taking on a variety of assessment roles which have profound implications for contributing to important decisions which affect the most vulnerable members of our society such as children and those with an intellectual disability (for example, see: Children, Young Persons, and their Families Act 1989; Search and Surveillance Act, 2012; Intellectual Disability (Compulsory Care and Rehabilitation) Act, 2003; Criminal Procedure (Mentally Impaired Persons) Act, 2003; Care of Children Act, 2004; Mental Health (Compulsory Assessment and Treatment) Act, 1992; Protection of Personal and Property Rights Act, 1988).

I have been in Court on many occasions as an expert witness. I was going to say I was there to “defend” what I had written to court, but I think that is probably the wrong thing to say. Being in Court is a very unusual experience for psychologists, as this is a very different application of skills and knowledge than being in a therapeutic relationship with a client. Being an expert witness means that you are there to provide assistance to the Court. In my experience the Court is very interested in hearing from psychologists and gaining expert testimony to assist the Court in the difficult decisions they have to make such as about custody of children or disposition of offenders. I think about appearing in Court as in part as a conversation with the lawyers and in particular the Judge, to describe technical psychological assessments in ways which are accessible to

the court. It is also vitally important to declare the limits of what you know and in particular what you can predict.

I think that psychologists have excellent background training for leadership, though this is not something that is emphasised or generally referred to in professional training courses, though there have been more recent moves in New Zealand through both the College and the Society to promote psychology leadership. Overseas literature has also noted the significant skills which psychologists bring to leadership roles (Callahan, 2005; Chu et al, 2012), though also noting that leadership is not sufficiently promoted. One of the key issues for me in working to the top of scope is the willingness to take responsibility for what you do, and not to expect others to be accountable. Medicine is very good, through their chain or seniority, in expecting someone to take ultimate responsibility, usually the consultant. I think that psychologists generally also need to be thoughtful about clearly claiming responsibility.

...working to the top of scope is the willingness to take responsibility for what you do, and not to expect others to be accountable.

For me, working to the top of your scope for psychologists means taking a more meta level view of how you can be influential for the benefit of clients/ service users. Working with individual clients or families is a great thing to do, however, I believe that the perspective and skills that a psychologist can bring can be more widely impactful if these are also deployed at an organisational level.

So what are my thoughts for working “to the top of your scope”? The first is that rather than seeing this as a bit of jargon, see this as an opportunity to be the most effective and most influential possible. As a psychologist, at any stage of your career, how can you be most influential? Psychologists are trained as “scientist-practitioners” with high level research skills as well as advanced assessment and therapy skills. How can all aspects of that training be deployed within your work setting? Use your research and analytical skills for being up to date with the latest literature, so that you are a resource for the team and the service, as well as informing your own practice. Be aspirational for your skills and knowledge, and actively look for ways to promote best practice and service improvement through the wide-ranging skills you already possess. Consider that you do not have to be in a designated position of authority for you to have an impact on the team/service that you work in- the Leadership framework developed by the Division of Clinical Psychology of the

British Psychological Society is useful in identifying activities accessible to clinical psychologists at all career points with reference to clinical, professional, and strategic domains.

References

Callahan, Charles D. (2005). Rehabilitation Psychologist as Health Care Executive: A Platform for Professional Diversification. *Rehabilitation Psychology*, 50 (2), 177-182

Chu, Joyce P., Emmons, Luli., Wong, Jorge., Goldblum, Peter., Reiser, Robert., Barrera, Alinne Z., Bryd-Olmstead, Jessica. (2012). The Public Psychology Doctoral Training Model: Training Clinical Psychologists in Community Mental Health Competencies and Leadership. *Training and Education in Professional Psychology*, 6 (2), 76-83

Department of Health. (2007). *Mental health: New ways of working for everyone*. London, U.K.: Department of Health.

Te Pou. (2015). *Scope it right- Working to top of scope literature review- Mental health and addiction workforce*

Russ Harris' online course "Act and Mindfulness for Trauma": A review

Joyce Fennel



Joyce Fennel is the health psychologist for ADHB Respiratory Service with an active interest and engagement in optimising health and well-being by incorporating psychological principles such as ACT in her practice and her life.

The quality and relevance of course content, ease of access to material or sessions, time and cost are all important determinants of which professional-development option one chooses. I am pleased to report that Russ Harris's *Act and Mindfulness for Trauma* online course delivered well on all these points.

This course assumes at least beginners-level Acceptance and Commitment Therapy (ACT) knowledge, which was operationally defined on their web-site <<https://imlearningact.com/>>. Foundational ACT knowledge was an important prerequisite.

Time, Commitment and Content

At the onset of the course, participants were recommended to allow 3-hours per week to cover the basic content of the trauma course which was released, week-by-week, over the 8-week period. During week 1, we were recommended to allow 5-6 hours of study time. In fact, I committed at least 6-hours-per-week as content was so relevant and dense and there was much more available than just the basic content. The on-demand delivery meant I could choose when to view or review material.

The basic content consisted of direct-to-camera presentations of theory and specific trauma practice considerations. Animations brought aspects of the model and processes to life. The actors so effectively portraying a range of common trauma issues you

could easily have thought you were watching actual sessions. You were skillfully guided through the rationale for and implementation of sound clinical decision making. A wealth of supplementary written and audio material was provided. Emphasis was placed upon skill development with encouragement to practice delivering exercises from scripts. Multi-choice quizzes throughout the course also provided useful feedback and integration.

Another useful feature of the course was the discussion forum where participants posed clinical challenges. Russ, members of his online advisory panel, and other participants provided detailed feedback. The depth and specificity of responses from Russ and the advisory panel was exemplary and added another layer of learning. While I did not present a case, it was a golden opportunity for expert clinical supervision in implementing ACT. One of the overriding comments throughout the forum was the necessity for establishing explicit behavioural goals with the client at the onset of therapy.

ACT refresher course content recapping the ACT basics, including key metaphors, constructs and exercises, was also provided but could be left until the end to ensure keeping up with the

trauma content and discussion forum. An extended 4-weeks access to course content enabled review or catch up.

Technical Support

I had heard disparaging comments about technical glitches from colleagues who had enrolled in earlier versions of Russ's online ACT courses. However, any earlier technical problems had obviously been resolved as transmission was efficient and technical support was responsive. I easily progressed through the course using various devices including my home computer, work computer, iPhone, and iPad with seamless synching of my progression regardless of which device I'd used in the previous sitting.

It was very easy to access and download resources from the library of handouts which I have frequently referred to and incorporated into subsequent clinical work.

I completed the course within the prescribed 8-week time while working full time, with one week's leave for a tramping holiday, but with little time or energy for much else. Yes, it certainly required committed action in the service of the value of becoming more psychologically flexible at implementing ACT with clients presenting with the impact of trauma. When I compared the cost for many two day courses to this high calibre 8-week intensive advanced course with extensive additional resources, I believe it was time well spent and value for money.

Behaviour analysis in Aotearoa today

Dr Angela Arnold-Saritepe



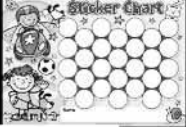
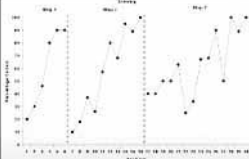




Angela is a Board Certified Behaviour Analyst with over 25 years experience working with children and young people with developmental disabilities in New Zealand, Canada and the United States. Angela is currently a Senior Lecturer, Applied Behaviour Analysis Programme, School of Psychology, University of Auckland. She also consults with families, schools and other organisations to support children and young people with developmental disabilities. Angela has a particular interest in working with young people and their families to address challenging behaviour.

The misconceptions around applied behaviour analysis (ABA) are pervasive and you may have stopped reading this article simply because of the title alone. However, for those of you who are still here by the time you reach the end of this article, hopefully any misgivings you had around ABA will have left. The pool of Board Certified Behaviour Analysts (BCBAs) in Aotearoa is small, but growing rapidly. This increasing trend follows the worldwide trend for BCBAs and is due to the increased demand for the services they offer. In its infancy ABA was plagued by unqualified and unskilled practitioners, whose actions undermined the field and added to the misconceptions many have about ABA. However, with increased demand comes increased scrutiny. With the help of qualifications and governing bodies such as the Behaviour Analyst Certification Board (BACB) we will hopefully see a decrease in the provision of rogue and damaging services provided under the name of ABA.

What do Behaviour Analysts do?

Behavior Analyst

		
What my friends think I do	What my parents think I do	What society thinks I do
		
What my boss thinks I do	What I think I do	What I actually do

I found the above picture online and thought it summed things up quite well (<https://nz.pinterest.com/pin/61713457368660038/>). Though to be honest, I really do not think my parents have a clue about what I do and they are still wondering when I will get a real job in an office with nice nine to five working hours. As for my acquaintances, many associate my qualification with the behaviour analysis unit on the television show “Criminal Minds”. I am not sure they believe me when I say my job is way more interesting than flying around on a private jet. What I do know is that ABA is more than just M&Ms and working with children with autism, although this is often how it is portrayed in society. ABA involves working with individuals, families, and professional teams to implement evidence-based interventions to improve a person’s quality of life. We choose behaviours that are important to those involved, and we make sure that we can measure or show that the programmes we put in place were responsible for the change in the individual’s behaviour. Given this person-centred focus and implementation of evidence-based practices, it constantly bewilders me as to why behaviour analysts and ABA have such a bad reputation, as I always thought that was the good stuff. Although, it may be difficult for you to believe, it is not unheard of to have other professionals refuse to return my calls because of the fact that I ‘do ABA’.

Amongst other people, the likes of Gandhi, Abraham Lincoln, Jimmy Carter and Pope John Paul II have been credited with saying ‘the measure of society is how we treat those most vulnerable’. As behaviour analysts we frequently find ourselves working with vulnerable populations (e.g., intellectual disability, autism and

other developmental disorders, brain injury, dementia, ADHD, conduct disorders, other childhood disorders, addiction, mental un-wellness, and those at risk of abuse and neglect). Indeed ABA is at its strongest when helping children and adults who are often marginalised because they have difficulty with regular learning and/or complex problem behaviours. We are often called in to assess and treat challenging behaviour. However, we are also skilled in teaching new behaviours and skills (e.g., increasing engagement, increasing self-feeding and reducing tube dependency, toilet training and increasing independence in other skills of daily living, increasing language skills, improving health and well-being through exercise and weight management, social and leisure skills training, fear and anxiety management, classroom management and improving learning across all educational stages).

ABA involves working with individuals, families, and professional teams to implement evidence-based interventions to improve a person’s quality of life.

In New Zealand we currently have 28 BCBAs, most of whom are also registered as psychologists with the New Zealand Psychologists Board. To become a BCBA you need a graduate degree that includes many hours of class time in ABA, in addition to a 1500 hour internship, and you need to pass the Behaviour Analyst Certification Board (BACB) exam. It takes a minimum of three years to complete this work. There are also a number of registered psychologists in New Zealand who would be considered ‘behavioural’ in that they have completed some of these requirements or did their training prior to the BCBA qualification being available in New Zealand. Those of us

who are both New Zealand Registered Psychologists and BCBAs work for a variety of organisations and services including; universities (engaged in a wide range of research and teaching), the Ministry of Education, District Health Boards, residential care for people with disabilities, Ministry of Health funded behaviour support services for people with intellectual disabilities, ACC funded services including acute and long term brain injury care and rehabilitation across all ages, adolescent conduct disorder and mental health services, private ABA-based services, and variety of individual short term contracts with service providers in health, disability and education.

What is ABA?

ABA is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviours to a meaningful degree and demonstrate that the procedures used are responsible for the improvement in behaviour. In 1968 Baer, Wolf & Risley defined seven characteristics that must be present for something to be considered ABA.

- **Applied:** ABA interventions must deal with problems of demonstrated social importance. This means the behaviour that is under intervention must be important to the person, their significant others, or society. BCBAs will always choose this behaviour in conjunction with those involved in treatment.
- **Behavioural:** ABA interventions deal with measurable behaviour. This does not mean that ABA ignores thoughts, feelings, and emotions, rather ABA sees these as behaviour that is just more difficult to measure. For example, thoughts are seen as instances of

private verbal behaviour, meaning thoughts are not unlike public verbal behaviour (e.g. spoken language) except for the lack of intersubjective observability. To a behaviour analyst thoughts are a dependent variable, rather than an independent variable or cause. This means a behaviour analyst treats thoughts as a behaviour that can be changed, but they alone do not change behaviour (either private or public behaviour).

- **Analytic:** ABA interventions require a demonstration that the procedures caused the behaviour change. Behaviour analysts place a strong emphasis on small-N designs as they allow demonstrated individual effects. Small-N designs are stronger than case studies, but can be adapted to support the behaviour change of the individual.
- **Technological:** ABA interventions must be described well enough so that they can be implemented by anyone with correct training and resources.
- **Conceptual Systems:** ABA interventions must arise from a specific and identifiable theoretical base, rather than a set of tricks or a package. Behaviour analysts do not learn a set of cookie-cutter interventions that can be cut-and-pasted across clients. Rather, they learn about the relationship between human behaviour and its support system and they learn how to implement interventions that support behaviour change within this context.
- **Effective:** ABA interventions produce strong, socially important effects. Indeed, it is not the BCBA alone that determines the effectiveness, but those involved in the intervention. For example, reducing a challenging behaviour so that it only occurs 5% of the time may be appropriate (e.g. yelling out in class), however, in other situations this would be ineffective (e.g. jumping out of a moving car).
- **Generality:** ABA interventions are designed from the beginning so that any change in behaviour continues after the formal interventions have ended and the changes occur in all appropriate settings and with all appropriate people.

It is worth pointing out that interventions that do not feature all these dimensions are incomplete and potentially compromise the effectiveness of the intervention. For example an intervention that cannot be run by others, with appropriate training, is not technological and would decrease its usefulness as no one else would be able get the results you did. It is also necessary for an intervention to be generalisable, as an intervention is of minimal benefit if

you can only make your cup of tea in one kitchen or if your tantrum behaviour at school decreased but you continued to tantrums at high rates everywhere else.

Subspecialties in Behaviour Analysis

I hope by this time you no longer believe, if you ever did, that ABA is just a treatment for children with autism. ABA was around long before the relatively recent finding that the intensive application of ABA principles to young children with autism significantly improved their outcome (Lovass, 1987). Indeed, by now I hope that you are starting to see ABA as a science used by behaviour analysts to make a socially significant change to a range of behaviours exhibited by a range of people. Behaviour analysts usually work as part of an interdisciplinary team of professionals and family members. They provide expertise in the assessment and treatment of challenging behaviour (be it behaviours that would benefit from reduction or behaviours that would benefit from an increase). Many behaviour analysts specialise in a particular area such as autism, developmental disabilities, mental health, paediatrics, geriatrics or brain injury and just a few of these will be commented on here.

Indeed ABA is at its strongest when helping children and adults who are often marginalised because they have difficulty with regular learning and/or complex problem behaviours.

Autism and Developmental Disabilities

As noted above ABA may be most well-known for its work with children with autism. A comprehensive technical review by Mudford et al. (2009) evaluated New Zealand and international evidence on the effectiveness of ABA for individuals with autism. This review was consistent with previous reviews and concluded there is strong evidence that ABA produces beneficial outcomes for people with ASD. ABA interventions produce meaningful and desirable behaviour changes in both behavioural excesses and deficits that last over a long period and generalise across environments. The evidence exists beyond the early intensive behavioural intervention to all areas of social development, communication, cognitive development, leisure, vocational and organisational skills in addition to reducing and preventing challenging behaviours.

Education

Effective teaching methods based on the principles of behaviour analysis have been available in schools for some time. Large numbers of children have difficulty in

learning basic academic skills and behavioural approaches have been found to be effective. As a whole behavioural approaches to education include the following key elements; a well sequenced set of tasks or curriculum material that gradually increases in difficulty, repeated practice opportunities, prompting, feedback and reinforcement to maintain correct responding and ongoing performance monitoring (Martens, Daly, Begeny, & Van Der Heyden, 2011).

Drug addiction

Behaviour analysis in the treatment of drug addiction has a history of 40 years with applications in the treatment of addiction to illegal (cocaine, heroin) and legal (nicotine and alcohol) substances. Abstinence reinforcement programmes are the most common application in this area and the research has shown that high magnitude and long duration reinforcers are required to initiate and sustain long term abstinence. The most well-known and practical application is the take home methadone clinics where clients are provided methadone contingent on clear drug tests (Silverman, Kaminski, Higgins, & Brady, 2011). ABA has also demonstrated interventions designed to increase pro-social behaviours, such as employment skills, to be associated with a decreased likelihood of relapse (Taylor, Mudford, & Phillips, 2011).

Clinical Behaviour Analysis

Clinical behaviour analysts work with populations more familiar to clinical psychologists or psychiatrists, i.e., verbally competent clients often in outpatient settings. Behaviour analytic interventions (often referred to as third generation behaviour therapy models) are well used and examples include; dialectical behaviour therapy for the treatment of borderline personality

disorder and other severe problems, behavioural activation therapy for the treatment of depression and acceptance and commitment therapy for the treatment of depression, anxiety, and a variety of other quality of life concerns (Gunther, & Dougher, 2013).

Brain Injury

The population of individuals with brain injury is often seen as distinct from other populations due to the wide scatter of skills that can be impacted by injury in both the short and long term. However, the assumption that ABA will be less effective for individuals with brain injury is mistaken, as the complexity of deficits displayed by individuals with brain injury is so broad that it requires a more thorough assessment and integration of findings to develop effective intervention strategies.

Selective brain damage to memory, perceptual, motivational and executive brain function suggest the increased use of antecedent based interventions (Russo Dunn Pace & Coddling, 2007). A skill set that is right down a behaviour analyst's path.

Behavioural Paediatrics

Behavioural paediatrics is the branch of paediatrics that focuses on behaviour and health care in children. The contribution of ABA to the development, implementation, and evaluation of paediatric issues is substantial and spread across all areas of child health. Behaviour analysts work with issues as wide ranging as encopresis, nocturnal enuresis, bed time problems and feeding difficulties ranging from food selectivity to food refusal (Friman & Piazza, 2011). Interventions in this subspecialty generally involve collaboration between disciplines as evaluation and intervention requires addressing physiological, behavioural, and other

issues that contribute to the problem. At this time an interdisciplinary study is underway by a PhD student in Auckland that involves the collaboration of paediatrician, dietician, speech and language therapist and a behaviour analyst to reduce tube dependency in tube fed children. Behavioural paediatrics also requires liaison with behaviour analysts for children with other childhood behaviour disorders such as ADHD, ODD and noncompliance to medical procedures (another study is underway in Auckland to increase compliance to fMRI).

...a behaviour analyst treats thoughts as a behaviour that can be changed, but they alone do not change behaviour (either private or public behaviour).

Becoming a Board Certified Behaviour Analyst in Aotearoa

New Zealand has two high quality ABA training programmes run out of The University of Auckland and The University of Waikato. Both these programmes are well respected and have international ties. The programme in the School of Psychology, University of Auckland was the first programme outside of the United States to receive BACB accreditation. The Auckland programme's graduates have a 100% pass rate for the BACB examination meaning it is ranked amongst the top programmes in the world.

So Why a BCBA, Why Not Just a Psychologist?

So why should someone seek certification with the BACB in addition to registering as a psychologist in New Zealand? First it provides you with an internationally recognised qualification and second

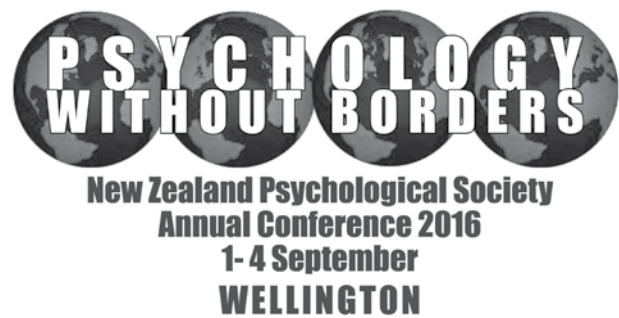
becoming board certified shows that you have reached a required level of competence in ABA, thus providing consumer protection by ensuring quality in behaviour analytic services. The BACBs mission and vision is to protect consumers of behaviour analysis services worldwide by establishing and promoting professional services and thereby solving a wider number of socially significant issues. So is my job really better than flying around in a private jet? I think so.

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References

- Baer, D. M., Wolf, M. M., & Risley, T. R. (1968). Some current dimensions of applied behaviour analysis. *Journal of Applied Behavior Analysis*, 1, 91-97.
- Friman, P. C., & Piazza, C. C. (2011). Behavioral pediatrics: integrating applied behavior analysis with pediatric medicine. In W.W. Fisher et al., *Handbook of Applied Behavior Analysis* pp 433-449. NY: Guilford.
- Gunther, P. M., & Dougher, M. J. (2013). From behavior research to clinical therapy. In J. Madden (Editor-in-Chief), *APA Handbook of Behavior Analysis: Vol. 2. Translating Principles into Practice*, pp. 3-32. Washington, DC: APA
- Lovass, I. O. (1987). Behavioral treatment and normal education and intellectual functioning in young autistic children. *Journal of Counseling and Clinical Psychology*, 55, 3-9.
- Martens, B. K., Daly III, E. J., Begeny, J. C. & Van Der Heyden, A. (2011). Behavioural approaches to education. In W.W. Fisher et al., *Handbook of Applied Behavior Analysis* pp. 385-401. NY: Guilford
- Mudford et al. (2009). *Technical Review of Published Research on Applied Behaviour Analysis Interventions for People with Autism Spectrum Disorder*, Auckland Uniservices Ltd. Wellington: Ministry of Education.
- Russo, D. C., Dunn, E., Pace, G., & Coddington, R. S. (2007) Pediatric brain injury. In J. W. Jacobson, Mulick, J. A. & Rojahn, J. (Eds.) *Handbook of Intellectual and Developmental Disabilities* pp. 97-114. New York, NY, US: Springer Publishing Co.
- Silverman K., Kaminski, J. A., Higgins, S. T., & Brady, J. V. (2011). Behavior analysis and drug addiction. In W.W. Fisher et al., *Handbook of Applied Behavior Analysis* pp. 451-471. NY: Guilford.
- Taylor, S. A., Mudford, O. C., & Phillips, K. J. (2011). Training employment acquisition skills for adolescents with a substance abuse history. *Behavioral Interventions*, 26 (4), 282-308.



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Reflections on the challenges in psychotherapy of clients

Mgr. Štěpánka Gassmann



Stepanka Gassmann obtained her Master's degree in psychology at Palacký University in Olomouc, Czech Republic, in June 2013. During her studies she took part in research internships in positive psychology at Victoria University in Wellington, New Zealand and at the University of Zürich, Switzerland. Stepanka presented the results of her Master thesis Subjective Well-being and Social Capital: Their Link and Comparison Between Czech, Indian, South African and New Zealand University Students at the 2nd International Conference on Positive Psychology in the Czech Republic (<http://socawe.phil.muni.cz/en/results>). Since 2014 she works as a psychologist in the mental health field. After her inpatient therapy experience in Rhein-Jura Klinik, Bad Säckingen, Germany she works as a psychologist specializing in CBT in Medizinisches Zentrum Geissberg, Kloten, Switzerland, giving individual and group outpatient therapy.

How does my cultural background influence the psychotherapy process with my patients? As a foreigner myself, do I possibly evoke a certain sympathy for migrants? How should I cope with issues in the psychotherapy process given cultural and historical differences? These questions are part of my everyday job since I moved to Switzerland from the Czech Republic—a very multicultural society with 36% residents with a migration background (Bundesamt für Statistik, 2015).

My experience abroad

In 2009 I made my first big trip abroad. As a young Czech woman studying psychology at the Palacký University in Olomouc in the Czech Republic I decided to have a one-year break in my studies to learn English and experience another culture as far away as it was possible to go. This is how in Christchurch, New Zealand in 2009-2010, I met my husband. He is Swiss and at that time he was working there as a skilled migrant. We had a very good time together and our love held even though I went back home to continue my studies. After meeting again in Wellington in 2011 we planned to move to his hometown close to Zurich, Switzerland. This is

how I landed in an out-patient clinic in a Region of Zurich, practicing psychotherapy in German.

Even though there are not so many differences between everyday life in Switzerland and the Czech Republic, I had to cope with certain obstacles living and practicing in a completely different language (Swiss German dialect) and difficulties finding a job on a market with approximately 800 graduates annually! Through dedication and hard work as well as the support of my partner I got back on my feet and today I feel blessed having had this experience which has made me grow. Most of my clients have a migrant background too and some of them feel a certain connection to me knowing I am a migrant myself. I am very passionate about my job and feel blessed to be able to work with people from so many cultures.

Challenges in psychotherapy of migrant patients

As everyone knows, cultural differences may cause conflicts in personal and societal relationships. Of course therapists are trained to reflect on their own thinking patterns as well as emotions and control them in the therapeutic process. But we are

undeniably also human beings with our own values and norms derived from our backgrounds. In other words, our own beliefs and values which we are willing to stand up for will govern our behaviour in society. These can of course be in huge disagreement with beliefs, values and norms of some of one's clients with different historical and cultural backgrounds. I believe this topic is very relevant in Western Europe where societies have become very multicultural due to freedom of movement as well as the European migrant crisis. Compared to the politics of migration and immigration in New Zealand, which is according to my experience strictly regulated, there is much freer movement of people within the European Union and Switzerland. For example, when moving from one European Union State to another, there are no language skills or a certain education level required (Neville, 2016). So it can easily happen there are migrants who do not speak the official language of the country even though they have been living and working in this country for many years (possibly doing job that does not require qualifications or being employed in their own community using only their mother

from culturally and linguistically diverse backgrounds

tongue). There are also differences between refugee politics in New Zealand and in Europe: In New Zealand there is a refugee quota per year and it should be decided within 140 days when claiming refugee and protection status in New Zealand (Immigration New Zealand, 2016), whereas in Europe there are no refugee quotas so far and the asylum procedures can take years. This means that someone who asked for a refugee status can be sent home after few years. This is very stressful for migrants themselves and creates huge challenges for people working with them (asylum centre guards, social workers, psychologists etc.).

I have one client, who has been in Switzerland for more than 20 years. His residential status is called 'temporarily admitted refugee', which means he has been recognised as refugee but excluded from asylum under Swiss law.

From my experience, some of the challenges when providing psychotherapy to migrant patients in Switzerland are:

1. Position of men and women in a society: Some migrants come from societies where women do not have the same rights as men. In fact, some of the women from those societies define themselves through their men. They believe their father or husband can make decisions about them in many aspects. They put up with physical and psychological violence, which may be partially tolerated in their communities. To achieve rapport with women and men from these societies it is necessary to understand the culture and its history they come from very well. I also believe there should be sensitive interventions provided to the whole family system they live in, but this is usually not possible.
2. Resources: language, education, finances, chances on a job market.
There are many unqualified jobs in Switzerland which attract especially people from poor countries. You can live quite well in Switzerland doing an unqualified job but the trouble starts once you have health issues. These jobs require a lot of physical strength. If you have an accident or a chronic disease and you cannot provide for your family anymore you can get into serious trouble. A requalification is paid for only if you have achieved a qualification already and your background education has been recognised. If you cannot speak and write the official language properly you have hardly

any chance of success on a job market. No wonder that an affective disorder, for example depression, is an outcome of a being long-term in a helpless situation like that. There is very little a psychotherapist can do in this case, the reality of our Western culture focused on personal autonomy is very hard when resources like education and finances are missing.

3. Waiting years in uncertainty - another trap?
I have one client, who has been in Switzerland for more than 20 years. His residential status is called 'temporarily admitted refugee', which means he has been recognised as refugee but excluded from asylum under Swiss law. (Schweizerische Flüchtlingshilfe, n.d.). Basically he is entitled to work, but the requirement is that the employer must submit a corresponding request and according to his experience there are not many employers who are willing to do this. He believes his chances on the market would be better if he gained a residence permit or Swiss citizenship. To get Swiss citizenship can be very hard, because regular naturalisation in Switzerland takes place at three levels: You must apply for citizenship of the Confederation, the canton and the commune. Apart from that, the candidate should not be provided the social assistance benefit. So basically he is not eligible to become a Swiss citizen. The whole situation works in a kind of inevitable circular way. Most of our sessions are strongly influenced by helplessness given these political rules.

For some clients it is very difficult to understand the concept of psychotherapy, especially that psychotherapy is more than 'talking about problems'.

4. Explaining the concept of psychotherapy
For some clients it is very difficult to understand the concept of psychotherapy, especially that psychotherapy is more than 'talking about problems'. This is a general challenge, not only when working with migrants. However, my experience is that people from societies governed by authoritarianism are more likely to expect the psychotherapists to have solutions for their problems about not having work; they ascribe responsibility to the therapist. This is understandable given that this is how they have been taught to think. Sometimes, this can be the hardest nut to crack.

Humanistic psychology and positive psychology as an answer?

I have mentioned a few challenges my clients and myself have to cope with. But there are also their light sides. Already as a student I was fascinated by humanistic and positive psychology, which tend to look beyond the medical model of psychology in order to open up a nonpathologizing view of the person and focus on personal growth, human resilience and well-being. Bad life circumstances are not being denied, but there is also enough space to question a meaning of a crisis and to see problems as a chance to grow. I believe it is important to work with a client in a compassionate and optimistic way, support his or her strengths in a therapeutic process so that he or she can flourish in any possible aspects. Most of the time it is the development of a solid treatment alliance which is the core mechanism for a patient's therapeutic progress. And sometimes it might be enough to have someone you can talk to without having a fear of being judged. And maybe it is not that much a psychotherapist can do, is it?

References

- Migration und Integration- Indikatoren. Bevölkerung mit Migrationshintergrund. (2015). Retrieved September 18, 2016, from Statistik Schweiz: <http://www.bfs.admin.ch/bfs/portal/de/index/themen/01/07/blank/key/04.html>
- Neville, D. (2016, May). Free movement of persons. *European Parliament. At your service*. Retrieved September 18, 2016, from http://www.europarl.europa.eu/atyourservice/en/displayFtu.html?ftuId=FTU_2.1.3.html
- Schweizerische Flüchtlingshilfe. (n.d.). Retrieved September 18, 2016, from <https://www.fluechtlingshilfe.ch/asylrecht/rechtlicher-status/vorlaeufig-aufgenommene-auslaender.html>
- Supporting Refugees and Asylum Seekers. (2016). Retrieved September 18, 2016, from Immigration New Zealand: <https://www.immigration.govt.nz/about-us/what-we-do/our-strategies-and-projects/supporting-refugees-and-asylum-seekers>

Psychology, mindfulness and Mexico:

Naomi White



Having completed her clinical psychology training Naomi returned to Whangarei, her place of birth, and commenced her first job in January 2015 with Northland DHB. She very quickly became established as an extremely valuable team member bringing new skills and learning to colleagues and clients alike. Naomi further studied Acceptance and Commitment Therapy, presented a course on Mindfulness for Mental Health Workers and provided guided yoga sessions for staff at lunch times. She became very much liked and appreciated by all those she came in contact with. It was with sadness that her resignation was accepted, but also acknowledging the fact that Naomi was engaging next with a longstanding dream of completing an extensive yoga teacher training course.

Gazing at the crashing waves, chewing on chiliquillies (a Mexican dish that resembles nachos), sweating profusely and practicing being present over and over, I reflect on what advice I might give a new grad entering the workforce, and indeed what advice I might give that workforce, after my experience going from a student in the lecture halls to a practitioner in the consulting room with 'Clinical Psychologist' plastered on the door.

When I first set out in my training I felt split between an interest in yoga and meditation versus pursuing a vocational qualification in clinical psychology.

I may as well start from where I am, which is a little beach village in Mexico. I'm here doing a yoga and meditation teacher training course that I have wanted to do for the past 5 years. Those 5 years spanned applying for and completing the clinical psychology programme at Victoria University of Wellington along with my first 18-months on the job thereafter.

When I first set out in my training I felt split between an interest in yoga and meditation versus pursuing a vocational qualification in clinical psychology. At times during my clinical psychology training it was a challenge to keep going in the face of my more whimsical desire to follow other interests (namely, coming here and doing this yoga course). In hindsight, of course, I am so glad that I stuck at the clinical psychology training, not only because of the invaluable learning I gained and the love of the job itself, but because one of the beauties of being a psychologist is that you can take the career in so many different directions. And so something that I spent those 18-months fresh out of university doing was not only cementing what I had learned but doing so while also developing my own style of practicing in alignment with my other passion: mindfulness.

As part of the clinical programme I wrote my Master's thesis on (the theoretical underpinnings of) mindfulness; over the years I read every book about mindfulness that I

one new-grad's journey

could get my hands on; I have spent hours on the internet trying to wrap my head around the different aspects and explanations of the many nuances of mindfulness; post-university I completed training in mindfulness-based therapies; and now I'm delving deeper into it from a personal perspective so that I can share even more of it with others. So yes in a word it is a passion (at times bordering on an obsession!). While doing all this, I haven't rejected CBT – the basis and framework of my training – but have rather sought to integrate both approaches. The conclusion I've come to is this: mindfulness entails various practices that bring about the experience of a self-identity that is beyond thoughts. That is, you are not your thoughts but rather are the observer of them. As a treatment option mindfulness offers a way to take clients further into this experience as the observer. CBT is definitely not at odds with this, as it works from the notion I'm sure we are all familiar with, that thoughts are not facts. So in CBT it is implied that you are not your thoughts (because if you were and we changed them then you would simply vanish!). I see CBT and mindfulness-based interventions now on more of a spectrum. With the course I'm doing here in Mexico, that spectrum is lengthening into infinite depths...but I digress. My point is that one piece of advice I'd give to a new grad is follow your passions and bring them into your practice. My advice for the workforce is – support them to do that.

I started out in a team of colleagues who had mostly been in the profession and the area for more than a decade and it was easy to feel intimidated (they'd been doing this since I had been entering lip-syncing competitions at my high school down the road). I had a serious case of the 'imposter-syndrome' that I can tell you any honest psychologist will admit to! However, as it turned out the support and guidance I received meant that their strength was my strength, as they shared what they knew and offered to guide me through those first few months (ok, at least 8 months) of stumbling blocks. They also showed an interest in what I brought to the table, and that made me feel special and valued.

Further to that, my colleagues treated me like I knew what I was talking about and like my opinion mattered. They would seek me out to discuss a case and listen to what I said and take it on board. They collaborated with me on our patients' care. Their confidence in me boosted my confidence in myself, as I realised that I had a valuable professional opinion to contribute. Moreover, the other psychologists within the service made themselves available

for peer supervision, which was invaluable in terms of dealing with applying my theoretical knowledge to day-to-day ethical decision making, treatment planning, and managing the demands of the job. The nurses, doctors, social workers and counsellors within the service were also readily available for their brains to be picked and this proved integral to building my confidence, competence and feeling like part of the team. I found that the more open and honest I was about the areas where I was struggling, the more help and support I received. I cannot stress enough how useful it has been to cultivate sitting with my own vulnerability in terms of being able to cope with the imposter syndrome. And trust me, it's an ongoing project.

...my colleagues treated me like I knew what I was talking about and like my opinion mattered. They would seek me out to discuss a case and listen to what I said and take it on board.

There were times when I felt completely frustrated and confused trying to figure out things like what exactly the referral pathway was, what the level of responsibility was for picking up referrals from other teams, and how to decline a referral and send a rationale to the referrer. There were times when nobody could give me straight answers and the general tears that exist in the fabric of any organisation were visible and it seemed to cause general discomfort that I was noticing and asking about them. In such a big organisation that was undergoing major re-structuring at the time it was really difficult to find my way sometimes. That's when a colleague's open office door and available ear became a refuge. I realised that I couldn't keep everybody happy but I could make the effort to maintain good working relationships by being respectful while also assertive. Having the confidence to state my opinion and work collaboratively with that has been a huge learning curve, and it helped that my supervisor and colleagues would validate my clinical reasoning. Slowly but surely I started to realise that yeah, after 6 years of study and training I did have some clue what I was talking about after all!

I am ever grateful for the opportunity I had to give back to my community while they gave back to me ten-fold, helping me to find my feet, cementing me in my practice and then sending me off on my next adventure, with love.

One on One - with Devon Polaschek



Devon Polaschek was invited as our 'one on one' contributor.

Devon was awarded the 2016 Hunter Award. *She is a forensic clinical psychologist and professor of criminal justice psychology at Victoria University. Her research interests include theory, intervention, and intervention evaluation with serious violent and sexual offenders, and cognitive experimental approaches to the assessment of offenders.*

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

Watching students grow and develop as people, as researchers, and in their professional roles.

One event that changed the course of your career

Hmm. There are a few. Meeting a clinical psychologist at a party when I was 17.

One alternative career path you might have chosen

When I left school I was going to be a professional musician (classical) and then a mechanical engineer.

One learning experience that made a big difference to you

Two years ago I had the opportunity to spend 6 months in New York at the John Jay College of Criminal Justice. I started to learn some of the more complex statistical techniques while I was there, such as structural equation modelling and growth curve modelling. I know how that sounds, but especially in clinical and other forms of applied psychology in New Zealand we are too often working with small data sets and have little ability to do more than correlate a few things. These kinds of techniques enable us to consider much more interesting questions that, if answered, provide a better platform for application.

One book that you think all psychologists should read

Lots of choices here too. Current favourite is Cal

Newport's deep work: *Rules for focused success in a distracted world*. I think it is more and more difficult and important to preserve, or for some of us (e.g., me), to (re)develop, the ability to focus our attention on one thing for more than 3 milliseconds in this world that is constantly clamouring to control our attention. Without that ability we can't even give another person that most precious of gifts, our full attention.

One challenge that you think psychology faces

The twin challenges of maintaining professional roles that add something distinct to what others can also contribute and/or disseminating psychology effectively so other professions can use it well in their work.

One thing that psychology has achieved

So many things. In my area and during my career, the biggest achievement has been the ability to identify how to reduce criminal risk and improve the likelihood of desistance.

One aspiration for New Zealand psychology

The ability to provide more and better professional training for people wanting to enter the profession of psychology. That means more places on courses, and better financial support for internships for instance. And with that we still need to do better with developing the Māori and Pasifika workforce.

One social justice issue psychology should focus on

Better family/whanau functioning. I put it that way so I can fold in poverty, family violence, and all the other things that need tackling to contribute to families that are happier, less stressed and conflicted, and raise healthier tamariki. Is it cheating to combine all those into one?

One big question

Where is the chocolate?

One regret

I really had to think about this one. Because mostly if I think of something that could have come out better, I remember that the reason I made the choice I did was that I thought it was the best one at the time. And you can only be where you are in life, not somewhere different where you would have made a different choice. At least not as I understand the space-time continuum.

So, maybe, that my grandfather did not live long enough to make it to my PhD graduation.

One proud moment

Getting gay-married in New Zealand finally!

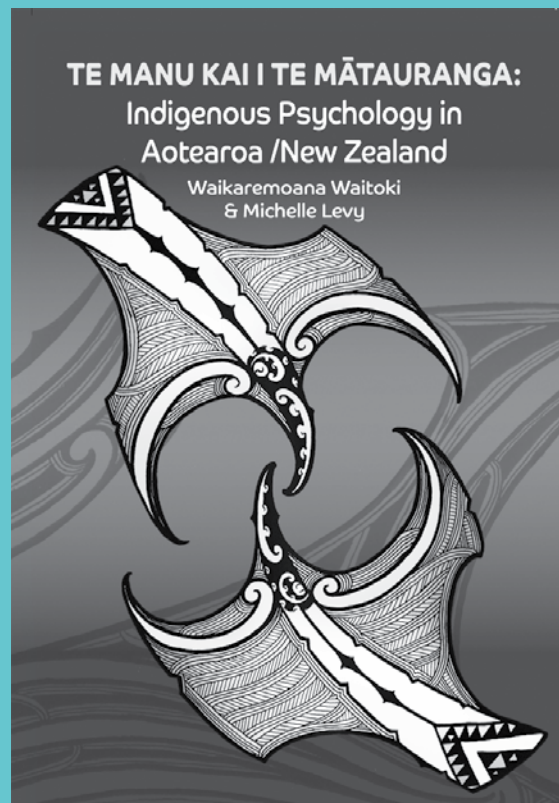
And of course, getting the Hunter Award. Really humbling in the face of the people who went before. Thanks NZPsS!

One thing you would change about psychology

Especially with regard to clinical psychology, I would like to see more awareness of the likely importance of environmental factors in human behaviour. I think especially in clinical psychology, we are much too wedded to the fundamental attribution error. Relatedly, we may be too focused on the idea people need to change cognition to change behaviour. Whatever happened to our recognition that the arrow can go the other way and that's a much easier way to work with all those people who don't take to directly working from the inside out?

One piece of advice for aspiring psychologists

No amount of money makes up for having to drag yourself to school or work each day, so it is important to do something you enjoy rather than what you think you SHOULD be doing. That said though, get really good at what you do. That takes time. If you get really good at it, there will always be work.



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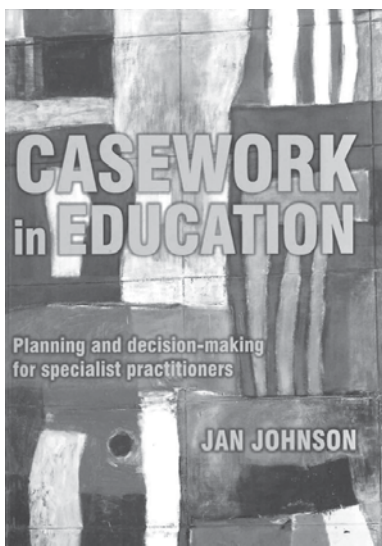


This is my first time as review editor and I am grateful for the guidance and support provided by John Fitzgerald who did such an excellent job as the previous editor. We have three reviews for this issue and they all relate to psychological practice. Thank you very much Carmen and John for the present reviews. I would like to encourage readers to contact me if they are thinking of writing a review about any book (or moving image) that relates to psychology (which means pretty much anything can be considered!).

Peter Stanley- Review Editor
pstanley0@xtra.co.nz

Casework in education: Planning and decision-making for specialist practitioners

Reviewed by Carmen O'Meeghan, Psychologist, Special Education, Tauranga



Casework in Education delivers a very compact inside perspective on the various components involved in psycho-educational casework from referral to closure and reflection. This book is an excellent entry level text for postgraduate students studying educational psychology, and for those moving

into a Special Education advisory role, or for Resource Teachers of Learning and Behaviour (RTLb). That is not to say that seasoned practitioners working in the education sector won't find some value in this book. With 34 years' experience in casework practice and supervision, the author, Jan Johnson (psychologist), reminds us of a range of practice competencies including collaboration, evidenced based practice, and professional development. There are some useful discussion points and prompts for supervisors that educational specialists will find useful. The chapter on reflection provides numerous questions to challenge our thinking as practitioners, and it acts as antidote to reflective autopilot.

Building on the success of her earlier works on casework

practice (reserved primarily for intern educational psychologists), Jan Johnson's new book represents a culmination of her knowledge, hands-on experience, and insights into the intricacies of educational fieldwork in New Zealand. The result is a representative compendium of activities that consolidate into a seven-phase framework for working cases involving students with moderate to severe behaviour or learning issues.

Each phase is divided sensibly into three distinct categories of action:- behind-the scene activity, direct activity, and writing activity, and these guide and prompt planning and decision making. It is this consistency within each chapter that adds to the book's seriousness and straightforwardness.

As a psychologist working in Special Education, this text is very illustrative of the enormity and complexity of educational casework from process to practice. Jan Johnson's style is welcomingly candid and direct. Instead of delving into a plethora of theory, or specifics around assessment and intervention, she very simply outlines a logical and linear progression for casework, but she also acknowledges that loopbacks to earlier phases may be necessary given the complexity of student needs. For pre-service practitioners this information will undoubtedly 'unlock' the actualities of educational fieldwork, while adding value to practicum and assignment efforts.

Readers will be appreciative of the itemized overview of each phase in the casework framework provided at the very beginning of the book. Each overview will certainly be helpful as a quick reference guide to phase activities, and particularly for the 'on-the-go' practitioner seeking a quick reminder or activity prompt. There is also a noteworthy diagrammatic of a hypothetical 20-week casework timeline in the Appendix that readers may find interesting, though Jan Johnson recognises there is no such as thing as a 'standard' timeframe for referrals when students present

with severe concerns.

Overall, it is difficult not to like the author's unpretentious and down-to-earth approach in this book. Jan Johnson has very kindly brought many of the invisibilities of casework to our attention, and highlighted the colossal number of day-to-day activities that are required for effective and efficient casework. On that note- for seasoned practitioners, it's clearly time to ask for a much deserved pay rise. For pre-service practitioners, welcome to the realities of educational casework!

Casework in education: Planning and decision-making for specialist practitioners

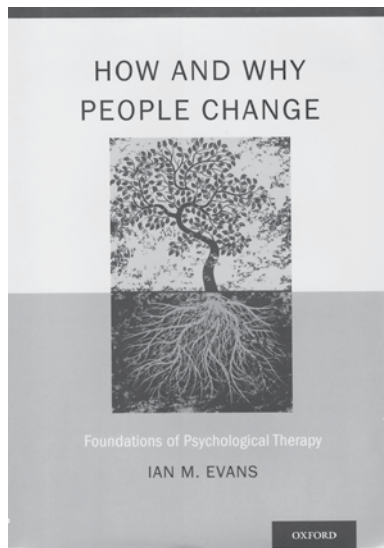
Jan Johnson (2016)

Dunmore. ISBN 1927212219

140 pp. Paperback. \$19.86 (Fishpond)

How and why people change: Foundations of psychological therapy

Reviewed by Peter Stanley, Counselling psychologist, Tauranga



Ian Evans PhD will be familiar to many readers as he was Professor of Psychology at both the University of Waikato and at Massey University. Prior to coming to this country he taught behaviour therapy at the University of Hawaii and was Director of Clinical Training at SUNY-Binghamton. Evans

has also been a clinical psychologist in private practice.

How and Why People Change is the culmination of a lifetime of experience and thinking on the fundamental questions that confront therapeutic psychology and psychologists.

In this book Evans argues that it is important to derive principles of change that can be applied to any problem of living and he contrasts this with the present preoccupation amongst practitioners with techniques, discrete therapies,

and evidence-based programmes. The author describes the personal difficulties that bring clients to therapy as being like the “wicked” problems of mathematics, in that they are complex, multicausal, and resistant to resolution. To make sense of them it can be helpful to adopt something like a circles of influence model (similar to Bronfenbrenner’s systems theory) with the inner ring consisting of personality and cognition, the intermediate ring reflecting more immediate contextual effects, and the outer ring representing culture and society. Evans contends that we cannot regularly prioritise one of these circles of influence over another in therapy. “Daily routines are as important as emotional schemas; relationships with family, friends, and workmates are as important as the relationships between overt behaviour, thoughts, and feelings” (p. 265). In these circumstances, the prerequisite to planful therapeutic change is understanding the chains of causal influences in a client’s life and targeting some or all of them for intervention.

How and Why People Change underlines the significance of stimuli in people’s lives for eliciting thoughts and actions, and most especially in giving all manner of objects emotional valences. Equally, altering behaviour through contingency management is described as one of “the great technical success stories of psychology” (p. 115). But, notably, humans have the advantage of personal agency and so they can select rewards and punishments for themselves as well as for other people. An individual’s personality determines his or her unique response to a common context, although as a social species we tend to be motivated by opportunities for acceptance, intimacy, and influence. Cognitions are at the core of what we do, and these include both fleeting thoughts and studied self-reflection. Typically operating through words, cognitions give us the interpretations that we place on events and settings, and they also allow us to adjust in more or less adaptive ways in relation to the routines and rituals of the cultures to which we belong.

Evans acknowledges that evidence-based programmes frequently contain principles of change, but the packages are often applied to a clinical syndrome without a detailed understanding of the processes that are maintaining the problematic behaviours in the present instance. Something is “being done” to the client and this could represent an affront to his or her culture, and it might also deny the active role that people can choose to take in their own affairs. Evans makes clear that the meaningful measurement of therapeutic change is fraught and complex; and evidence-based programmes can give undue, and uncritical, prominence to dubious outcome measures. The author

argues that the history of evidenced-based treatment packages shows that the movement is actually antithetical to good treatment principles because they “drop them as quickly as possible when a new one comes along” (p. 261). Effectively, a therapy market place has developed, with “name brand” treatments, and “a professional culture of ‘mine is better than yours’” (p. 264).

How and Why People Change is a challenging text to review because it contains an extended argument with innumerable enrichments and many insightful digressions. The central thesis regarding principles of change does not ultimately result in a tidy integration of all that is best in psychological theory and research. Quite simply, this cannot be done. Schools of psychotherapy are, in effect, social movements with their own language systems, methods of enquiry, and standards of proof. Similarly, psychological research covers a multitude of topics and is highly fragmented. It is difficult enough to achieve some familiarity with this vast knowledge base, and it is a more demanding matter again to derive a specific therapeutic response as this will typically call on a number of separate streams of psychological investigation. Nonetheless, Evans has made a major contribution to therapeutic psychology by elevating our gaze above packaged programmes and the assorted pickings of eclecticism. His view of the significance of experience for behaviour is also an optimistic one, and it means that proven principles and processes of change “can be *translated* into multiple ingenious, humane, and socially just intervention practices” (p. 249).

How and why people change:
Foundations of psychological therapy
Ian Evans (2013)

Oxford University Press. ISBN
9780199917273

303 pp. Hardback. \$19.86 (Book
Depository)

Solution-focused case management

Reviewed by John Fitzgerald, Senior lecturer in Clinical psychology, Massey University, Wellington



I was keen to read this text for two reasons. First, I have a sustained interest in solution-focused assessment and intervention within clinical practice. Not only does it inform a way of working that challenges established ideas about the therapy process, but it can also be enlivening for practitioners, and effective for service users. The second reason for being attracted to this text was the increasing involvement of psychologists in the case

management process. This seems to be a double-edged sword with psychologists taking on a greater role in generic case coordination, where they have a greater opportunity to support change at a systemic level, but (theoretically) having to reduce therapy caseloads to release the additional time required. Before I started reading *Solution-focused case management* I was hopeful that a case management model based on solution-focused brief therapy (SFBT) would itself be brief, and therefore be a good fit for psychologists in a case management role.

The first thing the authors do is clarify that *case management* is an old term and that *case co-ordination* or even *case empowerment* are preferred and more accurately describe the focus of their commentary. They use the word ‘management’ because of its currency.

The authors start their presentation by locating the solution focused approach within the social constructionist framework outlined by writers/practitioners such as Milton Erickson, Harlene Anderson and Harry Goolishian. In summarising the basic assumptions and tenets of this general approach the reader is provided with a solid introduction to the theoretical underpinnings and rationale behind SFBT. Following this there is a chapter entitled ‘Solution focus: Its history and practice’ which is a great primer for practitioners who want to know more about this innovative approach, and the contributions of Steve de Shazer and Insoo Kim Berg. Not only is SFBT linked back to its theoretical origins, but key techniques and therapy strategies are detailed. From this point the text is rich with case vignettes and exercises to aid exploration and skill development.

The second half of the book focuses more explicitly on the application of SFBT to systems and organisations within the context of case management. The authors build on the knowledge that has been

presented in the earlier chapters, and apply this initially to the enhancement of collaborative relationships, and then more specifically to work with other agencies. As in the previous chapters the approach taken is highly applicable with copious case examples and exercises to assist the reader. It is interesting how the authors have adjusted and re-purposed the basic SFBT techniques to fit the case management objectives.

There is a chapter outlining strategies for keeping the case management engagement brief, which is also a key focus of the approach when used within a therapeutic setting. The main elements here are (a) consistent movement towards the client's own goals, and (b) supporting clients in transitioning between different levels of service as independence is achieved. Again, there are useful tips and strategies offered which would be helpful to someone in this role.

The final chapter was a little surprising as it has as its focus Standards of Practice for Case Managers. It is not that this is irrelevant, rather that it is uncommon. The brief chapter is excellent, focusing on the importance of practice-based evidence, evaluations of outcome, self-care (very important!), and moral and ethical issues.

Solution-focused case management is well written and formatted. It is not overly technical and reads more like a workbook or clinical sourcebook. Indeed, the publishers indicate that there is a set of Powerpoint slides available to support trainers who want to use the text as a foundation for teaching. The material presented is easily understood and is closely linked to the exercises and examples provided. This will be a very useful book for any practitioner who doesn't know much about SFBT, but wants to learn more and explore the techniques on offer. The authors do a good job of mapping the solution-focused approach onto case management and it is likely that a practitioner who is involved in case management would benefit from studying this text.

Solution-focused case management

Robert Blundo & Joel Simon (2016)

Springer Publishing. ISBN: 9780826171856

368 pp. Paperback. \$97.46 (Book Depository).

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Click here: <http://www.psychology.org.nz/members-only/find-a-supervisor> for the form.

Mentoring Service for those new to NZ or recently graduated

The Society is about to set up a mentoring database to assist members who are new to NZ or who have recently graduated giving them the opportunity to talk with an established colleague.

How is mentoring different from professional supervision?

Mentoring is different from professional supervision. Supervision is a formal relationship focused on work with clients within which the supervisor often carries responsibility for the safe practice of the supervisee. Mentoring, on the other hand, is an informal supportive relationship designed to help new graduates or newcomers to New Zealand to negotiate the broader professional environment. This might for example involve discussing opportunities for career development or offering reflections about what helped you in your own career. It would not ordinarily involve discussion of actual client work. Professional supervisors usually charge a fee for supervision whereas a mentoring relationship is normally a collegial relationship without a fee.

If you would like to put yourself forward as a mentor on the NZPsS database please contact us at pd@psychology.org.nz and we will provide more information.

Editorial



Anna Kurek
NZPsS Student Forum Editors



Ariana Krynen
NZPsS Student Forum Editors

Welcome to *Psychology Aotearoa*. It has been an incredible year of study, conferences, late night writing, and being part of this edition. We have really enjoyed working together as a team and collaborating with other psychology students in putting together this Student Forum. This joint effort resulted in many interesting and diverse conversations about the benefits of studying psychology and the current and novel challenges that exist outside of our academic training and institutions. A common theme emerged about the importance of fostering research and practice within Aotearoa, while also recognising psychology as an international field and how this transnational presence takes on a different meaning for each graduate and post-graduate student.

For this Student Forum we take both a national and international perspective and bring you a number of interesting pieces on the diverse nature of the field in today's global environment. First, Stacey Ruru, recipient of the 2015 Karahipi Tumuaki President's Scholarship, presents findings from her Master's thesis on Māori women's leadership roles and the importance of waiora (wellbeing). Kate Goss and Samantha Lee present their papers which jointly won the Best Student Conference Paper Prize at this years' NZPsS Conference in Wellington. Kate shares her experience as an intern psychologist at Auckland South Corrections Facility, and Samantha outlines findings from her PhD which used data from the Canterbury Methadone in Pregnancy (MIP) Study to explore the academic outcomes of children born to opioid-dependent women.

Moving to an international focus, Nick Laurence from Massey University writes about psychology's exciting role in shaping the 21st century. AUT Master's student Walter Hamer provides an opinion piece on urban design and flourishing, discussing the impacts of environmental surroundings and city life on individual psychology and wellbeing. PhD student Sandila Tanveer from Canterbury then discusses her experiences as an international student in New Zealand, and offers personal insights into the doctoral journey and the challenges that exist locally and abroad after graduation. Lastly, we present a jointly written article about the international challenges of studying psychology and the barriers that exist in evaluating transferable skills in a global environment.

We trust that you will find the Student Forum topics as intriguing as we have

in the process of putting together these various perspectives. We hope these topics generate much-needed conversation that lead to new and innovative ideas on how to enhance wellbeing within Aotearoa and make the field of psychology a more international experience for both students and academic institutions.

We also want to say congratulations to all the active students in New Zealand for completing another year of study. We would like to extend a warm kudos to all those finishing their programmes this year and embarking on new adventures in the New Year. Enjoy your summer holidays and we look forward to meeting fellow students at NZPsS future functions.

Best of luck,

Anna & Ariana

anna.kurek@vuw.ac.nz &
akry030@aucklanduni.ac.nz

Māori women perspectives of leadership and wellbeing

Stacey Mariu Ruru



He hōnore,
He kōroria ki te ātua,
He maungarongo ki te whenua
He whakāro pai ki ngā tangata kātoa
E kui mā, e koro mā, e rau rāngatira mā
Tēnā kōutou kātoa.
Ko Stacey Ruru tōku ingōa, nō Ngāti Haua me Ngāti Raukawa ahau.

I am a graduate from the University of Waikato and have completed a Masters of Applied Psychology in Organizational Psychology. I decided to pursue a Masters in psychology to register as a psychologist and to build on my passion for Māori research. I also enjoy Kyokushin-kai and being involved in the Nawton Community.

Stacey Ruru was awarded the Karahipi Tumuaki -President's Scholarship in 2015.

Introduction

This article is a summary of my Master's thesis with a primary focus on the findings. My research sought to understand how Māori women in leadership roles maintain their *waiaora* (wellbeing) to stay strong. 'Leader' or 'leadership' from a te ao Māori perspective refers to rāngatira which is the *mana* (power) and *tapū* (sacredness) of a leader and how that leader portrays those attributes within leadership (Walker, 2006; Wihongi, 2010). Māori women leaders such as Dame Whina Cooper, who led the *hikoi* (land march) in 1975 for Māori land rights, and Te Puea Herangi, who established the *kingitanga* (king movement) (Wihongi, 2010; Wirihana, 2012) showed *mana wahine* (the ability to practise and share mātauranga or mana). They both led change and are an example for future generations to follow (Pihama, 2001; Te Awekotuku, 1991). While the values of traditional Māori leadership such as weaving people together, *tikanga* Māori and *whakapapa* continue to be practiced in contemporary Māori society (Henry & Pringle, 1996; Mahuika, 1992; Walker, 2006) there is growing research that specifically focus on Māori women as leaders but not the importance of wellbeing within Māori leadership. This research aims to fill that void.

This research followed a qualitative kaupapa Māori framework using values such as *kānohi kitea* (greeting face to face) and *ako* Māori (learning, teaching, reciprocity). (Pihama, Cram, & Walker, 2002; Russell, 2008; Smith, 1997) to gather the leadership journeys of five Māori women leaders from academic or chief executive

backgrounds across Aotearoa. The interviews were analyzed by thematic analysis to generate codes from raw data and led to the identification of eight main themes (Braun & Clarke, 2006; Bricki & Green, 2007; Coolican, 2014; Flick, 2009). These themes were further explored by five *whakataukī Māori* (Māori proverbs) to delve within the layers of each theme. Whakataukī are Māori proverbs that detail mātauranga and *tikanga* (customs) within te ao Māori (Le Grice, 2014; McNeill, 2009; Wirihana, 2012). Each whakataukī will be presented in the findings of this article and link to quotes from each participant to emphasize their leadership stories.

Findings

Kāore te kumara e kōrero mō tōna reka: The kumara does not speak of its sweetness.

Each participant shared stories about hūmarie that discussed the influence of others. Hūmarie translates to humility and has been associated with whakaiti, whakahihi and whakamā.

Te Rina comments on maintaining a balance between hūmarie:

One of the things for me. . . you need to be careful, because your strengths can also be your weaknesses. . . You can have confidence, but your confidence can also be arrogance. . . I've just got really comfortable in my own skin. (Te Rina, Chief Executive)

Te Rina discusses the importance of *kia tūpato* (to be careful) within leadership contexts, as individual attitudes or actions can influence others. The 'kumara' is a metaphor for humility within *te ao Māori* and was described by participants as a leadership quality to maintain.

Ēhara tāku toa i te takitini, he toa takitahi: My success would not be bestowed onto me alone, as it was not individual success but success of a collective.

This whakataukī captures the ability to work together as a team or group to accomplish something great as a collective. It also refers to sharing achievement with other people rather than self-advancement.

This research followed a qualitative kaupapa Māori framework using values such as kānohi kitea (greeting face to face) and ako Māori (learning, teaching, reciprocity).

Aroha shared a narrative about a Māori leader she admired:

She won't ever say that she's done anything individually. It's always a collective. . . you find actually across Māori women – Māori in general. . . we tend not to act individually. (Aroha, Chief Executive)

Aroha shared this story as an example to aspire to be within her own leadership role and it links to *mana wahine*, because this story empowered Aroha to share it with others. In relation to Māori leadership, it is evident that collectivism is important to relationships and trust.

Pātua i te taniwha o te whakamā: Don't let shyness overcome you.

This whakataukī refers to a *taniwha* who is a guardian within *te ao Māori*. The *taniwha* symbolises a challenge or opportunity to develop knowledge and

character. In this context the enemy refers to the individual's strengths and weaknesses to overcome challenges.

A dimension of this whakataukī questions what the *taniwha* represents for these leaders. Katarina identified the *taniwha* and the impact it has on her experiences as a leader:

When I'm the only Māori . . . the only woman on committees. . . it's largely white men – old white men too. . . not usually direct challenges. . . although I have had one . . . the veiled language that they use. . . the ways in which they'll try. . . to consciously. . . more unconsciously. . . marginalise. . . you just have to figure out what's the strategy for this. . . You can't be . . . calling people out . . . directly. . . that. . . becomes counterproductive . . . I'll just do a direct consultation, just call them out directly for their kind of racism which I've done with a few senior people, and other times there has to be a more subtle approach. (Katarina, Academic)

Katarina describes an experience that many women face within the workplace or on committees. The *taniwha* in this context is about how Katarina faced those challenges and highlights the importance of speaking up for your rights, but the importance of finding strategies to neutralise any situation.

Pātua te taniwha o te whakamā was a whakataukī that described how participants faced and overcame challenges. The outcome of facing challenges resulted in growth, strength and resilience for Māori women.

Piki kau ake te whakāro pai, hauhake tōnu iho: When a good thought springs up, it is harvested, a good idea should be used immediately.

This whakataukī refers to using ideas as an opportunity to develop

a pathway for future generations. Participants shared stories of sharing knowledge and being influenced by *tamariki* (children) or *taura* (students) that they worked with.

The *tūakana-teina* mentoring relationship was discussed by Aroha with reference to *tāmariki*:

Encouraging kids to use their muscles, their mental muscles in a way that they might not have otherwise. It's never really a fair exchange where . . . they think they're getting advice from me. . . I actually get a huge amount of energy from them. . . you can see a real light in them. (Aroha, Chief Executive)

As Aroha was the *tuakana* (eldest) her role is to guide the next generation of leaders, who are the *teina* (youngest). Boundaries were not set between the leader and *tamariki*; rather, space was created for knowledge and trust. Significantly *tuakana-teina* represented 'piki kau ake te whakāro pai' and is a leadership quality that participants discussed in their narratives.

He ōranga ngākau, he pikinga waiora: Positive feelings in your heart will enhance your sense of self-worth.

This whakataukī refers to emotional, spiritual and family *waiora* dimensions of an individual and the importance of maintaining balance.

Te Rina discusses finding a balance between the *hinengaro* and *tinana*:

I realised in my 40s that. . . physical activity didn't quieten my mind to have clarity of focus, the physical activity wasn't doing that, you need a balance between those two things. They suggested that I do yoga or Pilates, I really resisted it. I went away with a friend of mine to a wellness place, they did like stretching in the morning and Tai Chi, and I

suddenly realised it wasn't natural for me to meditate. I felt really good after I did it, my head just felt really clear. (Te Rina, Chief Executive)

Te Rina described her experience of achieving balance and that physical activities maintained wellbeing to an extent, but did not offer peace of mind. Being encouraged by others to maintain wellbeing was a significant finding because change was initiated and resulted in growth. Overall whakataukī provided a lens that explored what leadership and wellbeing meant to Māori women leaders. Stories about learning from others, being humble and participating in activities that balanced waiora were significant to the leaders within this study.

Each participant shared stories about hūmarie that discussed the influence of others. Hūmarie translates to humility and has been associated with whakaiti, whakahihi and whakamā.

Conclusion

This research primarily found that Māori women leaders integrated leadership and wellbeing to balance their lifestyle. Leadership ability and wellbeing practices developed over time for Māori women leaders that made them resilient to change and challenges. Practices such as being connected to others, participating in meditation or sharing mātauranga were central to work and life balance. Significantly the use of whakataukī provided a greater understanding of the themes and the importance of being connected to others adding depth to the leadership journeys by Māori women leaders. Overall the leadership and wellbeing practices found in this study such as mana, mātauranga and ako Māori can potentially contribute towards leadership development or mentoring for future generations to follow. Finally, practices such as overcoming boundaries or being humble within leadership should be considered opportunities to develop rather than boundaries.

References

- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Bricki, N., & Green, J. (2007). A guide to using qualitative methodology. from <http://fieldresearch.msf.org>
- Coolican, H. (2014). *Research methods and statistics in psychology*. East Sussex, United Kingdom: Psychology Press.
- Flick, U. (2009). *An introduction to qualitative research* (Vol. 4). London, England Sage Publications Ltd.
- Henry, E., & Pringle, J. (1996). Making voices, being heard in Aotearoa/New Zealand. *Organization*, 3(4), 534-540.
- Le Grice, S. J. (2014). *Māori and reproduction, sexuality education, maternity, and abortion*. (Doctoral thesis, The University of Auckland). Retrieved from researchspace.auckland.ac.nz
- Mahuika, A. (1992). Leadership: Inherited and achieved. In M. King (Ed.), *Tē ao hurihuri: Aspects of Māoritanga* (pp. 42-62). Auckland, New Zealand: Reed Publishing Group.
- McNeill, H. (2009). Māori models of mental health. *Tē Kaharoa*, 1(2), 96-115.
- Pihama, L. (2001). *Tihei mauri ōra: Honouring our voices; mana wahine as a kaupapa Māori theoretical framework*. (Doctoral thesis, the University of Auckland), Auckland, New Zealand.
- Pihama, L., Cram, F., & Walker, S. (2002). Creating methodological space: A literature review of kaupapa Māori research. *Canadian Journal of Native Education*, 26(1), 30-43.
- Russell, B. (2008). Te Kotahitanga: kaupapa Māori in mainstream classrooms. In N. Denzin, Y. Lincoln & L. Smith (Eds.), *Handbook of critical and indigenous methodologies* (pp. 439-447). LA: Sage Publications Ltd
- Smith, G. (1997). *The development of kaupapa Māori: Theory and praxis*. (Doctoral thesis, The University of Auckland), Auckland, New Zealand. Retrieved from <https://researchspace.auckland.ac.nz/handle/2292/623>
- Te Awēkotuku, N. (1991). *Mana wahine Māori: Selected writings on Maori womens art, culture and politics* (Vol. 6). Wellington, New Zealand: New Women's Press.
- Walker, R. (2006). Māori sovereignty, colonial and post-colonial discourses In H. Paul (Ed.), *Indigenous peoples rights: In Australia, Canada and New Zealand* (pp. 108-122). United Kingdom Oxford University Press
- Wihongi, H. A. (2010). *Tino rangatiratanga in health policies and practises: A kaupapa Māori analysis of the 1996 national cervical screening programme's policy document the years 1990 to 2000*. (Doctoral thesis, The University of Waikato), Hamilton, New Zealand. Retrieved from <http://www.waikato.ac.nz/>
- Wirihana, R. (2012). *Ngā pūrākau o ngā wahine rangatira Māori o Aotearoa: The stories of Māori women leaders in New Zealand*. (Doctoral thesis, Massey University), New Zealand Retrieved from <http://mro.massey.ac.nz/>

Seeing new territory charted at Auckland South Corrections Facility: Psychology across the whole facility

Kate Goss



Kate Goss is an intern psychologist at Auckland South Corrections Facility. She is currently working towards completing the Postgraduate Diploma in Psychological Practice through Massey University, and gave a presentation about her internship experience at the New Zealand Psychological Society Annual Conference in September.

Traditionally, efforts to reduce recidivism focus on the individual. I am currently an intern psychologist at Auckland South Corrections Facility (ASCF), where an attempt is being made to apply psychological knowledge across the whole site in the hope of creating an environment more conducive to change and rehabilitation. The value of psychologists in prisons is well known, but as resources are limited it is hoped that psychology can be used to influence more prisoners than just those who work with psychologists in a one to one setting. ASCF opened in May 2015, and provides a unique opportunity to test innovative ideas and do things differently.

One example of this is a Responsible Prisoner Model which aims to

mitigate the often detrimental effects seen when incarceration reduces the responsibilities of offenders in comparison to what they experienced in the community. This involves a variety of things including prisoners booking their own appointments and visits, and choosing meals. Prisoners also apply for internal prison employment with a CV and cover letter, then go through an interview process. Another important component of the Responsible Prisoner Model is the self-care residences (which include 240 of the 960 total beds at ASCF) in which prisoners order supplies within their budget each week, cook their own meals, and have the freedom to move around the site to work/education/programmes without being escorted. Usually rehabilitative programmes attempt to give prisoners the tools and motivation to take control of their lives - this model aims to make this philosophy more consistent across their whole sentence and allow them opportunities to use the skills they have learned.

Another initiative in development is a progression pathway, where inmates evidence motivation for change through ongoing behaviour management. It is hoped that a clear pathway will help offenders move through their sentence effectively, gradually increasing skills that will benefit them on release. This pathway starts in the high security unit (Houseblock 1), progresses through Houseblocks 2 and 3, and ends with self-care residences and reintegration activities. Care needs to be taken within this model to ensure that all prisoners have access to rehabilitation

and opportunities to show they are ready to progress.

Although it is too early to measure the impact of these initiatives, it is expected that applying psychological knowledge across the whole prison is a step in the right direction. There are many more ideas in the pipeline such as increasing the focus on mental health, and changing rehabilitation programmes offered based on the changing needs of the prison. From an intern's perspective, along with learning to carry out the daily responsibilities of a psychologist in a correctional facility, having the opportunity to work in this environment provides valuable learning and demonstrates the widespread impact psychology can have.

Psychology's exciting role in shaping the 21st Century

Nick Laurence



Nick Laurence is a clinical psychology student at Massey University in Wellington. His doctoral research project is investigating the impact of Mindfulness-integrated Cognitive Behavioural Therapy (MiCBT) on participants' levels of general distress, compassion and wellbeing. Nick is interested in how psychology and mindfulness/compassion-focused approaches can be used to foster positive social and environmental change, and wellbeing-centric approaches to working with individuals, groups and organisations. Nick recently undertook a programme with Lifehack HQ, a Ministry of Social Development-funded organisation taking a Social Labs/systemic approach to improving youth wellbeing in New Zealand. If you're interested in getting in touch with Nick, please email nick@mindfulnessforchange.co.nz.

I'm excited about the possibilities for psychology in the 21st century. We face bigger, more psychologically complex challenges than perhaps any time in human history, with issues such as climate change and wealth and income inequality seemingly not able to be solved with any one solution alone. I believe psychology has a big part to play in helping to generate solutions to these issues and crises, and creating a better world for us all to live in: a world characterised by not only increased surface-level connectivity, but also deeper empathy and recognition of our common humanity.

As a millennial, born in 1991 (at around the same time as the internet was created), my introduction to psychology and perspective on it has been shaped by forces that simply didn't exist twenty or more years ago. The introduction of TED-style talks and decentralisation of media/knowledge production have radically changed the landscape and constructed realities that we all live and work in. I've learned at least as much about psychology outside of university as I have within it – much of the early inspiration for getting into psychology was shaped by Martin Seligman's TED talk on what makes psychology good, where he introduced the inspiration behind the positive psychology movement (TED, 2004). Over the course of the nearly 8 years I've been studying psychology in a university context, I've been able to – at the click of a button – be exposed to research about:

- The importance of self-compassion in wellbeing and academic learning (e.g., Neff, Hsieh, & DeJitterat, 2005; Neff, Kirkpatrick, & Rude, 2007);
- The link between growth mindsets and academic achievement (Blackwell, Trzesniewski, & Dweck, 2007);

- The necessity of openness and vulnerability in dealing effectively with shame and other difficult emotions (Brown, 2006);
- In developing nations where there is no funding for psychiatrists and clinical psychologists, task shifting to community members to provide them with the ability to participate in their own mental health (TED, 2012);
- The link between meditation and neuroplasticity, and the discovery that empathy and compassion could be trained, resulting in measurable changes in brain activity (Lazar et al., 2005; Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008);
- The use of mindfulness-based techniques in research from MIT researchers proposing new ways of tackling complex problems such as climate change and food production: research that emphasises doing away with central planning in favour of sensing and responding, in a process referred to as “leading from the emerging future” (Scharmer, 2007, p. 1).

Of course, watching TED talks about exciting ideas to do with psychology, mental health and wellbeing doesn't replace the need to learn how to critically appraise scientific literature. But it does provide the ability for curious minds to gain exposure to a broader range of ideas than ever before, which we as psychologists can then use to inform research and investigations into more effective ways of working for our clients, communities and society.

Having access to online journal databases then allows the next step in the process – from learning about a general concept such as positive psychology, indigenous psychological worldviews, or the benefits of meditation, to investigating that subject area in more detail and critically

appraising the literature on it. This is where specialist tertiary education is invaluable in learning to distinguish what the research actually says and what it doesn't.

Why are TED talks important to psychology in the 21st Century?

TED talks aren't important in themselves as much as what they represent: a wider, internet-enabled shift towards decentralisation of knowledge and expertise and open access to new ideas and solutions. This is important because the ways we have been working are leading us on a path to runaway climate change that could devastate lives all over the planet. This will happen unless we change our course, rapidly – and this is not Donald Trump-style fear-mongering with no basis in reality. Evidence shows crime rates in developed countries and conflict around the world at record lows, contrary to what UKIP/Trump style politicians spout, but equally evidence tells us that climate change is something that poses an existential threat to our civilization if we don't drastically reduce our emissions. Reducing our emissions is not a simple fix – it requires a radical change in our behaviour. As psychologists trained as both scientists and practitioners, there is a desperate need for us to recognize climate science and act accordingly, applying our scientific knowledge of behaviour change in the direction of sustainable behaviour.

The situation we are in is difficult to comprehend, both intellectually and emotionally. Given the gravity of the situation, the most risk-averse and ethical response is to radically change the way we operate as a society: doing nothing, or accepting the status quo, is the riskiest option. This goes against the behaviour we see in society around us, but as psychologists we can and must see through this. We

must remember what we're taught in undergraduate psychology about the power and ubiquity of social learning and heuristic biases such as anchoring, which can serve to keep individuals and society as a whole chained to the status quo rather than responding based on the scientific evidence we see.

We as a society are desperately in need of positive alternatives to the highly material and carbon-intensive way of life that is dominant in Western countries at the beginning of the 21st century. The promising truth, which we can promote as psychologists, is that many of the things that contribute to wellbeing once people are above the poverty line are non-material and depend more on psychosocial and lifestyle factors than wealth or material possessions (Diener & Biswas-Diener, 2002). The discipline of psychology can offer evidence-based solutions to help rapidly transition to a low carbon society over the course of the 21st century – a society grounded in ways of living that serves human wellbeing rather than gross domestic product growth (e.g., Sithey, Thow, & Li, 2015). As psychologists we have a responsibility to research and promote these solutions, in keeping with our code of ethics and the principle of social justice (Code of Ethics Review Group, 2002), and with our own basic wish to minimise harm to future generations.

Evidence-based psychological qualities to assist in the transition to an environmentally sustainable, psychologically flourishing society

Pro-social orientation, gratitude, and play

Positive psychology has identified many qualities to be beneficial in promoting human wellbeing that aren't emphasised in traditional western psychology, or the interventions we are trained in as trainee psychologists.

Pro-social attitudes and behaviours are linked with psychological flourishing (Nelson, Layous, Cole, & Lyubomirsky, 2016; Post, 2005) and positive emotion (Aknin, Broesch, Hamlin, & Van de Vondervoort, 2015): why aren't pro-social attitudes and behaviours a more explicit target for treatment in disorders such as social anxiety and depression, which involve a high degree of focus on self? Regular gratitude practice has been linked with wellbeing, albeit with limited effect sizes (Davis et al., 2016; Wood, Froh, & Geraghty, 2010). Higher levels of self-reported playfulness correlate with lower rates of perceived stress (Magnuson & Barnett, 2013), higher rates of resilience (Chang, Yarnal, & Chick, 2016), and increased creativity (Russ & Wallace, 2012). We need creative solutions to the climate crisis, and promoting play as part of a treatment package offers a way to not only reduce stress but also boost creativity.

TED talks aren't important in themselves as much as what they represent: a wider, internet-enabled shift towards decentralisation of knowledge and expertise and open access to new ideas and solutions

Acceptance and mindfulness

Third wave therapies involving acceptance and mindfulness-based approaches are becoming increasingly popular. This is no doubt fuelled in part by the exponential increase in research on mindfulness, and the growing evidence base of interventions such as ACT (Öst, 2014). We are also witnessing the emergence of second-generation mindfulness-based interventions which include an emphasis on including practices that traditionally accompanied mindfulness, such as the generation of empathy and compassion towards self and others, and the focus on

ethical behaviour as a basis for sustainable wellbeing (e.g., Van Gordon, Shonin, & Griffiths, 2015). The broadened focus on others emphasised in these therapies may help to reverse the decline in empathy that's been observed in the United States over the previous three decades (Konrath, O'Brien, & Hsing, 2011). Preliminary research has shown that psychological states such as happiness and stress tend to spread through social networks. As psychologists we can come to understand these processes in more depth and utilise them to spread positive, pro-social behaviours through these networks in our communities.

Building te taha wairua: Spirituality, meaning, and learning from other wisdom traditions and indigenous cultures

While mindfulness has numerous benefits for dealing with a range of clinical conditions and boosting wellbeing, and need not be practiced as a religious or spiritual practice, some individuals do find spiritual meaning in mindfulness and surrounding practices. It has been theorised that one of the mechanisms through which mindfulness works is by broadening attention, allowing for positive reappraisal and individuals to make useful meaning out of the experiences that they undergo. In this way, mindfulness is theorised to lead to individuals living lives of increased personal meaning (Garland, Farb, Goldin, & Fredrickson, 2015). For some individuals, this may allow for spiritual growth, as is observed in the post-traumatic growth literature (e.g., Roepke, 2013). There is evidence that holding spiritual beliefs is beneficial for wellbeing, especially in the context of connection to nature (Fry, 2000; Kamitsis & Francis, 2013). Spiritual aspects of existence are also seen as central to identity and wellbeing in many indigenous worldviews, including Māori perspectives.

Tying the strands together: An integrated, culturally sensitive and ethically informed science of human psychology

Western psychology stands to learn and benefit greatly from a more nuanced understanding of traditional worldviews from other cultures, whether these stem from Buddhist, Daoist, Native American, African, or Māori or Pacific traditions. Positive psychology is a young science, and much more research needs to be done to integrate and build on the findings of its first fifteen years as a discipline. Schrank et al. (2014) noted that one of the shortcomings and challenges for positive psychology as a field is to present theoretically sound and complex theories that integrate ethics in their explanations of human development and behaviour. Initial findings point to the importance of meaning, spirituality, mindfulness, acceptance, prosocial behaviour and compassion, play and creativity in enhancing human wellbeing. These findings echo the wisdom in

many Eastern and Indigenous traditions, which are usually underpinned by deep and well-integrated bodies of knowledge and thought, and it is hoped that psychology as a science moves towards integrating these worldviews in its development as a science in the 21st century.

We as a society are desperately in need of positive alternatives to the highly material and carbon-intensive way of life that is dominant in Western countries at the beginning of the 21st century.

If current trends in positive psychology and the integration of bicultural and indigenous psychologies continue, psychology as a discipline may develop into an ethically-integrated body of knowledge that helps society move towards more emphasis on non-material values such as playfulness and creativity, social relationships, spirituality and connection to nature. At the recent NZPsS Annual Conference I was struck by Dr Sonja Macfarlane's keynote presentation and how she highlighted the centrality of the land in indigenous identity. Unlike Pakeha, Māori view the land as a vital part of their own identity. Being of Pakeha descent, I resonate with the need to move towards this kind of deep respect for land – the kind of attitude that says that if my local river is polluted, I myself am polluted, but that if my local river is healthy, I and my family and friends are healthy. It is this kind of deep respect and empathy for the environment that we need in order to put a stop to environmental issues such as climate change and on a path to a way of living that leads to the regeneration of our natural environments, rather than damage mitigation.

This is the psychology we need to base our collective worldview on if we are going to truly tackle the overwhelming, urgent and existential crises facing down this generation and each generation to come after us. More of us must come to recognize, deeply, that we as humans don't exist in a vacuum, in isolation from our natural environment (e.g., Abraham, Feather, & Harré, 2016). Happily, there are ways to do this that are much better for our wellbeing than our current way of living. Separation doesn't contribute to our wellbeing, social connection and living lives of meaning and value does.

My hope is that in the 21st century psychologists will work with individuals, organisations and communities to unlock psychological flexibility, social connection and connection with nature, meaningful achievement in valued life areas, and help create positive feedback loops that spread through social networks. Psychologists can help facilitate individuals and society to make the behaviour changes it needs in order to address climate change and other important issues that

we can only make serious progress on through operating collectively. Psychology in Aotearoa New Zealand is well-placed to lead the world in this transition, with the progress that has been achieved in moving towards a truly bicultural psychology thanks to the persistent work of many dedicated individuals and groups.

References

- Abraham, Q., Feather, J., & Harre, N. (2016). "Bigger-than-self" issues: Implications for psychological practice in Aotearoa New Zealand. In W. W. Waitoki, N. R. Robertson, J. S. Feather, & J. J. Rucklidge (Eds.), *Professional Practice of Psychology in Aotearoa New Zealand* (3rd ed., pp. 543–560). Wellington: New Zealand Psychology Society.
- Aknin, L. B., Broesch, T., Hamlin, J. K., & Van de Vondervoort, J. W. (2015). Prosocial behavior leads to happiness in a small-scale rural society. *Journal of Experimental Psychology: General*, 144(4), 788–795. <http://doi.org/10.1037/xge0000082>
- Blackwell, K. L., Trzesniewski, K. H., & Dweck, C. S. (2007). Implicit Theories of Intelligence Predict Achievement Across an Adolescent Transition: A Longitudinal Study and an Intervention in Child. *Child Development*, 78(1), 246–263. <http://doi.org/10.1111/j.1467-8624.2007.00995.x>
- Brown, B. (2006). Shame Resilience Theory: A Grounded Theory Study on Women and Shame. Families in Society: *The Journal of Contemporary Social Services*, 87, 43–52. <http://doi.org/10.1606/1044-3894.3483>
- Chang, P.-J., Yarnal, C., & Chick, G. (2016). The Longitudinal Association Between Playfulness and Resilience in Older Women Engaged in The Red Hat Society. *Journal of Leisure Research*, 48(3), 210–227. <http://doi.org/10.18666/JLR-2016-V48-I3-6256>
- Code of Ethics Review Group. (2002). *Code of Ethics: For psychologists working in Aotearoa/New Zealand*. <http://doi.org/10.1044/policy.ET2010-00309>
- Davis, D. E., Choe, E., Meyers, J., Wade, N., Varjas, K., Gifford, A., ... Worthington, E. L. (2016). Thankful for the little things: A meta-analysis of gratitude interventions. *Journal of Counseling Psychology*, 63(1), 20–31. <http://doi.org/10.1037/cou0000107>
- Diener, E., & Biswas-Diener, R. (2002). Will money increase subjective well-being? *Social Indicators Research*, 57(September 2001), 119–169. <http://doi.org/10.1023/A:1014411319119>
- Fry, P. S. (2000). Religious involvement, spirituality and personal meaning for life: Existential predictors of psychological wellbeing in community-residing and institutional care elders. *Aging and Mental Health*, 4(4), 375–387. <http://doi.org/10.1080/13607860020010547>
- Garland, E. L., Farb, N. A., R. Goldin, P., & Fredrickson, B. L. (2015). Mindfulness Broadens Awareness and Builds Eudaimonic Meaning: A Process Model of Mindful Positive Emotion Regulation. *Psychological Inquiry*, 26(4), 293–314. <http://doi.org/10.1080/1047840X.2015.1064294>
- Kamitsis, I., & Francis, A. J. P. (2013). Spirituality mediates the relationship between engagement with nature and psychological wellbeing. *Journal of Environmental Psychology*, 36, 136–143. <http://doi.org/10.1016/j.jenvp.2013.07.013>
- Konrath, S. H., O'Brien, E. H., & Hsing, C. (2011). Changes in dispositional empathy in American college students over time: a meta-analysis. *Personality and Social Psychology Review*, 15, 180–198. <http://doi.org/10.1177/1088868310377395>
- Lazar, S. W., Kerr, C. E., Wasserman, R. H., Gray, J. R., Douglas, N., Treadway, M. T., ... Dusek, J. A. (2005). Meditation experience is associated with increased cortical thickness. *Neuroreport*, 16(17), 1893–1897.
- Lutz, A., Brefczynski-Lewis, J., Johnstone, T., & Davidson, R. J. (2008). Regulation of the neural circuitry of emotion by compassion meditation: effects of meditative expertise. *PloS One*, 3(3), e1897. <http://doi.org/10.1371/journal.pone.0001897>
- Magnuson, C. D., & Barnett, L. A. (2013). The Playful Advantage: How Playfulness Enhances Coping with Stress. *Leisure Sciences*, 35(2), 129–144. <http://doi.org/10.1080/01490400.2013.761905>
- Neff, K. D., Hsieh, Y.-P., & Dejjattarat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity*, 4(3), 263–287. <http://doi.org/10.1080/1357650044000317>
- Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality*, 41(1), 139–154. <http://doi.org/10.1016/j.jrp.2006.03.004>
- Nelson, S. K., Layous, K., Cole, S. W., & Lyubomirsky, S. (2016). Do Unto Others or Treat Yourself? The Effects of Prosocial and Self-Focused Behavior on Psychological Flourishing. *Emotion*. <http://doi.org/10.1037/emo0000178>
- Öst, L. G. (2014). The efficacy of Acceptance and Commitment Therapy: An updated systematic review and meta-analysis. *Behaviour Research and Therapy*, 61, 105–121. <http://doi.org/10.1016/j.brat.2014.07.018>
- Post, S. G. (2005). Altruism, happiness, and health: It's good to be good. *International Journal of Behavioral Medicine*, 12(2), 66–77. <http://doi.org/10.1207/s15327558ijbm1202>
- Roepke, A. M. (2013). Gains without pains? Growth after positive events. *The Journal of Positive Psychology*, 8(4), 280–291. <http://doi.org/10.1080/17439760.2013.791715>
- Russ, S. W., & Wallace, C. E. (2012). Pretend Play and Creative Processes. *American Journal of Play*, 6(1), 136–148. Retrieved from <http://eric.ed.gov/?id=EJ1016123>
- Scharmer, O. C. (2007). *Theory U: Leading from the future as it emerges*. Cambridge, USA: The Society for Organizational Learning.
- Schrank, B., Brownell, T., Tylee, A., & Slade, M. (2014). Positive Psychology : An Approach to Supporting Recovery in Mental Illness. *East Asian Archives of Psychiatry*, 24, 95–103.
- Sithey, G., Thow, A.-M., & Li, M. (2015). Gross national happiness and health: lessons from Bhutan. *Bulletin of the World Health Organization*, 93(8), 514. <http://doi.org/10.2471/BLT.15.160754>
- TED. (2004). Martin Seligman: The new era of positive psychology. Retrieved from https://www.ted.com/talks/martin_seligman_on_the_state_of_psychology?language=en
- TED. (2012). Vikram Patel: Mental health for all by involving all. Retrieved from https://www.ted.com/talks/vikram_patel_mental_health_for_all_by_involving_all?language=en
- Van Gordon, W., Shonin, E., & Griffiths, M. D. (2015). Towards a second generation of mindfulness-based interventions. *Australian & New Zealand Journal of Psychiatry*, 49(7), 591–592. <http://doi.org/10.1177/0004867415577437>
- Wood, A. M., Froh, J. J., & Geraghty, A. W. a. (2010). Gratitude and well-being: a review and theoretical integration. *Clinical Psychology Review*, 30(7), 890–905. <http://doi.org/10.1016/j.cpr.2010.03.005>

Urban design and flourishing: A psychological opinion on the VillageTown Project

Walter John Hamer



Walter grew up next to a reserve in Ellerslie, what used to be a quiet suburb in Auckland. He went to the local Steiner school up until high school, which, whenever he tells acquaintances this, often results in a comment along the lines of 'that explains a lot'. He usually woke to the school bell, and utilised a most fantastic method of transport, that of two legs, to arrive fashionably late on a reliable basis. He went to Selwyn College for high school, and gave his legs wheels to meet his transport needs. With his bike, and the aid of school traffic, he was reliable competition for some nearby friends that made use of a car for the journey. He continued to make use of his bike when he went to university, choosing almost at random the subject of psychology (with a dash of philosophy), and remaining blissfully unconcerned with urban design and transport issues, even as they pertain to mental health. Sometime during his studies, a friend introduced him to the

VillageTown concept, developed by one Claude Lewenz, who lived on Waiheke no less. After reading up on the book, and the next book, and phoning Claude a couple of times, Auckland, Christchurch, and most of Wellington were forever ruined for him. He became disillusioned with how poorly designed they are, at least from a human perspective (Auckland and Christchurch are quite lovely if you're a car... Wellington just has narrow hills, and everyone suffers). A few years later he fled the city, and re-discovered how lovely cars can be when driven at high speed, without interruption, along scenic country roads. He is currently studying a Master's degree as part of the Counselling Psychology programme at AUT, forcing him to venture into the city on a regular basis.

Abstract

This is an opinion piece on the role that urban design can play in mental health and wellbeing in New Zealand, drawing on the VillageTown model proposed by Claude Lewenz.

Car sized suburban sprawl

Cars are really quite wonderful. They let many people transport a large range of goods and/or a convenient number of people over large distances. Indeed, in a rural environment I have nothing to critique - cars are amazing in that context. In an urban environment, however, there are three unavoidable consequences of cars that are substantially less wonderful.

First, cars take a lot of infrastructure to be of any use. They are also really inconvenient to store. Indeed, I hazard a guess that most people reading this dedicate a larger room to storing their cars than they do to their own bedrooms, or the bedrooms of their children. Anyone that has fallen trap to the rent-seeking monopolies held by inner-city carpark owners will likewise be familiar with the nuisance of dealing with cars after they have served their transporting purposes.

Second, the wonderfulness of cars makes urban planners and developers incredibly lazy. No longer do these people need to consider the wide range of things that humans need in their local environment, because they can rest assured that the bulky infrastructure required for cars will allow

people to drive to everything they need. So, instead of cities built for a comprehensive range of human needs and wants, we get cities made of individual sections for each need and want, spread out in a manner most convenient for cars, but most frustrating for any human without a car. We have a place for sleeping and living, different areas for socialising, separate regions for education, still more separate regions for working, different areas for shopping, other areas for entertainment, and yet more areas for spiritual or religious needs. Taken individually, none of these separations are that significant. However, because each and every aspect of what people need and want from their environment is spread out, this has a knock-on effect of adding a huge amount of travel time to anyone with more than one interest. Ten to twenty minutes for each journey quickly adds up when you need a handful of journeys each day, and Auckland journeys can easily be double that in peak traffic. Furthermore, rather than try and plan better urban environments, the band-aid solution usually touted is to improve public transport. Either way, the city is car-sized (not human-sized), and all travel costs time and money.

Finally, the major drawback of cars is how isolating they are. No longer do people pass people on the street. Instead, people sit in boxes navigating through a maze of other boxes. The boxes dehumanise other travellers to an absurd level - no facial features, no human-shape, nothing resembling a person is left to be perceived. I was

quite amused by the “Drive Social” campaign put out a few years ago, as the concept seems an oxymoron. These boxes compete with each other for space on the road. Because of the car-sized nature of cities, the city itself becomes isolating. Pedestrian traffic is relegated to second-class status, given little better than the gutter to travel in, and last priority at most intersections. Public transport is hardly an improvement - I have yet to see a genuinely pro-social public transport environment anywhere in the world. We live in large boxes, travel from this box to other boxes via small boxes, and encounter other humans only by active intent.

Psycho-social implications

An obvious consideration of the isolating nature of car-based environments is that this isolation is a risk-factor for psychopathology, either contributing to causes or maintaining problems. Because car-based cities make travel always cost, this should, in theory, act as a behavioural barrier to travel. A knock-on effect of this would be to make people selective around which areas of the city to visit. With car-sized cities spreading out the range of human needs and wants, it forces people to choose between these needs and wants, based on their available resources. Anyone with little money or time is discriminated against by a car-sized city.

The isolation also limits access to social networks and social supports. Socialising needs to be actively maintained in a car-sized environment, because people do not encounter their social groups unless they put effort in. Often, this is hardest to do when people need those supports the most, such as during a state of distress or while experiencing psychological problems.

The dehumanising nature of cars,

coupled with the need to compete for road space, should in theory increase anti-social behaviour towards other travellers. Indeed, this is a notable issue, and even has its own name: road rage. Any environment that passively increases levels of hostility in the population that uses it can be considered psychologically detrimental.

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The infrastructure of cars has a very visible impact on how dangerous our local environments are. With risk of children getting run over whenever they go outside, parents must be controlling towards their children. As a result of this environment, children are taught that the outside world is dangerous from a very young age. Without this risk, the dynamic between parent and children can be far more permissive and nurturing - children can be free to explore their local environment.

In a car-sized environment, children develop isolated from adults. Adults disappear from child-rearing environments in order to work, shop, learn, be entertained, and go about the myriad of other activities that make up adult life. As a result, any path to a perceived future within the community is physically obscured from children throughout their development.

I emailed Claude about this piece, and had included a mention of the psychological requirements of driving a car into the major disadvantages of a car-sized city. After all, modern cars require high concentration, high motor coordination, and good reaction time. Psychosis, many types of drug

use (recreational and medicinal), fatigue, anxiety, distractibility, being distracted, impulsivity, thrill-seeking, suicidal inclinations, and anything else that impacts cognitive requirements of driving, are all mental health factors that can significantly increase risk (or prohibit autonomous travel) in car-based transport compared to walking-based transport. A possible positive spin could be that cars are a source of forced mindfulness, but I suspect any benefits of this required vigilance are offset by the stressful nature of car-based commuting. Claude pointed out that this may soon be a thing of the past, with self-driving cars meaning travellers require only time and money to move about. Still, with modern cars, a city-sized environment discriminates against anyone impacted by these psychological issues. Self-driving cars may also reduce our need to attend to long distances and directions, with GPS doing that work for us, though that will only be an issue for anyone that travels these distances without access to GPS or self-driving cars. Once self-driving cars become mainstream, car-sized cities will merely remain isolating, economically discriminatory, and continue to be unsafe for pedestrians, especially children.

Car-sized cities also produce a lot of pollution. As self-driving, quiet electric cars overtake noisy, petrol cars, the chemical and noise pollution of cars will drop off. The quiet nature of electric cars has an unintended consequence of increasing the danger of a car-based environment, as auditory cues for danger are no longer as reliable. Either way, car-based environments can be considered a stressor. Speaking as someone that now lives away from car noise and car smell, the difference is terrific. Living in an area with much less car danger is also great whenever I have children

over – they can just run off and play outside, requiring minimal supervision or permission.

Overall, I suspect car-sized cities have a marked impact on attachment and psycho-social development, which plausibly impact risk factors for later psychopathology. Car-sized cities result in a more hostile environment, and promote early learning of how dangerous the world outside is. This potentially increasing the chances of people developing ideologies more prone to prejudice, such as right-wing authoritarianism and social dominance orientation. Insofar as people that are experiencing psychological problems are often discriminated against, car-sized environments potentially contribute to a world that is more hostile to people experiencing psychological problems. In short, I believe car-sized cities should be considered well within the concern of psychologists.

Alternative models

Claude Lewenz developed the VillageTown model as a theoretically viable alternative to suburban sprawl. It is certainly not the only model, with numerous attempts around the world to build human-based environments. Indeed, as Claude mentioned to me, even malls were developed to improve the social nature of suburbs. As Claude stated in his email, “In regard to the mall-town, it is interesting to note that Jim Rouse invented the shopping mall as a place of social connection for the new development pattern called the suburbs. I knew Jim, indeed his wife Libby was a very strong supporter of my work. Jim later admitted it was a bad idea. At its core, as soon as decisions are made for pecuniary interest rather than being made by the people who will live with the results, the social and psychological outcomes become distorted.”

... I suspect car-sized cities have a marked impact on attachment and psycho-social development, which plausibly impact risk factors for later psychopathology.

The VillageTown, then, is a move away from sprawling urban planning and feudal-capital models of power and control. The idea is to start with a range of economic opportunities, attract a substantial portion of the future inhabitants of the town, and provide a structure for these people to build a town-sized urban area, sized for humans. Rather than moving people to destinations, it moves destinations to people. Most human needs and wants are located within walking distance, with cars excluded from the human area and relegated to long distance travel. We are in the age of information technologies, and they offer greater opportunities for decentralised economic hubs,

which is perfect for this type of environment. Creative control and property rights remain in the hands of the inhabitants, with a view to providing for current and future generations across a range of developmental needs and personal preferences.

The role of psychologists

Padesky's five-part model should suggest environmental factors feature predominantly in psychological work, given how all individual factors are situated within it. The impression I have of mental health work in New Zealand is that instead, systemic environmental factors get put into the too hard basket. Small, practical considerations are certainly doable, but getting down into the nitty-gritty parts is seen as too far outside of the psychologists' job description.

Psychologists are given significant status within New Zealand, potentially enough to sway national and local governing bodies. The VillageTown project offers an opportunity to explore alternatives to suburban sprawl from a clean slate, and as such I believe it is well worth championing. However, existing cities could also benefit from change, though retrofitting is always more difficult than starting fresh. With local body elections coming up, this could be an opportunity for psychologists to start conversations with the newly elected members on how they can make urban environments more human-friendly. Perhaps some may be amenable to championing a VillageTown nearby. Having a tangible alternative to the status quo is a good way of persuading others of the benefits, while also allowing people to explore the implications in more detail.

Conclusion

I hope I've provided a plausible rationale why psychologists should concern themselves with urban design in New Zealand. Urban design may encompass areas of human life outside of the “approved” scope of practicing psychologists. Arguably, it is also unhelpful to exclusively focus on a reductionist view of urban living that only considers the psychological needs of a community. However, I believe this profession has a lot it can offer urban design, and better urban design can make several aspects of psychological work far easier. The conversation of urban design is certainly bigger than this profession, but adding a psychological perspective has the potential to add depth and nuance to the complex issue.

If you would like to read up more on the VillageTown project, their website is: <http://thecompany.ltd/>

If you would like to email me, I am easily accessible via email: walter.hamer@gmail.com

The life of an international student in New Zealand

Sandila Tanveer



Sandila is an international PhD candidate at the University of Canterbury (UoC) from Pakistan. Having extensive experience as a lecturer and career development officer in her home nation, and now as teaching assistant in New Zealand, she hopes to highlight the life of an international PhD student here in New Zealand and touch on the PhD crisis discourse.

Background

I began my PhD journey in 2015 with passion and energy in hopes of obtaining a respectable academic position after graduation. In addition to being a full time student, I am also a full time mother. As such, I feel very lucky to have been awarded a UoC Doctoral Scholarship and credit UoC in making my doctoral dream come true. This lack of financial backing from Canterbury would have otherwise made pursuing a doctorate very difficult. From my understanding, most of the international PhD students are self-funded mature students and have numerous financial responsibilities. This undoubted financial stress has resulted in many of these students struggling to balance study and work, which could raise concerns regarding the quality of

their research work. Moreover, as a result of financial restrictions, most international doctoral students are forced to live in affordable low cost rentals which are often cold, damp, and mouldy, leading to various health concerns, specifically for graduate students who live with their young children. Despite having health cover, these students often don't have enough finances for visits with a general practitioner and mostly rely on over-the-counter medications in the winter days, specifically as health claims could take months. In an effort to alleviate these additional stressors from student life, it would be a great help to international students if universities could provide on-campus family support and accommodation allowing their families to get enrolled at university health centres. This additional support could allow active students to focus more of their time on research and career development.

Presently, in addition to my studies, I also represent international and doctoral students as the representative for psychology doctoral students, student mentor, and student wellbeing advisor. In this capacity, I have observed students at all the stages of their PhDs, from mid PhD crisis to the complete loss of direction after successful completion. The key feature of this crisis discourse is that the universities are producing too many PhDs for the limited academic positions; and often many PhD students lack the various skills that enable them to seek jobs outside of academia (Cuthbert & Molla, 2014).

The PhD Crisis

Presently, international PhD students comprise more than 50% of universities in the United States and

70% in New Zealand, and according to the International Education Factsheet (Ministry of Education, NZ) 50% of these international PhD students stay in New Zealand to work. For those who stay in New Zealand and fail to get a job matching their advanced qualifications, several resort to hiding their doctoral degree on their CV from recruiters so they won't be overlooked or seen as over-qualified. Others enrol in another programme with the anticipation that they will have better job prospects if they switch gears and go in a new direction. For example, one international student from India completed her doctorate in psychology but is now a nurse in Christchurch. Other students report spending nearly 4 years seeking employment in New Zealand before heading home where they typically find a job straightaway. Hence, for some international doctoral graduates, the decision to stay in New Zealand means having to let go of the doctoral dream of prestige and obtaining an affluent position.

It concerns me as an international PhD candidate that doctoral programmes do not address the demands posed by a challenging job market and that most job-ready programmes offered by universities are designed for undergraduates. While discussing the lack of job readiness of PhD students with fellow colleagues, one academic replied that this is a part of ongoing international debate. Moreover, the same academic added that it's a part of the 'internationalisation' of New Zealand tertiary education. The revenue generated from international students and the 'Export Education' programme is making a hugely positive economic impact on the

nation's gross domestic product (GDP). In this instance, the design of targeted job readiness programmes should be prioritised for doctoral students in order for them to more effectively use their qualification, and further contribute to the development of New Zealand's society. This would arguably not only create a positive impact on the reputation and demand of New Zealand doctorates globally, but if addressed properly, could also benefit the internationalisation of New Zealand tertiary education. However, consideration also needs to be given to the doctoral students who return to their home country to develop professionally. For several of these students, new challenges emerge in terms of global competition, with many finding themselves undertrained and underqualified for positions they've trained for several years.

...as a result of financial restrictions, most international doctoral students are forced to live in affordable low cost rentals which are often cold, damp, and mouldy, leading to various health concerns, specifically for graduate students who live with their young children.

In light of this, I wish to make some recommendations in order to improve the international students' doctoral experience, the job-readiness of PhD students, and increase the number of international PhD students obtaining relevant jobs post-qualification. First, department(s) should review the standards for prospective students who wish to enrol in a PhD. These standards can include relevant qualification/s, research experience, and/or work experience. Further, I strongly believe that an enrolment interview or assessment be conducted to evaluate whether the prospective doctoral student has the personal and academic attributes required for this challenging yet desirable pursuit. Based on those preliminary assessments, an individual needs-based doctoral readiness programme could be designed so that international students have a productive start to their doctorate. This would not only save a lot of time on the part of the student, but would also greatly enhance the overall quality of research produced and overall rank of New Zealand universities globally. I have witnessed countless students enrolled in the PhD programme who are not emotionally or psychologically ready to take on the challenging road of the PhD process. Often, it is in fact these students with whom I empathise, recognizing the various ways they experience difficulties and struggle with completing a doctorate that they lose interest in for the sake of obtaining the credential, or other more complicated reasons, such as immigration interests.

Secondly, it should be mandatory for PhD students to

undertake 'Thesis Student Workshops' and 'Academic Skills Centre' courses during the first six months of their research proposal and at least one research methodology course during their PhD. This course work would give PhD students an academic edge in the job market in the long-run, help them adapt to the academic standards of New Zealand more systematically, and also greatly help reduce the mid-PhD crisis by engaging in activities outside the office space. Further, psychology departments and New Zealand universities have a range of helpful resources to facilitate learning and research; however, there's a strong need to review the frequency and use of these facilities, and how to increase accessibility and/or usage of such facilities among those whom it would immensely benefit.

Finally, PhD success is widely attributed to incremental success and peer support. In this respect, fostering a more supportive community in and out of academia would greatly benefit the overall morale of the doctoral student community.

References

- Cuthbert, D. & Molla, T. (2015). PhD crisis discourse: a critical approach to the framing of the problem and some Australian solutions. *Higher Education*, 69(1), 33-53.
- International Education Fact Sheet – Outcomes for International Tertiary Students (Online document). Ministry of Education, New Zealand. Retrieved from <https://www.educationcounts.govt.nz/statistics/international-education/international-students-in-new-zealand>

Academic outcomes of children born to mothers maintained

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Samantha is a PhD candidate at the University of Canterbury. She has been a member of the Canterbury Child Development Research Group since 2011, when she enrolled in a Master of Arts degree under the supervision of Professor Lianne Woodward who was then lead investigator of the Methadone in Pregnancy (MIP) study. Samantha is now undertaking her PhD research under the supervision of Dr Jacki Henderson, the primary investigator of the 9.5 year MIP study follow-up. Samantha was awarded a New Zealand Lottery Health Research PhD Scholarship to study the 9.5 year educational outcomes of the MIP study children. At the New Zealand Psychological Society Conference held at Massey University in Wellington in September, Samantha was the joint winner of the Best Student Conference Paper prize for 2016 for the presentation of her preliminary PhD findings.

An Overview of Opioid Dependence in Pregnancy

Opioid misuse is an increasing global health concern. Rates of opioid dependence are reportedly between 0.5% to 1% in New Zealand and worldwide, including dependence on natural opiates such as heroin, and prescribed synthetic opioids such as methadone and oxycodone (Adamson et al., 2012; United Nations Office on Drugs and Crime, 2016; Wilkins, Prasad, Wong, & Rychert, 2013). Among pregnant women, the prevalence is estimated at 1% to 2% (Minozzi, Amato, Bellisario, Ferri, & Davoli, 2013). Illicit opioid dependence during pregnancy is associated with an increase in health and social harms for both the mother and infant. These include increased maternal risk of contracting HIV or hepatitis, risk of overdose, and increased engagement in illegal activities to obtain the substances or the money to buy them (Bruneau, Roy, Arruda, Zang, & Jutras-Aswad, 2012; Deering, Sellman, & Adamson, 2014; Wilkins et al., 2013). Obstetric risks associated with opioid dependence include placental abruption, miscarriage, stillbirth and preterm birth (Maeda, Bateman,

Clancy, Creanga, & Leffert, 2014).

In New Zealand, methadone maintenance therapy (MMT) is considered a “gold-standard” treatment for opioid dependence in pregnancy (Ministry of Health, 2014). Enrolment in MMT involves a comprehensive assessment of individual treatment needs, access to specialised antenatal care, and a daily therapeutic dose of the prescribed opioid substitute methadone (Farid, Dunlop, Tait, & Hulse, 2008; Ministry of Health, 2014). The treatment is associated with a reduction in illicit opioid use, and therefore a reduction in the risks of infection, maternal death, and involvement in criminal activity. In addition, the relatively long-lasting action of methadone prevents fluctuations in maternal and foetal opioid intoxication and withdrawal, and reduces the risk of preterm birth (Chan & Moriarty, 2010; Kandall, Doberczak, Jantunen, & Stein, 1999; Wilson, Desmond, & Wait, 1981). Despite these clear benefits of MMT over continued illicit opioid use in pregnancy, concerns remain about the longer term neurodevelopmental consequences of prenatal methadone exposure for the infant.

Foetal and Child Outcomes of Prenatal Methadone Exposure

Methadone readily crosses the placenta and as a result can directly impact the developing foetus (Nekhayeva et al., 2005; Woudes, Roberts, Pryor, Bagnall, & Gunn, 2004). Evidence from human and animal studies suggests prenatal methadone is associated with altered neuronal migration and myelination, with potential impacts for later neurodevelopment (Farid et al., 2008; Walhovd, Watts, Amlen, & Woodward, 2012). Methadone exposure may also indirectly impact development by restricting foetal growth, as evident in studies finding that methadone-exposed (ME) infants are born lighter, shorter, and with a smaller than average head circumference for their gestational age (Farid et al., 2008; Woudes & Woodward, 2010). Infants born to mothers enrolled in MMT during pregnancy are also at increased risk of experiencing neonatal abstinence syndrome (NAS); a withdrawal syndrome characterised by central nervous system irritability, autonomic dysregulation and gastrointestinal distress (Maguire et al., 2016).

In addition to these effects of prenatal

on methadone during pregnancy

methadone exposure on child development, there is added risk for many of these children that they will be raised in a high-risk caregiving environment which may further exacerbate their early developmental vulnerability. Methadone-exposed children have therefore been described as a group at “dual-hazard” risk for adverse later child development (Lester & Tronick, 1994). That is, children born to mothers maintained on methadone during pregnancy show impaired growth and are more dysregulated during the neonatal period. These infants are then more often than not raised in family situations characterised by social disadvantage and environmental risk that do little to scaffold and support their needs (Dawe, Harnett, Rendalls, & Staiger, 2003; Hans & Jeremy, 2001; Hogan, 2007). Mothers enrolled in MMT during pregnancy are commonly characterised by low socioeconomic status (SES), low educational attainment, single parenthood, and psychological comorbidity (Davie-Gray, Moor, Spencer, & Woodward, 2013). Methadone-exposed children are also more likely than non-exposed children to experience multiple out-of-home care placements, and therefore several changes in primary caregiver (Lean, Pritchard, & Woodward, 2013). Additional factors, such as prenatal poly-drug-exposure and of course genetics are also associated with the postnatal neurodevelopmental outcome of children born to opioid-dependent mothers, adding to the complex interplay of potential direct and indirect risks to ME children’s development (Bunikowski et al., 1998; Ornoy, Segal, Bar-Hamburger, & Greenbaum, 2001).

Obstetric risks associated with opioid dependence include placental abruption, miscarriage, stillbirth and preterm birth.

Collective findings from existing longitudinal studies indicate that infants and preschool children born to mothers enrolled in MMT in pregnancy are at increased risk for a range of adverse outcomes across a number of developmental domains compared to non-methadone exposed children. Methadone-exposed infants and preschoolers have lower average psychomotor development than non-exposed children (Hans, 1989; Hunt, Tzioumi, Collins, & Jeffery, 2008; Johnson, Diano, & Rosen, 1984; Melinder, Konijnenberg, & Sarfi, 2013), and have more social-emotional and behavioural adjustment problems (Baar & Graaff, 1994; Hunt et al., 2008; Sarfi, Sundet, & Waal, 2013). Performance on specific cognitive tasks measuring language, attention and other executive function skills are also lower for ME children (Baar, 1990; Hunt et al., 2008; Konijnenberg & Melinder, 2014; Melinder et al.,

2013), however their general cognitive performance, e.g. IQ, is typically within the normal range on standardised tests (Hans & Jeremy, 2001; Hunt et al., 2008; McGlone & Mactier, 2015). In some studies, socio-environmental risk factors were related to child cognitive and behavioural outcomes over and above prenatal methadone exposure (Hans & Jeremy, 2001; Konijnenberg & Melinder, 2014; Sarfi et al., 2013). However further research with larger, more representative samples is needed to identify the extent of these relationships.

What is also currently lacking in the literature is a longitudinal investigation of ME children’s development to middle childhood. In particular, an examination of their functioning in key domains of educational achievement such as reading and mathematics is essential, because these are important foundational skills for long-term academic and social success. The current study aimed to address this gap by assessing the educational outcomes of a group of children born to mothers enrolled in MMT during pregnancy, and a regionally representative comparison group at age 9.5 years.

The Canterbury Methadone in Pregnancy Study

The Canterbury Methadone in Pregnancy (MIP) Study, University of Canterbury, is a prospective, longitudinal study of the neurodevelopmental outcomes of a regional cohort of children born to opioid-dependent women enrolled in MMT during pregnancy from 2003 – 2008 in Canterbury. Mothers in MMT were recruited through Christchurch Women’s Hospital and the Christchurch Methadone Programme during their third pregnancy trimester or at birth. Excluding 5 stillbirths, 100 mother-infant dyads were successfully recruited to the methadone group at term (recruitment rate: 84%). A comparison group of pregnant, non-opioid dependent mothers with delivery dates matching those of the women in MMT was also successfully recruited from the same hospital (110 mother-infant dyads, recruitment rate: 64%).

The project was designed as a multidisciplinary study, drawing on expertise from researchers and health professionals led by the middle author. All study children were assessed at birth, were visited in their homes at 18 months, and attended developmental assessments at the Child Development Centre at the University of Canterbury at 2, 4.5 and most recently, at age 9.5 years. At each follow-up assessment parents/caregivers were interviewed by trained researchers, and child neurodevelopmental testing was conducted by a team of postgraduate level staff and students supervised by a registered clinical psychologist. Additionally, health data was collected over the perinatal

period, and teacher reports of school progress and achievement were collected at 9.5 years. Informed consent was obtained from all mothers/primary caregivers.

Term Evaluation

A comprehensive maternal lifestyle interview was conducted at term. Mothers were interviewed on their socio-familial background and maternal behavioural health (psychological well-being and drug use during pregnancy). At birth, infant clinical data were collected and included: foetal growth restriction assessed by measuring birth weight, length and head circumference, and NAS treatment information such as duration of NAS symptoms and morphine treatment dose.

Evidence from human and animal studies suggests prenatal methadone is associated with altered neuronal migration and myelination, with potential impacts for later neurodevelopment.

Toddler Evaluation

When the children were 18 months old, a researcher visited the children and their primary caregivers in their homes. The quality of the home environment was assessed by observing the nature and variety of activities available to the child in their home, and through observing parent-child interactions. Primary caregivers completed a social background interview, and answered questions regarding their psychological well-being, current drug use, and about aspects of parenting. They also provided information on any child caregiver changes.

At age 2 years, children completed a neurodevelopmental assessment that included standardised tests measuring infant psychomotor, cognitive

and behavioural development and non-verbal communication skills. Problem solving skills and inhibitory control were also assessed using non-standardised measures. Primary caregivers completed questionnaires regarding the child's social-emotional and behavioural adjustment, early executive functioning behaviour, and physical health.

Preschool Evaluation

At age 4.5 years, children completed another multidisciplinary neurodevelopmental assessment involving standardised tests measuring IQ, visual-motor co-ordination, language development, and early learning-based skills. Non-standardised tests of problem-solving and inhibitory control were also administered. Caregivers once again provided information regarding their social-background and family circumstances, their own psychological well-being and drug-use, and child physical and mental health.

The Current 9.5 Year Follow-Up Study

The Canterbury MIP study is currently undertaking the 9.5-year follow-up assessments under the direction of the senior author. The study has maintained good retention rates, with 89% of the methadone group and 95% of the comparison group seen at age 4.5 years. Reasons for attrition in the ME group were sudden unexpected death in infancy (SUDI; n=4), and seven families withdrew from the study. Three comparison children withdrew their participation and two moved overseas. Data from the 9.5-year developmental assessments have been collected for 62 ME and 72 comparison children to date, representing around 72% of all study children eligible to participate in this follow-up wave to 2018.

The current sample size and 9.5-

year longitudinal retention rates make the Canterbury MIP study the largest systematic longitudinal study of children born to mothers treated with methadone during pregnancy worldwide. The success of this study over the years would not have been possible without funding support from the Neurological Foundation of New Zealand, The New Zealand Lotteries Board, Cure Kids, and the Wayne Francis Trust. A Health Research Council (HRC, NZ) emerging researcher award is currently funding the 9.5-year follow-up, and I received a Lotteries Health Research PhD Scholarship. The current follow-up involves conducting comprehensive middle childhood clinical developmental assessments measuring cognitive development, language development, educational achievement, and psychological functioning. The primary caregivers are being interviewed about family circumstances, caregiver well-being and child health and well-being. In addition, study children's teachers are being contacted to complete school performance and behaviour questionnaires.

Preliminary 9.5 Year Academic Achievement Findings

The general aim of my PhD research was to assess the academic achievement of ME and comparison children at age 9.5 years. The Woodcock-Johnson III Tests of Achievement (WJ-III) (Woodcock, McGrew, & Mather, 2001) were used to assess reading and mathematics achievement, and teacher reports of reading and mathematics achievement in the classroom were collected.

Clear trends have emerged from the data collected for the 62 ME and 72 comparison children to date. The results show that children born to mothers enrolled in MMT during

pregnancy are at significantly elevated risk for educational delay in reading and mathematics compared to their non-exposed peers. Significant between-group differences were found on all WJ-III reading and mathematics subtests, with 57% of ME compared to 13% of comparison children showing delay in at least one educational domain on this measure. Additionally, a significantly higher proportion of ME than comparison children were reported as performing below the National Standard in reading (55% vs. 17%) and mathematics (61% vs. 18%) at school. These findings emphasise the importance of early childhood and school-based support for these high-risk children and their families.

The results show that children born to mothers enrolled in MMT during pregnancy are at significantly elevated risk for educational delay in reading and mathematics compared to their non-exposed peers.

To better understand why there are such high rates of educational delay for ME children, ongoing analyses are examining the specific mechanisms, both biological and social, that place these children at longer-term risk. Therefore, the next step for this PhD research will be to assess the extent to which reading and mathematics delay are related to prenatal methadone exposure and/or to confounding variables associated with maternal methadone maintenance during pregnancy. Variables to consider include other prenatal drug exposures, maternal social background factors such as low SES and maternal education level, and infant clinical risk. Future research should also aim to identify potential environmental intervening variables such as the quality of the home environment, and postnatal caregiver psychosocial well-being that could impact children's later educational outcomes beyond confounding influences present in the neonatal period. Identifying potential malleable risk factors to target in intervention will assist health and education professionals in supporting families affected by opioid dependence with the development of academic skills and therefore better educational outcomes for their children.

References

- Adamson, S. J., Deering, D. E., Sellman, J. D., Sheridan, J., Henderson, C., Robertson, R., . . . Frampton, C. M. (2012). An estimation of the prevalence of opioid dependence in New Zealand. *The International Journal on Drug Policy*, 23(1), 87-89.
- Baar, A. (1990). Development of infants of drug dependent mothers. *Journal of Child Psychology and Psychiatry*, 31(6), 911-920.
- Baar, A., & Graaff, B. M. (1994). Cognitive development at preschool-age of infants of drug-dependent mothers. *Developmental Medicine & Child Neurology*, 36(12), 1063-1075.

- Bruneau, J., Roy, É., Arruda, N., Zang, G., & Jutras-Aswad, D. (2012). The rising prevalence of prescription opioid injection and its association with hepatitis C incidence among street-drug users. *Addiction*, 107(7), 1318-1327.
- Bunikowski, R., Grimmer, I., Heiser, A., Metze, B., Schafer, A., & Obladen, M. (1998). Neurodevelopmental outcome after prenatal exposure to opiates. *European Journal of Pediatrics*, 157(9), 724-730.
- Chan, C., & Moriarty, H. (2010). A special type of 'hard-to-reach' patient: experiences of pregnant women on methadone. *Journal of Primary Health Care*, 2(1), 61-69.
- Davie-Gray, A., Moor, S., Spencer, C., & Woodward, L. J. (2013). Psychosocial characteristics and poly-drug use of pregnant women enrolled in methadone maintenance treatment. *Neurotoxicology and Teratology*, 38, 46-52. doi: 10.1016/j.ntt.2013.04.006
- Dawe, S., Harnett, P. H., Rendalls, V., & Staiger, P. (2003). Improving family functioning and child outcome in methadone maintained families: the Parents Under Pressure programme. *Drug and Alcohol Review*, 22(3), 299-307.
- Deering, D., Sellman, J. D., & Adamson, S. (2014). Opioid substitution treatment in New Zealand: a 40 year perspective. *The New Zealand Medical Journal*, 127(1397), 57-66.
- Farid, W., Dunlop, S., Tait, R., & Hulse, G. (2008). The effects of maternally administered methadone, buprenorphine and naltrexone on offspring: review of human and animal data. *Current Neuropharmacology*, 6(2), 125-150.
- Hans, S. L. (1989). Developmental consequences of prenatal exposure to methadone. *Annals of the New York Academy of Sciences*, 562, 195-207.
- Hans, S. L., & Jeremy, R. J. (2001). Postneonatal mental and motor development of infants exposed in utero to opioid drugs. *Infant Mental Health Journal*, 22(3), 300-315.
- Hogan, D. M. (2007). The impact of opiate dependence on parenting processes: Contextual, physiological and psychological factors. *Addiction Research & Theory*, 15(6), 617-635.
- Hunt, R. W., Tzioumi, D., Collins, E., & Jeffery, H. E. (2008). Adverse neurodevelopmental outcome of infants exposed to opiate in-utero. *Early Human Development*, 84(1), 29-35.
- Johnson, H. L., Diano, A., & Rosen, T. S. (1984). 24-Month neurobehavioural follow-up of children of methadone-maintained mothers. *Infant Behaviour and Development*, 7, 115-123.
- Kandall, S. R., Doberczak, T. M., Jantunen, M., & Stein, J. (1999). The methadone-maintained pregnancy. *Clinics in Perinatology*, 26(1), 173-183.
- Konijnenberg, C., & Melinder, A. (2014). Executive function in preschool children prenatally exposed to methadone or buprenorphine. *Child Neuropsychology*, 21(5), 570-585. doi: 10.1080/09297049.2014.967201
- Lean, R. E., Pritchard, V. E., & Woodward, L. J. (2013). Child protection and out-of-home placement experiences of preschool children born to mothers enrolled in methadone maintenance treatment during pregnancy. *Children and Youth Services Review*, 35(11), 1878-1885.
- Lester, B. M., & Tronick, E. Z. (1994). The effects of prenatal cocaine exposure and child outcome: Lessons from the past. *Infant Mental Health Journal*, 15, 107-120.
- Maeda, A., Bateman, B. T., Clancy, C. R., Creanga, A. A., & Leffert, L. R. (2014). Opioid abuse and dependence during pregnancy. Temporal trends and obstetrical outcomes. *Anesthesiology*, 121(6), 1158-1165.
- Maguire, D. J., Taylor, S., Armstrong, K., Shaffer-Hudkins, E., Germain, A. M., Brooks, S. S., . . . Clark, L. (2016). Long-term outcomes of infants with neonatal abstinence syndrome. *Neonatal Network*, 35(5), 277-286. doi: 10.1891/0730-0832.35.5.277
- McGlone, L., & Mactier, H. (2015). Infants of opioid-dependent mothers: neurodevelopment at six months. *Early Human Development*, 91(1), 19-21.
- Melinder, A., Konijnenberg, C., & Sarfi, M. (2013). Deviant smooth pursuit in preschool children exposed prenatally to methadone or buprenorphine and tobacco affects integrative visuomotor capabilities. *Addiction*, 108(12), 2175-2182.
- Ministry of Health, N. Z. (2014). New Zealand Practice Guidelines for Opiate Substitution Treatment. Wellington: Ministry of Health.
- Minozzi, S., Amato, L., Bellisario, C., Ferri, M., & Davoli, M. (2013). Maintenance agonist treatments for opiate-dependent pregnant women. *The Cochrane Library*. doi: 10.1002/14651858.CD006318.pub3
- Nekhayeva, I. A., Nanovskaya, T. N., Deshmukh, S. V., Zharikova, O. L.,

Hankins, G. D., & Ahmed, M. S. (2005). Bidirectional transfer of methadone across human placenta. *Biochemical Pharmacology*, 69(1), 187-197.

Ornoy, A., Segal, J., Bar-Hamburger, R., & Greenbaum, C. (2001). Developmental outcome of school-age children born to mothers with heroin dependency: importance of environmental factors. *Developmental Medicine and Child Neurology*, 43(10), 668-675.

Sarfi, M., Sundet, J. M., & Waal, H. (2013). Maternal stress and behavioral adaptation in methadone- or buprenorphine-exposed toddlers. *Infant Behavior and Development*, 36(4), 707-716. doi: 10.1016/j.infbeh.2013.08.006

United Nations Office on Drugs and Crime. (2016). *World Drug Report*. Vienna: United Nations Publication, Sales No. E.16.XI.7.

Walhovd, K. B., Watts, R., Amlien, I., & Woodward, L. J. (2012). Neural tract development of infants born to methadone-maintained mothers. *Pediatr Neurol*, 47(1), 1-6. doi: 10.1016/j.pediatrneurol.2012.04.008

Wilkins, C., Prasad, J., Wong, K., & Rychert, M. (2013). *Recent trends in illegal drug use in New Zealand 2006-2013: Findings from the 2006, 2007, 2008, 2009, 2010, 2011, 2012 and 2013 Illicit Drug Monitoring System (IDMS)*. Auckland: SHORE and Whariki Research Centre.

Wilson, G. S., Desmond, M. M., & Wait, R. B. (1981). Follow-up of methadone-treated and untreated narcotic-dependent women and their infants: health, developmental, and social implications. *The Journal of Pediatrics*, 98(5), 716-722.

Woodcock, R., McGrew, K., & Mather, N. (2001). *Woodcock-Johnson-III Tests of Achievement*. Itasca, IL: Riverside.

Wouldes, T. A., Roberts, A. B., Pryor, J. E., Bagnall, C., & Gunn, T. R. (2004). The effect of methadone treatment on the quantity and quality of human fetal movement. *Neurotoxicology and Teratology*, 26(1), 23-34. doi: 10.1016/j.ntt.2003.09.003

Wouldes, T. A., & Woodward, L. J. (2010). Maternal methadone dose during pregnancy and infant clinical outcome. *Neurotoxicology and Teratology*, 32(3), 406-413. doi: 10.1016/j.ntt.2010.01.007

The international nature of psychology

Anna Kurek and Ariana Krynen



Anna Kurek

Anna completed her bachelor's degree in Canada, her Masters of Science in the UK, and is currently studying towards her PhD at the Victoria University of Wellington in clinical and developmental psychology. Anna's PhD research is centered on adolescent development in relation to the way today's youth use and interact with technology. Investigating the links between the Dark Triad and technology use, her research is also interested in the impacts of technology on the development of self-concept and identity formation in adolescence. She has previously completed clinical training and supervision working with adolescents and families. She hopes to continue clinical training after the completion of her doctorate. Anna is involved in various research projects and is passionate about building international awareness about mental health. She is actively involved in Psych-Uncensored, a project aimed to provide the public with a safe, but public space, to share the unique realities of living with, and overcoming, existing mental health stigma.



Ariana Krynen

Ariana is in her final year of the Doctor of Clinical Psychology programme at the University of Auckland. She is currently completing her clinical internship with the Auckland Regional Youth Forensic Service. Ariana grew up in Lower Hutt and completed her undergraduate degree in psychology at the University of Otago. During her studies, Ariana has been involved in various research projects in the area of child and adolescent mental health and offending behaviour. She has previous work experience in a residential care setting with adolescents experiencing mental health difficulties, and providing in-home support for children and adolescents with autism spectrum disorder. Ariana has an interest in evidence-based practice and how to enhance service delivery to achieve best outcomes for service users. Her doctoral research aims to understand the therapeutic and educational needs of stepfamilies in New Zealand and the support services currently provided to these families.

Modern psychology has expanded beyond Wundt's first lab in Leipzig, Freud's beautiful Vienna, and Pavlov's dogs in Russia. Today, the field has reputable schools of psychology in almost every corner of the world. The discipline is also host to numerous international conferences aimed at uniting scholars, academics, and practitioners to share new ideas, research, and novel perspectives and approaches most relevant to the growth of psychology in today's vibrant global environment. The existence of this global community is integral to maintaining an international presence and fostering a dynamic and diverse discipline. The same discipline works diligently to understand and help mitigate issues and phenomena faced globally in relation to mental health, social and cultural psychology, neuropsychology, criminology, and many other fields of psychology. Psychology's international proliferation is equally important in stimulating interest in STEM fields amongst students whose interests and priorities are expanding from traditional ideals to more modern approaches to studying and lifestyle. Flexibility, creativity, and freedom are all growing priorities for today's generation of students, and research shows a growing number of students are opting to combine travel with their educational development.

New Zealand is no stranger to the phenomenon of international students, with the most recent census on international student migration boasting a 12% annual increase since 2014 (International Consultants for Education and Fairs Monitor, 2015). Similar trends are evident in other countries around the globe. For instance, the United Kingdom (UK) is rated as the number one international student destination, and from 2014 to 2015 welcomed more than 435,000

international students (UK Council for International Student Affairs, 2016). Canada reported over 300,000 new international students in 2015, a number that is constantly growing (Canada Immigration Newsletter, 2016). Similarly, in 2015 Australia witnessed the highest number of international student enrolments in the last 22 years (Department of Education and Training, 2016). The large number of those studying abroad has important implications for academic institutions and their programme structures. However, limited research has been undertaken to help understand the implications for students and institutions, both positive and negative, of the increased number of international students in tertiary education (Ward, 2001).

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While research has argued that international students bring an important international perspective to course discussion and challenge instructors to consider new methods or approaches to theoretical and practical training, very few tertiary institutions have made the necessary changes in either the process, or administration of their programmes to match international standards (Ward, 2001). In the span of the last 15 years, the growing international nature of tertiary education continues to be discussed, but still, few changes have emerged (MacGregor, 2014). The Council for Higher Education Accreditation's International Quality Group (CIQG) continues to debate the growing need for developing international and global standards, arguing that the explosion of

transnational higher education and the rise of international students mean an inevitable converging diversity in an increasingly integrated world (MacGregor, 2014). The CIQG has begun to recognise that institutional rankings are becoming an intermediary for quality that do not incorporate the needs of today's student body and graduating young scholars.

A pressing consideration is also given to international discrepancies in programme and grade equivalency conducted locally and around the world. Most international grade equivalency or accreditation agencies use the American tertiary education system as the gold standard for comparison; however, others do not use this guideline, resulting in increasing confusion for students. For example, grades falling in the 60s range in the UK are considered to be A-level, whereas the same grade in New Zealand is viewed as a C-level ranking. Speaking with several international students, trying to understand how to navigate these discrepancies is a common source of frustration. While universities claim to have institutional equivalency formulas, often inconsistencies arise between academic establishments and the standards set by international or government agencies responsible for managing cross-national standards, which differ from one nation to another. This national and international dissonance can be the deciding factor in whether one obtains local grants or scholarships for study. As such, with the strong weighting of grades in the academic environment, grade equivalencies between countries should be a point of cautious consideration for students planning to study abroad, or returning home further training.

This has only touched on the complexity and significance of

transferable credentials, grade equivalency, and international training standards for students.

Comparing and Contrasting the Graduate Experience

Determining how psychology training and qualifications compare across institutions, both nationally and internationally, should also be of increasing importance to the postgraduate student. At present however, information to help establish this appears to be scattered and minimal. Existing institutional rankings do not reflect differences in qualification programme structures, course work requirements, or placement and field work experience. Furthermore, the creation of an international regulatory body showcasing such information for existing or prospective internationally-minded students does not yet exist nor is there any indication that such a forum will exist in the near future. Whilst we recognise that examining such differences between international institutions is a significant undertaking, we believe that with the changing global environment there is a pressing need for this to be developed. Moreover, similar topics have been discussed by members from 30 countries who participate in the CIQG advisory council (MacGregor, 2014).

A brief review of the psychology qualifications provided by a number of leading universities across the United States (US), Canada, UK, Australia and New Zealand, illuminate the existing distinctions between training, qualification streams and programme structures currently offered. For example, while Canada, the US, and Australia must complete a four-year undergraduate degree to hold a Bachelor's, the UK and New Zealand require three-years of study and offer an optional fourth year honours or

postgraduate diploma. In North America, prior to a PhD, students must transition into a Master's programme typically after sitting standardised tests, such as the GRE or GMAT, in order to be considered. These Master's programmes require additional course work in a chosen field of interest in psychology, followed by a dissertation component. Alternatively, after one year of Master's studies, students can opt to transition into a PhD where they continue to complete course work and advanced research and thesis writing. In contrast, in the UK and New Zealand, a student can transition directly into a doctoral programme following their fourth year honours, skipping the Master's altogether. For students in New Zealand undertaking a Master's, there are no course work requirements and the degree is heavily weighted towards research and composing a dissertation. This results in varied programme credit weighting between institutions, leading to varied views on accreditation of one international programme against another. Moreover, internationally it is quite rare to not undertake further coursework at the doctoral level in almost any area of psychology; while in New Zealand, there is no course work requirement unless you are in a professional psychology training programme, such as clinical or counselling psychology.

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What has been discussed here merely highlights the differences between some qualifications and programme structures in New Zealand and overseas, and does not include other

professional programmes that should also be considered. Further, for professional psychology programmes, this has not highlighted the various therapeutic models taught or offered by different programmes or interest streams. It does, however, illustrate the need for such comparisons to exist for current students, trainees, and psychology professionals.

What does this mean for graduates?

These subtle differences have significant implications on career opportunities for those who obtain qualifications in New Zealand and want to work overseas as either an academic or a practising psychologist. Under the Commonwealth Trans-Tasman Mutual Recognition Act 1997, an individual registered as a psychologist in New Zealand can apply for registration as a psychologist in Australia. However, registration in other countries proves more difficult. New Zealanders interested in working in the US or Canada must first demonstrate that their education, degree and experience are equivalent to the requirements of a jurisdiction. An applicant must then pass the Examination of Professional Practice in Psychology (EPPP), and in most jurisdictions, an examination that covers local mental health laws and rules (Association of State and Provincial Psychology Board, 2016). While this is the standard process for students in the US and Canada, it is uncertain whether programmes in New Zealand meet the equivalence requirements needed, or if the education provided is comparable to help pass the EPPP assessment. In contrast, those trained in the US or Canada have a much easier time transferring their credentials, training, and expertise to other countries, including New Zealand, Australia, and European nations, despite their licensures being determined by the

state or province, rather than the country itself.

Moreover, in some provinces in Canada, a Master's is sufficient to practice clinical psychology without having specifically gained a clinical Master's. Rather, a student is encouraged to secure supervision in an area of psychological counseling that interests them, and obtain the required number of hours of professional supervision before registering with the local certification board. These hours of supervised practice can vary from province to province, and in some cases can be restricted by the Canadian Psychological Association (CPA) or American Psychological Association (APA) by a list of accredited supervisory programmes. Additionally, for those training and studying abroad, programme quality, accreditation, and international recognition is also of utmost importance as some psychology positions in North America require that your credentials be recognised by either the APA or CPA accrediting body. So while you may have studied at the best university with the highest national rankings, this same programme may not be recognised as such internationally.

Where do we go from here?

In a world that is becoming more fluid in terms of global connectivity and opportunity, the future of our discipline and the work we do may become increasingly dependent upon the future ability of academic institutions to better equip their students for an internationally versatile career. At present, the various differences in academic rankings, programme structures, and training requirements across institutions suggest an important need to investigate the new pressures of globalisation on academia. Consideration needs to be given to the needs of the student body at each level of tertiary education for training not only with a national mindset but also with an international approach, especially in terms of career planning and development.

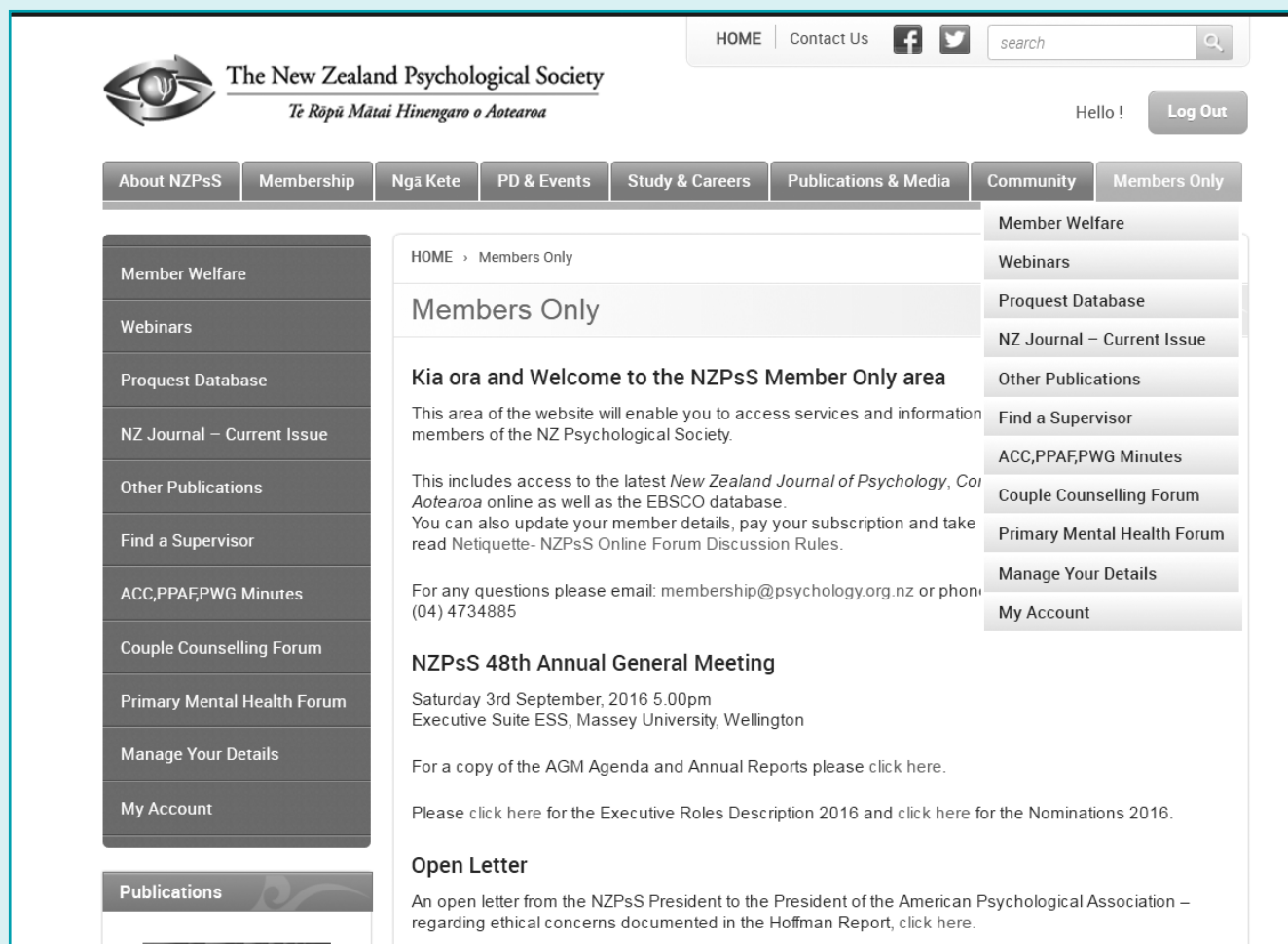
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It is increasingly difficult to ignore the flourish of students investing time and money into international scholastics and international career development. Institutions should be working to stay ahead of student needs by implementing career development workshops, mentorship initiatives for students interested in going into academia versus field work, while also striving to be transparent with their students about programme limitations for those interested

in a career abroad. If you are wanting to move and work as a psychologist overseas, contact the local regulatory board and ensure that you are gaining the experience that will allow you the best possible chance of moving abroad without requiring significant amounts of re-training. And as students, let's continue this conversation and raise these issues where possible.

Do you know what's on the Members' only pages of our website?

<http://www.psychology.org.nz/members-only>



The screenshot shows the 'Members Only' section of the New Zealand Psychological Society (NZPsS) website. At the top, there is a navigation bar with links for HOME, Contact Us, and social media icons for Facebook and Twitter. A search bar is also present. Below this is a secondary navigation bar with tabs for About NZPsS, Membership, Ngā Kete, PD & Events, Study & Careers, Publications & Media, Community, and Members Only. The 'Members Only' tab is selected, leading to a page with a breadcrumb trail 'HOME > Members Only'. The main content area is titled 'Members Only' and includes a welcome message: 'Kia ora and Welcome to the NZPsS Member Only area'. It explains that this area provides access to services and information for members, including the latest NZ Journal of Psychology, online access to the EBSCO database, and the ability to update member details, pay subscriptions, and read Netiquette. Contact information for questions is provided: email at membership@psychology.org.nz or phone at (04) 4734885. A section for the 'NZPsS 48th Annual General Meeting' is also featured, dated Saturday 3rd September, 2016 at 5.00pm at the Executive Suite ESS, Massey University, Wellington. Links are provided for the AGM Agenda and Annual Reports, and for the Executive Roles Description 2016 and Nominations 2016. An 'Open Letter' section mentions an open letter from the NZPsS President to the President of the American Psychological Association regarding ethical concerns. On the left side of the page, there is a vertical menu with links to Member Welfare, Webinars, Proquest Database, NZ Journal – Current Issue, Other Publications, Find a Supervisor, ACC,PPAF,PWG Minutes, Couple Counselling Forum, Primary Mental Health Forum, Manage Your Details, and My Account. On the right side, there is another vertical menu with links to Member Welfare, Webinars, Proquest Database, NZ Journal – Current Issue, Other Publications, Find a Supervisor, ACC,PPAF,PWG Minutes, Couple Counselling Forum, Primary Mental Health Forum, Manage Your Details, and My Account.

Member Welfare-Support for NZPsS Members

Webinars focusing on career and professional issues

Access to the ProQuest database

NZ Journal of Psychology: Current Issue. The Journal is an exclusively on-line publication.

Other Publications: *Connections*, *Psychology Aotearoa*, *International Union of Psychological Science*

Find a Supervisor: The Society would like to assist NZPsS members, who are registered psychologists and want to offer professional supervision and those who are looking for a professional supervisor.
(Find a Mentor will be added soon)

ACC, PPAF, PWG Meeting Minutes

Couple Counselling Forum and Primary Mental Health Forum: where members can initiate and discuss relevant topics

Manage Your Details - this allows you to update your contact details; add an employer or make changes to your PsychDirect listing.

My Account - will show any outstanding invoices (from there you can directly proceed to online payment)