Contents

President's Korero—Frank O'Connor

Psychology is many things. For disassembling things that happen. To enquire within. For people to follow to make change in the world. Or to account for it. According to Principle 4 of our Code of Ethics, psychology 'functions as a discipline to promote the well being of society.'

Society. That's about people. And about their interactions. All stuff they do. And make. Does it include the world they live in? Maybe not. Society is people. Environment is around people. What a curious separation. No wonder we find it hard to be at peace with our world, when some of our common constructs set us apart from it. Maybe if we accept our interdependence on the environment in which we live for our lives, society can link more usefully with our world.

"Psychologists, both as individuals and as a group, have responsibilities to the community and to society in general." Responsibilities? Obligations too. As a definition of the relationship of incoming British settlers and present Māori, the Treaty of Waitangi is one of our expressions of how power and influence are to be used in society. Other law also applies, and through the HPCA, our own Code of Ethics, though aspirational in tone, is given weight in law. Being judicious, then, in our relations with individuals and groups within communities is an obligation. As the Code says, "unjust societal norms and behaviours that disempower people at all levels of interaction" are unsuitable for good research, teaching or practice of psychology.

I find myself asking what this counts out and what it counts in. Many of you will know of my long interest in the very human (individualised and accultured) challenge of discrimination of something done to a standard that is 'good enough' compared with 'not quite good enough.' Perhaps I wrote too many 'compare and contrast' essays all those years ago. Yet it can be a fruitful way of thinking.

The Code picks out societal welfare, respect and benefit as areas for action. My 'not quite good enough' test explored these recently for me. I was asked to assist an organisation strengthen its support for people under strain in the aftermath of the earthquakes still swimming below Canterbury. I looked at the research,

talked to colleagues and concluded that a trauma-oriented approach was 'not good enough', as these people were coping. A number of people helped me ensure that the strengthening I suggested would not need undoing, should folk subsequently need help deeper than the coping support offered. We think we stayed clear of snake oil, but encountered a lack of clarity on what 'evidence' meant, and what benefit being 'evidence-based' confers in utility or well-being. And we filled a bit of a gap, as there is now a robust and adaptable process for helping leaders of churches, sporting codes, businesses and community groups use psychological knowledge in ways that promote the welfare of society in a part that wasn't well served. We've already shared what we've learned with lots of people.

One of the things I addressed was the need to adapt respectfully to the structures and customs of the groups in which I work. There is a lot I don't know, so I say so. And I ask people to guide me in working with them best. They know, and often help willingly, as it fits better for them. I do my homework about their culture, social structures, and customs before beginning work there. I work within their rules, and codes of conduct and sense of time and place. It takes longer sometimes to do things their way but it is 'their way' that I'm trying to strengthen, and doing otherwise would simply not be 'good enough'.

I also run into times when people act inconsistently with the first three principles of our Code: respect for the dignity of peoples, responsible caring and integrity in relationships. Sometimes I realise it was me. An apology, clearly accepting responsibility for the fall below 'good enough' is my place to start. Then a gentle query to ascertain damage or hurt. Similarly, I try to help others make the right kind of change in their own personal or group structures and policies. I am not surprised at the rise in aggression in some groups in the aftermath – the stress has to show somewhere. But compassion soothes, and acceptance can lead to insight. Even when the uncertainty of what the day will bring is enough, literally, to move mountains.

Editorial

Tēnā kotou katoa

This is the second issue of *Psychology Aotearoa* for 2011, and like previous issues it features a very diverse range of topics, issues and papers. The annual conference of the Society, held in Queenstown, was by all accounts an acclaimed success. (Unfortunately, for the first time in several years, I was unable to attend this event.) Next year's joint conference with the NZCCP will be held in Wellington 20-23 April, 2012.

In this issue, there are several specific articles of interest. One of these is a paper by Marianne Lammers (see pages 86-90). In the first of two papers to be published in *Psychology Aotearoa* (the second will appear in the next issue), Marianne discusses cultural safety and its implications for non-Māori practitioners. This is an important issue for us all to consider and she provides some valuable points for us to reflect upon. Belinda Borell follows this with a thought provoking paper on Pakeha privilege.

Other articles I would highlight in this current issue include an 'opinion piece' by Professor John Read (Auckland University) on the use of chemical methods to alleviate depression, distress and related problems. John articulates some of the major pitfalls associated with this usage and sounds a warning for both health professionals and consumers of their services. More constructive methods for dealing with these kinds of problems are advocated.

Another highlight in this issue is a feature article by Simon Crowe, president of the Australian Psychological Society. Simon discusses several recent developments in Australia, including their national registration scheme (including a list of areas of practice endorsement), their first research assessment exercise (similar to our own Performance Based Research Fund exercise, PBRF), threats to the funding of psychological services through Medicare, and factors which are affecting the psychological workforce in Australia. This is an informative paper which will be of interest to us all, and I'd like to take this opportunity to thank Simon for his contribution.

As in the previous issue of *Psychology Aotearoa*, we present abstracts from research theses recently completed (over the past couple of years). Here we focus on the field of community psychology, and include abstracts from Auckland, Massey and Waikato Universities. I wish to thank Niki Harré (Auckland University), Christine Stephens (Massey University) and Neville Robertson (University of Waikato) for compiling these abstracts for this issue.

I would also note the interdisciplinary perspectives section, which contains a thought-provoking interview with Professor Kevin Dew from Victoria University on the sociology of health and illness. Kevin's comments remind us that psychologists do not have a monopoly on the study of psychosocial issues relating to health and illness, and that we can learn much from the research conducted by other disciplines. Sociology, in particular, has a long history of interest and exploration of this topic, which has produced some very important and valuable findings and theoretical accounts. The interview with Kevin offers a coherent reflection on the sociological perspective.

We would like to give special thanks to Isabelle Miclette from Massey University, who has been editor of the student forum of *Psychology Aotearoa* for the past two years, and has performed a wonderful job in this capacity. As Isabelle will be completing her doctorate at the end of this year, she will be moving on from this role. We wish her all the very best in her new endeavours. Finally, we would like to thank all those who have contributed items to this issue of *Psychology Aotearoa* and I encourage you to continue sending your contributions. In addition, if you have any feedback on the content or the format of the journal, please do not hesitate to contact us.

Ngā mihi nui,
Michael O'Driscoll
Editor (m.odriscoll@waikato.ac.nz)

Report from the 44th NZPsS Annual General Meeting Monday 22nd August, 2011

In accordance with the NZPsS Rules, the New Zealand Psychological Society is required to hold an Annual General Meeting in each calendar year. This meeting is held during the NZPsS Annual Conference. This year the AGM took place in Queenstown. Forty-seven members were present at the AGM and there were ten apologies.

The AGM considered the minutes and reports published in the AGM agenda booklet which was published on-line in the members-only section of the website. Hard copies of the agenda were handed out at the meeting. Reports were received from the NZPsS President, Executive Director, Standing Committees, Institutes, Divisions, Special Interest Groups and Branches. The audited financial accounts were received and these are now on the members' only section of the NZPsS website.

Remits

A remit related to the establishment of the Bay of Plenty Branch was carried with enthusiasm. It was moved that a second remit from the Waikato Branch related to the involvement of psychologists in removing barriers of access to services related to child protection and advocacy, lay on the table until the next AGM but that the Executive bear in mind the spirit of the remit.

Election of Joanne Cunningham and farewell to Jack Austin

Joanne Cunningham was re-elected to the position of Director of Professional Affairs on the NZPsS Executive and Jack Austin, Immediate Past President was farewelled and thanked for his

contribution to the Society over a number of years.

Farewell to Huata Holmes and welcome to Angus Hikairo Macfarlane

NZPsS Kaumatua Huata Holmes was farewelled from his position with the Society. Warm acknowledgements of Huata's wisdom and guidance of the Society since 2006 were received. Angus Hikairo Macfarlane was warmly welcomed as NZPsS Kaihautu.

Discussion

There was a discussion of the joint conference with the New Zealand College of Clinical Psychologists to be held 20-23 April, 2012 and the forth-coming publication of a book based on bicultural keynote speakers' reflection on their presentations edited by Raymond Nairn. Appreciations were expressed for the work in organising the Queenstown conference and for the publication of *Psychology Aotearoa*.

NZPsS Conference 2011

The New Zealand Psychological Society conference was held in Queenstown, 20-23 August. The theme of the conference was People, Places, Paradigms: Growing and Changing- Hāpori, Wāhi, Anga Tauira: Rere ā Tipunga. International

and New Zealand keynote speakers and invited speakers and workshop presenters provided a rich programme which was very well received. The excellent variety of symposia were also very much appreciated by delegates. There was considerable interest from the media in the conference and in particular in the "earthquake response and recovery: the contributions of psychology" symposium.

The 20th birthday of NSCBI was celebrated at the conference along with the awarding of the Ballin Award to Dr Suzanne Blackwell, the G.V. Goddard Award to Dr Dione Healey, the Dame Marie Clay Award to Professor Ian Evans and the Karahipi Tumuaki President's Scholarship to Tess Chalmers. To find out more about these awards and the award recipients go to www.psychology.org.nz/Awards_Honours

This edition of *Psychology Aotearoa* feature articles from conference presenters Martin Milton, Jane Gilbert, John Read, Stephen Porter and Belinda Borrell.

The Society extends its warm thanks to sponsors, ACC, the Psychologists Board and the Joint Centre for Disaster Research for their support of the conference.

Branch News

Welcome to the new Bay of Plenty branch of the NZPsS

The Bay of Plenty Branch of the New Zealand Psychological Society held its inaugural meeting on 30 August with some superb food in Café Vesta in downtown Tauranga. President Frank travelled up for the event and provided the wine. Frank spoke about the roles of the institutes and the branches, and how the branches are the meeting place for psychologists from all backgrounds and orientations. Some really useful discussion ensued and the new branch was fortunate to have present Dianne Farrell, who is Chair of the Waikato Branch, and who knows the sorts of events that psychologists value and wish to attend. The BOP Branch has also been supported in its genesis by Donna, Dr Pam, and others from National Office, and from the entire of the Society through the recent AGM establishing the new branch. Pam asked for some photographs of the opening but, despite the camera being available, none were taken. The photograph that has been provided was taken the next day and is of the five developmental and educational psychologists who attended the event and who (largely by default) now serve as the office holders for NZPsS, BOP. They are John McGovern, Carmen O'Meeghan (Treasurer), Raewyn Douglas, Marie Petersen (Secretary), and Peter Stanley (Chairperson) (see photo above)

Waikato Branch

The Waikato Branch has the following events planned:

- Christmas celebration, 3 December 2011, Raglan, 12pm onwards

- Ethics workshop, early March 2012, St Peter's Cathedral, Hamilton

Please diary these dates and more information will be sent closer to the time.

Dianne Farrell , Chair

Professional Development Events

Managing Risk: Health Law for Psychologists

Presented by Assoc. Prof. Kate Diesfeld and Dr John Fitzgerald

Designed as an interactive session, this professional development programme will integrate case studies, lectures and small group discussion. They will be led by a legal academic and a practising psychologist.

Wellington 24 November 2011
Christchurch 25 November 2011
Auckland 28 November 2011

Enhancing Competence in Supervision: Power, Process and Emotion in Supervision

Presented by Fiona Howard

The course will be a one-day workshop that builds on the skills learned in the introductory supervision training workshops but may appeal more to those supervising practitioners with a therapeutic role in their work. Participants will be invited to share supervisory scenarios of relevance and participate in experiential exercises. Attendance will be open to any interested health practitioner who has attended an introductory supervision workshop.

Invercargill 21 November 2011

Enhancing Competence in Supervision: Essential Elements of Effective Practice

Presented by Fiona Howard

This workshop is an introduction to the key educational-developmental elements of supervision practice, which maintains the focus upon the supervisee's learning and well-being.

Auckland 5 December 2011 - due to popular demand

NZPsS members are invited to make suggestions for the 2012 professional development programme. Please contact Heike pd@psychology.org.nz

The benefits of thinking about our ancestors

(Courtesy of the British Psychological Society Research Digest at www.researchdigest.org.uk/blog.)

Psychologists have shown previously that thinking about our own mortality - 'where we're going' - prompts us to shore up our cultural world view and engage in self-esteem boosting activities. Little researched until now, by contrast, are the psychological effects of thinking about where we came from - our ancestors.

Anecdotally, there's reason to believe that such thoughts are beneficial. Why else the public fascination with genealogy and programmes like the BBC's "Who Do You Think You Are"? Now Peter Fischer and his colleagues at the Universities of Graz, Berlin and Munich have shown that thinking about our ancestors boosts our performance on intelligence tests - what they've dubbed 'the ancestor effect'.

'Normally, our ancestors managed to overcome a multitude of personal and society problems, such as severe illnesses, wars, loss of loved ones or severe economic declines,' the researchers said. 'So, when we think about them, we are reminded that humans who are genetically similar to us can successfully overcome a multitude of problems and adversities.'

An initial study involved 80 undergrads spending five minutes thinking about either their fifteenth century ancestors, their great-grandparents or a recent shopping trip. Afterwards, those students in the two ancestor conditions were more confident about their likely performance in future exams, an effect that seemed to be mediated by their feeling more in control of their lives.

Three further studies showed that thinking or writing about their recent or distant ancestors led students to actually perform better on a range of intelligence tests, including verbal and spatial tasks (in one test, students who thought about their distant ancestors scored an average of 14 out of 16, compared with an average of 10 out of 16 among controls). The ancestor benefit was mediated partly by students attempting more answers - what the researchers called having a 'promotion orientation'.

These benefits weren't displayed by students in control conditions that involved writing about themselves or about close friends. Moreover, the ancestor effect exerted its benefit even when students were asked to think about negative aspects of their ancestors.

'We showed that an easy reminder about our ancestors can significantly increase intellectual performance,' the researchers said. 'Hence, whenever people are in a situation where intellectual performance is extraordinarily important, for example in exams or job interviews, they have an easy technique to increase their success.'

Fischer and his colleagues emphasised their research is at an exploratory phase. Future work is needed to find out what other benefits thinking of ancestors might have, and also to uncover other possible mediating factors, which they speculated might have to do with 'processes of social identity, family cohesion, self-regulation or norm activation elicited by increased ancestor salience.'

_____

Fischer, P., Sauer, A., Vogrincic, C., and Weisweiler, S. (2010). The ancestor effect: Thinking about our genetic origin enhances intellectual performance. European Journal of Social Psychology http://dx.doi.org/10.1002/ejsp.778

See the British Psychological Society Research Digest at www.researchdigest.org.uk/blog.

Spotting Gender Online

A piece of software developed by Na Cheng and her colleagues Rajarathnam Chandramouli and Koduvayur Subbalakshmi at the Stevens Institute of Technology in Hoboken, New Jersey could be used to reveal the gender of online writers of blogs and emails. Paul Marks, writing in *New Scientist* vol 210 (2818), June 11, 2011, p 23 notes that the software allows users to conduct a gender analysis on an uploaded text file or pasted paragraph of 50 words or more. The programme will make a gender judgement of female or male or neutral. The last option indicates that the text is lacking in gender indicators. In creating the software Cheng and her colleagues located 545 psycho-linguistic factors which they pared down to the 157 which were gender-significant. These factors related to paragraph lengths or differences in punctuation style between men and women. They found for example, that men were more likely to use the word "I" and women to use question marks. The software combines Bayesian algorithm which guesses gender based on the balance of probabilities and is currently only 85% accurate but "learns" as more people use it. The developers say that the software could help protect children from grooming by predators who conceal their gender online.

The value of te reo in primary care

A paper published in the *Journal of Primary Health Care*, vol 3 (2), June, 2011 explores te reo Māori as a determinant of health from a Māori patient's perspective. The paper was written by Suzanne Pitama, Annabel Ahuriri-Driscoll, Tania Huria, Cameron Lacey and Paul Robertson. Thirty participants who identified as Māori were interviewed to explore their utilisation of health services, their comfort with service delivery and the perceived cultural competency of their general practice surgery. Although the survey did not ask specifically about te reo, this emerged as a significant theme in the focus groups held as part of the survey.

Three main themes emerged from the data. Incorrect pronunciation of names was noted by participants as a barrier to health care with correct pronunciation being viewed as a measure of 'gold standard' health care. A second theme to emerge was that the use of te reo had assisted in the development of positive relationships between participants and their general practice surgeries. Participants felt that the use of te reo assisted them to articulate their health condition and also to share their connection in relation to the Māori world and Māori beliefs with the practice. Participants noted that when general practice staff reacted to te reo negatively (through for example body language or verbal comment) participants took this as a sign that Māori perspectives were not valued or seen as valid and that the general practice did not want to develop a relationship with them. Some participants reported that these negative experiences had led them to disengage with the health system for a period of time.

The third issue that emerged from the study was that the participants did not see visual media depicting Māori themes (e.g. signs, brochures, posters) as sufficient on their own to engage Māori patients. All participants agreed that the patient-led use of te reo that was valued and responded to in a positive way was an important indicator of cultural competence in the practice. The authors concluded that despite some limitations in the study, the findings indicate that the use of te reo can significantly enhance the experience of Māori patients in general practice and primary care.

This paper can be accessed on www.rnzcgp.org.nz/jphc-june-2011/

Toddlers choose who they will learn from

Reporting from the April edition of *Infant Behaviour and Development*, the British Psychological Society publication *the Psychologist* vol 24(8) 2011, p 571 notes that infants of just 14 months are able to detect unreliable people from whom they will not bother to take lessons. A study by Diane Poulin-Dubois set up a 'reliable' condition where the researcher smiled and exclaimed with delight when discovering a toy in a container before passing it on to the infant to inspect. In the 'unreliable' condition the researcher similarly expressed delight but there was in fact no toy in the box. This was repeated several times.

Next, the same researcher placed a touch-on light on a desk and switched it on by leaning forwards and using her forehead. After three repeats of this, the light was passed to the infant. The study found that infants in the 'unreliable' condition were far less likely to bother imitating the researcher (34 per cent of infants) compared with 61 per cent in the reliable condition. The researchers concluded that infants seem to be able to perceive reliable adults as capable of rational action whose novel unfamiliar behaviour is worth imitating. The behaviour of a perceived unreliable adult is interpreted as irrational and inefficient and not worthy of repetition. These new findings support earlier research which suggests that children are selective about those they learn from. Examples of this are that children prefer to learn from people that they are familiar with and who appear more certain, confident and knowledgeable.

Scientific Ghostwriters

Ian Sample writing in the *The Guardian Weekly* (12 August, 2011:32-33) suggests that legal experts consider that doctors and scientists who put their names to articles that they have not written should be charged with professional misconduct and fraud. By doing so they hope to stop "guest authorship" where papers being written by pharmaceutical companies or industry-sponsored writers are "passed off as the work of influential, independent academics".

Sample notes

In the worst cases, doctors receive payments or other incentives to endorse articles without being familiar with the studies or data the reports describe. Often, the articles are biased and do not carry the names of real authors.

Articles which have had little involvement from guest authors have been published in leading journals on hormone replacement therapy, Vioxx, an anti-inflammatory

drug which was withdrawn because of safety fears, antidepressants and other pharmaceuticals. Whilst the practice of scientific ghostwriting is not considered to be illegal there are concerns in some quarters that it is unethical and that patients could be harmed by skewed information appearing in medical journals. Simon Stern and Trudo Lemmens, law professors at the University of Toronto writing in PLoS Medicine warn that measures to curb ghostwriting have so far failed. They call for more severe sanctions against the practice claiming that a guest author's taking credit for an article written by someone else constitutes legal fraud and could give rise to legal claims being pursued in a class action.

Psychology and the Law
in Aotearoa New Zealand

Edited by
Fred Seymour   Suzanne Blackwell   John Thorburn
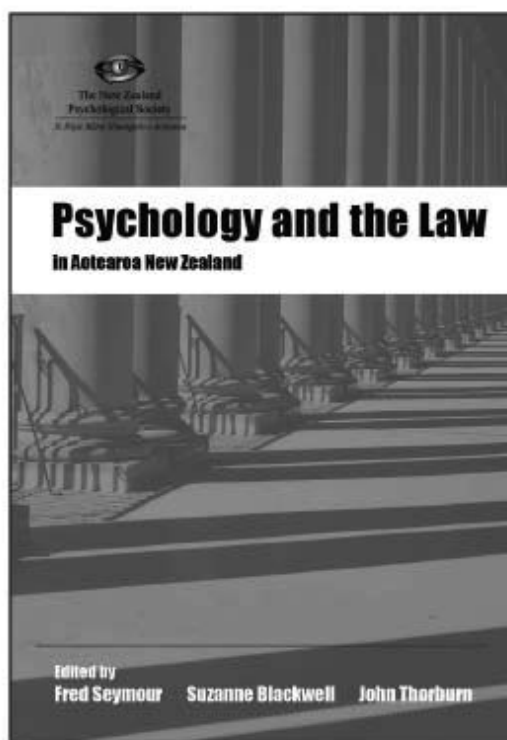
16 CHAPTERS, 300 PAGES, SOFTBACK COVER
ISBN 978-0-473-19160-3
For more information ph 04 473 4884 or email
office@psychology.org.nz
NZPsS Members $65.00
Non-Members $80.00

Complete this order form and send with payment to:

New Zealand Psychological Society
PO Box 4092, WELLINGTON 6140
or by Fax: 04 473 4889

ORDER FORM

Contents

Chapter 1   Psychologists' Obligations and Responsibilities
Chapter 2   Privacy and Privilege: Practice Implications for Psychologists
Chapter 3   Expert Evidence: The Conduct of Expert Witnesses
Chapter 4   Māori, Psychology and the Law: Considerations for Bicultural Practice
Chapter 5   Psychologists Working Within the Family Court
Chapter 6   Preparing Psychologists to Work Within the Family Court
Chapter 7   Psychological Reports for the Youth Court
Chapter 8   The Role of the Psychologist in Criminal Proceedings
Chapter 9   Psychological Reports for the Courts on Convicted Offenders
Chapter 10 Compulsory Assessment and Treatment of Mental Disorder
Chapter 11 Assessment and Care of Offenders with Mental Impairments
Chapter 12 Assessment and Care of Offenders with Intellectual Disabilities
Chapter 13 Neuropsychology and the Assessment of Competence
Chapter 14 Psychologists Working with Organisations
Chapter 15 Educational Psychology: Legislation and Regulation
Chapter 16 Migrants and Refugees

Psychology and the Law in Aotearoa New Zealand

Name .... NZPsS member   Yes / No

No of Copies .... (Limit 1 per Member at Member price)   Total Payment $ ....

Email .... Phone ....

Delivery Address .... Postcode ....
....
....

Payment Method   ☐ Cheque   ☐ Visa   ☐ Mastercard

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐   Expiry Date ☐☐ / ☐☐

Cardholder Name .... Signature ....

GST No. 42-486-868

TAX INVOICE

With more talk in mind

Professor John Read, the University of Auckland

After 20 years working in the UK, USA and New Zealand as a clinical psychologist, primarily with people diagnosed with 'schizophrenia' or psychosis, Dr John Read joined the University of Auckland, where he is now a Professor of Clinical Psychology. He is the Editor of "Models of Madness" (2004) and of the scientific journal *Psychosis*, and author of "A Straight Talking Introduction to the Causes of Mental Health Problems" (2010). He is on the Executive Committee of the International Society for the Psychological Treatments of Schizophrenia (www.isps.org).

In 2010 John received the NZ Psychological Society's Hunter Award for excellence in scholarship and professional accomplishments.

This Opinion Piece was published in the Sydney Morning Herald, the Melbourne Age and the National Times on Sept 15, 2011 in response to a series of reports about deaths and high use of compulsory ECT in the Victoria mental health system.

Serious problems in Victoria's mental health system have been revealed recently in *The Age*. The important thing now is to find solutions. In doing so we should remember that although Victoria is in the spotlight, similar ''crises'' occur regularly all over the world. Perhaps this is because Victoria is not alone in having a system based on fundamentally flawed principles.

Mental health services have become increasingly dominated by psychiatry's ''medical model'', which claims that feeling depressed, anxious or paranoid is primarily caused by genetic predispositions and chemical imbalances.

This has led to alarming rises in chemical solutions to distress. In New Zealand, one in nine adults (and one in five women) is prescribed antidepressants every year.

The public, however, in every country studied, including Australia, believes that mental health problems are caused by issues such as stress, poverty and isolation. The public also prefers talking therapies to drugs and electroconvulsive therapy (ECT).

Research suggests the public is right. For example, the single best predictor of just about every mental health problem is poverty, followed by other social factors such as abuse, neglect and early loss of parents in childhood, and - once in adulthood - loneliness and a range of adverse events including

Mental health services have become increasingly dominated by psychiatry's "medical model", which claims that feeling depressed, anxious or paranoid is primarily caused by genetic predispositions and chemical imbalances.

losses and defeats of various kinds.

Meanwhile, reviews of studies on anti-depressants (which only recently have been able to include those previously kept secret by drug companies) conclude that they are superior to placebos only for those at the extreme end of the ''most severe'' group of depressed people. This represents less than 10 per cent of the people who are receiving these drugs.

A recent Cochrane review (the type most highly regarded in the scientific community) for Risperidone, a leading anti-psychotic drug, ''suggests that there is no clear difference between Risperidone and [a] placebo''. A placebo (from the Latin meaning ''I please'') is not necessarily a bad thing. Indeed the talking therapies are effective partly because, if done well, they too instill hope and expectations of recovery.

The problem is that psychiatric drugs often have serious adverse effects. Anti-psychotics, for instance, can cause rapid weight gain, loss of sexual function, diabetes, heart disease, neurodegeneration and reduced life span.

As previously reported, my review of ECT studies (with Professor Richard Bentall of Liverpool University) found that this treatment is ineffective for most recipients and frequently causes permanent memory loss. This in itself can be depressing.

ECT also has a slight but significant risk of death, most frequently from cardiovascular failure. Inpatient units are equally ineffective and can also be damaging. When will we learn that putting large numbers of extremely

distressed people in the same building is not a good idea?

What I conclude from all this is that any review of mental health services in Victoria, or anywhere else for that matter, should probably be led by anyone other than a psychiatrist - and certainly not in Victoria's case the state's Chief Psychiatrist, whose job, according to Dr Ruth Vine herself, is "to watch over how the system is functioning".

Any review [of mental health services] should include mental health service users and their families, and other mental health professionals, including social workers, occupational therapists, psychologists and nurses.

It is unfair to expect Dr Vine to take an objective view on the failure of the system for which she is responsible. That lack of objectivity is amply demonstrated by her claims that ECT is "safe and effective" and that the problem is the public's "negative" views.

Perhaps a lawyer from the Mental Health Legal Centre might be a good choice.

Any review should include mental health service users and their families, and other mental health professionals, including social workers, occupational therapists, psychologists and nurses.

(Psychiatric nurse Philip Lynch reminds us that there are thousands of staff "who quietly continue to do important work every day, often in challenging circumstances"; so why only listen to the doctors?)

The review should also investigate what percentage of people receive drugs, and what percentage receive safer, more effective alternatives, and how a better balance can be achieved. It must scrutinise the contact and transactions between psychiatrists and

drug company reps and consider ways to reduce or eliminate these, and as well find ways to reduce the pressure on psychiatrists by helping them feel OK about sharing decision-making. When things go wrong, as they inevitably will sometimes, everyone should share responsibility, and support one another.

The review would need to explore the ''recovery model" recently introduced in many other countries, including New Zealand. (No, I am not saying New Zealand is superior to Australia - except, of course, when it comes to rugby.)

Further, the review would need to learn from the many innovative non-government organisations, such as Voices Vic and Mind, and study ways to prevent mental health problems developing - perhaps by focusing on providing safe and nurturing environments in the first few years of life. Also, simply listen to the public. Finally, *The Age* can assist by reporting the issues without exaggerated headlines such as "1000 DEATHS".

Dr John Read advises that no one should reduce or come off medication on the basis of information in this article but should, if they have concerns, consult the prescribing doctor.

Read more: http://www.smh.com.au/opinion/society-and-culture/with-more-talk-in-mind-20110914-1k9m2.html#ixzz1XyhOa4Ed

Toward cultural safety: clients –Part I

Marianne Lammers

Marianne Lammers, received her PhD in social psychology in 2002 from the University of Waikato. She co-ordinated the first year social psychology course at the psychology department of the university for six years, after which she accepted a position in the Hamilton Court managing the Restorative Justice Pilot Programme; a position she kept for five years. In January 2008 she started working for the Department of Corrections in Waikeria Prison as a facilitator in the Special Treatment Rehabilitation Programme for violent recidivist offenders who are mainly Māori; a position she still holds. Marianne noticed that in order to have a therapeutic alliance with her Māori clients she needed to become acquainted with kaupapa Māori, and to put that into practice in her work with her Māori clients.

Marianne was chair of the Waikato/BOP branch of the NZPsS from 2004 -2008 and is still on the executive. This year she organised and led the ethics workshop for the NZPsS Waikato branch in her region. She was also chair of the Institute of Counselling Psychology from 2007 to 2008 and is currently chair of the membership committee of the Institute.

Experiences of a non-Māori therapist working with Māori

This paper will be published in two parts. Part-one will incorporate a literary review of culture and how New Zealand's political and social history negatively impacted Māori identity formation. Part-two of this paper will be published in the next issue of Psychology Aotearoa. It will look at the values and practices of Māori culture, and how to incorporate these values and practices in treatment, so that culturally responsive interventions are delivered to Māori clients.

Abstract:

This study evaluates how a non- Māori practitioner finds ways to respectfully work with Māori clients. The author researches how New Zealand's political and social history has impacted on Māori identity formation. Furthermore, the deleterious developmental outcomes for Māori as a result of colonisation are discussed. This author learned to consider the psychological difficulties of Māori in the wider context of socio-political influence.

The writer identifies ways in which she familiarised herself with the values and practices of Māori culture and gained an understanding of the meaning of these practices. She comes to the understanding that if practitioners are committed to best practice, they will commit to a culturally responsive intervention for Māori clients, and show a willingness to understand and experience Māori culture so that they can deliver culturally safe treatment. Practical ways to incorporate Māori concepts and values into day-to-day work with Māori clients are discussed.

Declaration:

I am a group facilitator in a New Zealand prison in a Special Treatment Unit for recidivist violent offenders that offers a nine-month intensive group based cognitive behavioural treatment programme. I declare that I am a mature European woman, born into a middle-class family, have lived in New Zealand for over 40 years and feel that New Zealand is my home. Nevertheless, I am aware that the lens through which I view culture is coloured by the values, practices, biases and judgments related to my background that have helped shape my interpretation of the literature I hereunder review.

> ...we as non-Māori practitioners, need to familiarise ourselves with the values and practices of Māori culture, and have an understanding of the meaning of these practices, to the point where we feel comfortable working with people from both cultures

Literature Review

Researching Māori cultural approaches to evidence-based psychological treatment requires knowledge of the concepts of culture and biculturalism, as well as an understanding of Māori values and practices.

Culture is the learned, socially acquired traditions and lifestyles of members of a group (Nikora, 2001a) and refers to customs, practices, languages, values and worldviews that define social groups such as those based on ethnicity, region, or common interests; age or generation;

iwi, hapu and tribal links; gender or sexual orientation; religious or spiritual beliefs; and disability (NZ Psychologists Board, 2006). In order to effectively work with people of another culture one needs to not only have an understanding of of what the values and practices of that culture are, but to also have an understanding of the meaning of these values and practices. In Aotearoa/New Zealand, "cultural competence includes biculturalism and also other differences in culture, ethnicity, age, gender, ability, religion, and so on" (Department of Corrections, June 2008, p. 44).

Biculturalism specific to Aotearoa/New Zealand gives expression to the Treaty of Waitangi, the nation's founding document, and its principles of partnership, protection, and participation (NZ Psychologists Board, 2006). This partnership agreement, where two peoples met to sign an agreement for essentially two different groups to live together in respect and harmony is the basis of our work as therapists.

The New Zealand Psychologists' Code of Ethics (2002) stipulates that therapists working in New Zealand need to recognise that the Treaty of Waitangi sets out the basis of respect between Māori and non-Māori in this country. Showing respect for each other means needing to understand each other's culture so that one does not unintentionally disrespect the other out of ignorance. It also means that in everything we do as therapists, we need to see Māori and Pakeha values and practices as equal but

different (Nairn, in Evans, Rucklidge, & O'Driscoll, 2007). This means that we do not take Western values and practices as the reference point for Māori practices. For this reason we, as non-Māori practitioners, need to familiarise ourselves with the values and practices of Māori culture, and have an understanding of the meaning of these practices, to the point where we feel comfortable working with people from both cultures. Cultural safety needs to be incorporated in every interaction we have with our clients. It is not something to be put aside when the going gets tough and real issues are addressed. Only when culture is central to our work will we honour our obligation to show respect and grant dignity to all peoples as part of our common humanity, under the Treaty of Waitangi (NZ Psychologists Code of Ethics, 2002).

Ko te mea nui, he tangata (humanity is paramount) (Macfarlane, 1998).

Studies on Māori culture from a psychological perspective only commenced in the 20th century and are historically and culturally embedded. They have changed over time as New Zealand's values and political priorities shifted.

Only when culture is central to our work will we honour our obligation to show respect and grant dignity to all peoples as part of our common humanity, under the Treaty of Waitangi.

In the pre-colonial period Māori psychological forms were taken for granted, as they were the norm. Māori social policies were also well developed and had clear structural frameworks such as whanau, hapu and iwi (Young; 2005). With the advent of colonisation Māori psychological knowledge was usurped by Western knowledge bases and institutions (Herbert & Morrison; 2007). Their

prejudices and discrimination against Māori, resulting in loss of land, and loss of rangatiratanga through the introduction of several Acts, was reflected in the social failure of Māori people and the undermining of chiefly leadership (Young; 2005).

While in the first half of the 20th century psychological research on Māori perpetuated inequality, from the 1970s onward psychological research started to inform social policy that began to honour the Treaty.

The first studies conducted by Pakeha on Māori were studies from an outsider's perspective where Māori were studied as objects to be "acted upon" (Mead, 2003; Nikora, 2001b). These studies then informed New Zealand social policy at that time. The Hunn report is a well known example of assimilationist research that impacted negatively on Māori because of its Eurocentric focus.

The main danger of Eurocentric hegemony in psychology is the lack of attention to alternatives to mainstream knowledge. Moreover, the dominance of Eurocentric psychology acts to legitimise inequality. Howitt & Owutso-Bempah (1994) point out that the discounting of Māori worldviews in New Zealand perpetuated inequality in areas such as health, education, and crime (cited in Macfarlane, 2008). This came at great physical, spiritual, and psychological cost and impacted gravely on family structure (Mead, 2003) with consequences such as disproportionate representation in the criminal justice system and in negative health statistics (Robertson, Futterman-Collier, Sellman, Adamson, Todd, Deering, & Huriwai, 2001) - issues therapists are still dealing with in their work with Māori.

While in the first half of the 20th

century psychological research on Māori perpetuated inequality, from the 1970s onward psychological research started to inform social policy that began to honour the Treaty.

From the 1970s psychological research with a Māori focus started to be conducted by Māori graduates in psychology, and this started the onset of psychological studies of Māori from an insider's perspective. These studies highlighted how Māori were marginalised, stigmatised, and discriminated against; how they lost their land and language; and how this negatively impacted on identity, mental health, and on developmental outcomes (McFarlane-Nathan, 1994).

Mason Durie, leader in the areas of Māori health and development, contended that by the 1970s Māori had increasingly become more dependent on the State due to the upheavals of nineteenth century policies (Durie, 2003). The State was primarily committed to policies and programmes that would continue to assimilate Māori into the dominant systems of colonial New Zealand. However, research done by Māori on Māori highlighted the anomalies and we saw changes in governmental policies, such as the setting up of the Waitangi Tribunal in 1975 to deal with land claims, and the Department of Māori Affairs' setting up of Te Kohanga Reo in 1981 as a way towards honouring the Treaty principle of protecting Māori taonga, such as land and language. A start was made towards recovering Māori identity.

The late 1980s saw the introduction of Taha Māori and professional psychology training (Abbott & Durie, 1987).

You may ask why I revisit New Zealand political and social history when I am investigating how to respectfully work with Māori.

The answer is that New Zealand history puts in context how political acts diminished, demeaned, and disempowered the cultural identity of the Māori population through oppression, prejudice and discrimination, with detrimental effects on their psychological wellbeing (McFarlane-Nathan, 1994). Durie stated: "Identity is

dominant individualistic values to a communal view of people where individuals are responsible to and for others in the community. Although psychological theories about Kaupapa Māori are still in their infancy, we can interpret universal concepts in terms of local cultural patterns, and elaborate psychological concepts derived from Māori culture (Nikora,

the Psychologists' NZPsS Code of Ethics prior to 2002 which supported the rights of the individual adult in terms of rights to privacy and confidentiality, as compared to the Māori value of supporting the rights of the community where an individual and their whanau are responsible to and for each other (Te Wiata, 2006). Individual rights to privacy and confidentiality are therefore unhealthy in Māori terms (Durie & Hermansson,1990) as they fail to acknowledge the responsibility that the whanau has to support a family member in need, and the healing that comes from that support. In 2002 the Code of Ethics was revised, through input from the Society's National Standing Committee on Bicultural Issues (NSCBI) and the preamble now includes the following declaration, "In giving effect to the Principles and Values of this Code of Ethics there shall be due regard for New Zealand's cultural diversity and in particular for the provision of, and the spirit and intent of, the Treaty of Waitangi" (New Zealand Psychological Society, 2002, p.3).

> However difficult it is to reconcile clinical values with indigenous values, an interface is possible if practitioners bring their professional expertise, together with the best available research evidence, and have developed socio-cultural expertise, so that they can deliver culturally safe treatment.

not primarily an inner experience or personal conviction, rather it is a construct derived from the nature of relationships with the external world" (2003, p. 50). Devaluing Māori as a race therefore impacted their identity formation, their developmental outcomes and manifested through symptoms of mental illness (McFarlane-Nathan, 1994, 1997; New Zealand Psychologists Board, 2006).

Inadequate attention has been paid to psychological stresses arising from being belittled, in spite of the widespread sociological problems such as poverty, poor education, and unemployment faced by Māori (Macfarlane, 1998). This needs to be borne in mind when working with Māori, as it puts the psychological difficulties of Māori into the wider context of socio-political influences, rather than placing them in the basket of personal deficits.

The 1990s saw the onset of the development of Kaupapa Māori research, which is a research approach that validates indigenous ways of knowing and being (Macfarlane, 2006). It was a response to the inadequacy of recognition afforded Māori culture and cultural knowledges as contributors to change (Durie, 2003). This type of research shifted

2001b) through knowledge of Māori and other cultural styles, by focusing on what is meaningful and important to Māori. Herbert and Morrison (2007) stated that understanding and inclusiveness of Māori worldviews does not exclude standard treatment.

Angus Hikairo Macfarlane (Te Arawa) presented an evidence-based practice model that brings the divergent clinical and cultural streams together in his keynote address to the New Zealand Psychological Society's (NZPsS) 2008 Annual Conference. Because it takes account of clinical as well as cultural approaches, it has the potential to be stronger than either on its own (Macfarlane, 2008).

Clinical values, competencies, and approaches to knowledge that underpin New Zealand's societal institutions, professional practice, and scientific endeavours are not always readily reconciled with the indigenous values, knowledge and practices of Māori (Durie, 2007, cited in Macfarlane, 2008). An example of a clash of values in New Zealand between the clinical values of psychologists' professional practice Code of Ethics and indigenous values of Māori was discussed by Nairn and Lammers (1999). These authors reflected on the divergent values of

These authors [Love & Waitoki] further stated that essential aspects of culturally safe and competent practice allows for feedback from ethno-cultural peoples, and client feedback ought therefore to be part of treatment, together with cultural supervision.

However difficult it is to reconcile clinical values with indigenous values, an interface is possible if practitioners bring their professional expertise, together with the best available research evidence, and have developed socio-cultural expertise, so that they can deliver culturally safe treatment. Cultural safety relates to the experience of clients of psychological services and extends beyond cultural awareness, cultural sensitivity, and as

Love and Waitoki stated, "arguably, cultural competence approaches that lack a cultural safety analysis … are 'profession-centred' – in that the arbiters of sensitivity – awareness and competence are within the profession itself." (Love & Waitoki, 2007). These authors further stated that essential aspects of culturally safe and competent practice allows for feedback from ethno-cultural peoples, and client feedback ought therefore to be part of treatment, together with cultural supervision.

Furthermore, therapists need to take into consideration the dangers of using psychometric tests on populations that differ from the normative group, and make themselves familiar with culture-specific assessment procedures, tools and their empirical (or lack of) background (New Zealand Psychologists Board, 2006). Being able to function effectively and well as a non-Māori therapist in Māori cultural environments entails a lot more than just valuing culture. As Macfarlane (1997) points out, being able to switch between two sets of values and attitudes is even more important when working with people who have emotional and behavioural difficulties, such as our client base in Corrections.

Part two of this paper will be published in the next issue of *Psychology Aotearoa*. It will look at the values and practices of Māori culture, and how to incorporate these values and practices in treatment, so that a culturally responsive intervention is delivered for Māori clients.

Acknowledgments

References

Abbott, M. & Durie, M.H. (1987). A whiter shade of pale: Taha Māori and professional psychology training. N.Z. J. Psychol, 16, 58-71.

Craig, T. & Mills, M.(1987). Care and control: the role of institutions in New Zealand, Issue 2 of Report, Social Monitoring Group (New Zealand). New Zealand Planning Council.

Department of Corrections (2008). Community Probation and Psychological Services: Supervision to Registration programme. Wellington: New Zealand Government.

Durie, M. (2003). Nga kahui pou: Launching Māori futures. Wellington: Huia.

Durie, M. & Hermansson, G. (1990). Counselling Māori people in New Zealand (Aotearoa). International Journal for the Advancement of Counselling 13, 107-118.

Evans, I. M., Rucklidge, J. J. & O'Driscoll, M. (2007). Professional practice of psychology in Aotearoa New Zealand. Wellington New Zealand: New Zealand Psychological Society.

Herbert, A. & Morrison, L. E. (2007). In Evans, I. M., Rucklidge, J. J. & O'Driscoll, M., Professional practice of psychology in Aotearoa New Zealand. Wellington New Zealand: New Zealand Psychological Society, pp. 35- 48.

Howitt, D. & Owutso-Bempah, J. (1994) The Racism of Psychology. London: Routledge.

Lammers, M. (1993). Key issues to improve race relations in New Zealand. Unpublished manuscript, University of Waikato, New Zealand, 1993.

Love, C. & Waitoki, W. (2007). Multicultural competence in bicultural Aotearoa. In Professional practice of psychology in Aotearoa New Zealand. New Zealand Psychological Society: Wellington, New Zealand, pp.265-280.

Macfarlane, A. H. (Te Arawa) (2008). Kia hiwa ra! Listen to culture: A counter narrative to conventional approaches in psychology. Keynote address presented at the Annual Conference of the New Zealand Psychological Society 29-31 August 2008.

Macfarlane, A. H. (2006). Becoming educultural: Te whakawhitinga o nga matauranga. Kairanga, 7(2), 41-44.

Macfarlane, A. H. (1998). Piki ake te tikanga: Culture counts in special education. Paper presented at the 28th Annual Conference, Australian Teacher Education Associations: Hilton on the Park, Melbourne, 4-7 July, 1998.

Macfarlane, A H. (1997). Teaching students with emotional and behavioural difficulties: a bicultural approach. Waikato Journal of Education 3, 153-168.

McFarlane-Nathan, G. H. (1994). Cognitive behaviour therapy and the Māori client. Proceedings of Dept of Justice, Psychological Services Conference, held in March 1994.

McFarlane-Nathan, G. H. (1997). The bicultural therapy project: Psychological service, Department of Corrections, August 1996. Te Komako-Social work review viii(1) Jan 1997.

Nairn, R. (2007). Ethical principles and cultural justice in psychological practice. In Evans, I. M., Rucklidge, J. J. & O'Driscoll, M., Professional practice of psychology in Aotearoa New Zealand. Wellington New Zealand: New Zealand Psychological Society, pp. 19-34.

Nairn, R. & Lammers, M. (1999). Codes and cultures: a resulting ethical dilemma. The Bulletin of the New Zealand Psychological Society, 96,8-11.

Nikora, L. W. (2001a). 0518.102 Social Psychology. Cross-cultural Psychology notes and readings (27/03/2001) University of Waikato.

Nikora, L. W. (2001b). 0518.102 Social Psychology. Kaupapa Māori & Psychology notes and readings (29/03/2001) University of Waikato.

New Zealand Psychological Society (2002). Code of Ethics: for psychologists working in Aotearoa/New Zealand. New Zealand Psychological Society: Wellington, New Zealand.

New Zealand Psychological Society (2007). Professional practice of psychology in Aotearoa New Zealand. New Zealand Psychological Society: Wellington, New Zealand.

New Zealand Psychologists Board (2006). Cultural Competencies for psychologists registered under the Health Practitioners Competence Assurance Act (2003) and those seeking to become registered. Wellington, New Zealand.

Robertson, P. J. (Kai Tahu), Futterman-Collier, A., Sellman, J. D., Adamson, S. J., Todd, F. C., Deering, D. E., Huriwai, T. (2001). Culturally responsive treatment: Clinician beliefs and practices related to increasing responsivity to the needs of Māori with alcohol and drug problems. Substance Use & Misuse, 36(8), 1015-1032.

Te Wiata, J. (Ngati Raukawa) (2003). A local Aotearoa New Zealand investigation of the contribution of Māori cultural knowledges to Pakeha identity and counseling practices. Masters thesis, University of Waikato, Hamilton, New Zealand.

Young, D. (2005). Treasure Islands, c.1300-1642. In Dally, B. & McLean, G. (Eds.) Frontier of dreams; The story of New Zealand (pp.39- 62). Hodder Moa, Auckland, New Zealand.

Pakeha reactions to Pakeha privilege: invitation to a discussion

Belinda Borell (on behalf of the Privilege Project team, Whariki Research Group)

Belinda Borell (Ngati Ranginui, Ngai Te Rangi, Whakatohea) is a Māori researcher with a particular interest in rangatahi Māori, identity, racism, social justice, whiteness and critical race theory. In 2005 she has completed her Masters thesis - Living in the City Ain't So Bad: Cultural Diversity of South Auckland Rangatahi. She is currently completing a study that explores how societal privilege impacts on population health.

This year marks the twentieth anniversary of the establishment of the New Zealand Psychological Society's National Standing Committee on Bicultural Issues. Apart from the symbolic importance of this anniversary, the practical benefits the NSCBI brings to the Society are crucial to the ongoing effectiveness of research uptake and professional practice amongst its members. The Bicultural Symposium at this year's conference included many innovative papers and research findings. "Pakeha reactions to Pakeha privilege: invitation to a discussion" was this author's offering on behalf of the Privilege Project team of Whariki Research Group, Massey University.

In this paper we sought to create a conversation about an under-researched area of social importance - societal privilege. We particularly wanted to engage audience members in discussing responses to our privilege workshops that we have found both surprising and encouraging. These are reactions we have encountered from Pakeha participants at various workshops and lectures on this issue we have conducted in the last year. It was a topic that was very fresh for

me as I had only just returned from presenting on this topic in the USA where I had experienced very different responses. The workshop is described below.

We find that the stereotypes of ethnic minorities are numerous and overwhelmingly negative. In contrast, stereotypes of the dominant ethnic group are not only much more difficult for participants to name but the stereotypic characteristics that are named are generally positive in orientation.

Workshop context

First we outlined some of the workshop activities used to enable participants to understand the 'privilege' angle on the social order. The privilege approach is in marked contrast to popular contemporary explanations of social and health disparities as these often only scrutinise the disadvantaged and the adverse outcomes they experience. Because of that focus on persons it is easy for those explanations to prioritise perceived personal and collective failings. Obviously such explanations mask or ignore wider systemic processes and societal influences that

impact on the disadvantaged and, because those structural elements are ignored, the privileged are allowed to attribute their advantageous outcomes primarily to personal merit and hard work. Thereby, apparently confirming a deficit framing of the disadvantaged.

Central to the workshops is an activity that has each participant create an individual "privilege score-sheet". We use 20 statements taken from the wider list of 50 items in "The Invisible Knapsack" (McIntosh, 1990). We have had to adapt the language in some of the items to eliminate the Americanisms and to accommodate New Zealand terminology and usage (e.g. change 'race' to ethnic group). Examples of the items are:

- I can if I wish arrange to be in the company of people of my ethnic group most of the time.

- I have never been asked to speak for all members of my ethnic group.

- I can go shopping alone most of the time, pretty well assured that I will not be followed or harassed.

- I can be pretty sure that if I ask to talk to the 'person in charge',

I will be facing a person of my ethnic group.

- I can choose blemish or bandages in "flesh" colour and have them more or less match my skin.

Participants score a point for each statement that applies to them, tallying their score over the 20 items. Then those who have scored between 0-5 are invited to stand. This group usually contains a high proportion of non-white participants. Subsequent groups, 6-10, 11-15, are invited to stand and, last of all, those who scoring 16-20. This last group usually includes most of white-skinned participants many of whom identify as Pakeha. A similar process using 10 questions explores gender privilege and there is one question relating to heterosexual privilege. These activities, especially having the different groups stand up, makes an important visual statement to participants about the non-random accumulation of seemingly banal advantages to which members of different groups have inequitable access. The activity is intended to pose questions of the "taken-for-granted" nature of societal advantage and, in our experience it does so very successfully.

Next, participants are invited to explore commonly held racial and ethnic group stereotypes. We find that the stereotypes of ethnic minorities are numerous and overwhelmingly negative. In contrast, stereotypes of the dominant ethnic group are not only much more difficult for participants to name but the stereotypic characteristics that are named are generally positive in orientation. Again this helps participants understand the numerous language patterns minority group members have to struggle with on a daily basis while the same language patterns leave most dominant group members free from scrutiny both personally and collectively.

The final activity sets the context for understanding how societal privilege revolves around notions of culture. It is well documented that dominant group members often comment that they have 'no culture': that culture is what 'others' have. One common result of this invisibility of the dominant culture is that the cultural products of the dominant group are routinely not identified as a product of that group. Such cultural products and processes, because they are not marked as specific to the dominant group are commonly perceived as part of the culture of all New Zealanders and therefore as reflecting the national identity or 'kiwi' culture. For this activity participants are shown a small collection of 20 photographs. See Figure 1 below for an example of the pictures and how they are presented. The pictures were gathered using the photo link of the Google search engine using search terms: 'kiwiana', 'kiwi culture', 'New Zealand' and 'New Zealand culture'. The group is invited to discuss, for each picture whether it illustrates the culture of: 'kiwis', 'Māori', 'Pakeha' or another group. The decisions raise important points for all participants about the readily accepted notions of culture and national life, in particular it highlights just who may take their inclusion as a given and whose culture is marginalised in the national conversation.

Fig 1

Pakeha reactions

The second part of this presentation focused on some of the reactions the workshops have generated among Pakeha participants. Much of the international literature suggests that, in general, the reaction of dominant group members towards a societal privilege analysis is likely to involve much denial and defensiveness. However, in our New Zealand workshops such reactions have been the exception.

Numerous different forms of verbal and written feedback show that, in

this country, there is much more acceptance than denial about the privileged societal position of the dominant group. This has been particularly so for Pakeha participants, many of whom acknowledge that the analysis of societal privilege and the position of Pakeha people is an accurate reflection of their experiences at work, school, and in numerous other sites of public life. For others, illuminating the unearned nature of privilege that accrues in other contexts (by men vis a vis women, or the able-bodied vis a vis disabled) generated understandings about societal position and reflections on privilege that an analysis focused only on ethnicity or culture had not. This offers important lessons about the need to discuss the many complex and nuanced aspects of privilege while concurrently maintaining rigour around the

deconstruction of racism and ethnic group discrimination.

Much of the international literature suggests that, in general, the reaction of dominant group members towards a societal privilege analysis is likely to involve much denial and defensiveness. However, in our New Zealand workshops such reactions have been the exception.

For a smaller group of Pakeha participants their feedback on the workshops rather than highlighting denial or defensiveness was that the experience had been extremely affirming of their identity as Pakeha and as agents for positive change to the social order. In expanding on this, some workshop participants have said very clearly, that an analysis of privilege locates them, as members of

the dominant group, squarely within the discussion of social inequities quite unlike the way they experienced being located in other professional development training such as Treaty of Waitangi or cultural competency. It appears that a privilege analysis, rather than inviting participants to understand the social, ethnic, and cultural parameters and experience of 'others', places dominant group identity at the centre, making it the starting point. Doing that provides a place where dominant group/Pakeha identity and culture is rendered visible so it can be examined and discussed. And, because this is, for participants from the dominant group, an examination and discussion of their own group, they are able to see and question some of the assumptions they had previously taken for granted.

Secrets of the Human Face:
New Insights Into the Face and Covert Emotions

Stephen Porter, Natasha Korva, and Alysha Baker, Centre for the Advancement of Psychological Science and Law (CAPSL), University of British Columbia, Canada

Dr. Stephen Porter currently is a researcher and consultant in the area of psychology and law. After working as a prison psychologist, Dr. Porter spent a decade as a professor at Dalhousie University. In 2009, he transferred to UBC-Okanagan where he assumed a position as a professor of psychology and the Director of the Centre for the Advancement of Psychological Science & Law (CAPSL). Dr. Porter has published numerous scholarly articles on psychopathy and violent behaviour, deception detection, and forensic aspects of memory with funding from the Social Sciences and Humanities Research Council of Canada (SSHRC) and the Natural Sciences and Engineering Research Council of Canada (NSERC).

Abstract

Deception is a fundamental aspect of human communication and often is accompanied by facial expressions simulated or concealed to be consistent with the false message. Darwin hypothesized that some facial muscle actions are beyond voluntary control and may "leak" genuine emotion or reveal falsified expressions. Despite uncritical acceptance of this notion in scientific and popular media arenas, little empirical work existed to substantiate these claims prior to our recent studies. Laboratory-based experiments substantiate Darwin's claims; emotional leakage is most likely to occur during masking (attempting to conceal one's felt emotion with a simulated expression), particularly when the to-be-concealed emotion is strongly felt. Although individual differences - related to emotional intelligence and psychopathic traits - in emotional fabrication ability exist, careful attention to the face can also reveal deceit in high-stakes, emotional, real-world situations. Televised footage of a large international sample of individuals emotionally pleading to the public for the return of a missing relative was meticulously coded for emotional presentation. About half of the pleaders eventually were convicted of killing the missing person based on overwhelming evidence. Failed attempts to simulate sadness and leakage of genuine happiness revealed deceptive pleaders' covert emotions and, in combination with verbal cues, differentiated honest and dishonest pleaders with unprecedented accuracy in the study of deception detection. These findings offer an important and novel advancement in our understanding of involuntary aspects of human communication.

Secrets of the Human Face: New Insights Into the Face and Covert Emotions

My (first author) research team has spent the past decade conducting a comprehensive investigation of how covert emotional information is communicated in the human face. We have coded millions of frames of videotaped facial expressions - in both highly-controlled lab experiments and "real-life" emotional scenarios - with the goal of solving some of the mysteries and resolving some of the controversies around emotional deception. In this paper, we summarize the key observations to come out of this body of work.

In addition to a basic interest in emotional communication, I had practical motivation to pursue this line of research. While interning in a prison during my training as a forensic psychologist, I provided individualized treatment to a psychopathic sexual offender who - after eleven months of sessions - appeared to me to be making tremendous progress in therapy, assuming responsibility, expressing remorse, and exhibiting empathy for his victims. As I was preparing a positive evaluation of his therapeutic

progress, his journal was confiscated during a cell-search. In the journal, he detailed his progressively more violent and sadistic sexual fantasies, suggesting that his criminal tendencies had been exacerbated during the course of treatment, and revealed the fact that he was "fooling his stupid shrink". This incident sparked my interest in the deceptive behaviour and our natural (in)ability to detect deception. What made me believe this seemingly sincere offender? And how can I (and other professionals) accurately detect such deceit in the future?

The Face as a Window to the Soul

The complex musculature of the human face and its direct relation with affective processes of the brain makes it a rich canvas upon which humans communicate their emotional states and from which we infer those of others. In daily life, we "read" the faces of intimates and strangers to make inferences about their emotions and intentions, and adopt expressions ourselves to communicate genuinely or falsely how we are feeling. Indeed, the face is a primary focus of attention upon meeting a stranger. Valenza, Simion, Cassia, and Ultimà (1996) found that infants showed a visual preference for face-like patterns. Throughout life, it continues to be the focal point in social situations, directing both conversation and decisions about further interaction. Based on a glimpse of a stranger's face, observers form instantaneous (less than 1/10th of a second) and enduring impressions about that individual's trustworthiness (Porter & ten Brinke, 2009; Willis & Todorov, 2006). The foundation of this process originates in our evolutionary past; the discrimination of friend versus foe likely involved an assessment of the stranger's emotional state and physical strength and was one of the earliest

interpersonal judgments to evolve (e.g., Todorov, 2008; Williams & Mattingley, 2006).

In daily life, we "read" the faces of intimates and strangers to make inferences about their emotions and intentions, and adopt expressions ourselves to communicate genuinely or falsely how we are feeling.

Indeed, some traits and intentions can be accurately inferred from a glimpse of a stranger's face. For example, personality traits such as extraversion and conscientiousness can be judged at an accuracy level greater than chance just by viewing a face (Little & Perrett, 2007). Further, observers can distinguish males seeking relationships versus those who are interested in casual sex, just by looking at their faces (Boothroyd et al., 2008). In an investigation of the undefined concept of "creepiness", we found that pictures of men were creepier than women and sexual offenders were perceived as creepier than those of other violent offenders (Porter, ten Brinke, Shaw, & Strugnell, 2011). However, no available evidence suggests that first impressions of trustworthiness, specifically, are accurate. In a recent study, participants provided trustworthiness ratings of violent America's Most Wanted criminals and philanthropists (Porter, England, Juodis, ten Brinke, & Wilson, 2008). Participants were able to distinguish

individual concerned. In a mock juror paradigm, participants more often rendered a guilty verdict for untrustworthy- versus trustworthy-looking defendants accused of (the same) homicide (Porter, Gustaw, & ten Brinke, 2010). Thus, although we 'read' faces on a daily basis, findings suggest we are subject to error, sometimes resulting in 'misreading' a face and the construction of an inaccurate impression/representation of a person's actual intentions, emotional state, or character more generally.

The inaccuracy of trustworthiness assessments may be due, in part, to the evolved ability to alter facial expression in order to conceal or fabricate emotional information. In the modern context, the identification of falsified emotions is important in everyday life, the courts, parole hearings, politics, and corporations. Jung (1959) proposed that individuals have a preferred persona (or mask-like) archetype or image that we choose to project to the world in order to protect ourselves from negative evaluations. Most people want to display themselves in a way that will benefit them in all areas of their life (e.g., work, relationships, etc.), even if that means presenting a false persona. So how do we know when people are being honest? Deception is a fundamental aspect of human interaction that often acts to promote

The inaccuracy of trustworthiness assessments may be due, in part, to the evolved ability to alter facial expression in order to conceal or fabricate emotional information. In the modern context, the identification of falsified emotions is important in everyday life, the courts, parole hearings, politics, and corporations.

between the two groups only slightly above the level of chance. Despite the inaccuracy of these assessments, they can have a strong biasing effect on subsequent decisions about the

social cohesion. Research finds that people lie, on average, two times per day (DePaulo, Kashy, Kirkerdol, Wyer, & Epstein, 1996). For example, the wise husband responds with a nod and

a loving smile when his wife asks his opinion of her new dress, regardless of his genuine evaluation.

Despite the ubiquity of deception in our daily lives, we are naturally poor lie detectors (Bond & DePaulo, 2006). Is a passenger a potential threat? Is an offender's emotional display/remorse in a parole or sentencing hearing genuine? Much research demonstrates that observers generally are unable to discriminate genuine vs. faked expressions (Porter & ten Brinke, 2008; Porter et al., 2010), despite high confidence in such evaluations (Vrij & Mann, 2001). Porter, ten Brinke, and Wilson (2009) found that psychopaths were 2.5 times as likely as their counterparts to be successful in parole applications, which we hypothesized related to Academy Award-winning acting jobs. Clearly, credibility assessment is not a common sense task, contrary to the views of the Supreme Court of Canada (R. v. B. (K. G.), 1993).

Alluding to my personal incident I discussed earlier, it is of particular interest to me how people can deceive others so easily while speaking face-to-face. Previous research has suggested that individuals generally associate face-to-face lying with various nervous behaviours such as speech disturbances, gaze aversion, body movement, and fidgeting (e.g., Vrij, 2008). These stereotypes are also shared by the judiciary; in Morales v. Artuz, the judge noted that 'seeing a witness's eyes has sometimes been explicitly mentioned as of value in assessing credibility'. However, assessments of credibility based on nervous behaviour are likely to be inaccurate because these indicators are not substantiated by empirical research (Vrij, 2000) and can also be confounded by other factors, such as culture. For example, many aboriginals avert their gaze as a sign

of respect when interacting with other individuals (see Porter & ten Brinke, 2009). Given the apparent complexities of using voluntary body language behaviours as a cue to deception, recent research in my lab has focused on emotional deception via the alteration of universal facial expressions (happiness, sadness, fear, contempt, disgust, surprise, anger; Ekman, Sorenson, & Friesen, 1969; Matsumoto & Willingham, 2006) – a concept dating to the 19th century.

Whereas real remorse was associated with sincere expressions of sadness, false remorse contained leakages of anger and happiness.

Emotional Expression as a Cue to Deception

In 1862, Duchenne, a French neurologist, conducted the first experimental study that examined prototypical expressions of emotion, using electrical stimulation of facial muscles. He noted that the common notion of the happiness facial expression is the contraction of the zygomatic major muscle, which pulls the mouth corners upwards into a smile. When this muscle was electrically stimulated, he found that the resulting smile (in the absence of felt happiness) did not appear complete. Indeed, this was an inadequate expression of happiness because it did not involve the contraction of the orbicularis oculi surrounding the eye (pulling the cheek up and causing wrinkles, or "crow's feet", to form around the eye). Duchenne concluded that simultaneous contractions of these two muscles are necessary to produce a genuine expression of happiness (later established by Ekman, Davidson, & Friesen, 1990).

Following Duchenne's ground-breaking work, Darwin (1872) later

proposed the inhibition hypothesis, which suggests that facial actions associated with strong emotion cannot be inhibited voluntarily, and that the same muscle actions cannot be engaged voluntarily during emotional stimulation (Ekman, 2003). He further postulated that more powerful emotions would be associated with more "leakage" than less potent emotions. A related proposal by Ekman (1992) is that when an emotion is concealed, a manifestation of the true emotion is revealed in the form of a micro-expression, a full-face expression lasting 1/25th – 1/5th of a second (Ekman, 1992; Ekman & O'Sullivan, 2006).

Although the inhibition hypothesis, in general, and Ekman's micro-expression specifically, were widely assumed to be valid, they received little empirical scrutiny until recently. From 2005 to present, we have conducted five studies that exhaustively analyzed thousands of genuine and falsified emotional facial expressions to meticulously examine these related proposals.

Testing the Inhibition Hypothesis and Searching for Micro-expressions

We conducted the first empirical study to directly examine the assumption that facial expressions are involuntary, uncontrollable, and can "leak" one's true feelings (Porter & ten Brinke, 2008). To examine the presence of emotional leakage, expressions inconsistent with the intended emotional portrayal, and search for the presence of micro-expressions, participants viewed happy, sad, disgusting, frightening, and neutral images, and were asked to respond to each image with either a genuine or deceptive facial expression. We analyzed each 1/30th-second frame to determine the presence and duration of universal facial expressions, the

frequency of micro-expressions, and blink rate; a total of 104,440 frames in 697 expressions were analyzed. We found that relative to genuine emotions, masked – or deceptive – expressions were associated with more inconsistent expressions. In other words, masking one's true emotions does indeed result in more emotional leakage than is present during genuine expressions. Further, findings suggest that negative emotions (i.e., sadness, fear, disgust) were more difficult to falsify compared to positive emotions (i.e., happiness). Finally, inconsistent emotional leakage occurred in 100% of participants at least once, and most often lasted longer than the micro-expression defined by Ekman (1992). Micro-expressions only occurred in 21.95% of participants, in 2% of all facial expressions exhibited, and were not full-face expressions. Despite the presence of lengthy emotional leakage, naïve observers performed at the level of chance when detecting deceit.

The muscle activation pattern of deceptive pleaders likely reflected failed attempts at sadness in the upper face and leakage of masking smiles in the lower face. This important extension reveals that particular muscles deserve attention when attempting to reveal the false face.

In a recent follow-up study, we examined the influence of emotional intensity on people's ability to conceal and falsify emotional expressions (Porter, ten Brinke, & Wallace, 2011). Participants viewed happy, sad, frightening, disgusting, and neutral images that were previously rated in emotional intensity. Again, each 1/30th-second frame of 1711 expressions was analyzed for the duration and intensity of universal expressions, totaling 256,650 frames. Our findings lent further support to Darwin's (1872) hypotheses. High intensity emotion was more difficult to conceal than low intensity emotion, and occurred in 98.3% of participants during false emotional masking. Specifically, emotional leakage was displayed for a longer time in the upper versus lower face. Further, and replicating findings of Porter and ten Brinke (2008), leakage occurred more often during negative expressions (sadness, fear, disgust), and particularly during fear. And again, we found that observers were unable to differentiate between genuine and false emotions above the level of chance.

Individual Differences in Emotional Leakage

Although our previous research had established that emotional leakage often occurs, in our third study we hypothesized that individual differences in psychopathic traits and emotional intelligence would relate to the likelihood and duration of emotional leakage during

deceptive facial expressions (Porter, ten Brinke, Baker, & Wallace, 2011). As with the above lab-based studies, participants were asked to simulate insincere expressions in relation to a neutral or powerful emotional image (e.g., respond to a sad image with an expression of happiness). As predicted, our findings suggested that those high in psychopathy and emotional intelligence each had enhanced, but different, abilities at adopting deceptive facial expressions. Psychopathy - particularly interpersonal manipulation - was related to less emotional leakage during deceptive displays, whereas emotional intelligence was related to more convincing displays during emotional simulation. However, in accordance with Darwin's (1872) inhibition hypothesis, no participants (regardless of emotional intelligence and psychopathy) were immune to emotional leakage.

Emotional Leakage During Displays of Fabricated Remorse

Research suggests that psychopathic individuals are proficient emotional deceivers and are able to manipulate their way to reduced sentences and early releases in parole and sentencing hearings (e.g., Hakkanen-Nyholm & Hare, 2009; Porter, ten Brinke, & Wilson, 2008). While we postulated that psychopaths feign remorse to achieve leniency in these settings, no research had yet examined the behavioural differences between genuine and deceptive remorse. We examined, for the first time, the possible presence of leakage in the facial expressions of individuals pretending to be remorseful (ten Brinke, MacDonald, Porter, & O'Connor, 2011). Participants were videotaped while relating two true autobiographical transgressions, accompanied by either genuine or false remorse (i.e., the participant describing a serious transgression for which he/she felt powerful remorse, or felt no remorse but feigned remorse). After analyzing nearly 300,000 frames, we found that descriptions of falsified remorse were associated with a greater range of emotional expressions. Whereas real remorse was associated with sincere expressions of sadness, false remorse contained leakages of anger and happiness. In addition, falsified remorse was emotionally turbulent, with negative and positive expressions often following each other directly. In contrast, emotional expressions in genuine remorse progressed through neutral expressions.

Emotional Facial Leakage Reveals High-Stakes Interpersonal Deception

In our most recent research, we left the laboratory context and conducted the most comprehensive study to date of extremely high-stakes, real-life deception with a novel paradigm (ten Brinke & Porter, 2011). Televised footage

of a large international sample of individuals emotionally pleading to the public for the return of a missing relative was meticulously coded frame-by-frame (74,731 frames). About half of the pleaders eventually were convicted of killing the missing person based on overwhelming evidence. Failed attempts to simulate sadness and leakage of smiles revealed deceptive pleaders' covert emotions. Falsified and incomplete expressions of sadness were prominent during deceptive portrayals; typically deceivers failed in contracting the muscles associated with true distress in the forehead region and instead exhibited facial expressions that more closely resemble surprise. In addition, we found leakage of happiness (i.e., smirks) in the lower face of the deceptive pleaders. Deceptive pleaders also provided shorter pleas and used more tentative language in their messages. The combination of these four cues could discriminate deceptive murderers from genuinely distressed relatives at 90% accuracy.

In a follow-up study (ten Brinke, Porter, & Baker, 2011), we investigated the specific facial muscle action units (AUs; Ekman, Friesen, & Hagar, 2002) associated with these deceptive and genuine pleas by focusing on five crucial muscles: frontalis (AU1+2), corrugator supercilli (AU4), zygomatic major (AU12), and depressors (AU15). The prototypical expression of sadness in the upper face is characterized by activation of the frontalis (raising the eyebrows upward) and activation of the corrugator supercilli (lowering and pulling together of the eyebrows, creating a furrow). While most people can voluntarily activate the frontalis fairly easily, contraction of the corrugator supercilli is a more difficult task, particularly when cognitive load is heavy during high-stakes deception. Activation of the depressors, pulling the lip corners downward into a frown, completes the expression of sadness. Our results indicated that genuine pleaders were more likely to activate grief muscles (corrugator supercilli and depressors muscles), whereas deceptive pleaders were more likely to activate the frontalis and zygomatic major (turning the mouth upward into a smile) muscles. The muscle activation pattern of deceptive pleaders likely reflected failed attempts at sadness in the upper face and leakage of masking smiles in the lower face. This important extension reveals that particular muscles deserve attention when attempting to reveal the false face.

Conclusion

In summary, our research studies collectively emphasize the importance of the human face in revealing covert emotional information. In accordance with the inhibition hypothesis (Darwin, 1982; Ekman, 2003), our research supports the contention that people cannot completely inhibit powerfully felt emotions and are likely to fail when attempting to falsify these expressions in the absence of emotion. In both highly-controlled and real-life contexts, emotional leakage occurs that can be identified by the informed observer. Indeed, the secrets of the human face finally are being revealed empirically.

References

Bond, C. F. Jr., & DePaulo, B. M. (2006). Accuracy of deception judgments. Personality and Social Psychology Review, 10, 214–234.

Boothroyd, L. G., Jones, B. C., Burt, D., DeBruine, L. M., & Perrett, D. I. (2008). Facial correlates of sociosexuality. Evolution and Human Behavior, 29(3), 211-218. doi:10.1016/j.evolhumbehav.2007.12.009

Darwin, C. (1965/1872). The expression of the emotions in man and animals. Chicago: University of Chicago.

DePaulo, B. M., Kashy, D. A., Kirkendol, S. E., Wyer, M. M., & Epstein, J. A. (1996). Lying in everyday life. Journal of Personality and Social Psychology, 70(5), 979-995. doi:10.1037/0022-3514.70.5.979

Duchenne, G.B. (1990/1862). The mechanism of human facial expression. NY: Cambridge University Press.

Ekman, P. (1992). Telling lies: Clues to deceit in the marketplace, politics, and marriage. New York: W. W. Norton.

Ekman, P. (2003). Darwin, deception and facial expression. In P. Ekman, R.J. Davidson, & F. DeWaals (Eds.), Annals of the New York Academy of Sciences: Vol. 1000. (pp. 205–221). New York: New York Academy of Sciences.

Ekman, P. (2005). Conclusion: What We Have Learned by Measuring Facial Behavior: Further Comments and Clarifications. In P. Ekman, E. L. Rosenberg, P. Ekman, E. L. Rosenberg (Eds.), What the face reveals: Basic and applied studies of spontaneous expression using the facial action coding system (FACS, 2nd ed.) (pp. 605-626). New York, NY US: Oxford University Press. Retrieved from EBSCOhost.

Ekman, P., Davidson, R.J., & Friesen, W.V. (1990). The Duchenne smile: Emotional expression and brain physiology: II. Journal of Personality and Social Psychology, 58, 342–353.

Ekman, P., Friesen, W.V., & Hagar, J.C. (2002). Facial Action Coding System. Salt Lake City, UT: Network Information Research.

Ekman, P., & O'Sullivan, M. (2006). From flawed self-assessment to blatant whoppers: The utility of voluntary and involuntary behavior in detecting deception. Behavioral Sciences & the Law, 24(5), 673-686. doi:10.1002/bsl.729

Ekman, P., Sorenson, E., & Friesen, W. V. (1969). Pan-cultural elements in facial displays of emotion. Science, 164(3875), 86-88. doi:10.1126/science.164.3875.86

Häkkänen-Nyholm H, Hare R. Psychopathy, homicide, and the courts: Working the system. Criminal Justice and Behavior [serial online]. August 2009;36(8):761-777. Available from: PsycINFO, Ipswich, MA. Accessed September 30, 2011.

Hancock, J. (2007). Digital Deception: When, where, and how people lie online. In K. McKenna, T. Postmes, U. Reips, & A. Joinson (Eds.), Oxford handbook of internet psychology (pp.287-301). Oxford: Oxford University Press.

Jung, C. (1959). Collected works. Vol. IX, Pt. I. The archetypes and the collective unconscious. Oxford England: Patheon. Retrieved from EBSCOhost.

Little, A. C., & Perrett, D. I. (2007). Using composite images to assess accuracy in personality attribution to faces. British Journal of Psychology, 98(1), 111-126. doi:10.1348/000712606X109648

Martelli, M., Majib, J.M., & Pelli, D.G. (2005). Are faces processed like words? A diagnostic test for recognition by parts. Journal of Vision, 5, 58-70.

Matsumoto, D., & Willingham, B. (2006). The thrill of victory and the agony of defeat: Spontaneous expressions of medal winners of the 2004 Athens Olympic games. Journal of Personality and Social Psychology, 91(3), 568-581. doi:10.1037/0022-3514.91.3.568

Morales v. Artuz (2002) US. App (2nd).

Porter, S., England, L., Juodis, M., & ten Brinke, L. (2008). Is the face a window to the soul? Investigation of the validity of intuitive judgments of the trustworthiness of human faces. Canadian Journal of Behavioural Science, 40, 171-177. doi:10.1037/0008-400X.40.3.171

Porter, S. & ten Brinke, L. (2008). Reading between the lies: Identifying concealed and falsified emotions in universal facial expressions. Psychological Science, 19, 508-514.

Porter, S., & ten Brinke, L. (2009). Dangerous decisions: A theoretical framework for understanding how judges assess credibility in the courtroom. Legal and Criminological Psychology, 14(1), 119-134. doi:10.1348/135532508X281520.

Porter, S., ten Brinke, L., Baker, A., & Wallace, B. (2011, in press). Would I lie to you? "Leakage" in deceptive facial expressions relates to psychopathy and emotional intelligence. Personality and Individual Differences. doi:10.1016/j.paid.2011.03.031

Porter, S., ten Brinke, L., & Gustaw, C. (2010). Dangerous decisions: The impact of first impressions of trustworthiness on the evaluation of legal evidence and defendant culpability. Psychology, Crime & Law, 16(6), 477-491. doi:10.1080/10683160902926141.

Porter, S., ten Brinke, L., Shaw, S., & Strugnell, K. (2011, under preparation). Creeped out: The influence of facial characteristics and body language on perceptions on creepiness.

Porter, S., ten Brinke, L., & Wallace, B. (2011, in press). Secrets and lies: Involuntary leakage in deceptive facial expressions as a function of emotional intensity. Journal of Nonverbal Behavior.

ten Brinke, L., MacDonald, S., Porter, S. & O'Connor, B. (2011, in press). Crocodile tears: Facial, verbal and body language behaviour associated with genuine and fabricated remorse. Law and Human Behavior. doi:10.1007/s10979-011-9265-5

Todorov, A. (2008). Evaluating faces on trustworthiness: An extension of systems for recognition of emotions signaling approach/avoidance behaviors. In A. Kingstone, M. B. Miller, A. Kingstone, M. B. Miller (Eds.) , The year in cognitive neuroscience 2008 (pp. 208-224). Malden: Blackwell Publishing. Retrieved from EBSCOhost.

Valenza, E., Simion, F., Cassia, V., & Umiltà, C. (1996). Face preference at birth. Journal of Experimental Psychology: Human Perception and Performance, 22(4), 892-903. doi:10.1037/0096-1523.22.4.892

Vrij, A. (2008). Detecting lies and deceit: Pitfalls and opportunities. Chichester, England: Wiley.

Vrij, A. (2000). Detecting lies and deceit: The psychology of lying and the implications for professional practice. Chichester, England: Wiley.

Willis, J., & Todorov, A. (2006). First impressions: Making up your mind after a 100-ms exposure to a face. Psychological Science, 17, 592-598. doi:10.1111/j.1467-9280.2006.01750.x

Connectedness – what is it?

Jane Gilbert & Sarah Calvert

Dr Jane Gilbert is Chief Researcher at the New Zealand Council for Educational Research. Prior to this role she was a senior lecturer in the School of Education at Victoria University of Wellington. She has also taught science education in the School of Mathematics and Computing Sciences at Victoria University and sociology of education at the University of Waikato. She was also was a secondary school teacher of science and biology for ten years in the 1980s.

Sarah Calvert is a clinical psychologist in private practice in Auckland. She has worked for the Family Court since its inception and also worked for many years for Child, Youth and Family. She has been involved in the development of guidelines both for forensic settings and in other areas of practice.

This paper explores the concept of 'connectedness', looking in particular at how our view of it changed as we participated in research designed to investigate connectedness in a group of young adolescents.

The last 10-15 years or so have seen a growing interest in the concept of connectedness. Several major international studies have reported significant positive correlations between high levels of connectedness in young people and a range of different indicators of adolescent well-being, health and development[1]. Connectedness is now widely seen as a protective factor, and connectedness and well-being are seen as being linked to each other.

There is, however, no generally agreed definition of connectedness in the literature[2]. Connectedness is talked about as a state of 'being' and something you can 'have', 'get' or 'develop'. It is represented as a feeling of belonging, of being valued and accepted, of not being alone in the world. In some work, connectedness is thought of as being 'two-way': that is, as a relationship and as being 'built' in relationships. The measures of connectedness used in the research literature usually attempt to capture the extent to which people feel as though they belong/are accepted, or do things that fit with having those feelings.

There are some interesting issues here - methodologically,

[1] See, for example, Carter et al (2007), McNeely (2003), McNeely et al (2002), Blum et al (2002), Resnick et al (1997).

[2] Barber and Schluterman (2008), Fredricks et al (2004)

philosophically, and practically speaking. What actually *is* connectedness – and *can* it be measured? How is it linked with well-being? To what extent are these two concepts separate entities? If they are separate, does one 'lead to' the other – and if so, which one comes first? *How* does it produce the other? *How* does a person 'get' connectedness? What *helps* them get it?

The Connectedness in Youth project was designed to explore these kinds of questions. It began with the assumption that connectedness and well-being are separate but linked, aiming to find out if the relationship between them is one-way or two-way: that is, does one *produce* the other, or do they *support* each other?

The last 10-15 years or so have seen a growing interest in the concept of connectedness. Several major international studies have reported significant positive correlations between high levels of connectedness in young people and a range of different indicators of adolescent well-being, health and development.

This project was a three-year, longitudinal study carried out between 2006 and 2008. The study had three parts. In the first part, a sample of 2174 young people, recruited from 78 schools in New Zealand's lower North Island, completed a 300+ item survey (administered using laptop computers in the participants' schools) once a year for each of the three years of the study. These young people were 10, 12 and 14 years old at the beginning of the study. Survey items were designed to measure the young people's sense of connection to their families, friends, local community, and school, as well as their overall 'well-being'. This part of the study was by far the largest. It formed the core of the project as a whole, and was designed and carried out by researchers from the Roy McKenzie Centre for the Study of Families at Victoria University of Wellington[3].

The second and third parts of the study were carried out by researchers from the New Zealand Council for Educational Research working with a small sub-sample of 41 young people drawn from the main project, with equal numbers from the three age cohorts. These young people were interviewed once a year for each of the three years of the study, and, in addition, they made digital stories about themselves each year[4]. The interviews were designed to collect qualitative data from these young people, and the

digital stories, while they were not originally designed to do this, also provided rich data on the young people's sense of themselves, their connectedness, and their development over the period of the study.

This paper looks at the high-level findings from the second and third parts of the study alongside those of the first part. It then looks at what these findings mean from a practical point of view, and what they tell us about connectedness.

So, looking at the larger project's findings first: analysis of the three years of data showed that when connectedness was taken as a whole (that is, putting connectedness to family, friends, school, and community together) it predicted well-being one year and two years later. Well-being, however, did not predict connectedness over time. Thus the relationship appeared to be one-way. However, further analysis of the data, considering the four domains separately, produced a different picture. For family and school connectedness, the effect was two way: that is, the young people who had high levels of well-being later developed higher levels of connectedness, and this turn fed back to produce higher levels of wellbeing.

But: what should policymakers and practitioners take from this? Should the focus be on building well-being, or building connectedness? Or both? Jose and Pryor (the lead researchers) say that the findings tell us that well-being is best enhanced by supporting, not individuals, but the contexts in which connectedness develops – i.e. their families, schools, friends and community[5]. But what would this support look like? What kinds of support would make the most difference? How much support is enough? Is one (or more) of the four domains more important than the others? Would support in one domain help develop connectedness (or compensate for deficiencies) in another? The first part of the *Connectedness in Youth* study wasn't designed to answer these questions: however, the data collected from the smaller sample of young people in parts two and three of this study goes some way towards answering some of these questions.

Connectedness is now widely seen as a protective factor, and connectedness and well-being are seen as being linked to each other.

The smaller sub-project's methods of data collection and analysis were very different, but designed to complement the main study. The interviews were informal, with open-ended questions of the "tell us about yourself" type. All interviews over the three years were carried out by both authors: thus there was a strong relational context. All

---

[3]   See Jose and Pryor (2010) for further details of the measures and for more information on the design and findings of the larger, first part of the project.

[4]   The term 'digital storytelling' has been used to mean many things: this project drew on the work of the Center for Digital Storytelling, a coalition of media artists, designers and community activists that emerged in the San Francisco Bay Area in the early 1990s with the goal of making it possible for anyone to create their personal or community story in media forms that can be easily and freely shared. See Center for Digital Storytelling (2003) for more information.

[5]   See Jose and Pryor (2010), p. 97.

were videotaped. The interview videotapes and the young people's digital stories were analysed together, using a two level approach. First, conventional qualitative methods were used to look at what was said – how people, places, events and experiences had been consciously put together to form the interviewee's story; and second, psychodynamic approaches were used to explore deeper-level links between people, places, events, and experiences outside the interviewee's conscious narrative.

This produced a large amount of very rich material, which could have been organised and presented in a multitude of ways. We started by looking for patterns across the group of 41 interviewees. We developed a three point scale, which we used, not as an objective measure, but to evaluate the young people's connectedness in relation to each other, taking into account what we knew about the events and experiences in their lives so far. We decided to also evaluate their resilience and capacity on the same three-point scale, producing a score out of 9 for each individual for each year of the project.

However looking at the group as a whole was not especially helpful in developing the richer, more nuanced account of connectedness that was the aim of this part of the project, so we turned our attention to a detailed analysis of the stories of a few 'against the grain' individuals. This proved more productive. Four of these individual case studies are presented here to illustrate some of the complexities of connectedness that became apparent to us as we worked with this material.

Case Study 1

P is a Māori boy who lives with his mother in a country town about an hour's drive from a major city. He has very little contact with his father who lives in Auckland. He is strongly attached to his mother, who has worked hard to "give her children a better life" despite major issues in her own life (including domestic violence and drug/alcohol abuse). When we first interviewed P, he was attending the local kura kaupapa Māori. He strongly identified with this school and with being Māori, and through the kura he had developed a good sense of his intellectual capacity. However, his mother's connection with a local drug dealer and subsequent falling out with the kura whanau, led to him transferring to the local mainstream high school. P's connection to his mother stayed strong throughout all this. His ability to 'think through' adversity was scaffolded by her actions – including her (ultimately unsuccessful) attempt to reconnect him with his father, and her support of his developing identity as Māori, through the kura. P was able to use his abilities in music and sport to, as he put

it, "find a way in" to the new school, and to develop good - but realistic – goals. The fact that in his last year at school he was made head boy is evidence of his success - both in connecting to the new school and in achieving his goal of "getting good grades".

P's positive development trajectory in the face of difficult circumstances was scaffolded by a secure attachment to his mother. He is 'seen' – acknowledged and supported for who he is - first by his mother, and then by just about everyone around him - people in the community, at his schools, and his friends. His good basic attachment and resilience has scaffolded his ability to build other connections, which has in turn developed his capacity. The diagram below summarises our assessment of P's connection, resilience and capacity as these developed over the three years of the study.
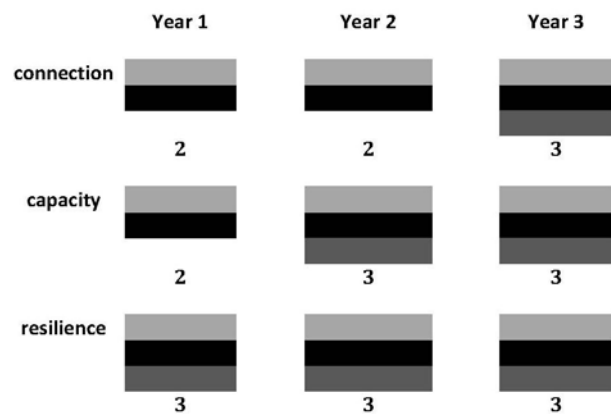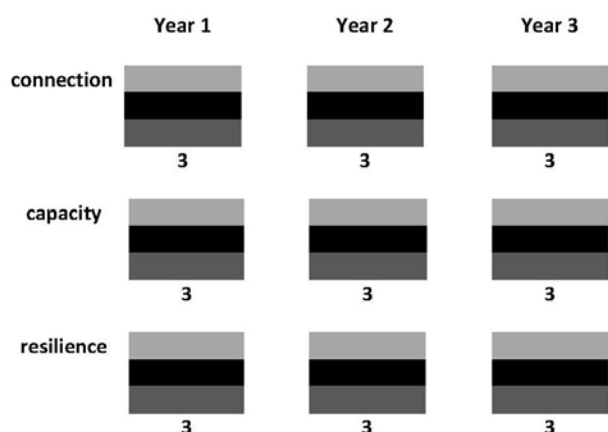

Case Study 2

M is a Pakeha girl who lives on a lifestyle block in a rural area about an hour's drive from a major city. She is strongly connected to her large, blended family (her mother died when she was very young and her father re-married). This is a family that values openness, creativity, and "following your interests", even where this involves being 'different'. M attended the local high school, where she was aware of – and largely at ease with - being seen as different: her interests include creative writing, fantasy, and microbiology – not sport. She has a very clear and coherent self-narrative, and is able to hold onto aspects of herself that are not supported by school and peers. School was tolerated as a means to an end - "it's OK as long as you're learning things". While she "gave up trying to be accepted" at school, saying that friendship was some "mystic thing" that she "kept failing at", during the project she was able to link up with peer groups outside school that 'worked' for her. In these groups (Armageddon, and Cosplay), her quirky

uniqueness and original thinking were acknowledged, valued and supported, whereas in her school life they were not.

M has now left school and is studying philosophy, classics and computer science at university. M's ability to 'be different' and to survive the 'standardising' influence of her school comes from her family. While she was not 'seen' at all by her school (despite being a vey successful student), she is seen by her family, and later, by her outside school peer group.
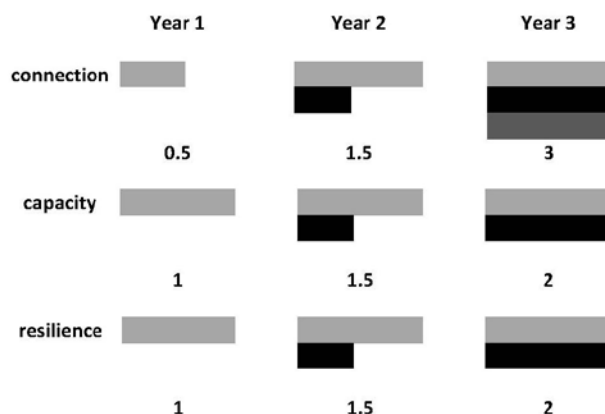

Case Study 3

N is a Pakeha male. He lives with his intact family in a lower decile suburb of a major city. However, he seems to have no connection at all to this family, and little sense of himself (he couldn't talk about himself directly at all). He attends the local high school. To us he appeared quirky and intelligent, with a good sense of humour, but sad, empty, distressed, and unconnected to anything. While he clearly thinks about things a lot, he is unable to find a 'way in' with his friends at school. During the project there were attempts by his friends and his school to connect him in. While these were partially successful (he played a key technical role in a school production), they were, in the end, too little, too late, and unable to foster wider connections. As we saw it, he 'lost' connection, resilience and capacity as the project progressed, and at one point was suicidal. N is not 'seen' at all in his family, and only partially 'seen' by his school and friends. While his school and peer group did attempt to engage him, he needed far more personalised attention than he was able to get. It is hard for us to see a good future for this young man.
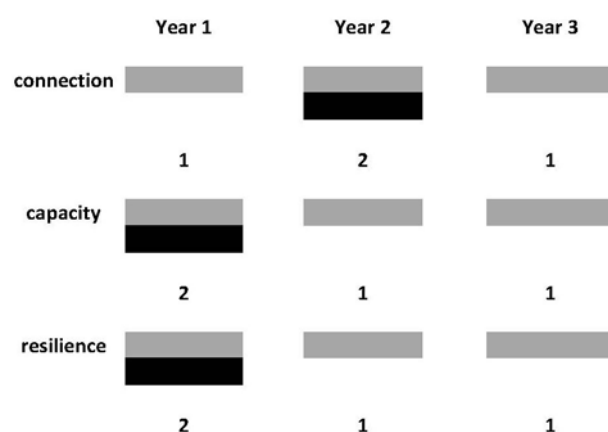
Case Study 4

K is a Pakeha girl who lives in a suburban area of a major city. Her parents have separated and she lives part of the time with each parent. She attends the local high school. K has no connection with, and is 'invisible' in, her family, and when we first met her she was having difficulty connecting with her school. Like M (case study 2 above), K experienced herself as 'different', but unlike M, this was not valued or supported in her family. However, during the first year of the project, there was a turning point. Her interest in fantasy characters (Animé, Manga and so on) led to her choosing Japanese as one of her subject options, and, as a result, her participation in a school trip to Japan. This trip gave her the 'leverage' she needed to build her connection to school, friends, a wider peer group, and the wider world, and to build her sense of herself (as she put it, it "made her a better person"). It also, ultimately, built her resilience. By the time of her third interview, K's aim was to make another trip to Japan, and to go to university – this despite her family's incomprehension and opposition. Thus during the three years of the project K was able to develop connections that have, at least in part, compensated for her lack of connection with her family.

These case studies show that there are multiple pathways to connectedness, and that it is a process that is never finished. While perhaps ideally it is built first in the family, and then 'added to' in relationships with wider community, friends, and school and so on, it does not *have* to be like this: where parts of the jigsaw are missing, other parts can compensate.

…for the young people participating in this project, the energising effects of connectedness were 'sparked off' when they were 'seen' – visible to, and acknowledged by, engaged, present others.

As we have thought more and more about connectedness, we have become convinced that it is not especially helpful to think about it as a 'thing', as a noun, or as a kind of 'matter' that can be 'constructed' from parts, or to try to measure it as *if* it were a thing. Instead, it seems to us that it is more usefully seen as a verb, a process, or a form of energy. To us, connectedness is energ*ising* in the way it creates new pathways and builds capacity. And, taking this metaphor further, for the young people participating in this project, the energising effects of connectedness were 'sparked off' when they were 'seen' – visible to, and acknowledged by, engaged, present others. The more they are seen, the more energy is generated, which in turn produces a more complex network of pathways, and more capacity. Thus, instead of seeing connectedness as something constructed in separate domains in a linear, directional, step-by-step way, we think it is more helpful to think of it as a series of networks that, as they build on, scaffold and energise the development of others, increase in complexity.

So put simply, the sub-project's findings support those of the main project, but they raise questions about how to think about connectedness.

References

Barber and Schluterman (2008). Connectedness in the lives of children and adolescents: A call for greater conceptual clarity. Journal of Adolescent Health, 43 (3), 29-216.

Bolstad, R. (forthcoming). Digital storytelling as a qualitative research methodology: Opportunities and tensions.

Blum, R, McNeely, C., and Rinehart, P. (2002). Improving the odds: The untapped power of schools to improve the health of teens. Center for Adolescent Health and Development, University of Minnesota, Minneapolis, MN. Downloaded from: www.konopka.umn.edu/peds/ahm/publications/home.html.

Carter, M.; McGee, R.; Taylor, B. and Williams, S. (2007). Health outcomes in adolescence: Associations with family, friends and school engagement. Journal of Adolescence 30(1), 51-62.

Center for Digital Storytelling (2003). History. http://www.storycenter.org/history.html.

Fredricks, J., Blumenfeld, P. and Paris, A. (2004). School engagement: Potential of the concept, and state of the evidence. Review of Educational Research 74(1), 59-109.

Jose, P. and Pryor, J. (2010). Does social connectedness lead to a greater sense of well-being in New Zealand adolescents? Findings from the Youth Connectedness project. Psychology Aotearoa 2 (2) pp. 94-97.

McNeely, C. (2003). Connection to school as an indicator of positive development. Paper presented at the Indicators of Positive Development conference, 12-13 March 2003, Washington DC. Downloaded from: www.childtrends.org/Files/McNeely-paper.pdf.

McNeely, C., Nonnemaker, J., and Blum, R. (2002). Promoting youth connectedness: Evidence from the National Longitudinal Study of Adolescent Health. Journal of School Health 72(4), 138-146.

Resnick, M., Bearman, P., Blum, R., Bauman, K., Harris, K., Jones, J. et al. (1997). Protecting adolescents from harm: Findings from the National Longitudinal Study of Adolescent Health. Journal of the American Medical Association 278(10), 823-32.

Holding the tension: Relational perspectives in counselling psychology practice

Martin Milton

Dr Martin Milton CPsychol, CSci, AFBPsS, UKCP Reg, is a counselling psychologist, chartered with the British Psychological Society, a BPS registered psychologist specialising in psychotherapy and a UKCP registered psychotherapist. He is Senior Lecturer on the University of Surrey Practitioner Doctorate in Psychotherapeutic and Counselling Psychology and also runs an independent practice in psychotherapy and supervision.

Web-links: www:swlondonpsychology.co.uk

http://www.surrey.ac.uk/psychology/people/martin_milton/

Psychological practice is complex and full of dilemmas which require navigation if we are to be confident in our knowledge and practice. This paper explores these tensions and suggests that relational perspectives have a great deal to offer.

Tensions? What tensions?

Tensions abound. For example:

Difference = problem		Difference = exotic
Individualism		Collectivism
Positivism		Constructionism
Short term work		Longer term work
Individual work	Couple work	Family work
Diagnosis		Formulation
Client		Patient
Symptom		Hidden meaning
Cure		Understanding
Internal world		External world
Conscious		Unconscious
Science		Art
Autonomous		Being-in-the-world

Specific tensions can be listed like this but it is important to remind ourselves that context and the position of the person can have a significant influence on our perception and experience. My own position may make this list of tensions more evident to me while some others – possibly more important to a New Zealand cohort – less obvious to me.

Despite our awareness of these tensions we can be taken off guard by them. Undergraduate students are often perplexed; my graduate students seem to experience enthusiasm and despair in equal measure; and unfortunately colleagues in some contexts report despair as the experience due to the way these tensions are - or are not - engaged with.

Our professional context is characterised by scientific advancement (mistakenly taken to mean increased certainty), global economic crises and a discourse of a 'moral imperative' for 'efficiency. These all manifest with a silencing discourse. The message is 'Don't stop and think – get on with it', 'Pick an issue and sort it' or 'We just don't have time for 'navel gazing'. Powerful statements, but we have to ask how scientific, how economically sound or efficient is it *really* to overlook the *actual* situation and act as if this complexity doesn't exist? Ernest Jones was alert to this tension back in the 1950s when he wrote that:

'Mediocre spirits demands of science a kind of certainty which it cannot give, a sort of religious satisfaction. Only the real, rare, true scientific minds can endure doubts which are attached to all our knowledge. I always envy the physicists and mathematicians who can stand on firm grounds. I hover, so to speak, in thin air. Mental events seem to be immeasurable and probably always will be so' (Jones, 1957: p418)

Despite this, the call for efficiency and advancements in our knowledge seem to have led us to act as if we can be *certain* about many things –an ability to *know* the other, make *definite* diagnoses and offer therapies that *will* work. This is one of the tensions; while we may be getting better at this, these limits will always frustrate us. And if we go for the illusion of certainty we overlook what we do with – or to – clients. Thankfully, clients act as one of the most important checks and balances of this dynamic, often wanting all of the tension attended to; the tension may be the distress.

Assessment

Many psychologists claim (or are constructed by their work contexts as claiming) to 'assess people and their needs'. A

more critical look at contemporary practice suggests that we may often limit our assessment to a client's eligibility for the limited therapies we already have on offer. For example, while writing on a different topic my colleague writes about his experience in the British NHS.

Our professional context is characterised by scientific advancement (mistakenly taken to mean increased certainty), global economic crises and a discourse of a 'moral imperative' for 'efficiency.

'I work in the NHS. I have 45 minutes allocated to 'assess' referred clients, and place them on one of four pathways:

Pathway one - Suitable for and likely to benefit from group pain management programme, [...].

Pathway two - Not suitable for group pain management programme but likely to benefit from pain management strategies – individual work indicated, [...].

Pathway three - Not suitable for pain service at current time - refer on and inform referrer.

Pathway four - Not suitable for pain service at current time and requires no referral on or does not wish to take up service - inform referrer'. (Boucher, in prep.)

So despite our training and despite clients' desire to tell their story, we don't often get to do a comprehensive, well rounded assessment. We have in mind what we offer and we go looking for the bit that fits. This is not 'wrong' per se as there are advantages to this type of approach, but there are disadvantages as well and it is important not to pretend otherwise (see Fletcher, in prep). It is important to recognise that such a narrow focus is part of a redirection of funding, a

revision of training curricula and a resultant deskilled workforce where we end up disregarding types of approaches/services. It seems that the question being asked is 'If we only offer X, why be aware of what Y could contribute?' or more specifically 'If we only offer CBT, why be aware of what group analysis, existential therapy, person centred theory, etc could offer?'

Models of therapy

The issue of complexity and our engagement with it is also played out in our discussions about psychological therapy. A great deal of energy has been put into the demystification of specific frameworks and we have constructed specific models of therapy as distinct from **all** others so that, like branded sore throat remedies, they can compete **against** each other. While the demystification of therapy is useful, the limits of the 'economic' approach and an adherence to positivistic assumptions means that we have started to 'define' and control particular therapies - in less than accurate ways. It means that CBT practitioners tend to see clients as 'faulty thinkers' and

psychodynamic ones see them as being riddled with unconscious conflicts. The behaviourist sees clients as needing direction and the client centred therapist suggests clients are intrinsically oriented towards health. These are very different positions and some very strong tensions exist.

This over-simplified approach may have merit as a basic introduction. But it is hugely problematic in the consulting room as the 'faulty thinking depressive' (who the manual

says I should 'treat' with a particular CBT protocol) may use his thoughts to defend against success. This is unlikely to be a deliberate ploy and the therapist may well need to draw on psychodynamic contributions to understand this process and to help the client understand this. This is becoming increasingly difficult as the contribution of psychodynamic, systemic, person-centred and other approaches are increasingly written out of practitioners' training if they are on the CBT track.

Directiveness vs Non-directiveness

When discussing 'models' another tension to consider is that of 'directiveness and non-directiveness'. Gone are the days of asking whether we influence people, but rather how we do, why we do, when we do, when we should, how we can communicate this, and what shapes the ways in which we influence (McAteer, 2010).

The issue of self-harm provides a useful example of the tensions that psychologists are faced with. In the world of certainty it might make

So despite our training and despite clients' desire to tell their story, we don't often get to do a comprehensive, well rounded assessment. We have in mind what we offer and we go looking for the bit that fits.

sense to always and inevitably focus on being directive and 'stopping' the behaviour. However this risks the client experiencing the therapist as being poorly attuned and can limit therapeutic engagement. An alternative is to be non-directive and read the behaviour as a meaningful communication that warrants open-minded exploration, offering that client a sense of being understood. But we remain embedded in tensions as family, service managers and society (not to mention the client

and therapist) may remain anxious about the risk. Not an easy place to be but a necessary tension to engage with because emotional pain and distress are inescapable features of the human condition. The tension is how to respect the meaning and wisdom that is often intertwined with 'the symptom' rather than simply trying to 'cure' or 'eradicate' it. Counselling psychologists find that relational frameworks are useful when meeting clients in pain as they help us learn from some of the damage that has occurred when using outmoded, individualistic ways of understanding people (see Milton, Craven and Coyle, 2010).

Professional tensions

Tensions exist outside of the consulting room too. They also affect the establishment of disciplines, relationships with other professions and the construction of identities. This paper will briefly look at the ways in which these were evident in the context of British counselling psychology. Of course this may vary from the New Zealand experience – or it may not.

Counselling psychologists find that relational frameworks are useful when meeting clients in pain as they help us learn from some of the damage that has occurred when using outmoded, individualistic ways of understanding people

Almost 20 years after our 'birth' as a formal profession, British counselling psychology seems to have moved beyond definition and fighting for the right to have some space although we still squabble over which space and how much. We seem to have developed a confident identity – albeit an ever evolving one. This has not always been easy though, as for many

a year – and at times still today – we faced questions such as 'Do you **REALLY** work in the NHS?', 'Are you like cheaper clinical psychologists?' or 'Are you like clever counsellors?' It is interesting to recognise the discourse has frequently been polarised and value laden. There have been lots of assumptions about hierarchy and status, who controls and colonises who. There is usually some sense of one or other profession being unfavourably compared. This is not surprising, because, as my colleagues Deborah Pugh and Adrian Coyle concluded 'counselling psychologists are competing for the same sector of the market place as counsellors, psychotherapists and clinical psychologists, and therefore could not expect to be welcomed by these professions' (Pugh and Coyle, 2000, p 97)

When power and economics come into play, the discourse seems to utilise polarised comparisons: Who is right? … and therefore who is wrong? Who is good? … and therefore who is bad? These are powerful and tempting ways of viewing phenomena, but they avoid the complexity of reality. They ignore the fact that therapies (and therapists) can be useful for one client but not very helpful for another.

Relational perspectives offer useful contributions

One perspective that was present at the birth of British counselling psychology and remains a core philosophical, academic, ethical and therapeutic priority is the understanding of people as 'relational beings'. Relational perspectives have an enormous contribution to make to understanding people and working towards greater wellbeing. This may be self-explanatory in terms of relationships between therapist and client, within families and between

intimate partners, but it is also a useful way of considering the relationships people have with themselves (Self-Self relations in terms of identity, self esteem and the like) and in terms of our Self-World relations (see Manafi, 2010). This framework reminds us that while there is an 'I' that exists, it is always in relation to someone and something. I exist in relation to myself, my values, my body, my power

> A relational perspective is pluralistic, recognising that every perspective may offer insight and so encourages a move beyond 'and-or' to at least consider 'both-and'.

and my emotion. I exist in relation to those close to me and to the wider community. While there may be some experience of consistency, this may be a lot less than we assume and theorise. There may be overlap between my experience, behaviour, expectations and hopes, I may actually experience them all very differently depending on the domain they relate to.

A relational perspective is pluralistic, recognising that every perspective may offer insight and so encourages a move beyond 'and-or' to at least consider 'both-and'. Pluralism relates to thinking and also to practice where we may make an interpretation about personal experience and another based on the social factors at play. This sits alongside the phenomenological method as a way of exploring experience. This perspective recognises that people are bio-psycho- and social in equal measure. A relational perspective is also particularly helpful in clarifying the meanings inherent in distress rather than seeing it simply as a meaningless, self-contained pathology to be excised.

For practitioners who may have a particular view of the world, a relational perspective usefully reminds

us that it **will** be insufficient. The more open we are to other meanings, the better. As a practitioner, a psychologist may focus on UCS internal objects but that cannot be to the exclusion of the reality of poverty, natural disasters and other real world effects on a person and their experience. From this viewpoint, the overtly political conversation becomes – at least potentially – relevant. As relevant as one about symptoms and one about early childhood.

One implication of a relational perspective is that it clarifies that to focus on the symptom and/or the therapeutic relationship is not enough. Relational perspectives open up our

> In our professional role we need to be continually mindful that racism, homophobia, heteropatriarchy, (to name just a few of the obvious discourses) are operating on us all.

understandings of how we are in the world, what affects us and what we affect. The very presence of the entire system can be meaningful and have an impact. It helps us to look at our existing knowledge bases and consider its relational implications. For example, we have long known that poverty can have an effect on the physical and psychological development of infants, children or adults - in the short term and in the longer term too; and we know that social and political oppression has an insidious effect on people's psychological wellbeing. This means that a variety of different investigative possibilities are legitimate and we now see burgeoning fields of ecopsychology (Higley and Milton, 2010, Milton, 2010) and its link to ecotherapy (Jordan, 2005), the resurgence of interest in the place of spirituality in people's lives (Coyle, 2010), research to understand our client's relational

worlds and of course the impacts of race (Lofthouse, 2010), disability and sexuality (Hicks, 2010, Hicks and Milton, 2010) on people's experiences.

To spell that out a little more. Being white gave a very different experience of South Africa than it did my black colleagues and fellow citizens. Equally, heterosexuals can claim that sexuality is not important but for the LGBT person who does very little without, at some level, negotiating rules, expectations and possible sanctions, this is simply absurd. In our professional role we need to be continually mindful that racism, homophobia, heteropatriarchy, (to name just a few of the obvious discourses) are operating on us all. It is only by considering them and their impact that we can be confident that we are doing the best by way of our clients. And this is not to choose to consider the individual or the impact of racism for example, but both; how one navigates well being in the context of oppression.

Conclusion

McAteer has written that:

'*the question arises: is it a case of 'many hands make light work', or 'too many cooks spoil the broth'? As is the dialectical prerogative, it's neither and it's both. Many hands or theories certainly don't make for light work when it comes to wrestling with these ideas, but nor do they spoil the broth. They are the broth. They are already in the mix, whether we like it or not, and the tension comes from communicating with opposing views that we cannot ignore*'. (2010, pp10-11)

In an age of ever-increasing awareness of complexity, the desire for simplicity and certainty grows. An instructive style is demanded and economics and a certain view of science and a moral discourse of 'the right thing to do' seem to become appealing. But this is not necessarily logical, scientific,

ethical or useful. An engagement with complexity is required. It has always been so.

References

Boucher, T. (In preparation) Pain: Working with meanings, in M. Milton (Ed) (in preparation) Diagnosis and beyond: Counselling psychology contributions to understanding human distress, Ross-on-Wye: PCCS Books

Coyle, A. (2010) Counselling psychology contributions to religion and spirituality, in M. Milton (Ed) Therapy and beyond: Counselling psychology contributions to therapeutic and social issues, Chichester: Wiley Blackwell.

Fletcher, R. (In preparation) Dealing with diagnoses, in M. Milton (Ed) (in preparation) Diagnosis and beyond: Counselling psychology contributions to understanding human distress, Ross-on-Wye: PCCS Books

Hicks, C. (2010) Counselling psychology contributions to understanding sexuality, in M. Milton (Ed) Therapy and beyond: Counselling psychology contributions to therapeutic and social issues, Chichester: Wiley Blackwell.

Hicks, C. and Milton, M. (2010) Sexual identities: Meanings for counseling psychology practice. In R. Woolfe, W. Dryden, S. Strawbridge and B. Douglas (Eds) Handbook of counseling psychology (3rd edn) London: Sage.

Higley, N. and Milton, M. (2008) Our connection to the earth: A neglected relationship in counselling psychology, Counselling Psychology Review, 23(2): 10-23.

Jones, E. (1957) Sigmund Freud: Life and work, vol 2, London: Hogarth Press

Jordan, M. (2005) The process of the Vision Fast: A (trans) personal journey. Paper presented at the Transpersonal Psychology Section of the British Psychological Society, 17 September 2005. www.ecotherapy.org.uk/fuiles/ecotherapy/home/The_vision_fast_unmarked.doc. Accessed 2 April 2008

Lofthouse, J. (2010) The 'R' word, in M. Milton (Ed) Therapy and beyond: Counselling psychology contributions to therapeutic and social issues, Chichester: Wiley Blackwell.

Manafi, E. (2010) Existential-phenomenological contributions to counseling psychology's relational framework, in M. Milton (Ed) Therapy and beyond: Counselling psychology contributions to therapeutic and social issues, Chichester: Wiley Blackwell.

McAteer, D. (2010) Philosophical pluralism: Navigating the sea of diversity in psychotherapeutic and counselling psychology, in M. Milton (Ed) Therapy and beyond: Counselling psychology contributions to therapeutic and social issues, Chichester: Wiley Blackwell.

Milton, M. (2010) Coming home to roost: Counselling psychology and the natural world, in M. Milton (Ed) Therapy and beyond: Counselling psychology contributions to therapeutic and social issues, Chichester: Wiley Blackwell.

Milton, M. Craven, M. and Coyle, A. (2010) Understanding human distress: Moving beyond the concept of 'psychopathology', in M. Milton (Ed) Therapy and beyond: Counselling psychology contributions to therapeutic and social issues, Chichester: Wiley Blackwell.

Pugh, D. and Coyle, A. (2000) The construction of counselling psychology in Britain: A discourse analysis of counselling psychology texts, Counselling Psychology Quarterly, 13 (1): 85-98

Life and Living in Advanced Age in New Zealand:

LILACS NZ –Research Study
Karen Hayman

for the LILACS NZ management team, including Professor Ngaire Kerse, Dr Lorna Dyall and Dr Mere Keepa

Karen Hayman joined the University of Auckland in 2002 as a research nurse. She is currently project manager and research fellow on the LILACS Study, a longitudinal cohort study investigating independence and survivorship for people of advanced age. Karen has a background in general nursing and has a Master of Science degree in Health Psychology. She is currently studying for a PhD looking into resilience in advanced age.

The research study LILACS NZ (Te Puwāitanga o Ngā Tapuwae Kia ora Tonu, Life and Living in Advanced Age: the Cohort Study in New Zealand) has been underway for 18 months (inception March 2010). The study broadly aims to investigate what contributes to independence and survival for people of advanced years (80-90 years of age) through a longitudinal cohort study design.

People over age 85 years are the fastest growing population group in New Zealand. Overall they currently make up 1% of the population, but by 2050 this proportion will have grown to 6% [1]. These are also the people with the highest spending on health in New Zealand [2]. Although they have survived the chronic diseases leading to early mortality, collectively they still have increased disability and dependence. However, little is really known about this group as the absolute numbers of people over age 85 included in routine surveys is small.

Increases in the numbers of people surviving into very advanced age across the globe is leading to increasing research by many countries to highlight the needs of older people. Outcomes are likely to reduce the burden of disability and improve lives by streamlining social and community supports. Longitudinal studies provide insight into epidemiological factors that contribute to successful ageing. Eleven longitudinal ageing studies across the world have been completed; another 37 are ongoing [3]. The importance of socioeconomic status is established and more specific studies show the prevalence, course and impact of changing cognition in ageing. Studies examining medical, psychological, social and economic factors in detail show the importance of breadth in protective factors [4]. Most such research focuses at the 'younger' end of old age, however, with advanced age, variability in any physiological and functional parameter increases [5]. There is good evidence that known factors predicting successful ageing for those from 65 years may act quite differently in the older population. This study will provide predictive data on a group of people in advanced age.

LILACS NZ is now beginning a longitudinal cohort study to a) examine the relative influence of various parameters - social cohesion, health services; diseases; physical function; psychological; functional; biomedical; environmental and economic factors - on successful ageing, b) establish the trajectories and pathways taken by people in advanced age and c) understand the relative importance of health, frailty, cultural, social and economic factors to independence, quality of life and survival.

People over age 85 years are the fastest growing population group in New Zealand. Overall they currently make up 1% of the population, but by 2050 this proportion will have grown to 6%

A feasibility project was conducted in 2008/2009 to determine the feasibility of undertaking such a large study within this population. Wave 1 of the LILACS NZ study (baseline) was conducted from March 2010 – March 2011. Nearly 1000 older people have now been enrolled from the Bay of Plenty and Lakes District Health Board areas and are undergoing the second year of data collection. Baseline and subsequent years involve a face-to-face interview, a health assessment, and if agreeable, a check of general practice medical records for diagnosed medical conditions and procedures (baseline only). For those not able to participate in a full assessment, minimal data is collected with permission to follow health statistics over time.

Participants are representative of urban and rural populations, and community-dwelling and residential

and rest home care residencies. The inception cohort includes 429 Māori

> We want to determine prevalence of dementia in the age group by interviewing 10% of the inception cohort who had a low cognitive screen at baseline, assessed with the Modified Mini Mental State Examination.

born between 1st January 1920 and 31st December 1930 (aged 80-90 in the 2010 calendar year) and 510 people of all other ethnicities born between 1st January and 31st December 1925 (aged 85 at entry). The Māori cohort has a wider age range because fewer Māori live into their 80s and Māori are a smaller percent of the overall population. Equal numbers are needed to be able to show relevant results for Māori.

Researchers from the University of Auckland are working with research partners in six areas across the Bay of Plenty and Lakes regions to manage enrolments and data collection. These research partners include three Primary Health Organisations, and four Māori Rūnunga. Four organisations have enrolled both Māori and non-Māori, one only Māori and one only non-Māori. The organisations undertaking these study processes are Ngā Mataapuna Oranga Kaupapa Māori PHO, Rotorua Area Primary Health Services, the Western Bay of Plenty Primary Health Organisation, Te

Korowai Aroha Health Centre, Te Rūnunga o Ngāti Pikiao, Te Rūnunga o Ngāti Awa and Te Rūnunga o Ngāti Irapuaia.

Some of our methods were revised following the feasibility project in order to facilitate engagement with older people living in all situations. Using widespread promotion (posters, GP support, public meetings, promotion through community and other health organisations and Māori iwi organisations) we focused on ways of accessing people who were not well connected to their community. A kaupapa Māori approach helped the study connect with older Māori. A Roopu Kaitiaki (governance group to protect the principles of proper conduct for Māori in the research) has also been set up to support the project throughout each wave. This group (Hone Kameta, Florence Kameta, Paea Smith, Betty McPherson and Leiana Raipae Reynolds) provides advice on all aspects of the study pertaining to Māori culture.

With permission, we will follow participants yearly to establish what variables predict changes in health and independence over time. Hospitalisation and

mortality data (outcomes) will be obtained by matching the NHI with New Zealand Health Information Services (NZHIS) and DHB data. This will be completed each year after enrolment until the participant's death.

In 2011 we have a particular interest in nutrition and in dementia. We want to find out about the foods people are eating, their mobility, and their heart health. Information is being collected via a 24 hour nutrition recall led by a trained nutrition assessor, where participants recall everything they ate 'yesterday'. We want to determine prevalence of dementia in the age group by interviewing 10% of the inception cohort who had a low cognitive screen at baseline, assessed with the Modified Mini Mental State Examination [6]. A clinical cognitive assessment will determine if further cognitive review and support is needed.

The contribution of our older participants is highly valued. With the information they provide we hope to find new insights about ageing which can help inform policy and decision-makers so that our older people receive better local services in the future.

LILACS NZ has generated interest from collaborators and students to conduct ongoing work. Although accessible to students,

use of data is governed by a Code of Practice via application to the management committee. Consultation with Māori stakeholders (Roopu Kaitiaki and subcontracting organisations) has allowed access to Māori data. Studies aligned with LILACS NZ include projects about daily physical activity and ageing, the meaning of 'ageing well' to participants, the impact of resilience on health outcomes, understanding 'happiness' for older Māori, understanding health for older Māori men, validation of the nutrition screening tool (SCREEN II [7]), analysis of time use using the 'Yesterday Interview', and geographical mapping of proximity to amenities.

The contribution of our older participants is highly valued. With the information they provide we hope to find new insights about ageing which can help inform policy and decision-makers so that our older people receive better local services in the future. We are proud that throughout the LILAC study we have also involved participants in decision-making [8]. Initial focus groups advised on questions to ask and we have referred back at different times to assess the acceptability of the questions and our interpretation of the findings. Valuable insights have been gained this way. Most recently, findings from wave 1 are being presented

back to participants in organised hui/meetings. Key results will also be presented back to general practitioners and the local communities later this year.

References

1. Statistics New Zealand. http://www.stats.govt.nz, 2004.

2. Ministry of Health. Health of older people strategy: health sector action to 2010 to support positive ageing. Wellington: Ministry of Health, 2002.

3. Schaie K, Hofer S. Longitudinal Studies of Aging. San Diego: Academic Press, 2001.

4. Baltes PB, Mayer KU. The Berlin Ageing Study. Cambridge, United Kingdom: Cambridge University Press, 1999.

5. Jagger C, Arthur A, Spiers N, Clarke M. Patterns of onset of disability in activities of daily living with age. J Am Geriatr Soc 2001;49:404-9.

6. Teng EL, Chui HC. The modified mini mental state (3MS) examination. Journal of Clinical Psychiatry 1987;48:314-8.

7. Keller H, Hedley M, Wong Brownlee S. Development of SCREEN-Seniors in the Community: Risk Evaluation for Eating and Nutrition. Can J Diet Prac Res 2000;61:62-72

8. Dyall L, Kerse N, Hayman K, Keeling S. Pinnacle of Life- Māori living to Advanced Age. New Zealand Medical Journal 2011;124(1331):75-86.

Abstracts of Students' Theses

In the previous issue of *Psychology Aotearoa*, we introduced a new section on student thesis abstracts. The aim of this section is to present recent (last 12 months or so) abstracts from student Masters and PhD theses, so that readers will get information on the range of research and research topics which postgraduate students have been engage in recently. In this present issue, we present a second 'set' of abstracts, from the area of community psychology. Abstracts have been obtained from Auckland, Massey and Waikato universities, and are presented below in that order. For more detailed information on any particular thesis, I suggest that you contact the thesis supervisor at the relevant university.

Ngā mihi nui,
Michael O'Driscoll

University of Auckland

Bullen, Pat (PhD, 2010)
Thesis title: Identity Projects and Positive Youth Development: The Importance of Efficacy, Integrity and Belonging during Adolescence
Chief Supervisor: Niki Harré

Theory and research have indicated that well-being can be enhanced via the fulfilment of three key well-being concerns or needs, namely efficacy, integrity, and belonging. This thesis used a positive youth development framework to explore well-being concern experiences within the context of a young person's most salient activities and goals, referred to here as identity projects (Harré, 2007). Guided by an adaptation of the identity project model (Harré, 2007), using a longitudinal design, this thesis incorporated both quantitative and qualitative methods to explore how identity projects were negotiated during adolescence; what impact well-being concerns had on commitment to projects; and how this related to subjective well-being (SWB). In the quantitative study, 162 ethnically diverse Year 12 high school students participated at time one (T1); and one year later 87 students took part at time two (T2). Participants completed an adaptation of the Personal Project Analysis tool (Little, 1983), and two independent measures of SWB. The main foci of the quantitative study were to explore the predictive value of each well-being concern to project commitment and SWB; and to investigate if commitment mediated the link between well-being concerns and SWB.

For the qualitative study, narrative interviews were conducted among 16 adolescents at three time points – Years 12 and 13, and after completing high school. The main foci of the interviews were to investigate how well-being concerns were voiced within the context of specific projects; and to gain insight into how projects were negotiated during life transitions.

The quantitative results showed efficacy and integrity, but not belonging, were predictors of concurrent commitment at T1 and actual commitment to T1 projects at T2. The mediating role of commitment (between the well-being concerns and SWB) was, however, not supported. Instead, each well-being concern directly predicted different aspects of SWB, and these relationships changed over time. Overall, experiences of efficacy and belonging, within identity projects, enhanced SWB in the short term, while only experiences of integrity enhanced SWB, namely life satisfaction, in the long term. The qualitative results indicated experiences of efficacy and belonging were most prevalent within leisure pursuits, while integrity was most commonly discussed within education and career projects.

Fenaughty, John Joseph (PhD, 2011)
Thesis title: Challenging Risk: NZ High-school Students' Activity, Challenge, Distress, and Resiliency, within Cyberspace
Supervisor: Niki Harre

Cyberspace, the digital environment produced by the internet and mobile phones, has become a major developmental context for young people in Aotearoa/New Zealand (NZ). From 2005, the phenomena of convergence and Web 2.0, enabled more cyber-activity, from more places, more often. The thesis utilised mixed methods to explore cyber-activity, and the challenges it produced. It also examined resilience; focusing on factors associated with successful resolution of distressing challenges. The first phase used eight focus groups (N = 36), as well as literature reviews, to produce a model for understanding cyber-challenge. The second phase deployed a questionnaire, based on aspects of this model, with 1,673 diverse NZ secondary school students. Cyberspace was accessed frequently (at least three or more times a week) by 98.4% of the sample. Participants reported an average of 7.29 (sd = 1.93) categories of cyber-activity annually. Activities classed as "communicating" and "researching" were most common. At least one cyber-challenge was reported by 67.5% of participants, however, only around half of them reported distress associated with a challenge. By volume, cyberbullying was the most distressing challenge reported (17.6%). Although ignoring was the most common management strategy used across six distressing challenges, it was never positively associated with resolution. On average, 38.3% of participants reported use of social support to manage distressing cyber-challenges. Significant age and gender differences highlighted aspects of adolescent development in cyberspace, for example older adolescents were more likely to report communication, banking, copyright-infringement, time-management problems; females reported more communication, phone-cyberbullying, distressing cyberbullying, unwanted sexual solicitation; and males reported more making new friends, dating, gaming, trading, internet-cyberbullying, cyberbullying others, sexual-content exposure, and distressing time-management problems.
Logistic regression identified features

associated with distressing challenge resolution. Although adult help seeking ability was associated with the resolution of four categories of cyber-challenge, actual adult support (or other social support) was not, suggesting that resiliency depends on the quality of the intervention, not its presence per se. Given the prominent place of social support as an intervention, adults (and peers) need to be equipped to better support young people to manage challenges. Cybersafety programmes should target common distressing challenges first.

Somervell, Julia (Doctorate of Clinical Psychology, 2011)
Thesis title: Participant Selection and Exclusion in a New Zealand Youth Development Programme.
Chief supervisor: Niki Harré

Decisions about participant selection are inherent to a programme based approach to positive youth development. As well as having a way of selecting potential participants, programmes often utilise some sort of exclusion criteria. This can be a sensitive issue: the wish to support young people in need by being as inclusive as possible must be balanced with an awareness of the limits of a programme's capability to safely contain disruptive or dangerous behaviours. This thesis deals with how the New Zealand positive youth development programme 'Project K' has managed the issue of exclusion. A collaborative approach informed by community psychology and action research methodologies was utilised. Understanding Project K's current practice around exclusion was the focus of the initial phase. This included a quantitative analysis of the rates of exclusion and demographics of excluded students and a qualitative component exploring stakeholder perspectives on exclusion and how decisions about exclusion are actually made. Findings emphasised the importance of having a robust process around exclusion in order to maintain safe practice and prevent unnecessary exclusion. However, unavoidable challenges were also highlighted including constraints related to limited information and time; and more complex issues related to the need for discretion and good judgment in making decisions even when there are clear criteria. The second phase of the research considered possible responses to the issue of exclusion including

action aimed at improving decision making around exclusion and options for supporting currently excluded young people. As the needs of excluded young people could not be directly assessed, this phase was guided by expert interviews. Expert perspectives on the needs of excluded youth emphasized the importance of individualized, responsive, and multisystemic interventions. Overall, this research illustrates both the importance and complexity of exclusion, an issue not often the focus of research. In considering the rationale behind the practice, wider implications related to the potential challenges posed by integrating 'at-risk' young people into the positive youth development approach are highlighted.

Massey University

Horrell, Barbara (MA, 2009)
Thesis title: Talking about End-of-Life Care for Older People in a Rural New Zealand Community
Supervisor Christine Stephens

Rural experiences are under-represented in the end-of-life care literature. In addition, population projections indicate that the numbers of older rural people are increasing. In an attempt to better understand their needs, this study considers how older people experience end-of-life (EoL) care in a rural New Zealand setting. Having responded to local media and community notices, seven participants, who in the last eighteen months had cared for someone over the age of 65 with a terminal illness, spoke about their experience of rural EoL care. Their stories were then transcribed and analysed, using narrative analysis. Participants spoke about similar issues, but from different, sometimes conflicting, perspectives. Positioning themselves primarily as carers, rather than as rural people, the participants' stories nevertheless reflected their social location for caring, as they talked about exhaustion and needing 24 hour support; limited access to specialist palliative care services; and the difficulties of caring for people with complex needs. At the same time they spoke of the joys and rewards of caring. The ambivalence and conflict evident in the stories indicates the participants' location in a particular place and time in the history of dying. Caught between two paradigms of care, these participants vacillate between

the desire for the empathic, compassionate care of yesteryear and the best that modern medical technology can offer. Discussing when to continue and when to stop medical intervention produced the most conflicting perspectives. However, all agreed that having time to form therapeutic relationships is a key component of EoL care. Overall, the stories demonstrate that the multiple and complex experiences of older rural people render stereotypical assumptions about rural life and dying at home problematic. However, as this study demonstrates, simply talking with people provides access to and understanding of their lived realities. Incorporating this kind of approach in future rural EoL care planning will move us closer to achieving contemporary goals of positive ageing and dying well.

Andrae, Daniela (Master of Science, 2009)
Thesis title: "Diabetes? I Can Live with It": A Qualitative Evaluation of a Diabetes Self-Management Programme.
Supervisor: Christine Stephens

Self-management programmes provide one form of education for people with diabetes. Evaluations of these programmes allow for a better understanding in regard to their impact and whether outcomes are met. Very little research has used qualitative methods to capture participants' experiences of these programmes and their perception of psychological outcomes. This is the first qualitative evaluation of the Diabetes Self-Management Programme in Whangarei. It has adopted an interpretative-phenomenological approach to explore participants' experiences of the programme and participants' perceptions in regard to their self-efficacy and quality of life after attending a course. A sample of 7 participants with diabetes provided data via interviews 4 weeks and 3 months after attending the course. The themes that emerged from the initial interview were separated into three evaluation components. In "6 weeks sounded very long but it was worth the time", participants discussed enrolment, benefits of the course and suggestions for future participants. In "I know what I need to do and I'm confident to do it", participants linked the gained knowledge from the course to improvements in their self-efficacy regarding

self-management behaviours, education and control of own life. In "life is good, diabetes is just another thing to handle", participants reflected on the impact of living with diabetes and changes to their life. An overarching theme of settling into a comfortable routine emerged from the follow-up interview. Participants reflected positively on their course and research participation. The programme was perceived to be beneficial to participants, impacting positively on increasing knowledge, self-efficacy development, behaviour changes and quality of life. The participants maintained these benefits in the short-term. These results are discussed in terms of the need for further research to evaluate if benefits are maintained in the long-term, referral process to the programme, decision-making process in regard to enrolment and impact of a support person attending the programme. Practice implications for the programme are discussed in regard to incorporating a follow-up phone call to participants after they attended a course and offering follow-up sessions with the latest information on diabetes care.

Noone, Jack (Master of Science, 2009)
Thesis title: Men, Masculine Identities and Healthcare Utilisation
Supervisor: Christine Stephens

Recent studies of gender inequalities in health have indicated that men's relatively poorer health status may be the result of behavioural factors that go beyond biological differences between men and women. Previous research has shown how men may interpret health related issues as a potential threat to masculinity, and this paper examines how men's under utilisation of medical services can be influenced by the social construction of masculine identities; . Ten men over 50 years of age discussed physical symptoms and health care use in individual interviews after watching a short segment from a feature film in which Jack Nicholson plays a man experiencing myocardial infarct symptoms. The recorded interview data were examined using discursive and narrative analysis techniques to produce a description of men's socially constructed and situated accounts of masculine identities. The analysis showed that constructions of masculine behaviour were drawn upon according to the social context. Physical sensations and bodily

changes were interpreted in terms of male identities that are an integral aspect of social relationships e.g. with doctors, partners, male friends, and work colleagues. It is in the context of these relationships that help seeking decisions were made. These findings highlight the salience of idealised or traditional masculine identities in respect to men's negative health behaviours, and the health status of men in general. The influence of idealised masculinities is of particular importance to health promotion focused on men's health issues.

Hayward, Penelope (MA, 2010)
Thesis title: Cancer Survivorship: Understanding the Issues Faced by Cancer Survivors.
Supervisor: Don Baken
International research on cancer survivorship has started to identify a range of issues that affect cancer survivors physically, mentally, emotionally and spiritually. These issues can be present at any time, from diagnosis, throughout treatment and for the rest of the individual's lives. The quality of life and well-being of cancer survivors depends on many interacting factors including the type of cancer they are diagnosed with, the type of treatment provided, healthcare utilisation, social support availability and use, employment status, locus of control, ethnicity and socio-economic status. The objective of this study was to investigate the influence of these factors on cancer survivor's quality of life, health outcomes and support needs within the New Zealand population. Of particular interest is whether ethnicity might affect outcomes. It is hoped that the information provided by this study will help to inform future policy and interventions for cancer survivors. This study analysed and discussed data from the 2008 Health Work and Retirement Survey. The Health and Work Retirement Survey collected information from over 3000 participants, ranging in age from 57-72 years. This age group has an increased likelihood of cancer diagnosis but also potentially has several more years of active participation in society. Results from this study were consistent with overseas research and indicates that New Zealand cancer survivors share similar issues to those overseas. Of all the factors, socioeconomic status was found to be the largest contributor to a poorer quality of life in cancer survivors.

Smit, Adele (MSc, 2011)
Thesis title: Experiences of Gynaecological Cancer and Treatment of Female Survivors.
Supervisor: Christine Stephens

Until recently, clinical management of gynaecological cancer focussed on prolonging survival of women, at the price of various side effects which can have a major impact on women's personal and social lives. Gynaecological cancer diagnosis, treatment and treatment effects can introduce a variety of changes and challenges and this study undertook to explore the lives and experiences of women with gynaecological cancer to attain better insight into women's experiences of changes. The purpose of this qualitative study was to explore and describe in-depth how women experienced and made sense of their gynaecological cancer diagnosis, treatment and effects. By listening to the stories of survivors, attempts were made to explore and gain insight into the meanings attributed to different cancer experiences by survivors. Purposive sampling was used to recruit four women diagnosed with gynaecological cancer who had undergone various treatments. Unstructured interviews were conducted to gain an in-depth understanding of the lived experience and recordings were transcribed verbatim. Interpretive phenomenological analysis was performed on the data collected. Analysis of the interviews revealed a range of shared experiences within a central theme of identity. Four main sub-themes emerged: women's sense of female identity during, as well as, following cancer treatment; threats to the identity experienced during diagnosis, treatment, and post treatment; protection mechanisms adopted by women to protect self identity; and reconstruction of a new identity due to changed circumstances induced by cancer. While some findings were consistent with previous research conducted on identity re-evaluation and reconstruction of cancer survivors, it became clear that women with gynaecological cancer must endure many unique challenges to their identity following gynaecological surgery.

University of Waikato

Scanlen, Anna (MSocSc, 2009)
Thesis title: The Health and Wellbeing of Homeless People: Complexities around the Provision of Primary Healthcare in New Zealand
Chief supervisor: Darrin Hodgetts, co-supervisor Ottilie Stolte
Homelessness is a pressing social issue, and people who are homeless, in particular those who sleep rough, often experience a confluence of physical and mental health issues. Health problems experienced by homeless people can be more severe than those experienced by domiciled people. Such problems can contribute to homelessness, and be exacerbated by homelessness. Previous research has found that for various reasons, primary healthcare services can be inaccessible for homeless populations. More recent research explores the growing availability of accessible, non-threatening health services targeting homeless people, with humanistic approaches to care. This thesis draws on a case study of an NGO clinic providing population-based primary healthcare to homeless and low-income people. The case study is informed by the perspectives of two groups of participants; homeless clinic patients and clinic staff. Ten semi-structured interviews were conducted with homeless clients, and six semi-structured interviews were undertaken with clinic personnel. Social representations' theory informs the interpretation, analysis and discussion of the participants' conceptualisations of health and wellbeing, illness and disease, homelessness, health services and the NGO clinic. Social representations from both participant groups (micro perspectives) inform shared social representations (macro perspectives) of the NGO clinic. This determines whether participants conceptualise the clinic as an 'ideal' health service for homeless people. NGO clinic staff responses reveal that clinic staff have a personal and professional ethos to work with people in need and those that may have been stigmatised from society. This shared ethos has shaped the development of the NGO clinic, into its current structure of a holistic, population based primary healthcare for homeless people integrated within a wider social service structure. In this setting, relationships are developed between practitioners and homeless clients to ensure homeless patients healthcare needs

are met. Also, practical needs are met as the clinic provides low-cost healthcare to homeless people within the context of an umbrella organisation that provides other much-needed social services. Collaboration is an important component to the efficacy of the NGO clinic, and meeting patient needs. However, clinic staff note that there are many dilemmas in providing healthcare to homeless people, and they can struggle to provide the service according to their vision, due to funding constraints. Nonetheless, NGO clinic personnel are committed to working with their patients, and find their jobs rewarding. The responses from homeless clinic patients brought to mind a military metaphor, which was utilised to anchor the experiences of homeless people in a familiar concept - the military. Each homeless client that was interviewed at the NGO clinic is written about in the form of a health biography, which summarises current health issues, health histories, health related practices and conceptualisations of health. The severity of three major health issues experienced by the participants - addictions, mental health issues and foot problems - are then explored in terms of detailed perspectives from homeless participants, and clinic personnel conceptualisations of those particular health issues. Social networks are discussed as important to homeless people's health and wellbeing, particularly through resource and information sharing. The clinic setting is conceptualised by homeless participants as a caring, welcoming environment; which contrasts with some negative experiences reported by homeless participants in other health service settings. This thesis explores the NGO clinic as a unique model for a health service that meets the various healthcare needs of homeless people. There is a need for more recognition from government organisations and policy makers of the impoverished life situations that many homeless people find themselves in - often without minimum standards of living, which jeopardises their ability to take care of their health. Appropriate health services need to be accessible to homeless people, in order for healthcare needs to be met.

Mueller, Sally (MSocSc, 2009)
Thesis title: How do you Sleep at Night? Investigating media representations and victim legitimacy of homeless individuals in the New Zealand news media
Chief Supervisor: Darrin Hodgetts   co-supervisor: Ottilie Stolte

Homelessness is a complex social issue affecting in excess of one billion people around the world. Despite varying definitions and cultural variations, key issues associated with homelessness appear to be similar across countries. Although New Zealand was once a country with high home ownership, recent governmental and welfare changes have contributed to a growing homeless population. Since contact between housed and homeless individuals is often limited, media coverage about the issue plays a vital role in the dissemination and distribution of information about homelessness and affected individuals. Although there are numerous studies analysing the portrayal of homeless individuals in overseas media, there is a distinct lack of comparable New Zealand based research. This study set out to investigate media representations and victim legitimacy of homeless individuals in the New Zealand news media, with a particular focus on how media representations and characterisations of homeless individuals may affect sympathy for them. This research encompasses both an overarching quantitative analysis of general reporting trends evident in the New Zealand news media (1995 - 2007), as well as an in-depth qualitative study of two particular case studies, namely media coverage following the murder of two homeless women, in order to further explore how sympathy can be supported or minimised, specifically during sad times. Findings from the content analysis reveal that homeless people are predominantly portrayed as negative stereotypes. Most were identified as rough sleepers, often depicted drinking in parks and socialising in public spaces. Homeless people rarely address audiences, as stories were mediated by professionals, journalists and service providers. Although there were aspects of the coverage that promoted a sympathetic understanding of the issue and affected individuals and moved beyond narrow characterisations and discussions of homelessness, the majority

supported the typecasting of rough sleepers which resulted in a dichotomous, almost voyeuristic relationship between housed and homeless individuals. All in all, the New Zealand coverage appears unsympathetic as it typecasts individuals and perpetuates the 'othering' of homeless individuals The violent death of two homeless women was expected to yield very sympathetic coverage and tragic storylines. The first victim, Betty Marusich, was a 69-year old homeless widow whose decomposed body is found in the Auckland Domain. The second victim was Sheryl Brown, a 45-year old homeless mother of three. Despite initial assumptions, the analysis revealed little sympathy for either victim. Instead a negative reporting framework supported by typecast terminology, reporting techniques, derogatory characterisations and implied blameworthiness, challenged each woman's victim status. Ultimately, this chapter questions whether either woman was ever considered a true victim deserving of public sympathy at all. The study concludes with a discussion about the findings and how typecast representations, narrow characterisations, and marginal coverage can influence perception about the importance placed on, and extent of homelessness in New Zealand. Some suggestions for further research are discussed, as are recommendations to make media coverage more inclusive and less dichotomous in order to stress that homeless people are no different to housed individuals, but are merely individuals without suitable and affordable housing.

Young-Hauser, Amanda Maria, PhD, 2010)
Thesis title: Conversing with 'monsters'? Narratives about men who sexually abuse(d) children
Chief Supervisors: Darrin Hodgetts, co-supervisor: Cathy Coleborne

This research has examined multiperspectival narratives told about and by men who sexually abuse(d) children. Drawing on institutional, public and private narratives, I have explored how men who sexually abuse(d) children are characterised, how meanings about these men are created, and how their reintegrative prospects are understood. The project has encompassed five research elements: historical narratives evident in archival materials; media

narratives evident in news articles; public discourse reflected in five focus groups; the accounts of support people of men who sexually abused reflected in one focus group; and the stories of ten men imprisoned for sexually abusing children elicited through pre-release and post-release conversations. These multiple levels of narration have allowed me to look within and across these settings to establish links and to demarcate points of convergence and departure of these diverse narratives. Results have suggested a mismatch between narratives about men who offend(ed) with those evident in the stories of support persons and the men themselves. The latter are anchored in, but contest the former; in particular the narrow representations of these men as inherently evil and not rehabilitatable. Subtle disruptions that question commonly held assumptions about men who sexually abuse(d) children and tell of alternative possibilities are evident in some narratives. My research shows that narratives can accumulate and reinforce assumptions over time and in many respects be discriminatory and exclusionary as well as being liberatory, enveloped in healing and open to change. By locating these men in their social environment and contextualising the crime, I examine the issues of child sex abuse from various angles. This research offers a more inclusive perspective on men who offend(ed) against children that can contribute to broadening public dialogue regarding the characterizations of these men, issues of community reintegration and repairing people's lives.

McKenzie Norton, Esmae, (MAppPsy, 2010)
Thesis title: The Emotional Lives of Men: The Complexities of Expressing Emotions
Chief supervisor: Ottilie Stolte co-supervisor: Darrin Hodgetts

This research responds to the widely held view expressed in academic and popular literature that men have difficulties expressing themselves emotionally. Both popular and academic literatures on men's emotional lives often approach the topic as though men are in crisis, in need of change, and that they require instruction from professionals on how to express themselves. This thesis explores the complexities of how men express themselves emotionally. Six

male participants took part in individual interviews about their emotional lives. Four of these participants also took part in a focus group discussion on the same topic. Findings challenge stereotypes of men as emotionally challenged. All participants were competent in expressing a range of emotions and did so verbally, through body language, in particular settings and using a range of material objects. These accounts provide insights into their emotional lives. The participants' candour, when talking about their emotional lives, challenges common stereotypes of men's reluctance to talk about their emotions. My analysis suggests that stereotypes of men's inability to adequately express their emotions need to be qualified as they are not applicable to all men. This demonstrates the need for a broader range of research and literature which includes multiple groups of men and their views of their emotional lives.

Little, Gaylene Robina (MSocSc, 2010)
Thesis title: Empowerment evaluation of Te Taiwhenua o Heretaunga Family Start: Improving service delivery
Chief supervisor: Jane Ritchie co-supervisor: Neville Robertson

This thesis explores child maltreatment in New Zealand by considering service delivery of the Family Start programme at Te Taiwhenua o Heretaunga through an empowerment evaluation. The purpose of this research is to evaluate the service delivery process of the Family Start programme at this site to inform the organization and other Family Start key agents of possible improvements to service delivery so that the Family Start programme is best able to reduce the risk factors that are known to influence child maltreatment in New Zealand. The best possible service delivery by kaupapa providers supports sustainability and the continuity of service with Māori through continual funding. The two objectives of this research are to look at how well the Family Start programme is implemented at Te Taiwhenua o Heretaunga and to consider the cultural appropriateness of service delivery. Community psychology is the paradigm within which I position myself. I respect the values of community psychology that aim to improve the position of disadvantaged people through their participation in social change and

community development. Te Taiwhenua o Heretaunga is a kaupapa Māori provider and I see an empowerment evaluation as a tool for internal evaluation to assist organizations who value self determination in their own practice. Both quantitative and qualitative data were collected and analyzed. There are two objectives to consider service delivery; firstly process aspects of service delivery are looked at and secondly the cultural relevance of service delivery to the population receiving the Family Start programme at this site. These are described as nine points about service delivery. The aim is to provide an empowerment evaluation for Te Taiwhenua o Heretaunga to inform, assist and improve service delivery of the Family Start programme in a culturally appropriate manner. The findings suggest better understanding is needed by Te Taiwhenua o Heretaunga Family Start staff, about the programme intentions, the use of tools such as Born to Learn/Ahuru Mōwai, individual family plans, service delivery levels, maintaining health records and ways to encourage collaboration between agencies. Te Taiwhenua o Heretaunga are shown in this research to be reaching the intended population for the Family Start programme, and service delivery appears to be culturally relevant to the clients on the programme at this time. The findings are limited by the fact that access to some information was restricted by Te Taiwhenua o Heretaunga Family Start management. Consequently, this research looked only at service delivery, and not the benefits of or barriers to the actual programme. The effectiveness of the programme in reducing child maltreatment is important but could not be measured in this research. Reducing child maltreatment is the main aim of the Family Start programme and would be measured through client outcomes. This research considered service delivery to see if the Family Start programme is offered optimally to assist the aim of reducing child maltreatment.

Paki, Helen Mary (MAppPsy, 2010)
Thesis title: Evaluation of Rongo Atea: Alcohol and Other Drug Treatment Centre for Adolescents
Chief supervisor: Neville Robertson

Abstract Rongo Ātea is a residential abstinence-based Kaupapa Māori alcohol and other drug programme accommodating youth between the ages of 13 and 17. This

evaluation investigates the role that staff play at Rongo Ātea along with a number of other factors including the physical environment; stages of change; programme implementation and aftercare. As a Kaupapa Māori programme, the role of how culture and identity can influence positive change is also explored along with the development of a youth-focused approach. I utilised a three phase framework borrowed from the work of Mason Durie (2008) to organise themes. These three phases, which Durie (2008) based on marae encounters, include Whakapiri (Engagement); Whakamarama (Enlightenment); and Whakamana (Empowerment) as they aptly reflect a three phase intervention approach: detoxification and early programme engagement; learning and development through ongoing programme commitment; and post treatment outcomes and aftercare. The data collection phase of this evaluation took place in 2006 and was initiated by the manager of Rongo Ātea who requested an evaluation to identify programme strengths and limitations from the perspectives of staff and students, and to make recommendations to Rongo Ātea that would assist with further programme developments. I utilised a collaborative and participatory approach (Bishop, 1996; Patton, 1990). Kaupapa Māori research principles were reflected in the use of 'kanohi kitea'— face to face contact (Smith, 1999). With appropriate training and management support, staff could have a greater influence on programme outcomes. Evaluation findings suggest that drug and alcohol intervention and treatment for young people in New Zealand is significantly under-resourced, particularly in the areas of detoxification and aftercare. To be effective, residential treatment programmes should consist of a three stage programme covering detoxification; treatment; and aftercare incorporating an integrated approach. A greater emphasis on working with whānau alongside the young person is recommended.

Wihongi, Helen Annette (PhD, 2010)
Thesis title: Tino rangatiratanga in health policies and practises
Chief supervisor: Neville Robertson

The purpose of my doctoral research was to investigate tino rangatiratanga in health policies and practises in Aotearoa. My research involved defining tino

rangatiratanga and exploring the expression of tino rangatiratanga in health policy and practises. A kaupapa Māori analysis of the 1996 National Cervical Screening Programme's Policy document was at the core of the policy investigation. The analysis involved developing a kaupapa Māori analysing framework and then analysing the 1996 National Cervical Screening Policy document for empirical and normative judgements at four discursive levels, health gains, health objectives, health goals and fundamental underlying values. A Kaupapa Māori research design drew on interdisciplinary scholarship on colonisation, Te Tiriti o Waitangi, community psychology, public policy, disability theory, feminist theory and discourse theory. I argue that the dominance of Western cultural norms and state-directed policies were made possible by the signing of Te Tiriti o Waitangi. The signing of Te Tiriti saw Crown sovereignty being implemented and tino rangatiratanga ignored. The consequences for Māori have been disastrous with loss of land and economic base which has resulted in poor health status. I also argue that tino rangatiratanga has the potential to transform the social and political context that frame Aotearoa society. Such an approach raises a critical dilemma for the state as meaningful recognition of tino rangatiratanga requires waiving full and absolute sovereignty which currently resides in the state. Hence some scholars argue that tino rangatiratanga is a site for constructive engagement where state and Māori relationships can be renegotiated. The extent to which this potential for constructive engagement is being realised in however is inadequately explored in the scholarly literature. Exploring the relationships between tino rangatiratanga and health policies and practises as undertaken in my thesis will therefore contribute to scholarly knowledge on the subject. The findings from the research show that tino rangatiratanga is indeed a complex, fluid, multi-faceted and context related concept. Within the context of my research, tino rangatiratanga is defined as Māori sovereignty, self determination, and positive Māori development. As a Māori value it is about mana and tapu of rangatira or leadership personified. Within policies, tino rangatiratanga has emerged through resistance and demonstration and is actualised through Tiriti legislation and policies. The legitimation of tino

rangatiratanga in cervical screening services sees Māori leadership at national, regional and local levels and Māori involvement through wide ranging consultation but the Crown still controls the policy process and therefore the outcomes. Most cervical screening services are still owned and operated by the Crown or Crown agencies. One of the consequences of Crown control is that Māori women are still twice as likely to get cervical cancer and four times more likely to die from it. To some degree this may be the result of resource allocation and the result of discriminatory service practices but also the result of resistance to the procedure itself. Tino rangatiratanga within cervical screening services could be strengthened through iwi ownership of some cervical screening register sites. At the time of my field work (2000) there were 14 sites, all owned and operated by Crown agents. Tino rangatiratanga could also be strengthened through funding criteria that ensure practitioners are safe to practise, through the adoption of less invasive procedures and through the legitimation of Māori healing practises such as rongoā and karakia. Overall if tino rangatiratanga is to be given full effect within the policy domain Māori must have a well established asset base, they must be in control of the decision making making process including resource allocation, service delivery must address the diversities of Māori realities and Māori must be the recipients of policy decisions made.

McRae, Karyn Okeroa (MSocSc, 2010)
Thesis title: Tangi and State Funeral: Te Arikinui Dame Te Atairangikaahu and Prime Minister Norman Kirk
Chief supervisor: Linda Waimatie Nikora co-supervisors: Ngahuia Te Awekotuku and Darrin Hodgetts

The tangi of Te Arikinui Dame Te Atairangikaahu (Te Arikinui) in 2006 paralleled the State funerals for New Zealand Prime Ministers like Norman Kirk who died in 1974. State funerals require the huge mobilization of people and resources and always attract the attention of the national and international media. The death of a Prime Minister is news worthy, but what of a minority indigenous fourth world leader like Te Arikinui? Why did her passing attract so much media attention? In this study I argue that media representation of

the tangi of Te Arikinui was largely about social, cultural and symbolic capital. In media saturated societies such as Aotearoa/ New Zealand, through mainstream media outlets like TV One News and the Waikato Times, Te Arikinui's tangi event claimed a dominant space in the lives of Māori and non Māori alike. The data source includes print news media coverage of the tangi of Te Arikinui and the State funeral of Norman Kirk. Descriptive narrative and abductive analysis inform the methodology used in this study. As expected, print media reporting of both events progressed through the three stages identified by Durkheim, those of, separation, liminality and reincorporation. The ownership of death, the deceased and the continued possession of their mortal remains, itself a cultural object with symbolic and cultural capital, reflected the actual power and control of the possessor. State funerals and tangi are about the ritualized performance of grief and mourning, and require the appropriate social, cultural and symbolic capital for its enactment.

Robins, Kathryn (MAppPsy, 2010)
Thesis title: Exploring mothers' experiences of separating from an abusive partner
Chief supervisor: Neville Robertson co-supervisor: Jane Ritchie

This research explored mothers' experiences of separating from an abusive partner. It focuses on the contextual factors which support or undermine women's ability to keep their children safe. Of particular interest was the extent to which dominant ideas about the importance of fathers in children's lives played a role in decision making about abusers' post-separation contact with their children. Eight women who had separated from an abusive male partner were interviewed. Their experiences, thoughts and views are presented in case-studies. Each begins with a background of the woman's relationship with her former partner, the processes that led her to initiate separation and her post-separation experiences. Separating from an abusive partner was found to present many challenges for mothers. Often, the women reported that they continued to be abused and to be subjected to the power and control tactics of their abuser. Women's accounts of their partners' behaviour suggested that the abusers' characteristics as a partner

spilled over into their parenting. The abusers were generally reported to be inconsistent, authoritarian and/or irresponsible in their parenting. In this context, the women held significant fears for the safety and well-being of their children should the abuser have contact with them. Despite this, the majority of the women agreed to contact. Indeed, most of the mothers felt responsible for maintaining the father-child relationship and went to great lengths to facilitate contact, even though the contact often exposed both mother and child to further abuse. To this extent, dominant, uncritical beliefs about the importance of fathers seemed to be quite influential. On the other hand, those women who had good family support were less likely to agree to unsafe contact. These participants' mothers were particularly important in recognising the dynamics and impact of the abuse. They played an important role in protecting the participants and their children, and prioritised safety over contact. These women experienced shorter periods of post-separation abuse. Women with support were less isolated, less likely to blame themselves and were able to begin the process of recovery earlier. Consequently, the welfare of their children was improved. This finding suggests that support of this kind may be one avenue that improves women's ability to keep their children safe and enhance their experiences after separating from an abusive a partner.

Black, Roseanne Marjory (PhD, 2010)
Thesis title: Treaty People Recognising and Marking Pākehā Culture in Aotearoa New Zealand
Chief supervisor: Jane Ritchie co-supervisors: Neville Robertson, Heather Hamerton

The suggestion that all people are cultural and live in cultural worlds acts to challenge members of culturally dominant groups as they tend to see their way of life as normal rather than cultural. Dominant group members usually talk about themselves in relation to their national identity (New Zealander, Australian, or American) rather than name being part of a cultural group within their nation state. This study, located in Aotearoa New Zealand, explores with a particular group of New Zealanders, how Pākehā who are members of the dominant group, may come to recognise themselves as being cultural, to name themselves

culturally, and to mark aspects of their culture. The contribution that recognising culture makes to a decolonisation agenda is also explored. This study of Pākehā culture is approached from both a realist and a social constructionist perspective. Culture, an abstract concept, is largely theorised as a constructed notion in a historically structured location. How culture is recognised, and the ways it is produced and enacted, through relationships and interactions in the broader structures of New Zealand society were explored using realist thematic methods of analysis. Treaty people are a network of mostly Pākehā activist educators who have engaged in promoting knowledge of and support for Māori claims for justice under Te Tiriti o Waitangi (the Treaty of Waitangi was the document signed by Settlers and Māori leaders in 1840 to establish settlement arrangements). Treaty people are practised in talking about cultural issues largely through their engagement with Māori - Pākehā relationships. The research focused on the situations and processes that stimulated a group of thirty four 'Treaty people' to start thinking about themselves as cultural; about what it meant to have a cultural identity; and what they recognised as markers of their culture. I have been a member of this Treaty People network for many years and carry the dual positioning of being the researcher, and a participant, both as a member of the group and as a Pākehā. Data was collected over an eighteen month period from two focus groups in 2003 and 2005. These sessions were video and audio-recorded and later transcribed. I meet with available participants in their own locations early in 2005 and audio-recorded the conversations. The transcriptions and notes form the data for this study. My findings from this study include: • Culture was often first recognised through encounters with different cultural groups and usually when a person is in a situation where they are in a minority. Although, dominant group members do not always see their own daily practices and values as cultural they often name as cultural the practices and values of people different from them. • Recognising and naming ourselves as cultural and marking our culture were difficult tasks that go against the grain of dominance. • Pākehā culture was recognised in a number of ways. Treaty people recognised that there were other forms of knowing about the world and that dominant group members valued being

'right' and in control of knowledge. Coming to recognise themselves as cultural unsettled a sense of certainty about their position in the world, and opened up possibilities for new ways to engage in intercultural relationships where participation rather than being in control was valued. • Accepting the name Pākehā implied having a position of responsibility to tangata whenua and to the land. In turn those who have accepted being Pākehā receive a sense of belonging to Aotearoa and a place to stand in justice alongside Māori and other people who are culturally different from them. • While this thesis does not make explicit links between 'being cultural' and a decolonisation agenda the Treaty People participants named strategies to support decolonisation and challenge Pākehā dominance which include: recognising practices and values that are perpetuated through colonisation, in particular egalitarianism, assimilation and superiority; recognising Māori as tangata whenua (first people of the land) and Te Tiriti o Waitangi relationships; taking up the challenge to seek justice through striving to deal with past wrongs and to engage in equitable relationships with Māori. This thesis contributes to the psychology and social science literature as it serves to address the question "We don't have a culture … do we?" I posit that all psychologists do have a culture and provide some rich descriptions, for those who are Pākehā, of how their culture may be recognised, how it might be described and talked about. This is a core cultural competency requirement for psychologists. My thesis also contribute to a growing body of literature from members of dominant groups, who are developing a discourse to explore and make visible their cultural or raced (whiteness) positions of power and privilege.

Moeke-Pickering, Taima (PhD, 2010)
Thesis title: Decolonisation as a social change framework and its impact on the development of Indigenous-based curricula for Helping Professionals in mainstream Tertiary Education Organisations
Chief supervisor: Dave Thomas co-supervisor: Jane Ritchie

This research examined the social and political approaches that Indigenous peoples undertook to situate Indigenous-based education programmes in mainstream post-

secondary/tertiary education organisations. Indigenous-based helping programmes assist to progress indigenous aspirations for self-determination and are sites that center indigenous worldviews. A decolonisation analysis framework that is embedded in the curriculum deepens students' understanding about the impacts of imperialism, colonisation and post colonial issues. This thesis involved researching two Indigenous-based programmes that are based within mainstream tertiary institutes. The first is the Te Whiuwhiu o te Hau Māori Counselling degree programme which is based at the Waikato Institute of Technology (WINTEC) in Hamilton, Aotearoa, New Zealand. The other is the Native Human Services Social Work degree programme which is based at Laurentian University in Sudbury, Ontario, Canada. I start this thesis with "opening the circle" and situating the context for my research. Next is the literature review chapter. This chapter provides a review of decolonisation-colonisation, decolonisation frameworks within Indigenous education, self-determination and Indigenous peoples, and Māori and Native self-determination strategies relevant to health and education. I used a case study method combined with an indigenous methodology to guide the research. This involved gathering key pieces of information as well as interviewing participants (graduates, tutors/faculty/developers) from each programme. In chapter four is the Te Whiuwhiu o te Hau case study and in chapter five is found the Native Human Services case study. Each case study covers pre-colonial and colonisation contexts and examines assimilative legislation on indigenous education and health. The backgrounds of social work and counselling, native social work and Māori counselling are also presented. In the case studies is the background and rationale for the development of each programme, as well as pertinent information on the course content. Chapter six presents on the findings and conclusion and chapter seven "closes the circle". The main findings highlighted that Indigenous curricula and pedagogies embrace Indigenous theories and discourse relevant to the helping practice fields. Secondly, each programme fosters students to make positive changes for themselves, for their communities, and for their professions. Another finding is that faculty/tutors promote an inclusive Indigenous pedagogy in the classroom that

incorporates cultural ceremonies, encourage personal introspection, builds cultural and professional skills, and teaches critical education. Both programmes reflected a pedagogy that taught students to counter negative narratives while instilling a critical analysis of decolonisation and colonisation. I propose that a decolonisation analysis is both a reflective and healing tool, in that students are provided with the hard evidence about their histories and what happened to their communities. I contend that Indigenous-based programmes contribute to the continuity of Indigenous culture and wellbeing of their communities and, that they play a vital role in advancing Indigenous education priorities.

Carlson, Teah (MAppPsy, 2010)
Thesis title: Medications and meanings in Māori households with chronic illnesses
Chief supervisor: Linda Waimarie Nikora
co-supervisor: Darrin Hodgetts

Domestic spaces have always featured as sites for health care. The home is increasingly referred to as a new therapeutic space within which chronic illnesses are managed within everyday life. This research explores the meanings and use of medications within four Māori households containing at least one chronically ill householder. A broad ethnographic approach was used to capture popular understandings and medication use in daily life. Multiple methods were used, including group discussions with household members, individual interviews, household mapping, and photographic and diary elicitation tasks. Findings shed light on the sources and uses of medications, householder knowledge of medications, communal practices of sharing, caring, rationalising use, grappling with side-effects and the management of illness. I consider what it means for householders to take medications themselves or give these to others, and the care-giving practices that feature in the everyday consumption of medicines. The research is based on the premise that medications are material objects with therapeutic uses that enter into and take on meaning within people's lives. Medications become culturally embedded phenomena that carry meanings and shape social relationships and practices with Māori households. As such, medications were used in a way that reflected the cultural values

and bonds within the households. Within household relationships, medications were invested within meaning to show aroha, support and care. Within a Māori whānau context, the values of maanakitanga, rangatiratanga, and whanaungatanga were recognised as having an integral role in understanding the social practices with medications in each household.

Tongi, Lolohea (MAppPsy, 2010)
Thesis title: Exploring medications amongst Tongan households in New Zealand
Chief supervisor: Darrin Hodgetts
co-supervisors: Linda Waimarie Nikora, Michelle Levy and Mohi Rua

The current thesis explores: how four related Tongan households understand, treat and use medications; and the 'flow' of medications into, around and out of these households. The participants for this research come from four Tongan families living in the Auckland area. A broad ethnographic approach which is multilayered, multi-method and multi-centred was to capture such data. This included individual interviews, household discussions, diaries and photo elicitation methods. Key themes reported on are Western and Traditional Medication Use; Faito'o fakatonga; Use of Western Medication; Prayer, Faith and Medications; and Flow. Tongan cultural values and practices shape how these four households treat, use and understand medications. Participants in this study structured their lives around Tongan customary relationships, obligations to respect and care, and to have faith that resolutions would be found to any ailments or illnesses suffered by household members. Household members clearly had a respect and regard for Western medications and trust in Western practitioners but were sometimes frustrated by the dominance of this model. The same was mostly true of Tongan medicine and associated healers. Some household members went as far as using both in conjunction with each other. However, across most households, there was the presence of a firm belief that a resolution of health issues required more than medication. Good health was a product of rightful relationships and faith and trust, in medications, health practitioners and God. This study adds to research on medication use by highlighting the importance of culture to extending existing understandings

of the everyday practices through which people use and share medications.

Hayward, Brooke Patricia (MAppPsy, (2011)
Thesis title: To Medicate or not to Medicate? Exchange, Identity and Care in Everyday Household Medication Practices
Chief supervisor: Darrin Hodgetts co-supervisor: Ottilie Stolte

In contemporary societies, medications are one of the most commonly used resources for the prevention, treatment, or cure of illness and disease (Shoemaker & de Oliveira, 2008). Despite this, there is a lack of understanding about how medications are used and understood by lay persons in private domestic dwellings. This research explores the medication experiences, understandings, and practices enacted by mothers caring for their chronically ill children. Four households containing children with chronic illness were involved in this qualitative interpretive research. Semi-structured interviews, mapping, diary keeping, and photo-production exercises were utilised to explore the ways in which medications are implicated in caring practices enacted by the mothers. Giddens' (1984) structuration theory and the concept of 'gift exchange' provide the theoretical foundation for this thesis. This research indicates that the medication understandings and beliefs held by the participants are central to the construction of everyday caring medication practices. These beliefs and practices are not fixed or homogeneous, but complex and changeable; reflecting differing contexts, experiences, and forms of knowledge. The agency of parents as they conceptualise 'care' and choose to embrace or resist medication use, challenges the notion of 'passive' medication consumers. As the use of medication impacts many relationships within and outside of the confines of the household, this thesis highlights the social and symbolic nature of medications. The relationship between a parent and child is central to medication use, but medical decisions made by parents also implicate various other individuals, including health professionals and lay persons. The findings point to the need for health policy which acknowledges and is responsive to, the shifting health needs and understandings of the lay population.

Cleland, Hannah Nicole (MSocSc, 2010)
Thesis title: Mental Health Service Provision for the People of Cambridge: Are services facilitating recovery?
Chief supervisor: Carrie Cornsweeet Barber co-supervisor: Doug Boer

The purpose of the present research was to investigate consumer perspectives of mental health service provision in Cambridge and whether services were helpful in facilitating recovery. Cambridge is a small township in the Waikato region, approximately twenty-five kilometres south-east of Hamilton. The study aimed to: gain an understanding of consumers' interpretations of recovery; identify consumer perspectives of service delivery in Cambridge; assess whether services in Cambridge are working from a recovery ethos; and determine how consumers' think service delivery could be improved. Interviews with 14 consumers of mental health services were completed. The key findings of this study suggest that the mental health needs of Cambridge consumers were not being met. More specifically, consumers' who had severe or mild mental illness were reasonably happy with service delivery. However, consumers whose mental illness impacted their life considerably, yet their symptoms were not deemed severe enough to access public services, identified significant discrepancies between service provision and recovery facilitation.

Ellis, Kenneth Desmond (MSocSc, 2010)
Thesis title: Māori cultural concepts and service provision for homeless Māori men
Chief supervisor: Linda Waimarie Nikora co-supervisor: Darrin Hodgetts

Homelessness is a pressing issue for indigenous minorities such as homeless Māori men. Their circumstances are more vulnerable in ways, than other homeless groups given that their lives are impacted upon by ongoing colonisation. Homeless Māori men, like other 'indigenous homeless groups', often find themselves homeless because of social/cultural dislocation where, they are disconnected from their culture and closest forms of support. This study set out to explore how homeless Māori men's

circumstances could be improved through administering interventions in the form of Māori cultural concepts like: manaakitanga, wairuatanga, whanaungatanga and whānau. The overall approach used to gather the research was based on hybridisation, where several different approaches were used simultaneously to generate research data. These were participant observation: a kaupapa Māori approach, semi structured interviewing, thematic analysis and the use of a socio-historical context to underpin the entire research process. Two groups of Māori participants were interviewed for this study, one group comprising staff members, and one made of homeless Māori men. Each group had a number of unique characteristics. For example, the entire staff group comprised skilled and qualified professionals, while the men's group was made up of individuals with severely impoverished backgrounds. The study produced several conclusive findings to show how Māori cultural concepts were used successfully as forms of social interventions. Concepts like whanaungatanga, manaakitanga, wairuatanga and whānau, were shown to produce positive social outcomes for homeless Māori men. These outcomes helped the men to stabilise their lives, as they attempted reintegration.

Li, Wendy Wen (PhD, 2011)
Thesis title: Shifting Selves: Home beyond the House - A Study of Ageing, Housing and Wellbeing of Older Chinese Migrants to New Zealand
Chief supervisor: Darrin Hodgetts co-supervisor: Elsie Ho

Older Chinese immigrants are one of the largest ethnic ageing groups in New Zealand. However, people's everyday experiences of settling in a new and unfamiliar environment have been largely overlooked, particularly for older adults. This research explores the biographies, identities and everyday experiences of filial piety among older Chinese immigrants. Particular consideration is given to the role of filial piety in participants' housing and ageing experiences. This research is one of the first explorations of Chinese immigrant ageing in place, which also considers changing enactments of filial piety. The research is informed by a hybrid narrative approach that draws on episodic, go-along and

fangtan interview techniques used with 32 older Chinese immigrants in Auckland and Hamilton. Findings support the importance of exploring positive experiences of migration and ageing. Older Chinese immigrants do often experience biographical disruptions and status-discrepancies when they move from China to New Zealand. However, in response, the participants engage in positive activities such as gardening and art as a means of cultivating a new sense of self and place in a new land that is compatible with their existing identities as older Chinese adults. The analysis explores the material-mediated basis for participant adjustment and acculturation. Through adaptive acculturation, older Chinese immigrants' abilities for both integrating into the host culture and maintaining their ethnic identities are realised. The analysis also demonstrates that traditional Chinese aged care models of family support with high level of intergenerational co-residence are evolving to encompass practices of filial piety at a distance and to encompass more pluralistic familial living arrangements. The analysis also demonstrates the importance of considering how ageing occurs beyond physical spaces and within cultural, social, relational and imagined landscapes. The analysis shifts away from the focus in existing literature on how older Chinese immigrants are passively transformed into minority subjects to how they are transforming themselves through migration and their efforts to age well in New Zealand.

Jacob, Juanita Emily (MSocSc, 2011)
Thesis title: Māori children : Conceptions of Death and Tangihanga
Chief supervisor: Linda Waimarie Nikora
co-supervisor: Jane Ritchie

Research pertaining to Māori children's experiences and perceptions of death and tangihanga is sparse. Much of what is available, relating to children and their experiences with death, particularly death of a loved one, is generalised and stems from Western paradigms of knowledge. In contrast, this study aimed to investigate Māori children's experience relating to death and tangi through the eyes of Māori parents. Five areas were explored with Māori parents: (1) childhood experiences of Māori parents relating to death and tangi, (2) parental conceptualisation pertaining to ideas of an afterlife (3) how and when Māori parents

talk with children about topics relating to death, tangi and an afterlife (4) how Māori children understand and conceptualise these events, and (5) how these practices will continue on in the future. Findings of this study suggest that Māori children: (a) received abundant support from kinship networks to help them cope with their grief, (b) they were included and involved in all aspects relating to death and tangi, (c) they were encouraged to express emotions openly and without restraint, (d) they understood and comprehended death through personal experience and exposure to tangi, (e) the business of grieving came secondary to the fact that tangi was more like a holiday with family, (f) Māori parents informed and talked to their children about death and tangi, and (g) they often use both Christian ideologies and cultural beliefs to explained death and afterlife to their children. From this study we learn that death was not hidden from children, that parents talked with their children in very open and age relevant ways, and considered their children's participation in tangi as an important way to grieve and ensure continuity with kinship networks and support. This study suggests that the challenge now is to ensure that these practices continue to persist between parents and their children, and continue on through generations.

To order a copy of the Code of Ethics please contact the office: phone 04 4734884 or email office@psychology.org.nz

An Interview with Kevin Dew

Kevin Dew is Professor of Sociology at Victoria University of Wellington. Prior to his current appointment he worked for eight years as a lecturer and researcher in the Department of Public Health at the Wellington School of Medicine and Health Sciences. His research interests include health professional-patient interaction, health inequalities and public health.

Your academic area in the School of Social and Cultural Studies at Victoria University is the sociology of health and illness. What do sociologists study in relation to health and illness?

The sub-discipline of medical sociology, or sociology of health and illness, is a broad one. We can go back to Friedrich Engels' "The Condition of the Working Class" for an early and still outstanding example of the exploration of social inequalities and health inequalities – which has been an enduring concern in the discipline.

From the 1950s sociologists became interested in the rise in social status and power of the medical profession and this analysis later became influenced by feminist theorising which explored the gendered nature and impacts of power asymmetries in health care.

The experience of illness has been another major area of interest in sociology – with early work referring to such things as the biographical disruption of chronic illness. Links between major historical trends – industrialisation and globalisation for example – and health continue to be a major focus. With the development of conversation analysis and other approaches to the study of everyday interaction there has been an interest in communication issues in health care settings and, amongst other things, how they might reflect or reinforce social and health inequalities.

What are some of the major insights that sociologists have brought to our understanding of health and illness?

Sociology as a discipline does not stand on its own, so it is not quite as straightforward as claiming that sociology alone brought about major insights. But picking up on some of the strands I have just mentioned – sociologists have played a major role in enhancing our understanding of the relationship between the social order and biological processes. We can see this most clearly in the well established relationship between social inequality and health inequality. But we also see it in some of the concepts developed by sociologists – such as Talcott Parsons' sick role. By using this concept we see sickness as not simply a biological event, but also a social one where particular rights and obligations pertain to those who are in the role of being sick and those who are in the role of providing therapeutic interventions. There are real consequences for those who do not carry out these roles.

Sociologists along with medical historians have shown how the professionalising of medicine in the 19th century was less a product of its perceived therapeutic capacity and scientific culture and more about claims to knowledge about the body and setting professional boundaries around medical work. These understandings allow us to distance ourselves from the claims-making of health professionals and explore the social processes that influence status differentials and so forth. Sociologists have also contributed to a greater understanding of the ways in which scientific theories become accepted as unalloyed facts and that this occurs through a number of socio-political processes which may result in scientific "facts" being accepted or rejected.

In relation to communication sociologists have demonstrated the subtle ways in which asymmetries in the health professional-patient interaction are maintained. Whether we see these asymmetries as a good thing or a bad thing is another matter. We can see ways in which certain topics get closed down or downplayed – such as talk about alternative medicine or concerns about side effects

– but also what can be done to get patients' concerns on the agenda.

You have co-edited a book looking at health inequalities in Aotearoa New Zealand. What do you consider to be some of the major contributors to health inequalities in New Zealand and what can be done to resolve these?

It is well established that social inequality leads to health inequalities. We have increasingly developed an audit culture, but policy-makers are not held accountable for social policies that increase the levels of premature death in a population or particular group within the population. I don't think we can 'resolve' health inequalities –because of the complex factors that are involved. But wouldn't it be great if we put mechanisms in place to keep health inequalities within certain bounds in the same way as we have mechanisms to control inflation, or if we set goals to promote social solidarity in the way we set goals to promote GDP. Of course health inequalities would require a 'whole-of-government' kind of focus – but perhaps we need to have the vision first before we can come up with a solution. I think we should be inspired by the anti-tobacco lobby in this regard. Twenty years ago nobody talked about the 'end-game' for tobacco addiction – but now it is given serious consideration. Someone had to come up with the vision so that the vision could become an aspiration.

But while we wait there are many other interesting areas to explore in relation to health inequalities. We also know that something seems to happen at the level of health service delivery that exacerbates health inequalities between Māori and non-Māori. Māori are less likely to get certain interventions, are likely to die quicker from the point of cancer diagnosis and

so on. Some of this can be explained by co-morbidities, but there appears to be something else happening. So before we can intervene to resolve this we need to know more about it – so some research in this area is likely to be useful. That is certainly an interest of mine – to try and see if we can find things happening at the health services delivery level that helps explain some of the inequalities in health outcomes.

There is a whole range of social determinants issues that could be addressed, for example, access to decent housing for those who need it and want it, resistance to multinational corporations making profits out of health-deleterious products that are more commonly consumed by those in more deprived circumstances and so on.

You have recently undertaken research tracking patients through episodes of care with general practitioners and others. What was the aim of this research and what are some of its findings?

The tracking study is part of a much bigger programme of research which comes under the auspices of the Applied Research on Communication in Health group based in the Department of Primary Health Care and General Practice at the University of Otago, Wellington. Our original question was to find out how health professionals used prioritisation criteria that determined whether someone got access to elective interventions in the public health system. I was particularly interested in how surgeons determined scores that related to subjective criteria, such as level of pain or limitations on social functioning. To do this we recorded actual consultations and found to our surprise that surgeons did not explicitly use the prioritisation tools in the consultation. So then

our research team started to consider why this was the case, and looked at the interactional demands within a consultation to suggest that the use of a linear, check-list type prioritisation tool breached these interactional demands. This suggests that applying these sorts of tools without understanding the context of their application and the demands of that context will not reach the policy goals of using such tools – such as achieving transparency and equity in decisions about who is offered or refused surgery.

We have since gone on to tracking patients from primary through to secondary care, and tracking patients newly diagnosed with diabetes for six months through their health care pathway. We are still analysing and writing up findings from this research. I have become interested in the interactional demands on some patients identified as having diabetes that appear to be quite different from other patients. When a patient turns up for a consultation one interactional demand is to demonstrate that they are not wasting the health professional's time – so they have to present their concern as being a 'doctorable' one as opposed to something the patient should deal with themselves.

For some of the diabetes patients, particularly those picked up through some screening process, they have something of a different problem – why they did not recognise that they had a problem and either do something about it or consult earlier. Diabetes is also associated with stigmatized behaviours such as sloth and poor diet. In many instances we see patients responded to these sorts of issues, often at the very beginning of consultations before there has been and real discussion. So my interest here is in the sort of moral work that goes on in the consultation. This

is of sociological interest – and the task for me in terms of the people I work with is to indicate how this might also be of clinical interest. By identifying the moral work required in the consultation, for example, does that allow for some interventions that would assist the smooth running of the consultations and provide opportunities for improving therapeutic outcomes?

What other research are you currently involved in?

One of the major projects I am involved in goes under the title of "the social meanings of medications". That is another collaboration, which was pulled together by Kerry Chamberlain from psychology at Massey, Albany. This is much more of a social science collaboration than the ARCH group (Applied Research on Communication in Health) – which includes clinicians as well as social scientists. There are a number of strands to the 'social meanings' research. It has been very interesting on many levels including methodologically. The idea of the research is to go into households and collect data on the use and understanding of those things people consider to be of therapeutic value. The data collection has included photo-elicitation techniques along with diary-elicitation interviews, map drawing and so on – creating a very rich data set. We also decided that all the principal investigators would do some of the data collection – and that was great to do. It gets you very close to the data, which is not always the case for me these days, but because of the nature of the research it also allowed a greater insight into the lives of people who in many cases struggle under difficult circumstances. I think it is important to be reminded of the day-to-day struggle of many people in our country.

Sociologists talk about the medicalisation of everyday life. What are they referring to and what are some examples?

To some extent we can see this in much of the research I have done. Some early research I undertook with health researchers in psychological medicine and general practice looked at the disclosure of mental health issues in the general practice consultation. There was an issue here about the epidemiological findings of the number of people with mental health issues in the population which were much higher than the levels diagnosed by GPs. So why weren't GPs diagnosing mental illness when they should be? Well there are all sorts of reasons, but one is a concern from GPs themselves about medicalising the problems of living. People had difficult lives, and sure a medical diagnosis could be assigned to people's responses to these difficult lives but is that the best thing to do? So here we had GPs being concerned about the medicalisation of everyday life. Should we be medicalising suffering?

More recently sociologists have used the term pharmaceuticalization of daily life to draw attention to the way in which drugs are developed and used for those conditions that fall between medical and social conditions – such as impotency, hair loss and obesity. These concepts also speak to the issue of the expectation for increasing functionality through the life course – so that 'aging' processes become in some sense denormalised – we are expected to act like twenty year olds until we die and we can do this with the aid of medical interventions.

In the social meanings of medication research we see the incredible range of possibilities available to people to 'medicalise' and medicate their lives, but of course there is a great deal of resistance to this from the general

population as there is from many health professionals. But drugs keep getting developed for a wider range of conditions and they must be making a profit for someone.

What are some of the public health issues in New Zealand that would benefit from a sociological focus- i.e. what are some of the priority questions we should be asking in relation to specific public health issues?

There are those issues that are defined by the public health world, and those issues we could ask about public health from a sociological perspective. In terms of the former – a big public health issue continues to be health inequalities. I think one interesting sociological question here is why, as a society, we seem to tolerate increasing levels of social and health inequality. How did the egalitarian vision of New Zealand come to such an abrupt end? Maybe our egalitarianism was overstated – but nevertheless we don't seem to have a great sense of collectivity with the exceptions of natural disasters and royal weddings. But are there social processes at play that may lead to the return to a more collective spirit?

Another massive issue is the likely impacts of broad global events on public health. What is likely to happen with the increasing cost of oil for example? How will that change society, communities, and institutions? What health impacts might that have – positive and negative? Similar questions could be asked in relation to climate change. Our national association – the Sociological Association of Aotearoa New Zealand – is holding its annual conference at Victoria University in December this year and our theme is "Looking Forward: Trends, Horizons and Utopias". I am hoping we can shed

some light on these sorts of issues.

Of particular sociological interest to me is the role of public health in contemporary society. I have argued in various articles and an upcoming book that public health plays an important role in society mediating what Emile Durkheim refers to as anomic and egoistic forces in society. The anomic forces relate to uncertainty, change and lack of regulation and egoistic forces to individuality and dis-integration. I have suggested that public health plays an important regulating and integrative role in society.

I am also interested in the way in which public health negotiates the uneasy continuum between science and advocacy – where the former is sceptical and critical and the latter is engaged, active and oftentimes denouncing those who take a sceptical position. One of my colleagues at the University of Wollongong, Brian Martin, has felt the brunt of this latter form of 'public health' denunciation of those who promote open argument about public health measures. The particular issue this relates to is vaccination – with pro-vaccination groups demanding that the Vice-Chancellor of his university reprimand Brian for writing an article describing and typologising the processes used to suppress debate about vaccination issues. A lovely irony, but this example does speak to a 'totalitarian' tendency in some strands of public health that requires resistance, particularly from a 'freedom of speech' and academic freedom standpoint. This sort of issue can be very emotive and difficult, but I think it is important that sociologists and others do not shy away from them.

What do you consider are some of the insights from sociology that may be useful for psychologists in their work?

Another strand of that research related to the 'social meanings of medication' was to look at some medical controversies as they played out in the media. This has allowed us to explore a very interesting controversy around a thyroid medication called Eltroxin. In this case people on the medication reported symptoms for which 'science' could find no cause. The reflex response to this, from psychologists as well as others, was to look for a mass hysteria or moral panic kind of explanation. I had a fantastic summer student, John Gardner, collect information on this and we have written up one paper for publication and have another one nearly ready to go. I think the sociological perspective allowed for a critical appraisal of the controversy by attending to it as a social process and highlighting the roles of different institutions in providing a social space for the expression of symptoms. This sociological perspective contested the rather simplistic view that science equals truth and people are irrational.

Sociologists are not all alike – just as psychologists are not. For me a driving force in my work is to question the taken-for-granted and the assumed. I like the idea that we can ask the question – how can things be otherwise? Ian Craib, a social theorist who recently died, talked about his intellectual position being based around 'opposition, argument and thought'. At one level this idea of opposition sounds very negative, but I think in the health arena someone needs to play that oppositional role – to test the orthodoxy and question what is seen as normal. Such a sociology is comfortable with uncertainty but may be unsettling

to others. I think one thing that psychologists should find useful is to have their worldviews unsettled – just as they should be unsettling mine.

I think that sociologists spend a great deal of time reflecting on social processes – and that this provides them with particular sets of tools and ways of interpreting the social world that can complement the work of psychologists, and at times contest their work.

But I think the best way of gaining insights from those using different disciplinary perspectives is to work with them. In my case that has been through research – with people from a wide range of disciplines. Not only do you learn about the different methodological and theoretical tools people bring to a collaboration – but also about the kinds of institutional and interactional influences and constraints on them. In other words, you learn about social practices, where humans as agents in the world respond to the structural limitations they confront. These learnings are, in my opinion, hugely informative and help you to develop as a human being, provide you with greater insight into the ways of the world, and also expand or test your disciplinary boundaries.

Interview by Pamela Hyde

The changing landscape of Australian psychology

Simon Crowe

Dr Simon Crowe is Professor in Clinical Neuropsychology and Biological Psychology at La Trobe University in Melbourne, Australia. He is a fellow of the Australian Psychological Society and a member of the Colleges of Clinical Neuropsychologists, Forensic Psychologists and Clinical Psychologists of the Australian Psychological Society as well as being a member of the National Academy of Neuropsychology, the International Neuropsychological Society, the Society for Neuroscience and the Australian Society for the Study of Brain Impairment. He is currently President of the Australian Psychological Society, and is immediate past Editor of the Journal, Australian Psychologist. He conducts an extensive practice in clinical neuropsychology and specializes in the area of the effects of brain impairment on cognitive functioning in both treatment and medico-legal settings. He has published three monographs and more than 100 articles on a variety of related issues.

The Australian Psychological Society (APS) is the peak national body for the profession of psychology in Australia, with over 20,000 members, representing over 60% of registered psychologists, and including nine specialist Colleges. As the representative body for psychologists, the APS has access to a vast pool of psychological expertise from both academic and professional service delivery perspectives. The APS has responsibility for professional practice standards, providing ongoing professional development and accrediting university psychology training programs across Australia. It is represented on a number of advisory groups involved in the planning, implementation and ongoing monitoring of Government policy initiatives.

The last few years have been tumultuous for the discipline and profession of psychology in Australia with changes to almost every aspect of psychological activity. These changes have included: the implementation of a single national registration scheme for health professionals across all States and Territories of Australia; the Government's first research assessment exercise which measured the quality of research performance across all fields of endeavour in Australian universities; the challenges resulting from the inclusion of psychological services in Australia's universal Medicare health scheme; and the incremental impact of the Medicare initiative and other factors on the diversity and availability of training places in postgraduate professional psychology training programs and the flow-on effects of these for the psychology workforce. I will address each of these issues in turn to give colleagues in New Zealand the picture of the contemporary landscape for psychology in Australia, and conclude with a brief discussion of ways in which the APS has assisted its members to meet some of the current challenges.

1. The new national registration scheme and its implementation

From 1 July 2010, a single national registration scheme has operated for all regulated health professions in Australia, including psychology, whereas previously registration was conducted by separate State and Territory registration boards. All practising psychologists are now required by law to be registered with the Psychology Board of Australia (PsyBA) and the national scheme allows psychologists to work in any Australian State or Territory with a single registration. All psychologists who held current registration with a State/Territory registration board at 30 June 2010 were automatically transferred to the national scheme.

The effect of the national registration scheme for the profession of psychology has been profound. The new scheme has a series of registration standards which were not a part of the independent State acts that operated before the commencement of the national scheme, and the introduction of these has brought significant 'change management' challenges for the profession. The new registration standards for psychologists include mandatory continuing professional development and professional indemnity insurance cover, maintenance of recency of practice, area of practice endorsements for recognition of specialist skills,

mandatory reporting obligations and criminal history checks. In addition, there are new rigorous requirements for the two-year internship program for provisionally registered psychologists seeking registration via this route.

The last few years have been tumultuous for the discipline and profession of psychology in Australia with changes to almost every aspect of psychological activity.

One of the most important changes has been the introduction of a mechanism to recognise suitably qualified specialist psychology practitioners through an area of practice endorsement, which allows them to use a title that indicates they are a specialised practitioner. The final approved areas of practice endorsement are equivalent to the nine specialist Colleges of the APS:

- Clinical neuropsychology
- Clinical psychology
- Community psychology
- Counselling psychology
- Educational and developmental psychology
- Forensic psychology
- Health psychology
- Organisational psychology
- Sport and exercise psychology

However, when the national registration scheme was first introduced, two well established and recognised areas of specialty psychology – community psychology and health psychology – were not included, with profound implications for the ongoing viability of these two specialist areas. As the result of an intense advocacy campaign by the APS and the two affected Colleges, this

decision was overturned and the two subspecialties subsequently achieved status as approved areas of practice for endorsement.

As a part of the initial implementation of the scheme, the APS was able to negotiate with the registration board for 'grandfathering' arrangements for all psychologists who were recognised as specialists through membership of any of the nine APS Colleges to automatically be included on the register of endorsed specialists. This enabled these psychologists to be recognised for their existing specialist status without further assessment according to the new criteria for endorsement as a specialist psychologist. Whilst this was an important development in terms of procedural fairness, a second issue emerged as the PsyBA altered its timelines for the transition arrangements from a period of several years down to a period of several weeks. This had significant implications for those psychologists who may have previously been eligible for APS College membership but had not sought to formalise this and would therefore not be included in the grandparenting arrangements. The APS was able to negotiate a grace period of three months and was completely inundated with applications for College membership from psychologists seeking to be included in the transitional arrangements. Many psychologists, however, missed these deadlines and feel that they have been significantly disadvantaged by the introduction of the new scheme. The transition arrangements for all psychologists other than those completing approved individual bridging programs closed at the end of December 2010, and as at August 2011, there are 7,154 endorsed psychologists of the total 28,883 individuals on the national register.

Perhaps a more divisive part of the endorsement component of national registration has been the effect of creating a more conspicuous division between generalist psychologists and those with an endorsed area of specialty. To suggest that this measure has created disquiet within the psychological community in Australia represents a considerable understatement, and it seems clear that the rancour and division that has grown out of the introduction of a registration mechanism for specialist recognition will be with us for many years to come.

2. Australia's first research assessment exercise

January of this year brought the results of the Excellence in Research in Australia (ERA) data collection, an auditing exercise conducted by the Australian government to ascertain the quality of research performance in Australian universities across each field of research (FOR) in comparison with an international standard. Whilst criticisms of the ERA initiative abound, the importance of measuring research performance, ascertaining whether it meets international benchmarks, and determining whether it represents good value for money, are each noble and appropriate aims.

However, when the national registration scheme was first introduced, two well established and recognised areas of specialty psychology – community psychology and health psychology – were not included…

The process involved evaluating research outputs (books, journal papers, conference presentations etc.), as well as other performance measures including research income, esteem measures, and the number of staff of the academic organisational unit (AOU) over a six year period

to the end of 2008. It should be stressed that the evaluation did not directly measure university schools or departments but measured the quality of the research outputs within the field of research (FOR) codes. For example in the psychology code it might be possible for the work of the respective academics to have come from psychology departments or from staff in the health science, tourism, accounting or any of a variety of other disciplines from across each AOU. Three FORs were relevant to psychology – psychology, cognitive sciences, and other psychology and cognitive sciences – as well as the neuroscience FOR. The performance of each of the universities in each FOR were ranked on a 5 point scale: not assessed due to low volume; 1, well below world standard; 2, below world standard; 3, at world standard; 4, above world standard and 5, well above world standard.

The results of the assessment for the psychology FOR indicated that only 28 of the 39 university schools and departments of psychology in Australia had produced a sufficient set of material to be able to be assessed, with 11 of the 39 not assessed at all due to the low volume of production. Of the units assessed, 43% were rated at or above world standard. The average national rating for the 28 AOUs was 2.6. Put another way, the assessment indicates that 57% of the assessed institutions performed at a level less than a national benchmark. Worse than this still, however, only 30% of the 39 universities in Australia were assessed as performing at a level of research performance at or above a world standard.

As yet it isn't clear what the implications of this data will be and how psychology departments across the country will be affected. However the relevant minister has made it very

clear that the Australian government will not support research which is not at or above world standard. It is clear that if indeed the government delivers on this view, the implications for psychology departments, psychology academics and psychology training programs in all institutions except those 12 that are performing at a level of 3 or above could be profound. The government has many levers to alter behaviour within the universities including altering workload allocations, the numbers of postgraduate training places as well as access to postgraduate scholarships. Clearly the APS is watching the developments on these issues very closely, particularly in the context of the next iteration of the ERA being already underway, with the data collection closing earlier this year.

3. Threats to the inclusion of psychological services in Australia's universal Medicare health scheme

In 2006, the Australian government introduced the Better Access to Mental Health Care initiative which provided new Medicare mental health items for services provided by psychologists. These items enable people with diagnosed mental health disorders to access psychological treatment services. The APS was instrumental in achieving this historic community access to services provided by psychologists within Australia's universal health scheme after many years of advocacy. There are two categories of Medicare items that can be provided by psychologists: one for generalist psychologists and the other for clinical psychologists. The two categories attract different levels of Medicare rebate, with the clinical psychology items attracting a higher rebate in recognition of specialist training. Clinical psychology items can

only be provided by fully registered psychologists who are qualified to use the title 'clinical psychologist' as determined by eligibility for membership of the APS College of Clinical Psychologists or as holding an area of practice endorsement in clinical psychology with the national registration board.

… only 30% of the 39 universities in Australia were assessed as performing at a level of research performance at or above a world standard.

The introduction of the two-tiered system of Medicare rebates for psychology providers under the Better Access initiative has stimulated a great deal of debate within the psychology profession due to the higher Medicare rebate associated with clinical psychology provider status. The issue has had considerable impact on the profession since 2006, and has consequently elevated the attractiveness of the specialisation of clinical psychology, some may say to the detriment of other sub-disciplines of psychology. This is a vitally important tension to manage in a profession where the broad spectrum of expertise and far-reaching applications of the discipline of psychology are highly valued. The ongoing divisive debate around the two-tiered Medicare rebate system continues to significantly threaten the cohesion of the psychology profession in Australia.

Despite this simmering tension between practitioners, the success of the Better Access program in the community has been overwhelming. An evaluation published this year (Pirkis et al., 2011) showed that over two million Australians with common mental disorders have now gained access to affordable, effective and cost-efficient psychological interventions

in a non-stigmatising way through the nation's universal health scheme. The evaluation also demonstrated that the initiative is reaching large numbers of people who had not accessed mental health care in the past. Specifically the evaluation noted that…" the vast majority of those who used the Better Access services had positive outcomes, with most shifting from high or very high levels of psychological distress before treatment to much more moderate levels after treatment… The positive outcomes were achieved at an average cost of about $750 per episode; this compares favourably with previous estimates of about $1,100 for the optimal treatment for anxiety and depression" (Pirkis et al., 2011).

The evaluation offered strong support for the Australian government's continued investment in the initiative, however, the initial cost projections for the Better Access initiative have more than tripled in its first five years of operation and rumours of funding cuts to the program frequently surface. The fragility of the status of psychology within the Medicare rebating system was revealed in this year's Federal government budget, which announced funding cuts to the Better Access program involving a reduction in the number of allowable sessions of psychological treatment. This outcome was particularly surprising in the context of the government's evaluation of the Better Access program which demonstrated its powerful clinical and economic effectiveness. The APS has been engaged in a sustained campaign against the funding cuts and will continue to vigorously defend this crucial program.

4. Impact of various factors on the psychology workforce

The last challenge I would like to discuss is the ongoing impact of

the Medicare initiative and other factors on the psychology workforce as we move towards 2020. Demand for psychologists in Australia has never been higher than it is today, and yet the training pathways for Australian psychologists are under stress. The workforce in Australia for psychologists grows at a rate of 2,000 new entrants per year, with half of this cohort coming from Master's and Doctoral programs in universities and the other half from the 'apprenticeship' model in which students leave university at the end of their fourth year and are supervised by practising psychologists for a period of a further two years. With the advent of the new registration arrangements, the level of scrutiny on the latter model has significantly increased and it is anticipated that this program will diminish in terms of the number of candidates that flow through this route over the next decade.

As a result of the higher Medicare rebate for clinical psychologists under the Better Access initiative, the demand for postgraduate training in clinical psychology far exceeds that for any other speciality in psychology. There has been a marked shift away from other specialist psychology programs to clinical psychology training programs. This has significant implications for the diversity of the psychology workforce in Australia.

The number of university programs training Master's and Doctoral psychologists has also significantly decreased overall. The economics of running clinical and applied psychology programs in Australia is poor, with conservative estimates on the basis of data gathered by the APS indicating that each university loses an average figure of $8.5K per student per year for running these programs. This is clearly an unsustainable scenario and as a result the universities are

moving to smaller intakes, developing programs that articulate better with their other goals including the importance of research training, or leaving these programs to someone else.

Taken together, these developments have created a situation in which demand for new psychology practitioners is increasing, but supply is decreasing. The APS continues to advocate for sensible workforce planning which is sustainable both financially and in terms of the provision of workforce availability in this crucial area of public policy.

5. Assisting Australian psychologists to meet the challenges

Despite the challenges discussed in this article, it has been a very successful year for the APS and we have recently reached the watershed of 20,000 members. As a membership organisation our highest priority must always be to benefit our members, which we have achieved by focusing on assistance to meet some of the current challenges in the external environment. Apart from the significant advocacy work of the APS in relation to the recent changes, a number of new member benefits have been introduced, particularly to assist practitioners to comply with the new registration standards under the national registration scheme. Recent initiatives have included:

- The redesigned and significantly elaborated continuing professional development (CPD) logging system to assist with understanding and monitoring the range of new CPD requirements under national registration

- Free member access to the EBSCO online psychological literature database, providing

full-text access to more than 550 international journals to encourage evidence-based practice

- An increased number of CPD opportunities with the development of more extensive offerings online Access to a large and growing number of APS peer consultation networks throughout Australia, again to assist compliance with new CPD requirements

- Development of a Member Assistance Centre to assist with the provision of comprehensive information on the new requirements of national registration among other matters

- A significant refresh of the APS journals – the Australian Journal of Psychology, the Australian Psychologist, and the Clinical Psychologist – to increase their accessibility and appeal

- Provision this year of no less than six separate conferences under the APS banner, including five College conferences and the APS Annual Conference held in Canberra.

- Provision of comprehensive

information on the APS website which had over one million visitors during 2010/11

- Provision of high quality, reasonably priced, professional indemnity insurance.

- Along with these new initiatives, we have continued to do all of the things that we have always done but hopefully are doing them just that bit better.

6. Conclusion

Certainly the challenges for the discipline and practice of psychology in Australia have never been more real. Changes in terms of regulation, accreditation, access and demand each operate to create a complex mix of challenges for the practice and the discipline. As President of the APS, I certainly welcome the challenge, and I strongly agree with the management aphorism that there are no such things as problems – there are only opportunities!

Reference

Pirkis. J., Harris, M., Hall, W., & Ftanou, M. (2011). Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative: summative evaluation. Melbourne: Centre for Health Policy, Programs and Economics. http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-eval-sum

One on One with Pip Pehi

Pip Pehi (Ngāpuhi; Nga Ruahine Rangi) is an academic staff member at Te Whare Wānanga o Awanuiārangi after recently completing a Foundation for Research, Science and Technology Post-Doctoral Fellowship at the Centre for the Study of Agriculture, Food and Environment (CSAFE), Otago University. Pip served as the principal researcher for Ka Ora te Whenua, Ka Ora te Tangata, a research project that aimed to blend participatory action research and Kaupapa Māori research to elucidate the link between the well-being of individuals and their communities with the health of their land. She has also served in various roles to support Māori students to succeed in their studies at Otago University. Pip completed a PhD in social psychology from Otago University and is a qualified clinical psychologist. Beyond the academic world, Pip has worked in a number of therapeutic settings to foster and support well-being for people including a residential therapeutic community for male offenders, public child and adolescent mental health, and care of the elderly within the hospital setting.

One aspect of your role that you find really satisfying

The main aspect I find satisfying about working as a psychologist, whether in research or practice, is that I get to learn so much about the world and human experience through the eyes of others. Much more than I believe I could do without this role.

One event that changed the course of your career

I have two events I would like to share that changed the course of my career. The first was being invited to apply for a postdoctoral fellowship by Professor Henrik Moller at Otago University. I had been working as a counsellor and clinician for about 8 years by then and was becoming very frustrated with the systems, institutions and processes that I believed were not helping people to be well. The project I ended up working on, Ka Ora Te Whenua, Ka Ora Te Tangata, changed my life. The communities throughout Aotearoa that I worked with opened my eyes to their reality and the urgent need for us to recognise that our health is inextricably entwined with that of the natural and spiritual world. These same people also inspired me with their dedication to their communities and the natural world, in the face of seemingly insurmountable odds and still be optimistic!! The project brought together all the strands of my life to reveal my life's purpose: to work for the wellbeing of people and Papatuanuku (Earth Mother). The second event was the invitation from Waikaremoana Waitoki, on behalf of the National Standing Bicultural Committee (NSCBI) to come and be part of the committee. This event brought me back to the psychology network after ten years of absence, and many opportunities to further my

life purpose have unfolded from that. To these two people I owe a debt of gratitude.

One alternative career path you might have chosen

Professional bum or nun! But seriously! There are times when I would love to step out of the rat-race, go somewhere serene and live out my days communing with nature and the spiritual world. Something within me however keeps bringing me back to earth and prods me to keep challenging the status quo for a better future for us all. Especially as our world faces so many threats to all our serene places.

One learning experience that made a big difference to you

Of all the experiences I treasure the most, being a mother has to be top of the list. I was terrified of becoming a mother! What a responsibility!! However, my beautiful Maia is hands-down my greatest triumph and challenge. I am a better person for her coming into my life and she is the main reason I keep working for a better future for her and the children to come. Maia grounds me and reminds me that to truly offer help and love to others, we must first extend that to ourselves. If I am not well, my daughter suffers. I have learnt to care for myself through loving her.

One book that you think all psychologists should read

This is a hard question... There are so many- and none of them strictly psychological! So 'The Alchemist" Paulo Coehlo is one. Read this to find out what it means to listen to the 'language of the world...' and the other book is anything written by Thomas Moore. He writes about therapy

that includes the soul meaningfully, and some of his thoughts are deeply profound. The last book I would recommend is 'The Prophet' by Kahlil Gibran. This is another spiritual book that offers gems to enrich any life.

One challenge that you think psychology faces

I challenge psychologists to remember the origins of psychology. The study of the soul... I think a psychology without heart and soul is missing the boat entirely. Do we strive for a better BDI score, or do we strive to be truly happy and joyous in our lives, and to follow our bliss? Anything less is selling ourselves short I believe.

One thing that psychology has achieved

When I came back to psychology after being away for so long, I was impressed by the way in which this discipline (in its highest form), attempts to embrace the many different facets of the human condition to better the experience of life for people. Psychology in Aotearoa (at least) has extended to embrace people from different cultures, and made room for other ways of looking at the world. I can certainly see a place for myself as an indigenous woman in psychology that I couldn't when I was studying back in the 1990s. There is certainly much more to do, but things have certainly changed for the better in my view.

One aspiration for New Zealand psychology

I guess because of my own life purpose, I would like to see the environment, personal creativity and spiritual understandings become more a part of every psychological assessment, therapeutic approach,

research project and so on. I believe these aspects are fundamental components of health and wellbeing (and the human experience) that are often excluded in standard psychological writings and approaches. Therefore I believe we are not addressing the fullness of who we truly are, or contributing all of what we need to be well and fulfilled.

One social justice issue psychology should focus on

One of the issues closest to my heart is the way in which we treat the most 'in need' within our society. One such group are the people we lock away in our prisons, and in many cases write off as 'lost causes'. Particularly for Māori in this country, I believe so much of our creative talent, humanity and strength lies dormant in our prisons. I am a believer in miracles and giving people the opportunity to choose again in their lives. So many of our most vulnerable people are not given the chance to be all that they could be. We choose to punish rather than to look more deeply at our society and how it is failing our own people.

One big question

That's an easy one for me now... "Who were you born to be?" And if you are not being that person, it is never too late to make new choices...

One regret

You know, I do not believe I have any... I have come to see my life as a mosaic (in all its twists and turns, and all the choices I have made), that makes perfect sense. I am sad for myself sometimes that I haven't always been the best person I could be, and sorry to those I have hurt or harmed, but those hard times and unhealthy

actions have sometimes brought me the greatest learning.

One proud moment

Anytime I manage to get over my over-size ego and say sorry to someone I have hurt is a proud moment for me, especially to my daughter.

One thing you would change about psychology

Probably many things! I don't know that that would be wise though, as I certainly don't know everything! I think perhaps my contributions may change it a little, but mostly I am happy and curious now to see where it will evolve to.

One piece of advice for aspiring psychologists

Go hard!!! Even though it can be difficult and painful at times, and the pressure to conform can be great, stay true to yourself and your passions. There will be many people who will judge you as not good enough, cause you grief just because they can and sometimes it will seem much easier to give in and try and be what others want you to be. However, I think that in the long run, this would be the greatest regret of my life. There is an inner peace I feel when I know I did my very best, and gave it all I had- even if it doesn't work out the way I wanted. At least I know I have always given it my best.

Welcome to the book and on-line resource review section. We have one review for this edition on the subject of critical thinking in counselling and psychotherapy.

We are always interested to hear of books or on-line resources which you think we could review or if you are willing to be a reviewer please get in touch through National Office. John Fitzgerald, Review Editor

Critical Thinking in Counselling and Psychotherapy

Reviewed by Mark Thorpe, Department of Psychology, AUT.

Mental health clinicians around the world are increasingly being asked to reflect and think critically about their practice and professional development. Closer to home, all registered psychologists in Aotearoa/New Zealand are required to engage in a critical Self-Reflective Review (SSR) as part of their annual Continuing Competence Programme. As critical thinking is a prerequisite to remaining registered, Feldman's 220 page book ought to be of interest to all psychologists.

Feldman defines critical thinking as "The willingness to approach all relevant traditions, practices, texts and questions sceptically and analytically, with an associated effort to articulate the grounds for criticism and to make possible alternative proposals" (p. 7). His aim is counter the extremes of post-modernism and political correctness and to establish a style of philosophical critical thinking which embodies the values of honesty and curiosity. To this end he provides the reader with a rich, stimulating and interesting book.

Feldman approaches a plethora of counselling-related topics with radical honesty. The 60 topics covered in the book are placed into nine sections; everyday counselling practice, training and curriculum issues, theories of counselling practice, professional issues and infrastructures, counselling and culture, spiritual and philosophical issues, counselling wisdom, the spectrum of suffering, and perennial and current topics. Some topics I found of particular interest include: What's wrong with counsellor self-disclosure? How important is the trainee's own personal therapy? What's wrong with CBT? What's wrong with psychoanalytic therapy? Does counselling rest on faith and hope? Is it all about the relationship? Who is the person of tomorrow?

The individual topics are around three pages in length, are all packed with numerous critical perspectives, interesting ideas and exercises. They can be read as standalone pieces and are excellent starters for stimulating critical debate but lack the depth expected of longer pieces.

I was particularly impressed by an example of critical textual analysis on a short passage on the necessity of supervision (Appendix 1). Clearly this is a highly experienced critical thinker at work. My main criticism of this section, and the book as a whole, is that Feldman does not show the reader the specific techniques and strategies of how to improve their own critical thinking.
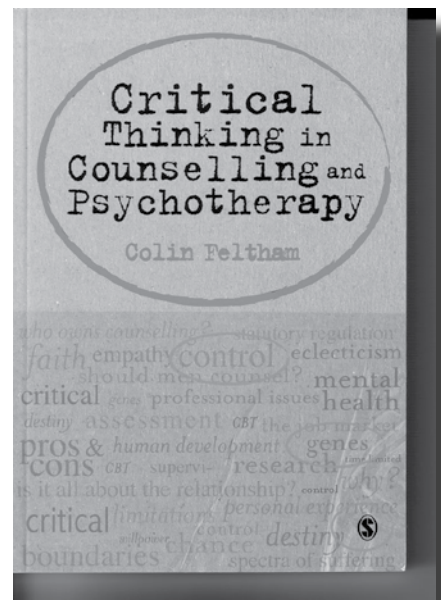
Editorial

Isabelle Miclette
Student Forum Editor

Tēnā koutou katoa. Greetings and welcome to this fifth edition of the *Psychology Aotearoa*, Student Forum.

This edition is my final one as editor. Arriving at the end of what has been an incredible three-year journey, including the inaugural edition of *Psychology Aotearoa*, leaves me short of words and packed with gratitude. This opportunity has been challenging and rewarding yet at the same time humbling: rewarding to see the student forum take shape, over time, resulting in an attractive glossy production; humbling to realise the extent of what is to yet be learned from the psychology student workforce in Aotearoa, New Zealand.

Congratulations to: Maree Foley (University of Victoria), who was awarded the Best Student Paper at the annual conference in Queenstown; Jessica McIvor (Massey University) for the Institute of Clinical Psychology Paper; and to Maria Polak (University of Otago), who won the Best Student Poster. Congratulations also to Tess Chalmers (Massey University), who reaped the Karahipi Tumuaki-President's Scholarship. Great effort and talent!
Without further ado, please welcome the student contributors this edition, who enthusiastically

and generously provide us with the opportunity to find out about their doctoral research: Thomas Huggins (Massey University) and winners Maree Foley and Jessica McIvor present their most up-to-date articles, whereas Kevin Austin (Massey University) and winner Maria Polak share their knowledge via posters.

The exciting thing about the end of a process is the beginning of another. The next edition will welcome the arrival of a new editor and fellow student. A warm welcome to you! I would like to sincerely thank Pam and the team at NZPsS for their trust, support, and kindness. I will look forward to collaborating with you again in the near future. Finally, heartfelt thanks to all contributors to this forum so far, and best wishes to all of those to come. See you in Wellington next year, for the NZPsS and NZCCP Psychologists joint conference!

"Whatever you do, or dream you can, begin it. Boldness has genius and power and magic in it".
Johann Wolfgang von Goethe (1749-1832)

"Luigi the cat tried his best to keep interested in learning about mixed methods research but decided to take a nap instead"

Veuillez agréer, chers collègues, mes plus sincères salutations.
Isabelle Miclette
Doctoral Student in Clinical Psychology , Massey University, Albany

Maria Polak received the best student poster prize at the NZPsS Conference in Queenstown. She is undertaking a PhD with Dr Tamlin Conner at the Daily Experiences Lab at the Department of Psychology, University of Otago. Sampling methods such as daily diaries and text messaging to collect close-to-real-time data and limit retrospective bias and memory issues are being used. Maria is particularly interested in the factors that are associated with greater wellbeing in our daily lives.

See over for her winning poster:

Extreme drinking and next-day functioning in university students

Extreme drinking and next-day functioning in university students

Maria Polak, BSc(Hons) and Tamlin Conner, Ph.D.

Daily Experiences Lab, Department of Psychology, University of Otago, Dunedin, New Zealand

E-mail: mariapolak@psy.otago.ac.nz

UNIVERSITY
OF
OTAGO

Te Whare Wānanga o Otago

NEW ZEALAND

INTRODUCTION

Tertiary students and alcohol

Excessive alcohol consumption is a major public health issue, and tertiary students are at increased risk of engaging in this behaviour. Acute and long-term consequences of heavy drinking are well known; however, little is known about the consequences of extreme drinking - more than twice the heavy drinking threshold. Additionally, the intermediate effects of alcohol consumption on next-day functioning have not yet been investigated. Alcohol may impair students in their daily lives through various mechanisms. Most directly, alcohol can disrupt the process of learning, although these effects are believed to be temporary. Alcohol consumption may affect many other factors – physical (sleep, feeling refreshed, tiredness and illness), cognitive (ability to concentrate and manage workload), and emotional (positive and negative moods and stress) – which in turn affect functioning in daily life.

NZ recommendations for alcohol consumption

The Alcohol Advisory Council of New Zealand (ALAC) recommends that men consume no more than 6 standard drinks per drinking occasion and women no more than 4. In New Zealand, one standard drink is defined as containing 10g of pure ethanol, roughly equivalent to a 330mL can of regular strength beer, a very small glass of wine, or a single shot of spirits (Figure 1). Consumption above these recommended levels is considered "heavy drinking" (formerly called "binge drinking") which leads to considerable intoxication manifesting as acute cognitive and behavioural impairment. Nevertheless, categorisation of drinking into safe vs. heavy drinking based on this single threshold may fail to capture other important differences among those who exceed safe drinking recommendations. Those who consume alcohol at considerably higher levels than the cut-off for safe drinking, extreme drinking, may differ in the nature and severity of consequences.

Fig. 1. Examples of 1 NZ standard drink

Current Study

The current study investigated the drinking patterns of students and the effect of different levels of alcohol consumption on the next-day physical, cognitive, and emotional functioning. The two aims of our study were:

(1) Investigate the frequency and quantity of drinking among this sample of young adults - special consideration was given to the prevalence and characteristics of "extreme drinking"- when participants consume more than twice the recommended amount for safe drinking (14+ drinks for men, 10+ for women).

(2) Investigate the relation between these drinking levels (none, safe, heavy, and extreme) and reports of next-day physical, cognitive, and emotional functioning.

We hypothesised that an increase in the amount of alcohol consumed the previous night will predict significant decreases in physical, cognitive, and emotional functioning the next day, but that the impairments may not be linear per se. Impairments to functioning may be minimal at or "safe" drinking levels; however, heavy drinking and, particularly, extreme drinking levels would be associated with the strongest impairments.

METHOD

Participants and procedure

Participants were 281 students (153 women (54.4%), mean age 19.8 years) at the University of Otago who were taking part in the Daily Experiences Study. During a 60-minute on-site laboratory session participants completed an initial online survey and were given brief training on estimating and reporting alcohol consumption as the number of standard drinks. Then they completed 21 consecutive 5-minute daily surveys available online every day from 3pm until 8pm through a password protected website. Response rate was high, with participants having completed 19 diary reports out the 21 on average, a response rate of 91%.

Measures

Embedded between other questions about daily life, participants reported how much alcohol they consumed last night as the number of standard drinks. Drinking level was computed from the number of standard drinks reported as none, safe (up to 4 for women and 6 for men), heavy (over the safe but below extreme) and extreme (10 or over for women and 14 and over for men). Participants also reported on their physical (sleep, refreshed, tiredness, and illness), cognitive (workload management and concentration problems) and emotional (positive and negative moods and stress) functioning on the day.

Statistical analysis

The association between level of alcohol consumption and reports of functioning on the following day was examined using hierarchical linear modelling in HLM v6. The daily reports were input as level 1 variables and participant characteristics as level 2 variables to account for the hierarchical structure of the data (Figure 2). We opted for a hierarchical linear model to take into account the within-person variability.
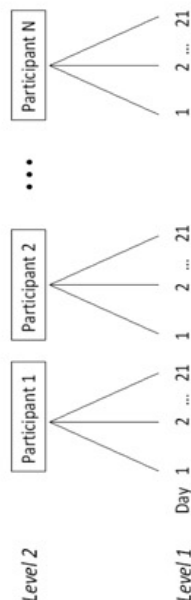
Figure 2. Graphical representation of the structure of our data

RESULTS

Drinking patterns

Participants reported drinking on 26.8% of the days, on two days per week on average. Most of the drinking occurred on Thursday, Friday and Saturday nights, with the proportion of heavy and extreme drinking also being greater on these days (Figure 3). Men drank more than women, but the weekly trajectory of drinking was similar for the two genders (Figure 4).
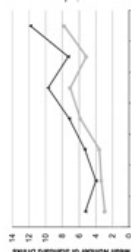
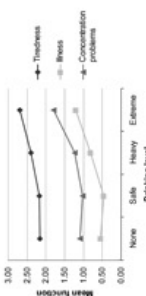Figure 4. Graphical comparison of male and female drinking patterns by day of week

Key: ● No drinking ● Safe drinking ● Heavy drinking ● Extreme drinking

Figure 3. Daily variation in drinking levels across the week.

Next-day functioning

Heavy drinking and, particularly, extreme drinking predicted significant decreases in next-day physical and cognitive functioning (Figure 5). However, drinking within safe limits was not associated with next-day impairment. All these patterns of impairment were similar for men and women.

Figure 5. Patterns of functional impairment for selected function variables, highlighting greater impairment with higher drinking level.
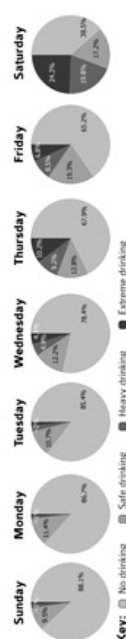
SUMMARY

- Students do not drink frequently, but when they drink, they exceed the safe drinking recommendations
- Drinking beyond the recommended safe level is associated with impaired physical and cognitive functioning the next day
- Extreme drinking – in excess of twice the recommended safe level – is associated with significantly more impairment than heavy drinking, suggesting the need for further differentiation beyond the safe drinking threshold

Acknowledgements

Parental consent for child participants in questionnaire development: A reflection on work-in-progress and invitation for discussion.

First author: Thomas Huggins
Corresponding author: Dr Linda Jones

Thomas Huggins is about to commence his Master's thesis which examines visual modelling for complex planning scenarios. He comes from a broad professional background that has seen him working alongside diverse communities in both New Zealand and Mexico. Thomas is currently an active contributor to Massey University in sustainable agriculture initiatives, and the School of Psychology as a tutor and research assistant in health psychology, and disaster recovery.

Linda Jones is a senior lecturer on Massey University's Wellington campus. While her teaching covers health psychology, her research is in the niche area of dental psychology. Her current work is on children's dental anxiety, leading an international collaboration of health psychology and pediatric dental researchers. Linda is the NZ representative for the international Stress and Anxiety Research Society (see www.star-society.org) and on the Editorial Advisory Board of the journal World Health Design (see www.designandhealth.com)

The aim of this paper is to present some considerations and approaches for gaining institutional ethics approval and parental consent to work with child participants in questionnaire development. In developmental work it is critical to have a wide range of participants to ensure instruments and validation data fit the diversity of contexts to which they may be applied. The context we will describe is one where health inequalities exist, producing the requirement to oversample children that may be disadvantaged in relation to the construct. We hope the paper will generate discussion and perhaps other ideas or options to maximise children's participation and have their opinions recorded, while ensuring the rights of these vulnerable participants are protected.

Our project, named Dental Jungle, involves a series of studies that are building an electronic resource for dentists and dental therapists to use when working with child patients. The project includes the assessment of dental anxiety and coping styles, as well as techniques to improve communication between patients and practitioners, and adherence to a negotiated treatment plan. It does not include topics where parents are likely to feel threatened by possible revelations their child might make.

Active parental consent is indicated on the Massey University Human Ethics screening questionnaire, for research involving minors, who are defined as participants under 16 years of age. This is standard procedure according to current literature (Carroll-Lind, 2006; Esbensen, Miller & Taylor, 1999). Active parental consent asks parents to submit a signed form to confirm they

have read the information provided by the researchers, understood the terms of agreement and their rights, and consent in writing to their child's participation in a particular project. In principle this will safeguard consent from the participants themselves being influenced by offers of rewards, inducements, acquiescence or inappropriate explanations (Coyne, 2009). Active parental consent also explicitly values the important role that parents and guardians have in the lives of their children (Carroll-Lind, 2006), and is more likely to receive support from institutions that depend upon the patronage of those parents.

Active consent has been more commonly received from minors with particular characteristics. Particular sampling biases have been observed by Esbensen, Meld, Taylor and Peterson (2008), who noted that active parental

consent was significantly more likely in the United States of America (USA), for children from school rolls with high socio-economic status (SES) and higher teacher/student ratios. In United Kingdom dental research, Monaghan et al. (2011) specifically found that active consent was more likely for Welsh children with lower levels of tooth decay. Both scenarios highlight the way that high-need respondents can be effectively excluded by active-consent requirements. In our project, which is underpinned with a need to address oral health inequalities in New Zealand school children, we particularly required responses from children whose parents were most likely to be apathetic in their response to research information sent to them, if these international trends apply in New Zealand.

Our project, named Dental Jungle, involves a series of studies that are building an electronic resource for dentists and dental therapists to use when working with child patients.

Furthermore, children whose parents give active consent are more likely to be Caucasian and academic achievers, with more educated parents, and with less risky health behaviours and prior exposure to preventative health interventions, according to a USA study (Anderman, 1995). Such sampling biases create problems when evaluating health interventions, because they are more likely to reflect a ready uptake of the programmes in question, while excluding demographics with particular health needs.

Active parental consent then, carries particular risks. Potential research participants may be excluded by way of parental apathy, when even purposefully engaging information sent to parents is simply ignored.

Applied to our research, planned oral health interventions would be less likely to be informed by the particular needs of children already missing out on resources and services. When validating our interventions, the work is unlikely to represent a range of child patients, if requiring active parental consent.

> Furthermore, children whose parents give active consent are more likely to be Caucasian and academic achievers, with more educated parents, and who had less risky health behaviours and prior exposure to preventative health interventions, according to a USA study…

It may be important then, on occasions, to use a passive consent procedure. Such a consent process can continue to value protective roles of parents and guardians, without overly impeding children's rights to offer their own participation. Such systematic exclusions of minority and high-need participants and families discussed have led to calls for passive consent processes (see Anderman et al., 1995; Esbensen et al. 2008), in order to increase the likelihood of diverse child research participation. Carroll-Lind (2006) made a more general call for passive consent processes. They suggested that Article 12 of the 1989 United Nations Convention on the Rights of the Child makes children's voice as potential research participants at least as important as the veto of parents and guardians - given adequate age and maturity of the children concerned. Within the spirit of this convention, passive consent processes require researchers to give information as for active consent, with the difference that parents only return a form when refusing their child's participation. The form returned is a signed non-consent form.

Such a passive non-consent process carries the assumption that non-return of a signed non-consent form reflects latent consent, rather than assuming that parents simply

neglected to read the material provided (Ellickson & Hawes, 1989). The arguably neglected risk of latent refusal becomes the necessary cost for more inclusive and representative questionnaire development. Passive consent procedures can minimise this risk of latent refusal by incorporating the strengths of certain active consent processes and maximise both response and consent rate. Albeit identifying a systematic bias against active consent from students in lower SES and otherwise marginalised groups, Esbenson et al. (2008) found that in depth collaboration with USA schools and incentives for both teachers and students helped achieve an active consent rate of 85%. Ellickson and Hawes (1989) achieved a comparable active consent rate of 86%, amongst minors in the USA. This rate was achieved through meetings with, and phone calls to parents, while maintaining daily contact with teachers.

However, Ellickson and Hawes (1989) outlined limitations of such findings, for anyone attempting to resource larger-scale research. Costs such as daily contact with teachers may be unsustainable for many projects, prompting a more strategic selection of effective consent procedures. Bearing resource limitations in mind, Ji, Pokorny and Jason (2004) found that procedures of attaching consent forms to school correspondence, and being invited in person, most effectively increased active consent rates amongst year 7 to 10 USA students. These procedures are likely to increase parents' overall engagement with consent material, regardless of active or passive consent. For passive

consent, this means invitations in person, and consent forms sent with school correspondence minimise the risk of latent refusal, while avoiding the systematic biases of active consent samples.

Researchers can further minimise the potential harm of latent refusal by eliminating certain risks to questionnaire participants that would otherwise be cause for refusal. A major risk to questionnaire participants is the risk of disclosing personal information, which could be a major factor in parental refusal amongst unrepresented minority groups (Ellickson & Hawes-Dawson, 1989). This risk is most straight-forwardly minimised through participant anonymity, which will assure parents that their child will not be disclosing personally identifiable information. For example, confidential and anonymous data were not linked to consent documentation in research by Carroll-Lind, (2006), amongst a sample of New Zealand 9 to13 year-olds.

Researchers can further minimise the potential harm of latent refusal, by eliminating certain risks to questionnaire participants that would otherwise be cause for refusal.

Our current research into dental anxiety amongst young dental patients aims to combine effective strategies from both active and passive parental consent processes. Besides incorporating child assent as a key part of our protocol, we plan to incorporate at least two approaches to parents. The first approach will use active consent procedures, requesting the return of a signed consent form but without stipulating that this is an absolute requirement for their child's involvement. As in Esbensen et al. (1999), this would help clarify whether or not there is a need for

passive consent –by providing a preliminary indication of active consent sample bias. Where necessary for sample representativeness, a second letter would be mailed to parents, stating that their children will be offered the chance to participate unless parents return a refusal form. A third approach may be made to parents, by phone.

Our current research into dental anxiety amongst young dental patients aims to combine effective strategies from both active and passive parental consent processes.

However, this would depend on institutions we are working with, and the total number of responses received. A toll-free number will be provided for any parent or child inquiry at all stages of this consent process, as per Carroll-Lind, (2006). This approach also comes supported by Blom-Hoffman et al. (2009), as a key conclusion of their review of 500 parental consent procedures, and builds on our experiences during other stages of the Dental Jungle project.

We hope for our future work, to administer the consent processes through partnership with participants' schools or allied institutions. Besides providing a degree of protection in loco parentis, such consultation has been an important part of both informing, and achieving, a high standard of parental consent for USA health promotion research (Blom-Hoffman et al., 2009). Anonymity will be applied throughout, through the use of non-identifying time codes, in place of names on the dental questionnaires. These codes will only serve to unify each data set. As per Carroll-Lind,(2006), research data will be collected separately from the consent forms being mailed out by clinics, on account of personal

identifiers therein. Clinic staff will be prepared appropriately, to make sure only consenting clients will have access to the intervention being validated. All minors who have passed through the consent process will still have an explicit option to give or withhold their own assent, before beginning the questionnaire protocol.

Active consent procedures are to be preferred for research with minors, but it may be important to use a passive consent procedure, to ensure that apathy does not prevent the voices of child participants being heard. At times, when research is seeking to validate interventions, passive consent may help overcome apathy in key areas where health inequalities are a real issue. We have argued that, although there is a best case scenario for active consent, augmented passive consent empowers a necessarily diverse range of minors to participate. Parental protections are still fostered throughout, through making best use of the consent procedures outlined.

We would welcome discussion of the ethics of research with minors in the forum of *Psychology Aotearoa*.

References

Anderman, C., Cheadle, A., Curry, S., Diehr, P., Schultz, L. & Wagner, E. (1995). Selection bias related to parental consent. Education Review, 19(6), 663-674. DOI: 10.1177/0193841X9501900604

Blom-Hoffman, J., Leff, S.S., Franko, D.L., Weinstein, E., Beakley, K. & Power, T.J. (2009). Consent procedures and participation rates in school-based intervention and prevention research: Using a multi-component, partnership-based approach to recruit participations. School Mental Health, 1(1), 3-15. DOI: 10.1007/s12310-008-9000-7

Carroll-Lind, J. (2006). Children's perceptions of violence: The nature, extent and impact of their experiences. A thesis presented in partial fulfilment of the requirements for the degree of doctor of philosophy at Massey University. Palmerston North, NZ: Massey University.

Coyne, I. (2009). Research with children and young people: The issue of parental (proxy) consent. Children and Society, 24, 227-237. DOI: 10.1111/j.1099-0860.2009.00216.x

Ellickson, P.L. & Hawes, J.A. (1989). An assessment of active versus passive methods for obtaining parental consent. Evaluation Review, 13(1), 45-55. DOI: 10.1177/0193841X8901300104

Esbensen, F., Miller, M.H. & Taylor, T., Ni, H. & Freng, A. (1999). Differential attrition rates and active parental consent. Education Review, 23(3), 316-335. DOI: 10.1177/0193841X9902300304

Esbensen, F., Melde, C., Taylor, T.J. & Peterson, D. (2008). Active parental consent in school-based research: How much is enough and how do we get it? Evaluation Review, 32, 335-362. DOI: 10.1177/0193841X08315175

Ji, P.Y., Pokorny, J. & Jason, L.A. (2004). Factors influencing middle and high schools' active parental consent return rates. Evaluation Review, 28(6), 578-591. DOI: 10.1177/0193841X04263917

Monaghan, N.P., Jones, S.J. & Morgan, M.Z. (2011). Do parents of children with caries choose to opt out of positive consent dental surveys in Wales? British Dental Journal, 210(E1). DOI: 10.1038/sj.bdj.2011.26

The manager-employee relationship: A coaching psychology issue

Maree A. Foley

Maree is a doctoral student at Victoria University in the School of Management. She holds a TEC Top Achiever Doctoral Scholarship and a Shirtcliffe Fellowship. She is currently the President of the NZ Association of Infant Mental Health (IMHAANZ) and is a member of the Board of Directors of the World Association of Infant Mental Health (WAIMH) and a co-opted member of the NZ Coaching Psychology Steering Committee.

Levels of employee engagement are influenced by the manager-employee relationship and the manager-employee relationship is a common theme in coaching. This paper describes a doctoral research study that has been examining engagement via the manager-employee relationship and developing a manager-employee dyad coaching programme.

Employee Engagement (EE) is important for employee performance and wellbeing in the workplace (Albrecht, 2010). Effective management of employee performance, and by implication engagement, involves communication between managers and employees as a day-to-day activity. It is not surprising then that EE research identifies the manager-employee relationship as a central influence on EE (MacLeod & Clarke, 2009). However, much of the EE research focuses on the individual employee, or the aggregated business level outcomes of EE and not the manager-employee relationship.

The manager-employee relationship is a common theme in workplace coaching research (McGivern et al., 2001). However, coaching psychology research has predominantly explored models of coaching (cf Palmer & Whybrow, 2007) and the coach-coachee relationship (Dakin and Malinen, 2011). To date, the manager-employee relationship as a unit within coaching research has been under-explored.

In response, my doctoral research study has been examining the concept of engagement via the manager-employee relationship. This paper provides an overview of the study, reports interim findings, and concludes with examining potential implications for coaching psychology.

What is employee engagement?

The concept of engaged employees has been shown to affect organisational bottom line results including productivity, profitability, and employee retention (Buckingham & Coffman, 1999). An engaged and productive workforce is positively related to competitive advantage for businesses. A disengaged workforce risks revenue losses (Saks, 2006). For these reasons, creating an engaged workforce has increasingly become a primary business goal and a top management issue (Ken Blanchard Companies, 2009).

While popular and compelling, EE as a concept is difficult to define. For instance, definitions generated from the business community typically emphasise in some way:

what an engaged employee feels about their work; how they go about their work; and how an employee's level of engagement affects organisational outcomes (Robertson-Smith & Markwick, 2009). In contrast, definitions of EE generated from academia try to capture what is unique about the business community observations while simultaneously establishing convergent and divergent validity with pre-existing concepts such as job satisfaction and organisational commitment (Shuck & Wollard, 2010).

Shared across both the commercial and academic sectors is a view of EE as a "two-way street" between employer and employee. For example, from the Institute of Employment Studies: "The organisation must work to develop and nurture engagement, which requires a two-way relationship between employer and employee" (Robinson, Perryman & Hayday, 2004, p. 9).

…. much of the employment engagement (EE) research focuses on the individual employee, or the aggregated business level outcomes of EE and not the manager-employee relationship.

Further supporting the notion of EE as a two-way street, the manager-employee relationship is a central influence on EE levels (MacLeod & Clarke, 2009). However, the manager-employee relationship is not researched as unit of analysis. Instead EE research tends to focus on the relationship between the employee and their job and/or their organisation, or is oriented towards a worker's view of their relationship with their boss.

As a result, much is known about managers and employees and their respective engagement relationships with their jobs and organisations, and about employees' experiences

of their supervisors (cf Albrecht, 2010). However, in the absence of the manager-employee relationship as the unit of analysis, much less is known about this relationship as an engagement relationship when viewed from the vantage point of the day-to-day communication between managers and employee.

A manager-employee engagement study

Adopting an attachment theory (Cassidy & Shaver, 2008) lens, the manager-employee relationship is explored as an engagement relationship. Attachment theory, a systems theory commonly used to explore and explain parent-child relationships (cf Bowlby,1969) has been used to explore leader and follower behaviour (Mikulincer & Shaver, 2007). Attachment theory has not so far been used to inform the engagement literature.

Attachment theory is a life span developmental theory that explores and explains a wide gamut of normative, yet qualitatively different ways of communicating with oneself and others (Bowlby, 1969). Attachment theory assumes that when under pressure, adults think, feel and act in ways with significant others that are influenced by: a) actual experiences of the relationship; and b) an "internal working model" of how the stress is communicated to another, and how it is most likely to be responded to (Bowlby, 1969). By implication, an attachment theory lens on EE brings into direct view the communication patterns that managers and employees use to communicate as they go about the business of getting their jobs done.

My research bridges attachment theory with the engagement literature and has developed a new concept: "manager-employee engagement" (M-EE). In

sum, M-EE endeavours to capture something of the ways that managers and employees engage with each other as an additional view to "how much" employees are engaged. The current working definition of manager-employee engagement (M-EE) is as follows:

M-EE focuses on the interpersonal relationship between a manager and employee and the different communication strategies that managers and employees use to work together as part of meeting organisational goals.

Next, my research has integrated the concept of M-EE into a new relationship model of EE. This model includes: a) examples of antecedents Perceived Organisational Support (POS) (Eisenberger, Huntington, Hutchison & Sowa, 1986); and Perceived Supervisor Support (PSS) (Rhoades & Eisenberger, 2002) to EE; b) engagement variables, Job Engagement (JE) and Organisation Engagement (OE) (Saks, 2006); and outcome variables to engagement Organisational Commitment (OC) (Rhoades, Eisenberger, & Armeli, 2001) and Intention to Quit (ItQ) (Colarelli, 1984).

By implication, an attachment theory lens on EE brings into direct view the communication patterns that managers and employees use to communicate as they go about the business of getting their jobs done.

To test the model of EE, M-EE was operationalised and an exploratory series of survey questions were formulated, for example: "When you are under pressure, what kind of support do you usually seek from senior colleagues?" and "When you are under pressure, what kind of response do you expect to get from your senior

colleagues?" These new questions, in conjunction with previously validated items to test the other variables in the model, collectively formed the M-EE questionnaire. This questionnaire was distributed as an online anonymous survey using Qualtrics™ resulting in 400 useable surveys (200 managers and 200 employees) for data analysis.

In summary, survey findings showed that the concept of M-EE was related to, but distinct from, JE and OE; and that M-EE scores were related to JE, OE, OC and ItQ. Also, as a result of conducting principle component analysis with a promax rotation, M-EE could be represented as a three-dimensional concept. Drawing on the foundational work of Ainsworth, Blehar, Waters and Wall (1978), each dimension represented a different normative communication strategy. For example: Balanced (α = 0.83) represented (when under stress) a worker's communication strategy that functioned to balance relationship-seeking to help to do a job, with actually doing the job; Distancing (α = 0.79) represented a communication strategy characterised by distancing oneself from relationships when stressed, and preferring to be work focused; and the Preoccupied (α = 0.74) strategy was characterised by increased relationship-seeking at work, while engaging less with the getting the job done. Each dimension represented a patterned system of communication; the three dimensions, for managers and employees, each have alpha coefficients between 0.74 and 0.83.

Specifically, findings indicated that the Balanced strategy had better outcomes (i.e. increased job and organisation engagement) when compared with Distancing or Preoccupied strategies. Of note, participants indicated a preference for using Balanced strategies in their personal relationships

(Managers 67%, Employees 54%) but at work, use of this strategy decreased and use of the Distancing strategy increased. This trend was especially marked in the manager statistics, with an approximate 15% drop in use of the Balanced strategy at work and an approximate 15% increase in the use of Distancing.

Interim findings within this study support further exploration of coaching methods oriented towards the professional development of the manager and employee as a dyad as a means of improving organisational outcomes.

This indicative adaptation in communication strategy while within communication norms is potentially: a) counter to the goal of increasing engagement, namely job and organisation engagement; and b) challenging to address within coaching as each strategy represents both an inferred "internal working model", and an actual and unique manager-employee relationship.

Implications for the practice of coaching psychology

Interim findings within this study support further exploration of coaching methods oriented towards the professional development of the manager and employee as a dyad as a means of improving organisational outcomes. To this end, the next part of my study involves testing a brief coaching skills programme designed for managers and employees who work together. The programme focuses on day-to-day communication styles that managers and employees use as part of getting their work done. The programme aims to explore and develop relationship-specific communication skills within each unique manager-employee relationship as a way to increase the engagement of both employees and managers.

Finally, at the end of study, coaches will be invited to: a) participate in a focus group to review the aggregated findings from the manager-employee dyad coaching skills programme and; b) explore the potential of this programme for developing critical competencies such as communication within workplace relationships, especially the manager-employee relationship.

Conclusion

In summary, researching engagement via the manager employee-engagement relationship extends the current "how much" view of engagement to include "how" we engage with each other, especially when under pressure, as part of getting the job done. Finally, focusing on the shared ground between coaching and engagement creates a unique window to explore and further the current understanding of the manager-employee relationship.

References

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). Patterns of attachment: A psychological study of the strange situation. Hillsdale, NJ: Lawrence Erlbaurn Associates, Inc.

Albrecht, S. L. (Ed.). (2010). Handbook of employee engagement: Perspectives, issues, research and practice. Cheltenham: Edward Elgar Publishing Limited.

Bowlby, J. (1969). Attachment and loss Vol. 1: Attachment. London: The Hogarth Press.

Buckingham, M., & Coffman, C. (1999). First break all the rules: What the world's greatest managers do differently. Sydney, Australia: Simon & Schuster.

Cassidy, J., & Shaver, P. R. (Eds.). (2008). Handbook of attachment: Theory research and clinical implications (Second Edition) New York: Guilford Press.

Colarelli, S. (1984). Methods of communication and mediating processes in realistic job previews, Journal of Applied Psychology, 69, 633-42.

Dakin, S. & Malinen, S. (2011). The key to successful coaching? Exploring the coach-coachee relationship. Paper presentation, New Zealand (NZ) Psychological Society Annual Conference. Queenstown, NZ.

Eisenberger, R., Huntington, R., Huntington, S., & Sowa, D. (1986). Perceived organizational support. Journal of Applied Psychology, 71, 500 –507.

Ken Blanchard Companies (2009). 2009 Corporate issues Survey: A seven year look at the key issues organizations and leaders face. www.kenblanchard.com Downloaded: 05/05/2010.

McGivern, J., Lindenmann, M., Vergara, M., Murphy, S., Barker, L., & Warrenfeltz, R. (2001). Maximising the impact of executive coaching: Behavioural change, organizational outcomes, and return on investment. The Manchester Review, 6, 3-11.

MacLeod, D., & Clarke, N. (2009). Engaging for success: Enhancing performance through employee engagement. Department for Business, Innovation and Skills. Surrey: Crown Copyright.

Mikulincer, M., & Shaver, P. (2007). Attachment in adulthood: Structure, dynamics and change. London: The Guilford Press.

Palmer, S., & Whybrow, A. (Eds.). (2007). Handbook of coaching psychology: A guide for practitioners. London: Routledge.

Rhoades, L. & Eisenberger, R. (2002). Perceived organizational support: A review of the literature, Journal of Applied Psychology, 87, 698-714.

Rhoades, L., Eisenberger, R., & Armeli, S. (2001). Affective commitment to the organization: The contribution of perceived organizational support, Journal of Applied Psychology, 86, 825-836.

Robertson-Smith, G., & Markwick, C. (2009). Employee engagement: A review of current thinking. (Report 469). Institute for Employment Studies (IES). www.employment-studies.co.uk

Robinson, D., Perryman, S., & Hayday, S. (2004). The drivers of employee engagement. (No. 408). Brighton: Institute for Employment Studies.

Saks, A. M. (2006). Antecedents and consequences of employee engagement. Journal of Managerial Psychology, 21, 600-619.

Shuck, B., & Wollard, K. (2010). Employee engagement and HRD: A seminal review of the foundations. Human Resource Development Review, 9, 1, 89 – 111.

Will the needle make me bleed to death? Cognitions of chronically ill children

Jessica McIvor
Contributing authors: Joanne E. Taylor and Kirsty J. Ross

Jessica McIvor is currently a Masters psychology student at Massey University in Wellington and will be starting the Doctorate of Clinical Psychology programme in 2012. She is passionate about working with all children and adults experiencing anxiety disorders and has an interest in working cross-culturally. She enjoys mountain biking and running with friends in her spare time.

Abstract

Needle injections are required for vaccinations, blood donations, dental care and medical treatment. For some chronically ill children, having an injection is a regular occurrence and can result in distress and avoidance behaviour for both the child and their family. There can also be negative health implications of these children not having their injections. This study aims to manualise and evaluate a brief cognitive-behavioural therapy to alleviate needle-related distress among chronically ill children. The study will be completed later this year in collaboration with the Massey Health Conditions Psychology Service, and this paper briefly describes the rationale for and approach used in the research.

For most children, having a needle injection does not invoke any significant


Figure 1. *Fear of Injections*

trauma and they have adequate coping strategies to deal with these types of procedures (Blount & Loiselle, 2009). However, for a number of other children the process of having a needle injection is one of the most distressing and fear-provoking experiences when going to hospital (see Figure 1) (Humphrey, Boon, van Linden van den Heuvell, & van de Wiel, 1992). A frequently asked question by children about to enter hospital is "Am I going to get a shot?" (Schechter, 2007, p. 1185).

Several terms are used to describe the reaction children can have towards needle injections, and there are inconsistencies regarding their definition (Thurgate & Heppell, 2005). Needle-related distress (NRD) was used in the present study and broadly defined as "distress occurring in relation to the expectation

or experience of having a needle injection". There were two reasons to focus on this construct as opposed to other terms such as needle phobia and needle anxiety. First, this study aims to investigate any experience of distress, anxiety and avoidance rather than primarily needle phobia which requires Diagnostic and Statistical Manual (DSM-Fourth Edition) criteria for specific phobia (American Psychiatric Association, 2000). Furthermore, by focusing on the broader construct NRD, the study will be relevant for a wider range of children, as needle phobia affects approximately 10% of the population, while NRD affects at least 50% (see Table 1) (Agras, Sylvester, & Oliveau, 1969; Hanas & Ludvigsson, 1997; Humphrey et al., 1992; Meltzer et al., 2008).

Table 1

Prevalence Rates for Needle-Related Anxiety Problems
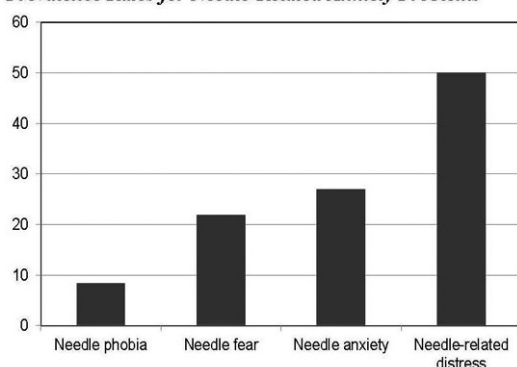
Second, needle injections are not benign stimuli for children, but unpleasant sensory and emotional experiences that threaten the child's sense of control (Humphrey et al., 1992). Therefore the child's response is not necessarily phobic, but can instead be a normal fear which involves the distress response.

The implications of NRD remaining untreated are significant. Initial short-term effects can include anticipatory nausea, insomnia, eating problems, anxiety, increased fear and pain responses, behavioural avoidance, and

less cooperation during subsequent needle injections (Howe, Ratcliffe, Tuttle, Dougherty, & Lipman, 2011; Jones, DeMore, Cohen, O'Connell, & Jones, 2008).

This study aims to manualise and evaluate a brief cognitive-behavioural therapy to alleviate needle-related distress among chronically ill children.

Long-term implications include increased anxiety and behavioural avoidance of future healthcare, as well as not receiving necessary medical treatment (Jones et al., 2008). For example, Yelland, Heathcote, and Ng (2009) found that, of 46.2% of adults who had a previous traumatic needle injection, at least 20.5% of them avoided medical treatment (e.g., flu shot, tetanus shot and donating blood).

The aetiology of needle phobia is predominantly based on classical conditioning, vicarious conditioning and negative information provision (Blount et al., 2009; Watson & Rayner, 1920). However, cognitive factors have also been recognised in theories of the acquisition and treatment of needle phobias (Thorpe & Salkovskis, 1995). For example, research shows that children may

Figure 2. *Child drawing exaggerating the size of the needle*
Note. Reproduced from Children's fear of needles," by D. Fassler and N. Wallace, 1982, *Clinical Pediatrics*, 21, p. 59.

believe the needle is significantly larger than it actually is (see Figure 2) and that the needle will penetrate their entire arm (Fassler & Wallace, 1982) (see Figure 3).

Figure 3. *Child drawing of the needle penetrating the entire arm*
Note. Reproduced from Children's fear of needles," by D. Fassler and N. Wallace, 1982, *Clinical Pediatrics*, 21, p. 60.

Alongside behavioural and cognitive factors, parents and health professionals also influence child distress and coping during injection procedures (Ayers, 2011). Research shows that carer anxiety, criticism, overprotectiveness, and apologetic behaviours are associated with increased child distress, whereas distraction, humour and the use of non-procedural talk are associated with decreased distress (Mahoney, Ayers, & Seddon, 2010). For example, Mahoney et al. (2010) found that parental behaviour contributed to 64% of child distress during needle injections, whereas parent and nurse behaviours predicted 40% of the variance in child coping. However, these factors have not been incorporated into published research on treatment for needle-related distress.

A range of interventions have been used to treat needle-related distress including physical restraint, sedation and behaviour therapy. Papa, Morgan, and Zempsky (2008) reported in a survey of 2188 paediatric nurses that children are physically restrained
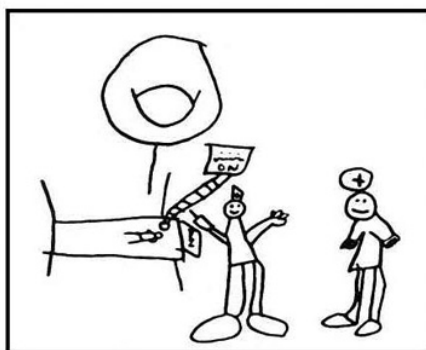
74% of the time by another nurse, parent or caregiver during needle insertion. Sedative techniques range from anaesthetics, antipsychotics, selective serotonin reuptake inhibitors, morphine, benzodiazepines and nitrous oxide (Hamilton, 1995; Pao & Bosk, 2011). Recent research shows, in a group of children aged 1 to 18 undergoing needle insertion, that morphine does not give any additional reduction of fear, distress or pain compared with placebo when combined with topical anaesthesia (Heden, Essen, & Ljungman, in press).

This treatment manual [Coping Kids Treatment Manual]was evaluated by comparing treatment to no treatment (i.e., the baseline phase). It was expected that child and carer anxiety would reduce and adaptive coping strategies improve following treatment and at one-month follow-up.

Alternative and less intrusive interventions include behavioural therapy, which is also the most empirically validated (Kazak et al., 1996; Manne, Bakeman, Jacobsen, Gorfinkle, & Redd, 1994; Manne et al., 1990). Followed by this, cognitive-behavioural therapy for needle distress was developed by Jay, Elliot, Ozolins, Olson, and Pruitt (1985) for five children aged 3 to 7 diagnosed with cancer. However, there are three significant limitations of these psychological interventions. First, although many researchers refer to their interventions as "cognitive-behavioural", cognitive elements that explicitly address maladaptive thoughts are absent. Second, there is a lack of active parental involvement in therapy, despite the influence they can have over child distress and coping (Mahoney et al., 2010). Third, interventions are based on one 10 to 45 minute therapy session, however

research now shows that multiple exposure sessions are more effective than one-session exposure treatments for specific phobias, particularly at follow-up (Olatunji, Cisler, & Deacon, 2010; Wolitsky-Taylor, Horowitz, Powers, & Telch, 2008).

Due to the limitations of previous research, the aim of this study was to manualise and evaluate a six-session cognitive-behavioural therapy for chronically ill children experiencing needle-related distress that incorporates cognitive components and carer involvement called The Coping Kids Treatment Manual. This treatment manual was evaluated by comparing treatment to no treatment (i.e., the baseline phase). It was expected that child and carer anxiety would reduce and adaptive coping strategies improve following treatment and at one-month follow-up. It was also expected that child cognition intensity and content would improve following treatment and at one-month follow-up.
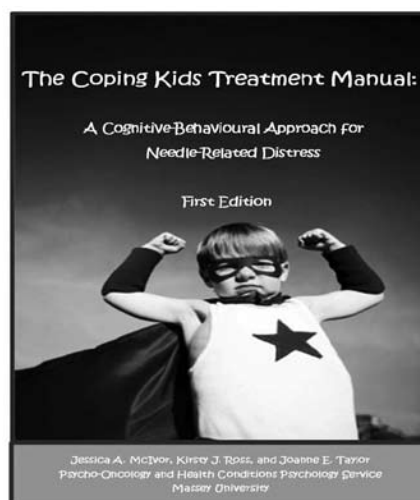
The Coping Kids Treatment manual

Figure 4. *The Coping Kids Treatment Manual*

(see Figure 4) is based on previous research and empirically validated techniques. Key features of the treatment manual are that it is short-term (six-sessions), structured (purpose, agenda, materials required and session format), flexible and easy to use. Several important techniques incorporated into the manual are relaxation, emotive imagery, cognitive restructuring and behavioural rehearsal. Also included are worksheets which have been utilised from previous treatments.

Method

A single-case, multiple-baseline across participants design was used to assess the effects of treatment on needle-related distress and coping in six chronically ill children (see Table 2). The children and their

Table 2

Participant Characteristics

Partici-pant	Sex	Age	Chronic Physical Condition	Type & Frequency of Needle Injection
P.1	M	5	Immune Deficiency	Blood test every 3 weeks
P.2	M	6	Blood Condition	Blood test every 4 weeks
P.3	F	6	Type 1 Diabetes	Insulin, four daily injections
P.4	M	10	Cystic Fibrosis	Blood test every 12 months
P.5	F	13	Thyroid Deficiency	Blood test every 6 months
P.6	M	14	Type 1 Diabetes	Insulin, two daily injections

families were referred by MidCentral Health to the Health Conditions Psychology Service and treatment was delivered by a Senior Clinical Psychologist. This service is a MidCentral Health DHB contracted service that works with children and families to assist in coping with chronic health conditions. Upon referral participants were randomly allocated to different baseline lengths ranging from two to four weeks. A non-concurrent procedure was utilised to allow for flexibility within an applied research setting, while maintaining the design parameters necessary for ruling out extraneous

factors (Watson & Workman, 1981). Continuous measures were completed throughout baseline, treatment and follow-up phases. Self-report measures included subjective units of distress (SUD) as well as two questionnaires developed for the study, the Needle-Injection Questionnaire for Children (NIQ-C) and the Needle Injection Questionnaire for Parents (NIQ-P). The NIQ-C and NIQ-P were developed and individualised for this study by the author and her supervisors because no existing measures were appropriate as indicators of child distress related to needles and injections. The measures are based on previous research and existing psychometric measures.

Figure 5 – Sample item from the Needle Injection Questionnaire for Children (NIQ-C)

The NIQ-C (**see** Figure 5 for example item) is a 7-item measure completed by the child that collects both quantitative and qualitative data and has four domains: (1) distress, (2) behavioural avoidance, (3) cognition, and (4) coping. The NIQ-P (see Figure 6 for example item) is an 11-item self-report measure completed by the carer that also collects quantitative and qualitative data and has three domains: (1) distress, (2) behavioural avoidance, and (3) coping. Also included in the NIQ-P is the Coping Behaviours Questionnaire (CBQ) developed by Field, Alpert, Vega-Lahr, Goldstein and Perry (1988), which is a 15-item behaviour checklist.

Preliminary results

Preliminary qualitative results will be presented here since therapy is underway and data for all participants is not yet completed. Qualitative information collected during the baseline phase of the intervention suggests children exaggerate the size of the needle. Other cognitions include "the needle is going into me" and "invading my body", "it looks scary and sharp", and "the needle is going to hurt me - a lot"! These thoughts are similar to those found in previous research in which children express physical pain contributes to their fear of injections (Fassler & Wallace, 1982). Furthermore, research shows the actual appearance of the needle (e.g., it's sharp, metal and pointy) and misunderstanding regarding its purpose may heighten the intensity of the child's reaction, particularly in younger children (Fassler & Wallace, 1982). Preliminary results of this study also show children focus on the needle penetrating the skin. It is suggested in previous research that children may consider this to be similar to a balloon and a sharp object, in which case to the child, having an injection represents frightening possibilities (Fassler & Wallace, 1982). Results also show that, prior to therapy and during the most recent needle injection, five of the six children gave verbal protest (e.g., "ouch", and "it hurts"), five cried and were afraid during the procedure. Two children were physically restrained and two were aggressive including biting and kicking, while four screamed and/or yelled during the procedure. Further quantitative and qualitative results regarding the effectiveness of the treatment manual will be available at the end of the year.

Conclusion

Needle injections have been administered for more than half a century. While there is no question that many children dislike injections, some children have a distress reaction that is more severe and can impact adversely on their health if they are not able to tolerate the procedure. Such reactions have not been examined in depth (Schechter, 2007), which has resulted in significant gaps in psychological research and clinical practice. This study aims to address some of these gaps regarding needle-related distress in chronically ill children, particularly the inclusion of cognitive elements in treatment along with carer involvement.

Preliminary results of this study also show children focus on the needle penetrating the skin.

Acknowledgements

References

Agras, S., Sylvester, D., & Oliveau, D. (1969). The epidemiology of common fears and phobia. Comprehensive Psychiatry, 10(2), 151-156.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders: Text revision (4th ed.). Washington, D.C: Author.

Ayers, S. (2011). Understanding needle-related distress in children with cystic fibrosis. British Journal of Health Psychology, 16(2), 329-343.

Blount, R., & Loiselle, K. (2009). Behavioural assessment of pediatric pain. Pain Research Management, 14(1), 47-52.

Blount, R., Zempsky, W., Jaaniste, T., Evans, S., Cohen, L., Devine, K., & Zeltzer, L. (2009). Management of pediatric pain and distress due to medical procedures. In M. Roberts & R. Steele (Eds.), Handbook of pediatric psychology (4th ed., pp. 171-188). New York: Guilford Press.

Fassler, D., & Wallace, N. (1982). Children's fear of needles. Clinical Pediatrics, 21(1), 59-60.

Field, T., Alpert, B., Vega-Lahr, N., Goldstein, S., & Perry, S. (1988). Hospitalization stress in children: Sensitizer and repressor coping styles. Health Psychology, 7(5), 433-445.

Hamilton, J. (1995). Needle phobia: A neglected diagnosis. Journal of Family Practice, 41(2), 169-175.

Hanas, R., & Ludvigsson, J. (1997). Practical Experience of pain from insulin injections and needle-phobia in young patients with IDDM. Diabetes International, 14(4), 95-99.

Heden, L., Essen, L., & Ljungman, G. (in press). Effect of morphine in needle procedures in children with cancer. European Journal of Pain.

Howe, C., Ratcliffe, S., Tuttle, A., Dougherty, S., & Lipman, T. (2011). Needle anxiety in children with type 1 diabetes and their mothers. The American Journal of Maternal and Child Nursing, 36(1), 25-31.

Humphrey, G., Boon, C., van Linden van den Heuvell, C., & van de Wiel, H. (1992). The occurance of high levels of acute behavioral distress in children and adolescents undergoing routine venipuncture. Pediatrics, 90(1), 87-91.

Jay, S., Elliott, C., Ozolins, M., Olson, R., & Pruitt, S. (1985). Behavioral management of childrens distress during painful medical procedures. Behavior Research and Therapy, 23(5), 513-520.

Jones, T., DeMore, M., Cohen, L., O'Connell, C., & Jones, D. (2008). Childhood healthcare experience, healthcare attitudes, and optimism as predictors of adolescents' healthcare behavior. Journal of Clinical Psychology in Medical Settings, 15(3), 234-240.

Kazak, A., Penati, B., Boyer, B., Himelstein, B., Brophy, P., Waibel, M., Johnson, K. (1996). A randomized controlled prospective outcome study of a psychological and pharmacological intervention protocol for procedural distress in pediatric leukemia. Journal of Pediatric Psychology, 21(5), 615-631.

Mahoney, L., Ayers, S., & Seddon, P. (2010). The association between parent's and healthcare professional's behavior and children's coping and distress during venepuncture. Journal of Pediatric Psychology, 35(9), 985-995.

Manne, S., Bakeman, R., Jacobsen, P., Gorfinkle, K., & Redd, W. (1994). An analysis of a behavioral intervention for children undergoing venipuncture. Health Psychology, 13(6), 556-566.

Manne, S., Redd, W., Jacobsen, P., Gorfinkle, K., Schorr, O., & Rapkin, B. (1990). Behavioral intervention to reduce child and parent distress during venipuncture. Journal of Consulting and Clinical Psychology, 58(8), 565-572.

Meltzer, H., Vostanis, P., Dogra, N., Doos, L., Ford, T., & Goodman, R. (2008). Children's specific fears. Child: Care, Health and Development, 35(6), 781-789.

Olatunji, B., Cisler, J., & Deacon, B. (2010). Efficacy of cognitive-behavioral therapy for anxiety disorders: A review of meta-analytic findings. Psychiatric Clinics of North America, 33(3), 557-577.

Pao, M., & Bosk, A. (2011). Anxiety in medically ill children and adolescents. Depression and Anxiety, 28(1), 40-49.

Papa, A., Morgan, R., & Zempsky, W. (2008). Competency, compassion and contentment: Nurses' attitudes towards pain on nurses working in burns and neonatal intensive care units. Paper presented at American Pain Society 27th Annual Scientific Meeting. Tampa, Florida.

Schechter, N. (2007). The ouchless place: No pain, children's gain. Pediatrics, 99(6), 890-894.

Thorpe, S., & Salkovskis, P. M. (1995). Phobic beliefs: Do cognitive factors play a role in specific phobias. Behavior Research and Therapy, 33(7), 805-816.

Thurgate, C., & Heppell, S. (2005). Needle phobia-changing venepuncture practice in ambulatory care. Paediatric Nursing, 17(9), 15-18.

Watson, J. B., & Rayner, R. (1920). Conditioned emotional reactions. Journal of Experimental Psychology, 3(1), 1-14.

Watson, P., & Workman, E. (1981). The non-concurrent multiple baseline across-individuals design: An extension of the traditional multiple baseline design. Journal of Behavior Therapy and Experiemental Psychiatry, 12(3), 257-259.

Wolitsky-Taylor, K. B., Horowitz, J. D., Powers, M. B., & Telch, M. J. (2008). Psychological approaches in the treatment of specific phobias: A meta-analyses. Clinical Psychology Review, 28(6), 1021-1037.

Yelland, M., Heathcote, C., & Ng, S. (2009). Fear of needles: Nature and prevalence in general practice. Australian Family Physician, 38(3), 172-176.

The Spirit of Change: Adapting Motivational Interviewing for Offenders

Kevin Austin

Kevin Austin is in his second year of the Doctor of Clinical Psychology degree at Massey University, Albany. He spends his spare time mountain biking, white-water kayaking or skiing. His professional interests include correctional, adolescent and forensic psychology. Kevin's doctoral research aims to understand, at a process level, if motivational interviewing (MI) can be effectively combined with cognitive-behavioural methods for offenders. The study uses a process measure to code MI sessions with offenders. Facilitator and offender language will be analysed to elucidate the nature of MI with offenders and the effect of integrating cognitive behavioural methods. The poster presentation describes the preliminary phase of this study.

The Spirit of Change: Adapting Motivational Interviewing for Offenders

Kevin P. Austin[a], Mei Wah M. Williams[a], Dave Clarke[a], Gordon Sinclair[b]

Massey University[a] and the Department of Corrections[b]

MASSEY UNIVERSITY

DEPARTMENT OF CORRECTIONS — ARA POUTAMA AOTEAROA

Introduction

Cognitive-behavioural approaches are the treatment of choice in reducing criminal recidivism (Andrews & Bonta, 2010). However, they are unlikely to be effective if offenders lack the motivation to enact behaviour change. The integration of motivational interviewing (MI) and CBT has been espoused as a method for working with offenders to increase motivation and change behaviour.

Early studies suggested adaptations of MI may be effective with offenders (Anstiss, Polaschek, & Wilson, 2010). One such example, designed by the Dept of Corrections, is the Short Motivational Programme (SMP). The SMP is a five-session programme that aims to foster motivation to change, through the use of MI consistent methods, while assisting offenders to reduce their risk of recidivism with cognitive-behavioural methods.

Recent process research has culminated in a theory of MI (Miller & Rose, 2009) (see Figure 1). This has allowed an informed approach to testing and developing integrations of MI and CBT.

Theory of MI

Therapist acceptance, empathy and MI Spirit →
Facilitator use of MI methods →
Client change talk / Diminished resistance →
Commitment to behaviour change →
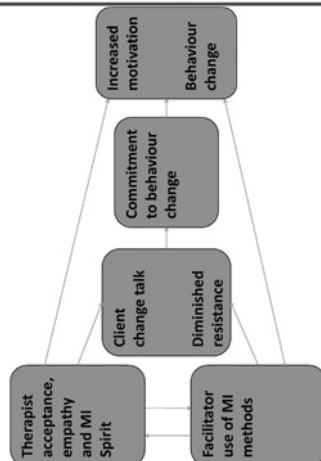Increased motivation / Behaviour change

Figure 1. Adapted from Miller & Rose (2009)

A measure based on this theory, the Motivational Interviewing Skills Code 2.1, was used to investigate the nature of a programme for offenders that combined MI with CBT to foster motivation and reduce recidivism.

Study Aims

1. Investigate the inter-rater agreement of the Motivational Interviewing Skills Code, version 2.1, with medium risk offenders

2. Describe the SMP in terms of facilitators' use of acceptance, empathy and the spirit of MI (collaboration, evocation and autonomy-supportive behaviour)

3. Describe facilitators' use of MI consistent and inconsistent skills

4. Describe offenders' change and resistance talk

Methods

This study was approved by the Massey University Human Ethics Committee and the Department of Corrections. The sample consisted of 12 programme facilitators and 26 offenders. There were equal numbers of male and female facilitators. They had, on average, 3.43 years of experience, received 2.33 days of MI training and delivered 8.5 SMPs prior to this study. The offenders were low to medium risk with a mean risk of recidivism within five years of release of 41 percent, ranging from 11 to 62 percent. The offenders were serving prison (n=12), community (n=9) or home detention (n=5) sentences.

SMP: The SMP consisted of five sessions. Session one involved eliciting a detailed description of the offending. Session two involved collaboratively developing an offence chain to assist the offender in understanding how their offending was linked by events, thoughts, feelings and behaviours. Session three focused on assisting the offender to articulate reasons to change offending behaviour. Session four focused on exploring how to manage the influence of cognitive distortions on offending. Session five involved the collaborative development of a change plan. All sessions were to be delivered by enlisting an MI approach and using MI skills.

The primary researcher and a second coder undertook eight days of training in the use of the MI Skills Code 2.1 (MISC) before coding SMP sessions. Training included familiarisation with the MI method, external training by Dr Simon Adamson, and further supervised practice. The MISC is an exhaustive coding system used for process research in MI (Miller, Moyers, Ernst, & Amrhein, 2008). First, therapist global ratings of empathy, acceptance and MI spirit and a client global measure of self-exploration are assigned. Next, the session is listened to again and each therapist and client utterance is assigned a code to reflect the use of MI consistent versus MI inconsistent skills and client change talk (language indicative of a move away from offending) versus client resistance talk (language indicative of maintaining offending behaviour). Frequency counts were converted to a ratio of the session length so sessions of varying lengths could be combined and compared.

The 12 participating facilitators provided an average of 2.2 SMPs each. These covered five sessions or the sessions that were otherwise completed and recorded. More than 300 hours were spent coding SMP sessions from April to June 2011. A sample of 22 percent were double coded to ascertain inter-rater agreement.

Results

In accordance with Cicchetti's (1994) guidelines, excellent inter-rater agreement across all MISC 2.1 global measures was achieved with .86 for acceptance and empathy, .80 for MI spirit and .87 for offender self-exploration. Change Talk (commitment) demonstrated only fair inter-rater agreement (.40). However, the remaining facilitator and offender summary scales demonstrated excellent inter-rater agreement with .95 for MI consistent behaviour, .90 for MI inconsistent behaviour, .87 for change talk, .92 for resistance talk and .90 for resistance talk (commitment).

Relationships between facilitator global measures and MI skills with offender change and resistance talk were investigated with Pearson product-moment correlation coefficients. These are outlined in Table one. The frequency of each construct is illustrated across sessions in Figures two, three and four.

Table 1.
Correlations Between Global Measures, MI Skills, Change and Resistance Talk (N = 98 SMP sessions)

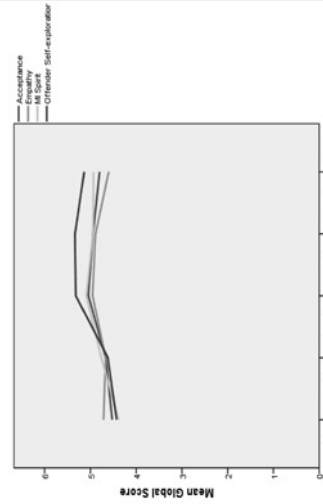|	Change Talk	Resistance Talk	Change Talk (Commitment)	Resistance Talk (Commitment)
Acceptance	.28**	-.17	.09	.20
Empathy	.25**	-.10	.07	.22*
MI Spirit	.34**	-.10	.13	.13
Offender self-exploration	.22*	.08	-.00	.12
MI Consistent	.15	-.03	.07	.23*
MI Inconsistent	-.08	.29**	.02	-.03

Figure 2. Facilitator and Offender Global Scores

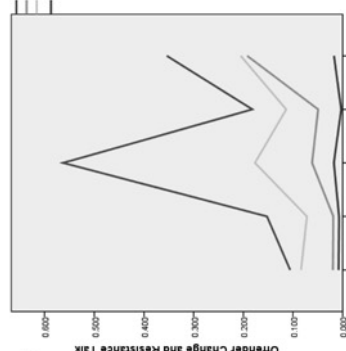Figure 3. Facilitator MI Consistent and Inconsistent Skills

Figure 4. Offender Change and Resistance Talk

Conclusion

The correlational analyses demonstrated a small positive relationship between facilitator and offender global scores with change talk. There was a small positive relationship between facilitator MI *inconsistent* skills and offender resistance talk. While small, these relationships were in the expected direction. Unexpectedly, there was a small positive relationship between facilitator empathy and MI *consistent* skills with offender resistance talk (commitment).

Facilitators demonstrated an average to high level of acceptance, empathy and MI spirit across SMP sessions. Offender self-exploration had a tendency to increase across sessions and this might reflect growth in the therapeutic relationship (see Figure 2). Facilitators used MI skills infrequently during the fourth session, and most frequently during sessions one, two and three (see Figure 3). Session four is dominated by a cognitive-behavioural task and so facilitators may have found it difficult to combine MI and CBT as a unified approach.

Offender change talk was highest during session three. Session three was structured with a specific MI task (a costs and benefits analysis) and this may have provided the requisite guidance for facilitators to effectively use MI skills to elicit change talk. This may suggest that some offenders remained ambivalent about change and resisted slightly in the final session. Change talk remained low across sessions but resistance talk increased slightly in the final session. This may suggest that some offenders remained ambivalent about change and resisted when a change plan was introduced. Change talk commitment, which has predicted behaviour change in past studies (Amrhein et al., 2003), increased in the final session (see Figure 4).

Combining CBT and MI is becoming more common across problem domains, including offending. More research into how these approaches can be effectively integrated is warranted.

References:

Amrhein, P.C., Miller, W. R., Yahne, C., Palmer, M., & Fulcher, L. (2003). Client commitment language during motivational interviewing predicts drug use outcomes. *Journal of Consulting and Clinical Psychology, 71*, 862-878.

Andrews, D. A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). New Providence, NJ: Lexis Nexis.

Anstiss, B., Polaschek, D. L. L., & Wilson, M. J. (2011). A brief motivational interviewing interview with prisoners: When you lead a horse to water can it drink for itself? *Psychology, Crime and Law, 1-22.*

Cicchetti, D. V. (1994). Guidelines, criteria and rules of thumb for evaluating normed and standardised assessment instruments in psychology. *Psychological Assessment, 6*, 284-290.

Miller, W. R., Moyers, T. B., Ernst, D., & Amrhein, P. (2008). *The Motivational Interviewing Skills Code (MISC) Version 2.1.* Retrieved November 18, 2010, from http://casaa.unm.edu/download/misc.pdf

Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist, 64*(6), 527-537.

Thinking about a career in health? Health psychology may be the right career path for you!

Iris S. Fontanilla, Director of Social Issues, NZPsS Executive

Iris is a registered psychologist specialising in health psychology. She currently works in Cardiac Services and New Zealand Heart Lung Transplant Service at Auckland District Health Board and in private practice in Auckland. Iris is an honorary lecturer at the Department of Psychological Medicine, University of Auckland where she is involved in training and supervision of pre-intern health psychology students and health psychology interns. She is a full member of the Society where she is Director of Social Issues on the NZPsS Executive and holds the Chair of the Institute of Health Psychology. Iris specialises in resilience, stress management, and long-term conditions management.

What is health psychology?

Health psychology is concerned with understanding the psychological influences on how people stay healthy, why they become ill, and how they respond when they do get ill. It has become a burgeoning field of inquiry over the last 20 years. The field emphasizes the importance of a biopsychosocial approach to health and illness. It covers areas of health behavior change, patient-practitioner interactions, health promotion, prevention, and treatment of illness.

How do I become a health psychologist?

You must complete a Masters of Science in Health Psychology and a Postgraduate Diploma in Health Psychology (Internship). Students who fulfil these requirements are then eligible to apply for registration with the New Zealand Psychologists Board. The University of Auckland and Massey University offer Masters programmes in health psychology.

Alternatively if you do not want to work as a practitioner, Postgraduate study in Health Psychology and Doctor of Philosophy (PhD) can also lead to academic and research careers and health promotion careers within tertiary institutions, health agencies, and within hospital environments.

Where do health psychologists work?

Health psychologists are scientist-practitioners and work across primary, secondary, and tertiary health care sectors. Many are working within hospital settings such as: cardiology, heart/lung transplantation, respiratory, diabetes, general surgery, oncology, pain, and renal services. Others work in primary healthcare organizations (PHOs), non-government organizations (NGOs), and in private practice. There is huge scope for health psychologists working in these areas from direct clinical delivery of psychological treatments to consultation with other colleagues in the health care system and relevant stakeholders. Health psychologists work with individuals, groups, families/whanau in the context of improving the health (physical and emotional) outcomes and long-term condition management of their condition.

If you are still not convinced about a career in health psychology … here's what Dr. Geraldine Meechan, Health Psychologist, PhD (Health Psychology) has to say:

IF: Why did you choose a career in health psychology?

GM: During the final year of my undergraduate study I was focused on doing postgraduate training in clinical psychology. However, I heard a lecturer in health psychology speak about their research and the developing role for health psychologists to work within medical and healthcare settings. This talk certainly was a turning point for me; as I subsequently enrolled in the Masters of Health Psychology programme at the University of Auckland and then went on to complete a PhD and clinical training in health psychology. People often

describe the field of psychology as down to "common sense" - for me, it certainly makes good sense to provide individuals and their family/whanau facing physical health changes and challenges with psychological support.

IF: What do you enjoy about your profession?

GM: The field of health psychology has grown and evolved rapidly in New Zealand over the past fifteen years - and I am very pleased to be a part of this change and growth. I work within the field of oncology alongside a range of other health professionals and it is rewarding to be part of a multidisciplinary team. Supporting individuals as they navigate their way through the challenges of diagnosis, treatment and life after treatment is a privilege.

IF: What advice would you give to a young budding health psychologist?

GM: If you are interested in health psychology, talk with researchers, lecturers and clinicians working in this area. Make contact with organisations such as the Institute of Health   Psychology, New Zealand Psychological Society and attend their seminars and peer reviews.

Many thanks to Dr Meechan for her contribution to this student forum. If you want to know more, please do not hesitate to contact the Institute of Health Psychology via the New Zealand Psychological Society.

Conference 2012

Joint Conference of the New Zealand Psychological Society and the New Zealand College of Clinical Psychologists
20-23 April 2012, Wellington Convention Centre

The theme of this year's conference is *Tūtahitanga - Standing Together as One.* The conference theme highlights the importance of joining together as a society, as communities and families to find effective and creative ways to support the wellbeing of people in their relationships, learning, working and leisure. The conference will be located in Wellington and will have wide appeal to a range of professionals because of its theme and quality keynote and invited speakers and symposia presentations which include:

David Barlow is Professor of Psychology and Psychiatry, and Founder and Director Emeritus of the Center for Anxiety and Related Disorders at Boston University. Keynote address: *Science and Practice in 2012 and Beyond* Workshop: *Unified Protocol for Transdiagnostic Treatment of Emotional Disorders*

Erana Cooper is a Clinical Psychologist and Lecturer in Kaupapa Māori Psychology at The University of Auckland.

Pat Dudgeon is a Research Fellow and an Associate Professor at the University of Western Australia and Head of the Centre for Aboriginal Studies at Curtin University.

Alan Fruzzetti is Associate Professor of Psychology and Director of the Dialectical Behavior Therapy and Research Program at the University of Nevada, Reno. Keynote address: *Process of Change in Dialectical Behaviour Therapy*

Heather Gridley fromVictoria University, Australia is a Community Psychologist and well known for her contributions related to women and psychology.

John Weinman is Professor of Psychology as applied to Medicine at the Institute of Psychiatry, King's College London. Keynote address: *Taking the Treatment: how can health psychology help?* Workshop: *The Patient's Perception of Illness: theory, measurement and intervention*

For more information about the conference and update of keynote, guest speakers and workshops please go to our website: www.psychology.org.nz/conf2012

David Barlow   Erana Cooper   Pat Dudgeon   Alan Fruzzetti   Heather Gridley   John Weinman