

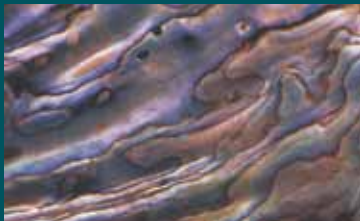


The New Zealand
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Foetal Alcohol Syndrome- a submission - 7
Educational psychologists and special education update - 17
White voices black spaces- 24

An ACT approach to dealing effectively with self-doubt - 32
A sociological view of psychology and professional boundaries - 41
Māori diagnosed with schizophrenia - 51



President's Korero	2
President Kerry Gibson reflects on psychology without borders	
Editorial	3
Fiona Howard previews the diverse and rich contributions to this edition of <i>Psychology Aotearoa</i>	
NZPsS News	
NZPsS new life member Dave George shares his psychology career journey	5
A Point of View	
<i>Oh dear, let's not go there': A response to the Ministry of Health's discussion document on Foetal Alcohol Spectrum Disorder</i> - Peter Stanley	7
Forum	
<i>The Australian Aviation Psychology Association – Expanding our members' contribution to the safety and efficiency of the aviation industry</i> - Matt Harris	14
<i>Tending the Garden: Educational psychologists and the special education update</i> - Quentin Abraham	17
Practice- Research-Education	
<i>White voices Black spaces: Authenticity, legitimacy and place in a shared decolonisation project</i> - Dawn Darlaston-Jones	24
<i>Reflections from the Australia and New Zealand Association for Contextual Behavioural Science (ANZ ACBS) Conference, Wellington 2015</i> - Ben Sedley	28
<i>Working with complex organisational systems: A Contextual Behavioural Science approach</i> - Tresna Hunt	29
<i>An Acceptance and Commitment Therapy Approach to Dealing Effectively with Self-Doubt</i> - Elizabeth Maher	32
<i>NZPsS Ethical Issues Helpdesk</i> - Jack Austin	35
<i>Psychological Resilience: Is this Construct of Benefit to Psychologists?</i> - Ian de Terte & Susan Iacovou	38
Interdisciplinary Perspectives	
<i>A sociological view of psychology and professional boundaries</i> - Edgar Burns	41
One on One	
NZPsS member Jodie Black reflects	46
Reviews	
Quentin Abraham reviews Max Rashbrooke's book, <i>Wealth and New Zealand</i> ; John Fitzgerald reviews a book in the excellent <i>Oxford Guides in Cognitive Behavioural Therapy</i> series <i>The Treatment of Mental Contamination</i>	48
Student Forum	
Student Forum guest editor Michele Blich introduces Karahipi Tumuaki President's Scholarship recipient Tai Kake's article, <i>Cognitive neuropsychological functioning in Māori diagnosed with schizophrenia</i>	51



The theme of our upcoming conference is 'Psychology without Borders'. This idea grew out of discussions about how psychology needs to develop into the future and how we, as psychologists, can maximize our potential to contribute to society.

One of the key ideas reflected in this theme relates to the need to develop and enhance communication between the different sub-disciplines that fall under the broad umbrella of psychology. The sub-disciplines in psychology have developed with the admirable goal of allowing researchers and practitioners to pursue depth of understanding within their own area of expertise. However, there are increasing calls to recognize the limitations of knowledge and practice within 'silos'. It might be stating the obvious but, as psychologists, our subject matter is the whole human being and when we allow branches of psychology to operate in isolation from one another we run the risk of developing specificity without a corresponding breadth of understanding. Some sub-disciplines in psychology have developed more sophisticated theorizing and research in one area rather than another – but I think the best psychology is one which helps to build a complex and integrated understanding of people. For example, in my own area of practice and research, clinical psychology, it is clear that our work is so much poorer without understandings drawn from community psychology, indigenous psychology and organizational psychology. Community psychology helps us to remember that so-called 'intrapsychic' problems are often a product of social problems; indigenous psychology has highlighted the significance of culture in clinical engagement; and organizational psychology helps us understand how to develop our working environments so we can attend more effectively to our clients.

Providing opportunities for the sharing of ideas across the borders of different areas in psychology is one of the strengths of our organisation. While other psychology organisations tend to focus on just one branch of practice, the Society has deliberately created a structure that represents a full spectrum of areas of knowledge and practice in our discipline. We have institutes that represent Clinical Psychology, Counselling Psychology, Organizational Psychology, Health Psychology, Educational and Developmental Psychology, Criminal, Justice and Forensic Psychology and Community Psychology as well

as representation from the National Standing Committee on Bicultural Issues to support Māori participation and development in psychology. In addition, we have a special interest group in Coaching Psychology and one soon to be established in Professional Teaching in psychology as well as a general membership that includes academics from a variety of areas of research psychology. Representing this broad array of sub-disciplines allows opportunities for cross-fertilisation and collaboration. Some institutes have actively pursued this, pooling their resources to set up training (for example, you would have noticed that the Institute of Criminal, Justice and Forensic Psychology worked with the Institute of Counselling Psychology to put on a workshop by international expert Jill Levenson on trauma informed practice, earlier this year). We encourage other institutes and interest groups to think of creative ways to facilitate cross-boundary communication such as mixed panel discussions or shared symposia at the conference.

The conference theme also reflects our increasing interest in being a part of conversations on issues of international significance such as the recognition of indigenous psychologies, growing economic inequality across the world and climate change which threatens the long term survival of life on our planet. We recognize that we can learn from other countries about how they are approaching these things but also believe that we have a great deal to contribute from our own locally developed expertise. To this end, we are taking part in a number of international forums and initiatives. Our relationship with the Australian Psychological Society is well established and we will be running a joint conference with them next year in Sydney. Our more recently established relationship with the American Psychological Association is starting to open up new ideas and opportunities for cooperation. We are signing a Memorandum of Understanding with the British Psychological Society in April and we hope that this will draw us into further fruitful discussions and collaborations. We will also be taking part in the Asia Pacific Forum later this year to set up better links with our neighbours in this part of the world, to share resources and also to see how we might best support the work of psychologists in countries where the discipline is less well established.

Finally, 'Psychology without Borders' also recognises the on-going importance of making links between psychology and other discipline areas. We can learn much from the work of colleagues across the spectrum of knowledge including economics, sociology, anthropology, philosophy, environmental science, medicine and biology – to name

just a few. Our efforts to draw attention to poverty as a key issue affecting well-being in our society have not always been as successful as we would have liked. We recognize that this is largely because we lack knowledge in areas which have a stronger basis in the broader material conditions of society. We are, however, about to embark on a project with the Child Poverty Action Group aimed at developing a clear, research informed position on the relationship between poverty and poor mental health and advocating for political change to address this. This provides an exciting opportunity to work collaboratively in an inter-disciplinary group which includes health professionals, economists, lawyers, educationalists and public policy experts amongst others.

The line-up of speakers and workshop presenters at our upcoming conference reflects the diversity and energy of both local and international psychology. We have keynote speakers from New Zealand, the United States, Australia and Canada, speaking on issues ranging from the psychological impacts of cancer, self-injury, ethics, cultural challenges to Western models of psychological development, 'rape culture' and recent developments in acceptance and commitment therapy.

On a personal note, I approach this conference with slightly mixed feelings as I will be stepping down as President and also ending a long standing role on the Executive of the Society. I feel privileged to have been a part of this dynamic organization and to work with its dedicated leadership who have done so much for the profession, largely in their own time and on top of other demanding 'day jobs'. I am also very pleased to have worked alongside an excellent team at the National Office. Pamela Hyde, as the Executive Director, has been a particularly central figure in providing stability in the organization across changes of president and executive.

I hope to see many of you at the conference on 1-4th September in Wellington.

Editorial

Tēnā koutou colleagues,



Herein lies a treasure trove of offerings from an array of sub-specialties both from within psychology's borders and from some of those who sit very close by. The latter are often those who can shed new light on our practice and engage us in some

critical reflection. 'Psychology without Borders,' the theme of our next conference, is often a theme of this publication and there are a number of articles within this edition which both extend and provoke.

First up it was heartening to read life member Dave George's account of his interesting career from primary school teacher to organizational psychologist. He has crossed a couple of borders in his career but emphasises a focus upon an ethical approach, and a sense of humour has continued regardless.

Peter Stanley's critical account of the Ministry of Health's discussion document on foetal alcohol spectrum disorder provides thought provoking reading as he calls for the application of more science to the field and an awareness or scepticism of the fads and fashions regarding the latest diagnosis under the public and professional spotlight. His article illustrates the huge range of professional opinions and contributions to this area over time. Similarly, Quentin Abraham presents the key themes within the recent submissions to the Ministry of Education on their Special Educational Needs Update made by the New Zealand Psychological Society (NZPpS). Quentin describes the diversity of what educational psychologists can and do offer within the arena of educational services in terms of philosophical stances, intervention approaches and the application of Māori cultural knowledge. Quentin also speaks to the approach educational psychologists need to take to provide the optimal service to our children.

Matt Harris' perspective is a great example of one of psychology's sub-specialties, he being a safety investigator for the Civil Aviation Authority of New Zealand. He writes of his passion for the study of human factors within this field, providing a compelling example of how human factors may have contributed in the crash of a small plane on Carter's beach in Westport in 2013. He enthusiastically invites our engagement with this field and invites us to join the Australian Aviation Psychology Association.

A key contributor who sits close to our borders is Associate Professor Dawn Darlaston-Jones, a keynote speaker from last year's conference. Darlaston-Jones extends us an invitation for us to consider 'epistemic critical reflexivity'. In so doing we may become agents of change within our profession. Darlaston-Jones presents the challenge to deconstruct and decolonise both ourselves and our discipline. She draws attention to the ways in which we operate within society to silence indigenous voices and privilege those of the majority.

A contribution from Dr Tai Kake speaks to the heart of Darlaston-Jones' topic in his account of his research in cognitive neuropsychology, studying Māori who have been diagnosed with schizophrenia. His findings provide insight to the impact of schizophrenia and its treatment on the cognitive functioning of Māori who have an elevated rate of diagnosis of schizophrenia, delayed access to treatment, and poorer outcomes.

Jack Austin, convenor of the NZPsS Ethical Issues Helpdesk presents his account of the work and function of the Helpdesk. What is evident in Jack's writing is his passion for this particular aspect of our work, that is, coming to understand the why or why not of the complex decisions regarding our ethical dilemmas. Jack describes the process of consulting the Helpdesk and gives examples of questions which most will relate to. This is a helpful article in terms of coming to understand how and when we should approach the Helpdesk.

I was reminded of a fascinating time-lapse video sequence of the changing country borders on a map of the world over the last few hundred years while reading Edgar Burns 'Sociological View of Psychology and Professional Boundaries'. 'Fluidity, not stasis, is the natural state of all professional boundaries' says Burns. Change is ongoing and inevitable and we are thus in the midst of a 'professional project', whereby we debate our future. Burns poses the question of whether we seek to develop our professional scope of practice with intention, or simply let the market position us. This big picture analysis from someone close to our border provides useful context to the future of psychology debate and great food for thought.

Jodie Black, our one-on-one contributor echoes Burns' spotlight on what the consumer wants as a way to approach our work. She emphasises our need to stay relevant and put the client at the heart of service provision amidst the increasing specialisation of our field and competition for resources. Jodie's career pathway from rural psychologist in NSW, Australia to counselling psychologist at the University of Otago via health promotion and suicide

prevention is reflective of a significant amount of adaptability and crossing of borders!

Finally, we have some contributions from presenters and attendees of the recent Australia and New Zealand Association for Contextual Behavioural Science (ANZ ACBS) Conference, held in Wellington last November. This conference attracted many psychologists from Australia and New Zealand who presented on a range of applications of their work. One such contributor was Tresna Hunt who herself covers many professional areas of psychology practice in her work as a therapist, facilitator, coach and lecturer. Tresna describes her approach to her work as an organizational consultant from a CBS perspective working in complex organizational systems be it a primary, secondary or tertiary level intervention. Also a presentation from the same conference, Elizabeth Maher, CBT therapist and an acceptance and commitment therapy (ACT) trainer describes an acceptance and commitment approach to working on self-doubt. Her account illustrates some of the concepts from the ACT perspective and how they apply to this particular problem. Ben Sedley, a clinical psychologist and ACT enthusiast who played a key role in organizing the conference, provides us with an overall review of the conference should anyone be entertaining attending one of these in the near future.

Again, I am impressed at the diversity of work represented in these pages and hope you enjoy the cross-fertilisation and reflection that will result from your reading. I am left with the impression that as psychology grapples with its borders, it will continue to push into new territories and evolve as our contexts change. It will likely do this most fruitfully via a process of looking beyond our boundaries and rising to the challenges from without.

Kia kaha,

Hei konā mai,

Fiona

Congratulations to new life members

Each year the Executive confirms and congratulates NZPsS members who have completed 30 years of membership of the Society. The 2016 life members listed below were invited to write about their journey in psychology and we feature the contribution which we gratefully received.

Janice Galvin

Dave George

Heather Gifford

Nikki Reynolds

Dr Dave George – A career journey



My early 'career years' were focused on primary school teaching in New Zealand, Australia and Africa, and fitting in as much travel as I could afford. For a number of years in the 70s I was in what is now Zimbabwe, and left teaching to work in a large sugar

company as a production shift supervisor (for a change). I next ran a training and education portfolio (company training programmes, and range of primary and secondary schools), and from time to time worked with organisational psychologists, who impressed the hell out of me with their ability to understand people, and to lift individual capability and performance. I wrote to Massey University and received a courteous and encouraging aerogram from Professor George Shouksmith, assuring me that Massey was a great place to study organisational psychology, and there were many opportunities to apply these skills in organisations.

I moved back to New Zealand in 1980 and joined the ranks of 'mature' students eventually completing an Honours degree and a PhD in organisational psychology. The latter was made possible with the valued support and guidance of my supervisor, Dr Mike Smith. I was fortunate enough to receive a number of fellowships and later a three-year appointment as a lecturer which supported me and my family. This came to an end in 1988 when I accepted a consulting role in KPMG. Over the next seven years at KPMG, along with Dr Sharon Rippin, Vivienne Bull

and other keen organisational psychologists, we set up an organisational psychology team determined to prove that psychology had a critical role to play in enhancing organisational performance (and was worth paying for). Acceptance by public and private sector organisations was not immediate. However, over time the value of clearly defining job capability requirements, taking a people-focused approach to organisational change, and providing insights through psychological assessment was recognised and became part of mainstream business.

In 1996, three of the organisational psychology team (myself, Dr Sharon Rippin and Russell McMurray a talented computer specialist) formed Cerno Limited to focus on leadership managerial assessment and development. My 20 or so years with Cerno has confirmed for me that leadership assessment is both a science and an art, and that as organisational psychologists the advice we provide must be soundly based on research evidence, 'best practice' standards and be easily understood by organisational decision makers and participants alike. Our approach has at times meant challenging clients' thinking about what 'good' assessment looks like, encouraging clients to think broadly about the range of skills individuals can bring to a role and better understanding what is reasonable to expect of their people. These challenges have at times been at a cost to future business when we have walked away from assignments where we could not operate in ways that were consistent with the key principles on which our practice as organisational psychologists was based. As the ownership of Cerno is transferred to Dr Kate Mirfin and Dr Tania Graham over the next year, the assessment focus and the key principles underpinning Cerno's approach will continue.

I have been fortunate to be part of developing and conducting a wide range of assessment programmes for participants in many different roles including chief executives, managers, fire fighters, aspiring medical students, prison officer, entrepreneurs, diplomats and more. The assignments started with organisations such as the Department of Trade and Industry in the mid-1980s, through to the design and delivery of public sector-wide programmes in the Victorian, Queensland and New Zealand public sectors over the past few years. As a result, I know that the expertise and experience of our New Zealand organisational psychologists is at least equal to, or more commonly in advance of our international neighbours. Cerno's established Australian business is well known for its New Zealand design expertise, practical but robust assessment solutions, and the respectful and principled way we engage with participants during assessment. Time

spent at international conferences has shown me, that Kiwis have built on and contributed to the learnings from international research and practice, and have successfully made assessment work accessible to decision makers.

In addition to assessment design and delivery, I have professionally supported organisational change initiatives, competence identification projects, team building programmes and organisational climate and engagement surveys. One experience I will always remember is conducting a review for the Minister of Police on the standards and assessment practices for police applicants. Media fuelled concerns dubbed the issue, 'the thick blue line'. While it was a political hot potato, I benefited from the contributions and support of a number of professional peers, and was highly impressed by the graciousness and a strong focus on understanding the actual truth from Annette King the Minister of Police and Howard Broad the Police Commissioner. While the media may have tested my sense of humour, it was one of those opportunities to do the right thing for the right reasons.

It is important to me that organisational psychologists practice ethically, base their contributions on sound evidence, and demonstrate a respect for (and a preparedness to challenge) the opinions of those they work with and for. Peer reviews of one's judgements and findings are an invaluable part of sound professional practice; they are a privilege to receive given the value they add to the practitioner and client. At the risk of sounding 'old-fashioned', I do not believe that software programmes or online assessment tools can replace a skilled psychologist as an assessor. I intend to continue working part-time as an organisational psychologist, and to challenge those promoting assessment practices that are not robust and as a result, do not deliver the promised outcomes from an organisation's and a participant's perspective. While sailing will become a greater part of my life over the next few years, I also hope my bullshit detector stays with me, along with a sense of humour.

NZPsS & ICP jointly hosted workshop

Worried Sick? Extending the application of cognitive behavioural approaches, from health anxiety to medically unexplained symptoms and long term medical conditions.

Prof Paul Salkovskis, UK

1st July Christchurch & 4th July Auckland

In this workshop, the theoretical and clinical underpinnings of CBT for health anxiety on its own and linked to Medically Unexplained Symptoms (MUS) and Long Term Physical Health problems (LTC) will be described, starting with the success of CBT and identifying its limitations in this context. The importance of using a transdiagnostic approach as a way of ensuring high quality therapy is considered in the context of the need to address the specific issues in diverse problems such as chronic pain, irritable bowel, chronic fatigue and so on. The result is a new hybrid transdiagnostic/specific approach, with core elements including engagement and developing a shared understanding supplemented by "modules" addressing specific aspects of MUS in the later stages of treatment, with behavioural experiments cutting across both aspects of the treatment. Treatment fundamentals and details will be discussed and, where possible, demonstrated. Time will be allowed for discussion of cases brought by participants who are prepared to role-play their clients.

Register online on the NZPsS events page or contact the Professional Development Coordinator: pd@psychology.org.nz

‘Oh dear, let’s not go there’: A response to the Ministry of Health’s discussion document on Foetal Alcohol Spectrum Disorder

Dr Peter Stanley, Counselling Psychologist, Tauranga



Dr Peter Stanley has worked in social work, teaching, counselling, and psychology. He has a particular interest in resilience and in working alongside parents and caregivers to nurture positive outcomes for children and youth.

The *Discussion Document*, a summary

The Ministry of Health (MOH) (2015) is calling for a national action plan to respond to Foetal Alcohol Spectrum Disorder (FASD). The associated *Discussion Document* describes FASD as a preventable condition, which is caused by the ingestion of alcohol during pregnancy, and which can result in physical abnormalities, and in sensory, communication, and behavioural challenges. It is hard to differentiate FASD from other childhood conditions because young people can have the issues that have been listed even when they have not been affected by alcohol. Conversely, other children who have had alcohol exposure in utero can be without difficulties. Currently, we do not have a “clinical consensus on how to diagnose the full foetal alcohol spectrum,” and validated screening tools are rarely used by primary health carers in this country.

The *Discussion Document* describes FASD as a neurodevelopmental disorder, which means that the problems that the individual experiences result from his or her brain not developing in a typical way. In addition, treatment needs to take into account how the brain works if it is to be successful for an individual with a neurodevelopmental disorder. Psychological interventions, like cognitive behaviour therapy and applied behaviour analysis, can be inappropriate. Neurodevelopmental disorders can only be ‘managed’, rather than cured; and the best that many adults with FASD can hope for is a life of ‘interdependence’ because of their ongoing needs for support.

Children and youth with FASD have mothers who are more likely to be unemployed, have mental health and substance abuse issues, have histories of trauma, have low educational levels, have unmet needs for health and maternal care, and have children in state care. FASD is described as a complex and multifaceted clinical outcome that includes genetic contributions and environmental determinants, as well as the ingestion of alcohol in pregnancy. The *Discussion Document* reports that, internationally, 30-50 percent of children in foster care have FASD. In New Zealand, “We expect children affected by

FASD to be over-represented in Child, Youth and Family care and to come into frequent contact with Children’s Teams as they roll out around the country.”

The MOH document is seeking early intervention and prevention measures; and holistic, strengths-based, and non-stigmatising approaches to children with FASD and their mothers and families. A coordinated cross-sectorial response is called for (with multiagency and wraparound engagements) and “everyone needs to be on the same page.” It is also admitted, however, that we are largely “flying blind” with respect to FASD in this country. We lack good local data on incidence, prevalence, interventions, outcomes, costs, and risk and protective factors. We have access to the international knowledge base on the much more defined condition of Foetal Alcohol Syndrome (FAS) but, even here, there is controversy about the consequences of foetal alcohol exposure. Nonetheless, a FASD action plan is intended to assist a variety of agencies in the human service sector in New Zealand to respond to the disorder with “a clear idea of how they can make a difference, and be supported to play their part.”

Introduction

This summary of the MOH *Discussion Document* offers multiple points for critique of FASD, as it has been defined and described. I intend to organise my response to the document and to the alleged disorder by successively considering contributions from psychological research and

analysis, from an historical and sociological investigation, from special education, and from disability studies. In the conclusion of the submission, FASD is depicted as pseudoscience, as a fad, and as a mistake. In the final section there is also a brief overview of other ways that learning, behaviour, and emotional challenges in young people might be identified and responded to in our community.

A psychological perspective on FASD

FASD is what Feinstein (2001) calls a 'premature etiologic label.' This is where a label implies a cause for a set of events before that cause has been established. Premature labelling of this sort can produce a number of negative personal and professional consequences. For instance, it may constrain the consideration of, and search for, other causative influences. For the patient (client), it can also mean that they focus on the pathophysiological aspect of the label and they may be less inclined to alter their circumstances or themselves. In medicine, it is an article of faith that it is necessary to diagnose a condition as a prelude to doing something constructive about it. In fact, in psychological and behavioural spheres, it is more scientific and sensitive to respond to an individual's presenting behaviour rather than attempt to slot them, in their uniqueness and entirety, into a predefined psychiatric category. Just as a presumption of aetiology can be premature (and erroneous), the notion that diagnosis is important to the resolution of psychosocial problems is often without foundation.

Currently, we do not have a "clinical consensus on how to diagnose the full foetal alcohol spectrum," and validated screening tools are rarely used by primary health carers in this country.

The *Discussion Document* makes no mention of a collection of major literature reviews that have been commissioned by the Ministries of Education and Health in recent times about best practices for responding to children and young people with challenging behaviour (Church, 2003; Meyer & Evans, 2006; Mudford et al. 2009). Presumably, the search is to continue for a specific treatment for the particular condition of FASD, because that is how it works in physical medicine, while a substantial research legacy shows that applied behavioural techniques are often the interventions of choice for behaviour issues.

Meyer & Evans (2006) studied effective responses for children and youth who have behavioural challenges associated with developmental delay, severe learning difficulties, intellectual disability, severe traumatic brain injury, and/or Autistic Spectrum Disorder (ASD). The

review included an extensive appraisal of the international literature, and a meta-analysis of relevant research reports. Positive, individual, behavioural programmes are recommended for children's difficulties, and a primary or secondary diagnosis does not moderate outcomes. Best effects typically occur when medication, aversive consequences, and other intrusive elements do not dominate the intervention. Multicomponent interventions are favoured, as are responses that are sensitive to the child's developmental level and to his or her environment and culture. The authors of the report advise that:

A well-targeted, carefully applied, and time-limited intervention, conducted within or close to the resources readily available to the treatment provider, is likely to be more useful and effective than alternatives requiring extraordinary resources, supports and extended durations of treatment. (p. 11)

The comprehensive technical review by Mudford et al. (2009) evaluated local and international evidence on the effectiveness of applied behaviour analysis (ABA) interventions for individuals with ASD. The authors, who included leading academics from five New Zealand universities, concluded that there is generally strong evidence that ABA interventions produce beneficial outcomes for people with ASD. The interventions produce meaningful and desirable changes in behaviour. Furthermore, treatment effects last over time, they transfer across settings, and they do not harm people. Specifically, there is good evidence for the efficacy of ABA in the areas of social development, cognitive development, communication, play/vocational engagements, the development of organisational skills, and the prevention and replacement of challenging behaviours. The authors of the technical review advise that this country has high quality ABA training programmes that have international links and validation.

The rise of ASD as a categorisation makes for an interesting comparison with the present situation for FASD. With ASD, as with FASD, there was the same professional fervour and preoccupation; the personal disclosures by patients and the emergence of support groups; and the demands for guidelines and action plans, multidisciplinary contributions, and for all practitioner groups to be on 'the same page.' Of course, differential diagnosis of challenging behaviour only makes sense if you believe that medicine has the one true view. Nevertheless, the *New Zealand Autism Spectrum Guideline* (Ministries of Health and Education, 2008) is revealing in what

it says. This document endorses ABA interventions as the most appropriate means of responding to the behavioural problems that can be evidenced by people with a diagnosis of ASD or with an intellectual disability. Cognitive behaviour therapy (CBT) is also recommended by the ASD *Guideline* as a suitable, and well supported, therapeutic approach for many behavioural, emotional and mental health difficulties, and for many different populations of clients.

We lack good local data on incidence, prevalence, interventions, outcomes, costs, and risk and protective factors [on FASD].

The third of the commissioned research reviews is the Church Report (Church, 2003). The author examined antisocial behaviour in children with the potential for normal development, and his recommendations regarding relevant programmes for these young people anticipated the series of reports that were later produced by the national Advisory Group on Conduct Problems (Blissett et al., 2009, and following reports). Pessimism about the long-term outcomes for people with FASD is a characteristic of the field, as is indicated in the MOH Discussion Document. However, as an attribution of alcohol damage is always a presumption that cannot be proven, and since social learning process are important even where biological and constitutional factors are implicated, the findings of the Church Report can assist in any systematic attempt to give young people a positive future.

Church (2003) makes a number of points abundantly clear. Firstly, we now have a fairly good understanding of the positive and negative reinforcement processes that shape and maintain coercive and antisocial

behaviour. Secondly, children with high levels of antisocial behaviours are at risk of going onto a number of other problem behaviours in adulthood. Thirdly, we now know of psychological interventions and programmes that can regularly realign negative developmental trajectories and, as importantly, of those involvements that cannot achieve this outcome. A fourth point is that interventions should occur early in life, because later they are much more costly and complex. Furthermore, to be successful, they very probably need to operate in both home and school settings. Finally, contingency management intervention strategies are again recommended.

An historical and sociological perspective

Armstrong (2008) provides an extraordinarily comprehensive critique of FAS; while of FASD itself, she says that there is no consistent evidence that the umbrella diagnosis exists at all. The author links the 'discovery' of FAS in 1973, and its subsequent attraction and expansion as a diagnosis of choice, to a host of technological developments and social forces. The 1960s and 1970s gave society reliable contraception and the sexual revolution; and ultrasonography, foetal monitoring, and abortion. It was an anxious time when there were pervasive fears about toxic and teratogenic threats in the environment, and about Thalidomide and rubella. The consequences of these developments and issues were a cultural ferment over gender and motherhood; and a conservative reaction which concluded that mothers made choices, and that they were responsible for birth outcomes by their behaviour and lifestyles. Armstrong contends that the medical profession exploits maternal anxiety, and parental guilt, and its practitioners

have become moral entrepreneurs who wish to impose their vision and control on society, and on all women of reproductive age in particular.

Armstrong (2008) says that FAS is similar to other conditions that have been medicalised and brought within medical purview, like alcoholism, addictions, mental illness, and child abuse. It is sometimes argued that medicalisation engenders more humanitarian responses for those who suffer an 'illness' because it is not the patient's fault. However, as the author says, a diagnosis of FAS in a child heightens, rather than diminishes, the personal responsibility of the mother; and it can only serve to increase the social opprobrium for both mother and child. A further major concern with medicalisation is that it 'individualises' larger social problems and determinants. Armstrong's research showed that the small number of women who drank heavily during pregnancy were of African American race, limited education, advanced age, and impoverished. The probable causes of any difficulties that children of these mothers might experience seem obvious, but many prefer to diagnose and to medicalise, and to individualise blame. By these means, the option of social action is ignored and "the poverty, chaos, suffering, and insufficiency of some women's lives" is misunderstood (p. 218).

The Discussion Document makes no mention of a collection of major literature reviews that have been commissioned by the Ministries of Education and Health in recent times about best practices for responding to children and young people with challenging behaviour.

Armstrong (2008) interviewed a total of 30 obstetricians, paediatricians, and family doctors about FAS. The

conclusion that she came to was that diagnosis is inevitably subjective and impressionistic, and effectively FAS is in the eye of the beholder. Doctors, either, started with a clinical examination and then sought to validate their impressions by asking about maternal alcohol use. Or they worked from a known history of drinking by the mother and then they looked for symptoms of FAS in the young person. There is no biological marker to confirm the condition, and none of the abnormalities believed to be associated with FAS are specific to it. In these circumstances, quantitative coding systems can only offer an illusion of objectivity to the diagnostic process. Armstrong says that the inherent subjectivity of diagnosis makes it especially susceptible to ascertainment bias, and this means finding FAS in subgroups (such as the poor) where it is expected to be found. The irony of the diagnostic ritual is that medicine has so little to offer patients after it is completed. The author concludes that the moral concern that practitioners have about FAS “is directly related to their powerlessness as medical doctors to do much about it” (p. 212).

Perspectives from special education

Diagnosis and categorisation are typically regarded as unnecessary by special educators, and from an inclusive education viewpoint it is inimical and alienating. Teachers individualise learning for students. That is what they do if they are competent, because that is what it means to be a teacher. The curriculum is modified, specific instructional strategies are utilised, and the assessment of learning is adapted; and this is quite different from the belief expressed in the *Discussion Document* that students with FASD have particular instructional requirements. Quite simply, the notion that there

is “a separate and special pedagogy to go with every special need” is mistaken (Stanley & Glynn, 2012, p. 64). In our country, as elsewhere, teachers are assisted in responding to student diversity with an array of supports (including teacher aides, specialist advice, and technology); and programmes of learning for students with special needs are usually formalised in individual education plans.

As a psychologist working in education over many years I came to see my job as assisting students with special needs to be ‘indistinguishable’ from their age mates.

Diagnosis is inimical to inclusion because to categorise is to exclude (Stanley, 2006a). At the least, a student who is labelled becomes ‘one of those sorts of kids.’ With a value-laden and derogatory label like FASD, all manner of other negative aspersions can be made. Official publications, like the *Discussion Document*, already make the links for others regarding the home lives of these families. Adults have an excuse for abrogating the natural responsibility and oversight that is owed to children, and they may support other young people in disassociating from them as well. In effect, children with FASD are to be alienated from the normal opportunities of growing up because of alleged deficits within their bodies that happened to them before they were born. As a psychologist working in education over many years I came to see my job as assisting students with special needs to be ‘indistinguishable’ from their age mates. In other words, to help boys and girls to acquire sufficient social and academic skills that they could enjoy reciprocal relationships and conventional successes. Giving a kid a label is giving them another problem, and applying a

diagnosis of FASD will probably make regular adjustment impossible for him or her.

The New Zealand education system does not generally embrace categorisation, and one of the few demarcations that is made of students with special needs is the ‘high needs’ and ‘very high needs’ divisions within the Ongoing Resourcing Scheme (Ministry of Education, 2015). This is a categorisation of sorts, but it focuses on specific support requirements; and this contrasts with diagnoses which can be required by some providers to access any services. As it happens, how educationalists see young people is a paradigm away (if not a world apart) from the views that are implicit in diagnoses. These different perspectives can often make it difficult for education professionals and health practitioners to work well together. Werry (2006), for instance, believes that the Ministry of Education is doctrinaire and obstructive to doctors because of its ‘extreme’ ecological approach and its unwarranted optimism for students with difficulties. Interestingly, relations between Child, Youth and Family and Child and Adolescent Mental Health Services are also described as poor (Office of the Children’s Commissioner, 2015), and perhaps social workers have different values and priorities as well.

One point of difference between medical doctors and education specialists (such as educational psychologists) is in the valuing of the multidisciplinary team (MDT). An MDT is clearly an important arrangement in physical medicine. A stroke patient, for instance, will likely call on many different medical staff such as doctors, nurses, physiotherapists, occupational therapists, and social workers; and it makes sense for these people to work together and to meet with each

other. Paediatricians and psychiatrists who believe that patients' psychosocial and adjustment issues also have organic causation can see MDTs as important provisions as well, although there is also commentary that they are essentially a self-serving device for doctors (Halpern, 1990). Nevertheless, despite the paradigmatic differences, medical professionals expect education workers to fit in with, and contribute to, MDTs.

A psychologist working in education with a child with challenging behaviour will undertake an assessment with all of the significant people in the student's life and then he or she will continue to have close relations with these people over time to effect measurable changes for the young person. Medical practitioners, social workers, and other psychologist specialties may make contributions at points along the therapeutic journey but the bulk of the tasks will transpire in the context of the psychologist and caregiver collaboration (Stanley, Stanley, & Hegan, 2014). In these circumstances, multiagency connections are conditional and functional; and anything more is system's churn that can entail unnecessary meetings, assessments, and correspondence for both practitioners and clients alike (Stanley, 2015a). Arguably, the terms 'multiagency' and 'MDT' are like so many other contemporary mantras (including 'strengths-based,' and 'child-centred'): they persist because they sound good and because other people are using them, but they rarely lead to very much as they are not critically examined.

Viewpoints from disability studies

There is significant overlap between the goals of inclusive education and the concerns of the disability sector. The New Zealand Disability Strategy (Office of Disability Issues, 2016) makes plain that while people have sensory, neurological, psychiatric, and intellectual impairments, it is society and other people who create disabilities for them by erecting physical and attitudinal barriers. FASD is obviously a case in point where learning and behavioural challenges are transmogrified into a stigmatising and disabling condition. A vision of a fully inclusive society underpins the Disability Strategy; and this will be achieved when people with impairments can say that they live in "A society that highly values our lives and continually enhances our full participation" (Office of Disability Issues, 2016).

The disability literature can describe the contrasting approaches to disability that exist in our society as discourses. Discourses are the ways that we think, and the ways that we live our lives. Fulcher (1989) suggests that there are four discourses of disability: the medical discourse, the lay discourse, the charity discourse, and the

rights discourse (cited by Neilson, 2000; O'Brien, 1997). As we might expect, the medical discourse is concerned with deficits, disorders, damage, and deficiencies and, consequently, personal attributes and humanness are diminished. Disability can be depicted as an individual and family tragedy, and a person with a disability may be considered to have a life that is not worth living. As we know, genetic screening for Down Syndrome is routine; and some commentators contend that women who have consumed alcohol prior to knowing that they have conceived should be able to terminate the pregnancy (e.g., Armstrong, 2008).

The rights discourse of disability challenges the medical, lay, and charity discourses, and it draws attention to the holistic nature of wellbeing and what it means to be a human being. Incidentally, the *Discussion Document* talks about 'holistic' approaches, but here it is being disingenuous; although obviously nowhere as much as when it expresses a commitment to being non-stigmatising. To be human is to have a concept of self, and a sense of agency and ability. Autonomous individuals have preferences, they make choices, they initiate actions, and they complete tasks (Wearmouth, Glynn, & Berryman, 2005). When a mother accepts a diagnosis of FASD for her child she is accommodating to someone else's view of her son or daughter. These comprehensive professional judgements, which are reinforced by ongoing engagements with the human services, effectively and efficiently define and constrain the futures that are available to the young person. The principal task of every parent (of whatever species) is to promote independence in their offspring, and a diagnosis of FASD is a functional impediment to this process for many boys and girls.

We [also] need to add some science to the ways that we identify young people for services from health, education, and welfare agencies.

Health Promotion Agency (2015) is a process evaluation of a FASD Assessment Pathway that is being operated by the Hawke's Bay District Health Board (DHB). The multidisciplinary pathway aims to be culturally responsive and it aspires to a non-stigmatising approach. Of the children who were assessed 2010-2015, 74 percent were boys and 73 percent were Māori. Some 93 percent of those who were assessed were considered to have more than one disorder. Diagnosis is by 'consensus' by the team. Most of the children came from deprived backgrounds. The report describes the DHB Assessment Pathway as an example of a best practice approach and it is seen as a blueprint for other

programmes. There are problems, however. There have been difficulties aligning the health and education paradigms and the service is expensive to run. Moreover, while the pathway claims to assist people to access effective services from the education, health, and social sectors, the report concedes that the lack of support for children, families, and schools following the FASD assessment is a limitation of the model.

The Hawke's Bay DHB approach is to offer a diagnostic service which may, or may not, connect in meaningful ways with real-life contexts. This is yet to be determined as an outcome evaluation has not been undertaken. What is concerning at this stage is the disproportionate numbers of boys and Māori who are being seen. Given what we know (and do not know) about FASD, an attribution of foetal alcohol effects is not a sufficient explanation for the statistics. It is one thing to associate FASD with social deprivation, but it is quite another to couple it with culture and with gender. I have written about the medicalisation of behavioural problems as a 'boy blaming' approach (Stanley, 2006b). Other commentators have addressed the culture question, and they have done so in terms of issues of power and control. For instance, Wearmouth, Glynn, and Berryman (2005) observe that where processes work to disadvantage specific ethnic groups "those groups may issue challenges of institutional racism" (p. 65).

If the Hawke's Bay model is emulated elsewhere in the country, as its stakeholders recommend, Māori boys in other places are clearly also at risk of being diagnosed with FASD (amongst other disorders). But it is Māori males who come into the care of Child, Youth and Family (CYF) who may be the most vulnerable because they are congregated in CYF homes and residences, as they are in our prisons. The *Discussion Document* uncritically anticipates this possibility, and it could be that the new Children's Teams will ultimately function as diagnostic stations as well. State-funded services and care should presumably be safe places where no further harm is done to young people who are powerless and defenceless (Stanley, 2015b). These facilities should also be models of best practices that respect individual autonomy and rights.

Conclusion

Alcohol is a teratogen that can cause visible effects in a small percentage of children whose mothers drank during pregnancy. This is a medical and physical fact. However, the extrapolation of neurophysiological damage from this small group of children to a much larger population of young people with learning and behavioural challenges is an article of medical faith. There is now a significant history of medical expansionism and entrepreneurship of this sort

(Halpern, 1990), and FASD is just the most recent of a succession of professional assaults which have included Attention Deficit Disorder (ADD), Attention Deficit/Hyperactivity Disorder (ADHD), ASD, and Dyslexia. For some time, sexual abuse was also popular as a predominant clinical explanation for behavioural excesses and deficiencies in children. As a corollary to the new complaints, we have been given a range of anatomical and physiological explanations, such as 'minimal brain damage' and 'chemical imbalance'; and now we have 'foetal alcohol effects.' Some medical practitioners and their followers would have us believe that each new diagnostic fashion is an established and incontrovertible condition when they typically represent no more than speculation and supposition (Rosemond, 2005; Wyatt & Midkiff, 2006).

Fads in medicine and special education are a topic of study in its own right and it has been found that they are frequently promoted by well-intentioned, professionals, or paraprofessionals, who lack the skills, knowledge, or motivation to evaluate the substance and adequacy of the novel approach (Jacobson, Foxx, Mullick, 2005). A fad is unlikely to be supported by data; and in the case of FASD it is impossible to obtain meaningful statistical information because the condition cannot be specified. Nonetheless, fads aspire to scientific respectability and they can do this by employing technical jargon and by referencing what is done to genuine scientific content (Vyse, 2005). And while simpler, better, and verified explanations are available, the proponents of a bandwagon are likely to hold to their belief system with a quasi-religious fervour because it strengthens and maintains their professional authority. Some commentators may see scientific legitimacy in FASD joining the new DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders-5*, American Psychiatric Association, 2013). Allen Frances (2012), who was one of the originators of DSM-IV, is disparaging of DSM-5 because the content was not evaluated in real-world settings; and since it "will start a half or dozen or more new fads which will be detrimental to the misdiagnosed individuals and costly to our society."

The medical perspective may seem irreconcilable with the contributions of psychology, sociology, special education, and disability studies. In fact, what can, and should, link and unify all of the human services are commitments to data, to rigorously supported interventions, and to ethical, empowering, and inclusive practices. We have good interventions operating in this country already, such as *The Incredible Years Parent* programme (<http://www.incredibleyears.com>), which has been the subject of a substantial cross-agency assessment (Sturrock, Gray,

Fergusson, Horwood, & Smits, 2014). The problems that children have, and the challenges that they evidence, (from whatever purported cause), occur in the context of parent and child relationships, and so systematic parental support should be considered as a part of every professional response. We also need to add some science to the ways that we identify young people for services from health, education, and welfare agencies. Intake systems based on diagnostic practices are especially flawed, whereas multiple advantages could flow from universal, needs-based, student surveying (Church, 2003; Stanley & Sargisson, 2012). Finally, surveying takes us into the realm of the prevention of problem behaviours, and obviously the elimination of extreme disadvantage and deprivation within our society should be a priority.

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

The Australian Aviation Psychology Association – Expanding our Aviation Industry

Matt Harris



Matt Harris is a safety investigator for the Civil Aviation Authority of New Zealand (CAANZ) and a non-executive board member of the Australian Aviation Psychology Association (AAvPA). He has been the investigator-in-charge (IIC) of a number of aviation accidents in his four and a half years as a safety investigator, of which aviation human factors has been an ever present consideration. Being actively engaged in the human factors aspect of safety investigation and having a keen interest in psychology and human performance, Matt has been a member of AAvPA since 2013, and is the point of contact for AAvPA in New Zealand.

This is an individual submission inviting New Zealand psychologists to get involved in aviation psychology and to become a member of the Australian Aviation Psychology Association (AAvPA). In recent years the aviation industry acknowledges that safety improvements come from understanding and controlling human error. The fields of aviation psychology and human factors can provide this understanding and it is the objective of AAvPA to promote the exchange of this information and knowledge, to aid in the improvement of aviation safety in the Asia Pacific region.

The Evolution of Aviation Safety

Over the last century aviation safety has seen significant improvements. This has largely been driven by the conduct of safety investigations and lessons learnt from accidents and incidents. Early improvements came from understanding technical issues, which brought about increased reliability of aircraft and equipment. However, with significant accidents continuing to occur, the focus shifted toward human error. In recent years, greater understanding of human factors and aviation psychology has led to the enhanced focus on the external

factors which can influence human performance. The following example demonstrates the importance of aviation psychology in understanding how accidents happen and further improving safety in this industry.

Learning From Tragedy

At approximately 2120 hrs on 30 January 2013 a Bantam aircraft with two persons on board crashed on Carters Beach, Westport, fatally injuring both the pilot and passenger. The subsequent safety investigation concluded that the accident occurred after sunset, approximately two minutes before the end of Evening Civil Twilight for the region¹.

The last positive sighting of the aircraft was made at approximately 2110 hrs, where it was observed flying towards the local vicinity of Cape Foulwind and Carters Beach.

At the time of the accident, several witnesses commented that Carters Beach was affected by thick fog and visibility was estimated to be less than 200 metres. The New Zealand Meteorological Service stated that after sunset due to the consequence of

increased cooling of the ground, fog formed and the cloud ceiling lowered to 200 ft.

... with significant accidents continuing to occur, the focus shifted toward human error

The pilot was flying under Visual Flight Rules (VFR). VFR flight in the vicinity of the Carter Beach area of Westport requires that an aircraft be flown clear of cloud and in sight of the surface (ground/sea). He was neither night nor instrument rated, and the aircraft was not equipped for night flight or flight into Instrument Meteorological Conditions (IMC). IMC describes a situation when the pilot is required to control and navigate the aircraft using flight instruments, as the outside view from the aircraft is restricted.

The safety investigation concluded that the pilot likely entered an area of thick fog in limited light conditions, most probably compelled by plan continuation bias. The reason the aircraft departed controlled flight was most likely because the pilot experienced the effects of spatial disorientation, due to the local weather conditions encountered, and the time

¹ https://www.caa.govt.nz/Accidents_and_Incidents/Accident_Reports/ZK-MLF_Fatal.pdf

Members' Contribution to the Safety and Efficiency of the

of day, being unsuitable for VFR flight.

Understanding Plan Continuation Bias and Spatial Disorientation

Plan continuation bias is fundamentally the result of a decision-making error, which involves continuing toward the planned destination or toward the planned goal, even when significantly less risky alternatives exist. It often occurs when there is bad weather at the destination, but factors such as time pressures or simply the intention to return home influence the pilot's decision making ².

The reason the pilot of the Bantam aircraft continued into deteriorating meteorological conditions could not be conclusively determined by the safety investigation. However, the pilot's decision to continue the flight into adverse weather conditions, even though indications were that an alternative course of action may have been safer, is characteristic of plan continuation bias or 'Get-there-itis'.

Spatial disorientation is a physical and mental phenomena experienced by pilots during flight, where the pilot essentially fails to correctly identify which way is up. A pilot maintains spatial orientation relative to the earth through senses transmitted by the nervous system to the brain by both the vestibular system (balance) and postural system (position and visual reference).³

Once visual reference has been lost, the powerful and misleading orientation sensations associated with spatial disorientation can very quickly lead to a pilot losing control of the aircraft. A study carried out by researchers at the University of Illinois showed that on average it took only 178 seconds for non-instrument rated pilots to lose control of their aircraft once all visual references were lost. Although the dangers of VFR pilots flying in IMC and the effects of spatial disorientation are well known, research has shown that they are still significant factors in aviation accidents, regardless of the pilot's experience level.

Both spatial disorientation and plan continuation bias are common aviation human factors influences on human performance. The knowledge gained through human factors research, can help pilots understand the illusions of spatial disorientation, allowing them to maintain control and

² [http://www.skybrary.aero/index.php/Press-on-itis_\(OGHFA_BN\)](http://www.skybrary.aero/index.php/Press-on-itis_(OGHFA_BN))

³ [http://www.skybrary.aero/index.php/Vestibular_System_and_Illusions_\(OGHFA_BN\)](http://www.skybrary.aero/index.php/Vestibular_System_and_Illusions_(OGHFA_BN))

disregard false sensations. It is also imperative for a pilot to understand and recognize when their decisions are being influenced by plan continuation bias, to avoid adverse outcomes.

The Role of Aviation Human Factors and Aviation Psychology

The field of aviation human factors has many disciplines, with an important one being aviation psychology. Aviation psychology has grown in recognition within the aviation industry in recent years, with airlines and maintenance organisations acknowledging that safety improvements come from understanding and controlling human error. The demand for aviation psychologists has thus been growing in commercial airlines, aviation organisations, and government agencies.

Aviation psychologists often find roles advising airline professionals or aiding in the pilot recruitment process. They may also be involved in designing aircraft user interfaces, assessing safety features or investigating aviation accidents and incidents.

... the pilot's decision to continue the flight into adverse weather conditions, even though indications were that an alternative course of action may have been safer, is characteristic of plan continuation bias

Unfortunately, there are few specific degree programmes offering aviation psychology and many aviation psychologists come from a cognitive, industrial or social psychology background. Employers, however, usually desire that aviation psychologists have a knowledge and understanding of the aviation industry. To achieve this many aviation psychologists also become members of aviation psychology associations.

One such association is the Australian Aviation Psychology Association (AAvPA).

The Australian Aviation Psychology Association (AAvPA)

AAvPA was formed in 1992 by a group of aviation psychologists and pilots, to build a platform for discussion of like-minded professionals and to host the AAvPA symposium, which is held every other year. Since then AAvPA has organised a total of eleven international symposia and several workshops, roadshows and other

events bringing together academia and aviation professionals.

Today AAvPA facilitates a professional network of more than 200 members in Australia and overseas to team up in the quest to improve aviation safety, through the understanding of human factors. AAvPA is a not-for-profit organisation, whose primary objectives are to: "Promote the exchange of information and advancement of knowledge in the fields of aviation psychology and human factors, and to thereby expand their contribution to the safety and efficiency of the aviation industry in the Asia Pacific region."

Becoming a member of AAvPA allows you to gain an understanding of the aviation industry and to meet many different aviation professionals. It will also provide you with the opportunity to be the first to find out about upcoming conferences, training events and career opportunities. Being a forum for both academics and practitioners you can contribute to finding integrated practical solutions for existing issues and future challenges, accessing the latest research and publications.

Membership also includes a subscription to the Journal, 'Aviation Psychology and Applied Human Factors'. The journal is accessible to both practitioners and scientific researchers alike, and the contents are broadly divided into original scientific research articles and papers for practitioners. A variety of technical and non-technical aviation articles may be submitted for publication in the Journal allowing you to participate in the current discussions.

While primarily aviation based, AAvPA actively engages with and encourages participation from a number of other industries including; healthcare, maritime, road and rail and the oil and gas industries. Human factors being about the human and not the specific domain humans operate in, is by nature cross-functional and therefore sharing of information and experience in different contexts is important to the advancement of knowledge.

It is to this end that AAvPA welcomes you to get involved in aviation psychology and to join the Australian Aviation Psychology Association, making lifelong friends that share a passion and promote the human side of aviation.

The next AAvPA International Symposium will be held at the Grand Stamford Hotel at Glenelg, Adelaide, from 7-10 November 2016. We hope to see you there! For more information on the Symposium or to find out how to join, please email Matt - Matt.Harris@caa.govt.nz.



Mā te mahi kakama, kō atu

**New Zealand Psychological Society
Annual Conference 1-4 September 2016
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Keynote speakers:

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Matthieu Villatte, USA

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Tending the Garden: Educational Psychologists and the Special Education Update

Quentin Abraham



Quentin Abraham is an educational psychologist with 21 years' experience. He has worked previously as a primary school teacher and as a residential social worker. He held a senior specialist post in Britain for challenging behaviour and offered specialist advice to a team of psychologists and special education workers delivering a service to a large metropolitan city. He completed a Diploma in Systemic Family and Systemic Practice in 1997 which included intensive intervention for children, families and the agencies that support them. Quentin worked for the Ministry of Education in Aotearoa New Zealand from 2002 – 2009 providing support for individual children, their families, schools and other agencies. He regularly supervises educational psychologists, RTLBs and specialist teachers. In the last three years he has worked in private practice and has been part of the team developing the new educational psychology course at Victoria University. Quentin is a member of the NZPsS Institute of Educational and Developmental Psychology and is also a Te Reo Māori student. He is also President-Elect of the NZPsS.

He iti tangata e tupu; he iti toki e iti tonu iho

A small person may grow but a small adze remains small forever - a person is more valuable than property. They are increasingly precious as they have the capacity to develop.¹

Introduction

The New Zealand Psychological Society (NZPsS) made recent submissions to the Ministry of Education on their Special Educational Needs Update (The New Zealand Psychological Society, 2015a) and to the Select Committee's Inquiry into the "Identification and Support for Students with the Significant Challenges of Dyslexia, Dyspraxia, and Autism Spectrum Disorders in Primary and Secondary School" (The New Zealand Psychological Society, 2015b). This paper outlines some of the key themes within these submissions.

Inclusion

We all know someone, an immediate or extended family member or neighbour who has a persistent or temporary special educational need. This issue affects us all with an estimated 80,000 to 100,000 children and young people in early learning or school receiving some form of special education support each year (Ministry of Education 2014).

The Ministry of Education, with its 'Success for All' has

reiterated a high aspiration for creating inclusive schools, early childhood provision and neighbourhoods (Ministry of Education 2014). Overall inclusive schools benefit everyone e.g. when advantaged and disadvantaged students attend the same school there is a smaller proportion of low performers. Systems that distribute educational resources and students more equitably across schools benefit low performers without undermining better-performing students. (OECD 2016a, p.14). The NZPsS supports the view that it is desirable for all young people, as far as possible to be taught in their neighbourhood schools regardless of their individual needs.

Systemic and Ecological Practice

We do not blame a flower if it does not grow. We do not expect the flower to fix itself. A gardener ensures that there is sunlight, water and nutrients in the soil for a flower to grow. Like flowers, educational psychologists tend the garden, supporting not only individual children, but those who nourish children such as their whānau, school teachers and other agencies.

Supporting systems that help children to flourish is at the core of our practice (Annan and Priestley, 2012; Bowler, 2005). Educational psychologists bring a wide range of frameworks that are applied to problematic situations that help frame understandings to offer the potential for change. Some selected examples include problem analysis (Robinson, 1987), situational analysis (Annan 2005);

¹ Mead & Grove, 2003 p429

problem-solving frameworks (Kelly 2006); narrative approaches (Annan, Priestley & Phillipson, 2006); solution focused approaches (Stobie, Boyle, & Woolfson 2005), psycho-social models (Miller and Leyden, 1999) functional behavior approaches (Scott, Nelson, & Zabala, 2003), consultative approaches (Wagner, 1995), Te Pikinga ki Runga: Raising Possibilities Macfarlane (2009).

Systems that distribute educational resources and students more equitably across schools benefit low performers without undermining better-performing student.

There will always be a need for professionals to work with individual students at a casework level. However, this work can be reduced to a minimum when systemic interventions produce effective teaching, learning and behaviour management for all students. This will involve professionals who are trained and can apply educational psychology using skilled consultative methods. Brown (2010 p15) refers to this as the capacity to work locally at 'a point of sophistication'.

Special Education

Good teaching is good teaching. All children can learn even if they have different starting points. There is no special pedagogy for special education and therefore we need universal design for curriculum and pedagogy (Slee, 2014). Likewise, within a Māori context, there is no binary of special education vs. normal education. These children not only belong to the community regardless of need but these needs are likely to be met well beyond the school gates (Macfarlane, Macfarlane and Gillon, 2014).

There has been an increasingly reliance on the use of untrained or

minimally trained teacher aides (TAs). The government announced a \$23.3 million additional funding for teacher aides in the last budget (Parata 2015). The available evidence is that teacher aides are limited in their effectiveness to create change for young people (Blatchford, Russell & Webster 2012).

The NZPsS advocates for the best teachers and professionals to work alongside young people who are experiencing the greater difficulties, in well-resourced schools and communities. If funding continues to be diverted to the use of teaching aides, then teachers will need to be given time to manage their support so difficulties are not exacerbated. A well-controlled research and evaluation programme would be desirable to illuminate the effectiveness of teacher aides in Aotearoa New Zealand.

Categories and Diagnosis

Psychologists have been increasingly concerned about the limitations of diagnostic and categorical systems especially with the revision of The Diagnostic and Statistical Manual of Mental Disorders (The New Zealand Psychological Society, 2014).

A high proportion of educational psychologist's time can potentially be consumed with diagnosis and assessment for entitlement for resources rather than assessment to inform intervention (Coleman 2010). The NZPsS would like to see educational psychologists provide assessments that lead to change and that do not limit the possibility for change. For example, a review of children with challenging behaviour and developmental disabilities found:

A child's primary or secondary diagnosis did not moderate outcomes; that is, the child's "syndrome" (and the cluster of behaviours associated with that syndrome) is of less

significance to the success of an intervention than the nature of the challenging behaviour (Meyer and Evans, 2006, p2).

Therefore, we need to avoid categories that apply unhelpful labels to children unless there is a sound evidential basis that will inform an intervention and make a difference to the outcome.

Equity of Access

We owe it to young people to create a system so that all young people receive the type of help they need regardless of whether they are wealthy or have better organised groups to seek resources on their behalf.

Research shows that poorest one fifth will start school already one year behind other children in terms of school readiness (Wickham et al 2016). This disadvantage is further compounded for children who continue to live in poverty. The most disadvantaged 25 percent of New Zealand students are more than six times more likely to do poorly in mathematics than those from the wealthiest 25 percent (OECD, 2016b). Likewise, achievement increases as socio-economic status increases for the international reading assessments for the top ten OECD countries (OECD, 2012).

While these background factors can affect all students, among low performers the combination of risk factors is more detrimental to disadvantaged than to advantaged students. Indeed, all of the demographic characteristics considered in the report, as well as the lack of pre-primary education, increase the probability of low performance by a larger margin among disadvantaged than among advantaged students, on average across OECD countries. Only repeating a grade and enrolment in a vocational track have greater penalties

for advantaged students. In other words, disadvantaged students tend not only to be encumbered with more risk factors, but those risk factors have a stronger impact on these students' performance. (OECD 2016a, p14)

Research has indicated that poor children as young as seven are on course for a life of failure. It is estimated that 80% of the difference in how well children do in school can be attributed to what happens outside the school gates (Save the Children, 2013).

The government intends to review the school decile funding system to redistribute resources more effectively (Moir 2016). There are risks that the use of proxy indicators might further stigmatise children e.g. (i) a parent who had been to prison (ii) suffered child abuse or sibling was abused (iii) a family on a benefit for a prolonged period (iv) the child's mother having no formal qualification. These indicators potentially stigmatise children further. Funding is better directed to children who have identified functional learning needs or addressing child poverty and inequality directly (Abraham, 2012).

Power Sharing

We are fortunate in Aotearoa New Zealand with Te Tiriti o Waitangi to have a model of power sharing with the first peoples of this land that might help us navigate some of the conceptual difficulties of inclusion and supporting young people with special educational needs.

However, the Treaty is not enough if unequal power relations remain between Māori, Pasifika and Pākehā (people of European descent) where relative health, life expectancy, rates of imprisonment, unemployment data, school non-completions and low tertiary education participation, poverty and family income are maintained within current structures.

Māori thinking is often absent in special education theory and policy. One approach is to devise special needs policy to apply mātauranga (cultural knowledge) to a problem and then use culturally grounded tikanga (policy) and kawa (practice) to test the application of this mātauranga (Macfarlane, Macfarlane and Gillon, 2014). This expertise in tikanga and kawa resides and endures within the Māori communities often with kuia/kaumātua (elders)

If such partnerships are ignored, well intentioned interventions might have poor outcomes e.g. the cultural mismatch of the Incredible Years parenting programme that failed to provide 'culturally competent facilitators and leaders, culturally appropriate language, tools and resources, culturally congruent activities, culturally inclusive venues, culturally grounded protocols, and culturally responsive

ways of engaging and communicating' (Macfarlane, Macfarlane and Gillon, 2014 p265).

The tail of underachievement in Aotearoa New Zealand has often been synonymous with discussions about the needs of Māori and Pasifika children who are over represented in national achievement statistics for example in literacy or mathematics (Tunmer et al 2013; MacFarlane 2015). The risk is our schools and whānau resort to quick fix solutions delivering a narrow curriculum that 'hothouses' our children teaching to the test. We will fail to nurture creative young people that will be the innovators of the future. Worse still we create a miserable, unhappy group of children who are at greater risk of poor mental health and suicide.

The NZPsS would welcome culturally safe and responsive forms of education that extend beyond school gates and ones that nurture wellbeing within young people and their communities. We would like less attention to searching for what is wrong but research, programme design and monitoring about what works for young people; for example, Ka Awatea (Macfarlane et al 2014)

Like flowers, educational psychologists tend the garden, supporting not only individual children, but those who nourish children such as their whānau, school teachers and other agencies.

Funding Systems

Aotearoa New Zealand compares favourably in terms of the proportion spent of GDP for education but dollar for dollar we spend less than other OECD countries. For example, in primary schools we spend \$7069 per child compared to the OECD average \$8247USD (OECD 2015, Table B1.2 p211). Educational environments in which all children are taught will need to be well resourced to provide a high quality education system.

A move towards a devolved funding, commissioning arrangement will need to have evidence that it will be more successful than the former Special Education Service (SES). Concerns regarding fragmentation, accountability, inequalities of resourcing, duplication and the difficulties associated with the casualisation of staff resulted in the return of Special Education to the Ministry of Education in 2000 (Selvaraj 2014).

Overseas evaluation of devolved funding within a common assessment framework overseas has also raised concerns (Holmes, McDermid, Padley and Soper, 2010). This evaluation noted that a 'substantial investment' was

required to make local teams work for children identified with special educational needs. A contestable funding mechanism that requires a competitive market which is not a good fit for social systems, with profits being taken out of the system and the risk of losing social capital.

Resources, Expertise and Attitudes

Three elements are required to create a successful inclusive system (Jordan, and Goodey 2002).

(i) Resources (ii) Expertise (iii) Attitudes

Each element is essential. For example, a community and school may have the resources but if they did not welcome students with diverse needs or if they were well-intentioned but lacked the expertise then these resources would be wasted.

Educational psychologists work across government departments, non-governmental organisations, with individuals, groups and organisations to design and implement such initiatives. We are uniquely placed to offer systemic approaches for individual children who find themselves in situations that are challenging within our education system e.g. High and Complex Needs (HCN 2005); Intensive Wrap Around Service (Burgon, Berg & Herdina 2016); Positive Behaviour for Learning School Wide (Savage, Lewis and Colless 2011; Boyd et al 2015) and Incredible Years (Fergusson, Horwood and Stanley, 2013; Sturrock and Gray 2013).

Educational psychologists are also trained to question evidence, to be rigorous and systematic. We are often the professionals that schools turn to when asking about unknown educational packages e.g. Brain Gym, Irlen lenses, kinaesthetic learning, self-esteem interventions, Arrowsmith

programme etc.

Educational psychologists are well placed to carry out applied research that will track the effectiveness of special needs initiatives in a systematic way. What information we have about the long term life chances of children who receive support from the Severe Behaviour initiative or the Ongoing Resourcing Scheme (ORS) is very thin. Practical, applied research alongside our colleagues in our universities can develop innovative practices for diverse learners and their communities.

We are well placed to deliver interventions that promote positive attitudes within institutions to receive children with diverse needs. For example, educational psychologists were involved in the Ministry of Education's Enhancing Effective Practice in Special Education (EPEP) project which promoted the Index of Inclusion (Dharan, 2006) and the Cultural Self Review (Bevan-Brown, 2003). More recently there has been the Inclusive Education Taskforce with Aotearoa/New Zealand Self review tool similar to the Index of Inclusion (IECB, 2013). These tools help schools, early education services and their communities reflect on how to create welcoming and effective learning environments for all children.

The available evidence is that teacher aides are limited in their effectiveness to create change for young people.

Educational psychologists are one of the core professional groups that disseminate expertise to educators and our communities in our informal and formal practice. For example, teacher support teams (Woodward, 2015) is a structured, collaborative way for psychologists to share expertise. A recent evaluation found that these groups were highly valued by teachers,

95% reported that the strategies devised were workable for the initial concern and 78% used them in similar situations with other children (Norwich & Daniels 2013)

Progress to Date

Representatives from the New Zealand Psychological Society have met bimonthly with those leading the Special Education Update within the Ministry of Education to discuss the recommendations from our submission/s (Abraham, 2015a; 2015b 2016).

Issues discussed included:

The Update

1. No structural change or the devolvement and commissioning of services has been indicated. However, a new system wide model will be designed in mid-2016 as a result of themes that emerge from 22 projects. Full implementation was not expected until 2017.
2. A series of 22 Special Education projects to meet local need were initiated by Special Education Managers in 11 locations around the country and they included psychologists (Ministry of Education, 2015a). Many of these have focused on difficulties about continuity of service that arise at transition points e. g. transferring from early childhood provision to school.
3. During this period the Ministry of Education (2015b) has produced a summary of the consultation with stakeholders. The existing provision has been mapped and costed noting that children/whānau find systems difficult to navigate, they are fragmented and subject to delays.

Inclusion

4. The inclusion of 95% of students educated in mainstream classrooms meant there was no intention to close Special Schools. The Ministry of Education took a 'pragmatic' approach to inclusion with a need to do more to equip educators around the practicalities of inclusion.
5. Much of the funding was concentrated for those with severe need and there are challenges to meet the needs of children who just missed the eligibility criteria. The broad role of educational psychologists supporting the learning needs of all young people was discussed.

Dyslexia and Persistent Reading Difficulties

6. The Ministry of Education did not feel the need to update its policy to reflect this latest evidence about dyslexia (Elliott & Grigorenko 2014). Educational psychologists were expected to deliver good, professional practice based on the literature but be willing to adopt a lay understanding of the term dyslexia.

The Value and Number of Educational Psychologists

7. Educational psychologists were acknowledged as having skills to deliver, design research, evaluate and disseminate information effectiveness on interventions to meet the needs of diverse learners. Barriers such as the time and the lack of ethics committee were discussed.
8. At present the Ministry of Education employs 181 psychologists. To provide a similar level of service to Scotland with a similar size population, we would require double the number of psychologists.
9. The current formula used to determine the number of educational psychologists and other professional practitioners in Special Education has evolved in a piecemeal manner. There will be a 'stocktake' of all special education staff. Psychologists were viewed as having a significant contribution to making a difference for young people
10. The new formula for determining the number of psychologists/educational psychologists required has not been decided but might be made according to the cost of each professional and the added value they bring.

Added Value

11. The measurement challenges given the complexity of our work were discussed to be able to attribute effect

sizes to the work of any particular professional group/family member particularly if they are encouraged to work collaboratively.

12. Currently practitioners are using the outcome measurement tool to self-rate the success of their work (for presence, participation and learning on a scale 0-9). The Ministry planned to aggregate this data at a national level to help meet the requirements for policy design if rating consistency could be established. We discussed the need for quantitative and qualitative information.

The Training of Educational Psychologists

13. The training of educational psychologists and making educational psychologists available to support teachers and other educators within our communities was discussed. There was no indication that the Investing in Educational Success (IES) \$359 million or other monies would be allocated to promoting the capacity of our workforce.

A high proportion of educational psychologist's time can potentially be consumed with diagnosis and assessment for entitlement for resources rather than assessment to inform intervention.

Privacy

14. Concerns were expressed about the privacy requirements for common database and record keeping systems for the benefit of our clients (Statistics New Zealand 2016). Reassurances were given about maintaining good consenting processes but it was also felt that the Privacy Act allowed anonymised, aggregated data sets to be used.

Educational psychologists are one of the often invisible hands that tend the 'garden' within our educational facilities and communities so our tamariki can thrive. To continue to offer this service, free at the point of delivery, for a wide range of situations, difficulties and complexity we will need to give examples, explain and encourage others to acknowledge the unique service we provide.

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NZPsS Professional Development Events

NZPsS & ACC jointly hosted workshops on working with clients with sexual violence trauma:

Workshop 2- The Assessment and Treatment of Sexual Violence Trauma

presented by **Eileen Swan**

29 July in Auckland, 4 August in Wellington and 5 August in Christchurch

Impact on clients (children, young people and adults) and their family/whanau of trauma and diagnoses/PTSD associated with sexual violence.

Support for clients who have experienced sexual violence, services offered by ACC to sexual violence clients, ways in which practitioners can work with ACC to offer services.

Assessment – aims/methodology of assessment of clients with PTSD and complex trauma associated with sexual violence trauma and other mental health issues - including cultural considerations, male and female clients, differing ages, intellectual and physical disability.

Treatment - evidence-based treatment approaches for clients with PTSD and complex trauma associated with sexual violence trauma, consideration of situations when other mental health issues coexist.

Reporting back to ACC.

How to further develop skills in assessment and treatment; quality professional supervision/self-care strategies/support.

Workshop 3- 'Ki te whakaora': Sexual Violence trauma - Towards healing for Māori victims/survivors

presented by **Julie Wharewera-Mika**

11 October in Auckland, 13 October in Wellington and 18 October in Christchurch

This workshop will explore understandings of sexual violence for Māori laying foundations to strengthen practice. Bicultural approaches in the assessment, intervention and prevention of sexual trauma will be discussed with a focus on enhancing knowledge and the development of useful tools and skills to best support Māori survivors.

The following is based on the keynote address by Associate Professor Dawn Darlaston-Jones at the NZPsS annual conference in Hamilton in 2015.

White voices Black spaces: Authenticity, legitimacy & place in a shared decolonisation project

Associate Professor Dawn Darlaston-Jones PhD MAPS



Dawn Darlaston-Jones is Co-ordinator of the Bachelor of Behavioural Science at the University of Notre Dame, Fremantle campus. Her research interests lie in the areas of critical psychology with particular emphasis on resistance and emancipation, decolonisation, and education. The focus of her current work is Indigenous education and the importance of embedding Indigenous knowledges and Indigenous psychology into the curriculum. This approach challenges hegemonic constructions of knowledge and contributes to a decolonisation approach to psychology education. Her current research is as Chief Investigator on a collaborative research project which received a \$350,000 grant from the Australian Government's Office of Learning and Teaching. The aim of the research is to investigate Indigenous participation levels in psychology and how this figure could grow through improved graduate outcomes in Aboriginal and Torres Strait Islander cultural awareness. She is an award winning educator receiving the ECU Vice Chancellors Award for Excellence in 2003, National Teaching Excellence Award (2003); the ALTC/APS Prize for Innovation in Teaching and Learning (2011) and has been nominated for the UNDA Vice Chancellors Award for Excellence (2012).

By employing the terms 'voice' and 'space' I am inviting conversations around who has the right to speak and in what context; who is privileged and who is silenced by that speech? This includes the deeper ideologies of hierarchical privilege that are constructed, reinforced, and legitimised through various discourses. I also draw attention to the spaces in which we work, acknowledging that both Australia and Aotearoa are Black spaces where Indigenous peoples need to be acknowledged as First Nations with Sovereign rights. Accepting this foundational truth means that the dominant non-Indigenous positions and voices need to be deconstructed to understand how they emerged and became embedded in the national psyche. By employing critical reflexivity, scrutiny of the unearned power and privilege that is the legacy of the settler in a colonised space becomes possible. Bringing this into focus enables a decolonisation process to occur that permits legitimate and authentic partnerships for change to emerge. This removes the binary constructions that currently exist and moves Indigenous and non-Indigenous peoples into a third space where alternate options are possible. Such a decolonisation process occurs at the individual level but it also needs collective level processes in order to embed a new ideology of substantive and sustainable reconciliation. It is within this framework of possibility that psychologists (and psychology) need to find an authentic and legitimate voice that is guided and informed by Indigenous peoples, knowledges and values to become a partner in that change agenda.

Kia ora, it is a great honour to be speaking with you all today and I extend my thanks to Moana Waitoki and the Bicultural Committee for this invitation. When I received this invitation, it led me to question roles, positions, and privilege and I began to wonder what it was that I could say to you. I was very conscious of my role as an English migrant in my adopted homeland of Australia and, being a representative of a colonising society in a settler space, I questioned what I could bring to another settler space when I represent that same coloniser. And so I started thinking about this idea of power and privilege and wondered what it was that I might be reinforcing by my presence here and it led to a lot of introspection. I started to think about these

notions of voice and space and I realised that a lot of my work has actually focused on deconstructing these notions of voice and space even though I had not necessarily clearly conceptualised it in those terms.

It is a journey I started some years ago; as a postgraduate student I was introduced to Linda Tuhiwai Smith's *Decolonising Methodologies* and it was this book that helped me recognise my colonising identity and the contemporary consequences of that, not only for Aboriginal and Torres Strait Islander peoples but also for myself – for my white identity and how I made sense of that. For a number of years, it left me paralysed because I did not know what to do with that knowledge; I began to wonder what that

identity meant for me as a psychologist and later as an educator, but also what it meant for me as an Australian. I was confused as to my place in a settler space and how to reconcile this coloniser identity with my commitment to a socially just world? Consequently, I wanted to talk to you today about notions of voice and silence and the underlying dimensions of power that exist within that binary. In doing this, I want to invite conversations around that journey in terms of the power that we create and the power that we need to resist and reinterpret. I want to start asking questions about who has the right to speak and what about and in what spaces do we have the right to speak? Who is privileged by having voice and who by definition is silenced by that voice and what does that mean?

I want to begin by talking about a recent incident and the subsequent responses to it; Adam Goodes plays for the Sydney Swans in the Australian Football League (AFL). Given that football is almost the national religion in Australia, you can imagine the esteem in which the top players are held – Adam Goodes is among that elite within his code, he is a dual Brownlow medal winner, an award that recognises the best player in the season, and in 2014 he was the Australian of the Year; he is a man of great talent, integrity and enjoys wide popularity – he is also an Aboriginal man who has been lauded for calling out racism and standing firm against discrimination whenever it occurs and whomever is the target or perpetrator. In July 2015, Adam Goodes celebrated scoring a goal by performing what he later described as a war dance. He was so caught up in the moment by the sheer joy of scoring this goal and giving his team a massive lead that he celebrated his excitement in a manner that reflected his identity as an Aboriginal man. The story, and the subsequent critiques and analyses, dominated the national conversation across mainstream and social media platforms and began a dialogue not in terms of a celebration but rather as a moment that allowed the dark side of the Australian psyche to emerge. Adam Goodes was subjected to an enormous amount of ridicule and criticism, his actions were condemned as aggressive at the lowest end of continuum and an act of overt racism at the other end; he was vilified across all media outlets, booed as he played; he was effectively persecuted. This was an interesting response because the AFL has stated many times that it is committed to celebrating and respecting Indigenous players, history and culture; indeed, this match occurred during the Indigenous Round in the season which is intended to be a celebration of Indigenous culture within the context of football.

A number of issues exist in this incident; on one hand you can argue that celebrating Indigenous players by naming a

series of games as the Indigenous Round is recognition of a shared history alternatively it can be seen as constraining that history and the expression of Indigenous identity to a specific time and place. Second, the expression of Indigenous identity is encouraged in various symbolic ways through the use of Indigenous themed uniforms etc. but it is condemned if it is in the form of a spontaneous war dance. Therefore, the implicit message is that you are only permitted to celebrate and acknowledge your Indigeneity, your identity, within prescribed temporal and spatial boundaries as determined and sanctioned by the coloniser. As long as an Indigenous player/person sits within these boundaries and is not disrupting the unspoken power dynamic, then Indigenous identity is accepted. Such mechanisms of silencing can be powerful and contribute to internalised oppression, and this is the final point I want to make in relation to this incident. When Adam Goodes was interviewed about the match he said that he had been “caught up in the moment...” that he was “proud...” and that “it was Indigenous round”. The fact that he justified or legitimised his action because it occurred during the Indigenous round suggests the possibility that at some level he is buying into those silencing mechanisms, where he recognised or acknowledged, that this was a space that he was or should have been permitted to exercise his Indigenous identity.

Who is privileged by having voice and who by definition is silenced by that voice and what does that mean?

I want to now look at psychology and talk about the many ways in which the discipline and profession silences those whom it constructs as ‘other’. In 1995, Rob Riley, a highly respected Noongar leader and activist, was invited to be the first Indigenous keynote speaker at The Australian Psychological Society Conference. Here he issued psychology and psychologists with this challenge:

*How many psychologists have an understanding of Aboriginal people? How many of you ... have an understanding of Aboriginal culture, history and contemporary issues? For many of you, this work is crucial given the social conditions and your work environment in such places as prisons and the welfare sector and where there are large numbers of Aboriginal clients. **It is your responsibility to seek that knowledge and understanding now, and to ensure that it is available for future generations of psychologists, in psychological training and education programs.** (Riley, 1995, *Emphasis added*).*

That challenge is yet to be met in Australia; almost all of the students graduating in Australia with the potential to become psychologists do not have any understanding of Indigenous peoples or culture, because this knowledge is not visible in the education or training of most psychologists in any meaningful way (AIPEP, 2015). This is in spite of the fact that inclusion of Aboriginal and Torres Strait Islander content has been required by the *Australian Psychology Accreditation Council* (APAC) Standards since 2010. The mono-cultural focus of psychology is in part due to the expansion of a global psychology that reflects a white North American version of the discipline that consciously and unconsciously reinforces white dominance. The evolution of psychology as a discipline and profession is discussed in a decontextualised, almost antiseptic, manner without linking it to the political and social spheres in which it operates. Consequently, while students learn about the emergence of this new science it is abstracted from Australia's colonial history and therefore the intergenerational transmission of knowledge within and between the settlers and the original inhabitants. Not only is the development of psychology as a discipline abstracted from the social fabric of its birth and subsequent growth, but the resultant theories and evidence on which the profession of psychology is founded is equally whitewashed. This results in students being inculcated into a form of human behaviour that is universalised and normative and which reduces cultural social economic and political variance to 'controllable noise' that reflects the dominance of certain ways of being whilst silently condemning alternatives as 'less than'. Consequently, students become attuned to the legacy that applies to Aboriginal and Torres Strait Islander

peoples; the deficits, disadvantage, and dispossession, within culturally safe narratives for the teller. We are never told about acts of resistance, challenge, survival, and of strength, we do not hear that story. But more importantly we are never taught the legacy that we as the colonising settler derive from that colonial history. That legacy is one of power and privilege, of dominance, and that needs to be destabilised, deconstructed, and dismantled before we are going to be in a position to actually achieve the social and economic equivalency that as a profession and as a nation we claim we want.

Psychology is complicit in silencing Indigenous voices because it has failed to live up to its potential, it has failed to lead and claim a place at the forefront of social change and social justice.

If Indigenous peoples are invisible in society, if they are invisible in education, then oftentimes the message that we are sending to ourselves, and to Indigenous peoples, is one of being silenced, of operating within the bounds that we afford: we say when you can speak, what you can speak about and therefore when you must be silent and what you must be silent about; and this is a form of cultural genocide. For example, as an undergraduate psychology student, I learnt that appropriate family practices involve parents cohabiting with children in a suitable dwelling; for many Aboriginal people, the definition of family is much broader than parents and kids and includes aunties, cousins, grannies, older siblings, broad connections within family groups and kinship relationships. From an Indigenous perspective that degree of family connection is a protective factor, but not so when seen through a lens of Western individualism.

Therefore, the lesson I am being taught in my safe white psychology classroom is that Indigenous constructions of family are problematic, the message that is silently communicated is one of cross cultural comparisons of deficit.

Despite being part of the dominant group I have found myself at many times in my life and my career being silenced. As with many researchers, my interest in the relationship between political processes and education reflects my own experience. When I was writing my Ph.D. I discovered critical pedagogy and critical psychology and realised that here was a language, a way of understanding the world and complexities and interconnections that occur and which contribute to human functioning that made sense to me. I became the student in the classroom who questioned normative assumptions and asked about context but this is not something that psychology does well. Psychology talks about big numbers and the pursuit of universal laws so it does not adequately consider that individual behaviour and responses are shaped, triggered, mediated, and constrained by context. As such the unspoken political economic, social, cultural discourses that exist within the space are deemed irrelevant to understanding human behaviour. So I know what it is like to be silenced as a critical psychologist, I'm used to being silenced – to some extent. There is a significant difference though; by my appearance alone, I can act the part of the dominant group. Until I speak, I can pass for, and in my silence, can be accepted as the same as everybody else. And that is a key difference, because many Indigenous peoples do not have the choice of choosing when to disclose their identity, when to live their Indigeneity, their culture, their history, and nor should they have to – nobody should. bell hooks, in

her 1994 book *Teaching to Transgress*, illustrates this notion of being silenced as she describes her experiences as a young feminist academic, and how, because she was a black woman, she was forced to teach within the black studies program not the women's studies program. Corraling the dissenting disrupting voices to specified spaces in which they are permitted to speak serves to reinforce the dominance of the silencer while appearing to offer opportunities for those who are silenced.

There is an interesting paradox about being an Indigenous student in any space really, but in particularly in a university. I first came across this paradox with a friend of mine, when we were undergraduate students together. She described how she would come out of the lecture theatre and would literally run to the Indigenous centre so that she could feel safe again because sitting among the 300 other first year students, she felt so visible whilst at the same time being completely invisible. What she meant was that by being the only Aboriginal person in that cohort she felt she was constantly under surveillance and yet at the same time there was nothing about her experiences, her life, her culture, her community's values or beliefs, and how this influenced human development and functioning, within the course content, that she was rendered invisible. That experience occurred in 1997, but I recently interviewed an Indigenous psychologist who had graduated in 2014, and she reinforced that same experience eighteen years later saying that throughout her undergraduate and postgraduate years, she constantly had to translate psychological theory and practice in ways that made it relevant and meaningful for an Indigenous person or context. This need to translate theory and research

evidence into something that makes sense in your life, emphasises my point about the paradox: you are ultra-visible by being different, but at the same time you are invisible in what you are being taught so your existence, your history, your culture, your norms, your beliefs, your ways of living your life are nowhere present in the discipline that you are studying and the profession that you seek to become a part of.

It remains the challenge for the discipline and for all practitioners to deconstruct and decolonise both themselves at a personal level but also the discipline and the profession.

We place the burden of translation solely onto the minority group, it does not matter who that minority group is. Psychology is complicit in silencing Indigenous voices because it has failed to live up to its potential, it has failed to lead and claim a place at the forefront of social change and social justice. Having said that, psychology has an enormous amount to offer; there is a lot within psychology that we can use to work in a different way, to create a better society, to be inclusive, to be genuine, and act authentically in partnership and this is demonstrated by many psychologists who work in different ways. Yet at the discipline level, its allegiance to notions of universality the view that culture is a variable to be controlled, reinforces white dominance and creates one of the primary barriers for Indigenous students who seek to study psychology.

One of the key ingredients needed to shift the discipline and profession into a more inclusive and respectful space is *epistemic critical reflexivity*. It is essential that as members of the dominant group, we find the power, the courage, and the voice to deconstruct our existing knowledge base and the very definitions we use to

construct that knowledge, and in order to dismantle the unspoken barriers that exclude different voices. As practitioners, educators, psychologists, as people, we must find the courage to ask the hard questions and say what do I do? What does my discipline do, to promote an inclusive agenda, an inclusive discourse? What is it about my presence, my actions, that inhibits others from speaking, from having voice, from having legitimacy? How do I embark on this process of change in an authentic way so that it is not tokenistic, so it is not just making me feel like I am a good person, so it is real, and visceral? To do this we need to understand that this silencing occurs across and within the array of intersections that occur within that space; class, gender, education, sexuality, religion - they all interconnect around those relationships. We need to understand and deconstruct our positionality within the spaces that we occupy and across those intersections and what our subject position means to those with whom we seek to work. This analysis needs to happen at the individual level as well as within the discipline, so as educators and practitioners we have to critique the psychological 'truths' we have been taught and which we in turn transmit to the next generation of learner/practitioners. This is what Rob Riley meant when he challenged psychologists to look inward to become the agents of change that the discipline and the profession had the capacity to become. It remains the challenge for the discipline and for all practitioners to deconstruct and decolonise both themselves at a personal level but also the discipline and the profession. This is the key to social change that liberates both the silenced and the silencer.

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Reflections from the Australia and New Zealand Association for Contextual Behavioural Science (ANZ ACBS) Conference, Wellington 2015

Ben Sedley



Ben Sedley is a clinical psychologist in Wellington, working part-time in private practice and part-time as Clinical Practice Advisor at Victoria University of Wellington.

There are many ways to learn how to do therapy – books and manuals, workshops, and of course trying techniques out and then reflecting afterwards about what worked and what could be better. However, conferences offer something more. At the ANZ ACBS conference I had a chance to get to know people from all around Australasia, with different areas of interest and different levels of expertise. And I learned from all (although, be warned – at an ACBS conference, you're quite likely to be asked to share personal stories with the person sitting next to you, so you might end up learning more than expected).

It was a real pleasure to meet people from Australia and New Zealand who are developing their own metaphors or techniques that help explain Acceptance and Commitment Therapy (ACT) to different groups, such as Jodie Wassner's Mindtrain programme for anxious children or Sacha Rombouts' Action Heroes programme (<http://www.actionheroes.com.au>) as well as learning about ACT with different populations, such as Sarah Roberts and Nigel George discussing using ACT with older adults or the Mana Wahine Bicultural

ACT for Mothers and Babies Group in Christchurch run by Donna Roberts and Kathryn Whitehead. One of the beautiful things about ACT (although this is also true for many therapies) is that once you understand the principles, you aren't bound to set manuals or a limited number of metaphors and examples, but can instead allow it to flow in so many ways depending on each client's needs.

It is clear that ACT is growing fast across Australasia, and the New Zealand community is mostly well-served by being part of one of the world's strongest ACBS chapters

I was also incredibly fortunate to have a chance to chat with keynote speaker Prof Steven Hayes, co-founder of ACT, as well as of Relational Frame Theory, the behaviourism of language that underpins ACT. We talked about the roots of ACT, and some of the early studies and line by line analyses that were used to first identify psychological mechanisms, as well as what BF Skinner would have made of this post-Skinnerian model, (Hayes suspects he wouldn't have approved because Skinner thought his own account of language was

comprehensive enough). But more exciting for me was the discussion about where ACT and Contextual Behavioural Science can go, and how it can work towards its broader goal of “creating a science more adequate to the challenge of the human condition”. ACT is being applied in a number of contexts from the work the International ACBS community did in Sierra Leone to help reduce the spread of Ebola to research being conducted around the world to look at ways to reduce discrimination and increase hope (for more on this, check out *The Nurture Effect* by Anthony Biglan).

It is clear that ACT is growing fast across Australasia, and the New Zealand community is mostly well-served by being part of one of the world’s strongest ACBS chapters. However, the incredibly high turnout of kiwis at the conference and pre-conference workshops shows there is more we can do to develop our own New Zealand ACT training and support networks. It is exciting that Matthieu Villatte is coming to run an Advanced ACT workshop at the NZPS conference in September 2016. There is also now an Aotearoa ACTion Facebook group to help share resources and contacts, as well as an increasing number of ACT Special Interest Groups forming around the country.

See page 16 & 44 for more information about the NZPsS conference and Matthieu Villatte.

Working with Complex Organisational Systems: A Contextual Behavioural Science Approach

Dr. Tresna Hunt



Dr. Tresna Hunt is co-founder of OetgenHunt, a consultancy specialising in group, culture and leadership development in New Zealand organisations. The business was cofounded with business development specialist, Brett Oetgen.

Tresna is a New Zealand registered psychologist with a PhD in psychology and leadership from the University of Otago and an International Coaching Community Certified Coach (ICC). She is an experienced therapist, facilitator, coach and lecturer.

How do psychology practitioners work with complex organizational systems? The answer to this question is not straight-forward, and can vary depending on the philosophical lens through which the practitioner views their practice. At the heart of these different lenses lie some deeply embedded assumptions about how we relate to our clients, and the way in which we help our clients to make sense of their organizational realities.

My training as a psychologist began in 1991 and through much of this time I was shaped toward the assumption that I was gaining expert knowledge about the ideal organizational state, and what people within organisations ought to be doing in order to reach that state. This form of training was consistent with the historical assumption that consultants held the expert knowledge about what actions organisations need to take in order to be successful, and the corroborating assumption that organisations themselves did not have access to this knowledge, except via an expert. These assumptions themselves were, and still often are, connected to a broader system whereby researchers develop theories about the ideal state, and practitioners train members of organisations to adhere to these new states with the aim of helping the organisation to be successful.

During my Masters training I gained a brief insight into alternative ways of working with knowledge when I came across the repertory grid by George Kelly. I didn’t know it at the time but the repertory grid represented a different way of working with people’s reality; it focused on trying to understand how people construct their own knowledge by subconsciously and linguistically connecting concepts. The repertory grid fascinated me, although at the time I did not understand the significance of its implications for my practice.

As a psychology practitioner I continued to consume theory and attempt to figure out how each theory could be used in my practice. And during this time I began to experiment with theories that had quite different philosophical roots, some of which sat at the margins of mainstream psychological science at the

time, namely constructionism and constructivism. My curiosity about the space between mainstream and alternative philosophical branches of psychology ultimately led to a doctorate, which was essentially an exercise in sense-making so that I could locate more firmly how I wanted to practice.

When I'm taking shortcuts in describing how I now approach organisational work I often differentiate between "content" consulting work and "process" consulting work. The former roughly translates into offering development, education, or training to people so that they can absorb new research-grounded knowledge and apply it to their lives. The latter roughly translates into helping people to make sense of their own knowledge and experiences, and working with them to generate new knowledge and experiences that make sense in the context of their lives. These two different ways of working clearly have different ontological and epistemological foundations, yet they can be very synergistic.

...contextual science helps us to understand how our habits of thought can subconsciously drive our behaviour, and how that behaviour itself can in turn reinforce the habits of thought, forming a closed circuit pattern that keeps us constrained to certain perceptions and behaviour.

Contextual Behaviour Science (CBS) is a relatively new branch of psychology that focuses on advancing a process/contextual way of working with people. It can be viewed as an extension, and a contextualistic interpretation, of B.F. Skinner's radical behaviorism, with a strong focus on how behaviour operates within a context, and how in order to influence

our thoughts and actions, we need to consider that context when working with clients (Villatte, Villatte, & Hayes 2015).

Details of the theory that underpin contextual science are beyond the scope of this article, although a thorough outline can be found in *The ABCs of Human Behaviour* (Romnerö & Törneke, 2008). At a simplistic level, contextual science helps us to understand how our habits of thought can subconsciously drive our behaviour, and how that behaviour itself can in turn reinforce the habits of thought, forming a closed circuit pattern that keeps us constrained to certain perceptions and behaviour (Lord, Brown & Harvey (2002). CBS work focuses on helping clients to create new relational patterns by learning to 'see' their habits of thought (and action) and then actively shaping new ways of engaging with the world, ways that are deeply meaningful and purposeful. CBS work therefore, requires that the psychologist adopt a process framework because she or he is helping the client to make sense of their own reality so that they can actively influence the direction of their own life.

Like other organisational psychology work, CBS-driven work can be categorized according to the level at which the psychologist is focusing their intervention. Murphy (1988) first described three levels of intervention including primary secondary and tertiary, which have in turn been aptly described by LaMontagne et al. (2014) in the following way:

Primary intervention aims to prevent the incidence of work-related mental health problems; it is 'work-directed' - aiming to reduce job stressors at their source by modifying the job or the work environment.

Secondary intervention is ameliorative and 'worker-directed'; it aims to modify how individuals respond to job stressors, usually through strategies to improve employees' ability to cope with or withstand stressors. Secondary level intervention can also prevent the progress of sub-clinical mental health problems to diagnosable disorders.

Tertiary intervention is reactive in that it responds to the occurrence of mental health problems; it involves treating affected workers and supporting rehabilitation and return-to-work.

Tertiary CBS interventions usually involve individual-level work by therapists who employ strategies such as Acceptance and Commitment Therapy to treat employees who have been significantly affected by stress. Employee Assistance Programmes are the most prominent systems through which tertiary interventions are delivered.

Secondary CBS interventions usually involve practitioners engaging employees in group-level training programmes aimed at helping employees to develop psychological flexibility skills in order to help them to manage stress and build resilience.

Primary CBS intervention programmes work with groups of people, tasks, and structures within organisations in order to build flexible, resilient, and sustainable cultural practices that promote systemic health.

In many respects all three levels of CBS organisational psychology interventions are in their infancy because CBS itself is still a relatively young science. However, it could be argued that of these three levels, the primary intervention is the least understood. This is because guidelines for implementing secondary and tertiary interventions are readily available for practitioners in the form

of books and research articles. No such resources are currently available for primary level interventions.

For this reason, my business partner (Brett Oetgen) and I have spent the last year and a half experimenting with ways in which we can apply CBS to group-and organizational-level issues. This journey has seen us working with diverse groups, including two not-for-profit organisations and two professional services businesses. We are also currently working with two larger organisations exploring how the CBS framework can be scaled across multiple group contexts within the organisational system.

The essence of our work focuses on helping groups within the organisation to make sense of their own reality, and to identify the obstacles preventing the group and the organisation moving toward their respective purposeful direction. It begins with a series of assessments, initially with the people who have contacted us (usually a senior leader, HR Manager or owner/operator), followed by relevant stakeholders. The assessment explores what it is that the organisation wants, and where the perceived blocks lie. The assessment has a strong behavioural focus and explores the contextual events that maintain the existing and problematic patterns of behaviour. Essentially we are exploring the dynamics within the system that prevent learning and growth. While there is an initial assessment phase whereby we develop a foundational understanding of the existing organizational reality, and the obstacles to change, in reality the assessment is ongoing and works alongside the intervention. In this sense the process is closely aligned with action research.

The intervention naturally ‘falls’ out of the assessment and is therefore a bespoke intervention plan that is co-designed by all relevant parties. Importantly, the intervention plan allows for the participants themselves to find answers to their own problems, using local knowledge and expertise. Here we can see similarities with Harlene Anderson’s work with Mutual Inquiry. During this process groups can sometimes get stuck and want ‘outsider’ knowledge. Where necessary, we may offer our own knowledge and in doing this we change hats and switch into content consulting mode, although this is always done through a climate of invitation, consultation and collaboration,

The development plan is transparent, dynamic and reflexive. As participants step into new behaviours in order to both realise their new direction, and break old patterns, they have opportunities to identify obstacles that might emerge over time, in new and different contexts. Importantly, stakeholders learn how to stay reflexive and critically aware of their cultural practices moving forward, providing the

organisation with independence and agency. Here we can see similarities with the critical coaching approach of Angelique DuToit and Stuart Sim. The consulting process ends when the relevant stakeholders feel they have stepped far enough into the new patterns of behaving that they can see the desired changes in the organizational culture, and when they feel they have the skills and strategies to monitor their own development on an ongoing basis.

The biggest challenge when using a CBS approach with groups and organisations is that we are working, not with one individual but, with groups of individuals who have their own different working theories and associated habits of thought and action. When these individuals come together to operate as a group they develop their own ‘ways of doing things around here’, and in the development of these cultural practices they also develop their own group-level blind-spots that can inadvertently inhibit growth and innovation. Our key challenge therefore rests on helping the individuals within the group to explore and become consciously aware of the cultural practices and dynamics that both promote and inhibit growth and innovation. In this way we help groups to discover new patterns of behaviour and thought within the context of their work that will lead to outcomes that are more aligned with their values and desired direction. This process approach to consulting work therefore supports our clients to develop deep insights, teaching them how to ‘switch off’ cultural auto-pilot mode and ‘switch on’ cultural awareness mode.

The biggest challenge when using a CBS approach with groups and organisations is that we are working, not with one individual but, with groups of individuals who have their own different working theories and associated habits of thought and action.

Psychology practitioners can work with complex organisational systems in many different ways. They can work at different levels within the system, and they can adopt different philosophical and theoretical frameworks at each of those levels. A CBS approach is an emerging process consulting framework grounded in radical behaviourism that is still globally very much in its infancy. Brett and I are attempting to discover how this exciting framework can be applied to the New Zealand organisational context and we are discovering that it is indeed very promising.

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An Acceptance and Commitment Therapy

Elizabeth Maher



Elizabeth Maher is a UK qualified cognitive behavioural therapist. She trained in cognitive behavioural psychotherapy at the Institute of Psychiatry, Maudsley Hospital in London. Elizabeth has completed mindfulness, and Acceptance and Commitment Therapy training and has used these approaches in therapy over the last fourteen years. She has worked in a variety of settings in the UK and in New Zealand, and currently works in private practice and facilitates ACT training workshops across New Zealand. She is a current Executive Board Member of the Australia and New Zealand Association for Contextual Behavioural Science (ANZACBS).

"I doubt, therefore I think, therefore I am" - Descartes

Self-doubt is a common human experience, and yet commonly viewed as a 'negative' experience that stands in the way of one's success. We are given the message that it is to be avoided, struggled with, changed and eliminated. And yet, despite the numerous self-help literature aimed at helping us to 'get rid of self-doubt', 'erase negative self-talk', and some promising us ways to "overcome self-doubt in 48 hours", it continues to be a shared human experience.

Self-doubt may cause an individual to modify or refrain from "anti-social" behaviour.

This workshop was presented at the Australia and New Zealand Association for Contextual Behavioural Science (ANZ ACBS) Conference. It focused on presenting a psychologically flexible approach to self-doubt, using Acceptance and Commitment Therapy (ACT) processes – particularly Self-as-Context, to help us to learn ways to respond and relate to our self-doubt so that we are still able to engage and commit to behaviours helping us to

live a life guided by our values.

The role and function of self-doubt within the context of our lives

Functional Contextualism – the function of self-doubt.

Functional contextualism proposes that experiences function differently in different contexts. Our experiences - thoughts, feelings, memories etc. are not inherently dysfunctional, maladaptive, and pathological. Instead, how they function is dependent on the context. From an evolutionary viewpoint, a "valuable" trait is one that assisted the species in achieving survival and reproductive success. From this perspective, there are contexts in which self-doubt could function as valuable trait. Self-doubt may cause an individual to modify or refrain from "anti-social" behaviour. Self-doubt can also function as a protective mechanism. This may include; alerting us to being ill-prepared, focusing our attention on an important detail, reminding us of past experiences that we could learn from and be of use in the present situation. However, self-doubt may also serve an unhelpful function in the context where it is based on fear; fear of the self-doubt, fear of not being able to

Approach to Dealing Effectively with Self-Doubt

overcome it, and fear that it is an accurate representation of ourselves and our experiences. We can become attached to a conceptualised past (based on past experiences) and a conceptualised future (based on future predictions) which become fused to the literal meaning of these thoughts, fears, and self-doubt narrative (cognitive fusion). This impacts on our ability to focus on the present moment and make values-based choices in the present moment, even in the presence of our self-doubt. This can therefore lead to psychological inflexibility, which is defined as the inability to choose and engage in behaviours that are in line with our values.

Popular message – self-doubt is a negative experience.

“Our doubts are traitors, and make us lose the good we oft might win, by fearing to attempt.” - William Shakespeare, *Measure for Measure*.

“The worst enemy to creativity is self-doubt.” - Sylvia Plath, *The Unabridged Journals of Sylvia Plath*

“I seek strength, not to be greater than others, but to fight my greatest enemy, the doubts within myself.” - P.C. Cast

The Struggle Solution

When self-doubt is viewed as being a negative experience that functions as an obstacle to valued living, then it sets up the struggle with this experience. Despite all our attempts, how successful have we been in eradicating this experience? Our own experience is that some continue to experience self-doubt. Our efforts might have been better served learning to develop a different relationship with our self-doubt experience, in which it may still be there, but lose the function of being an obstacle to valued living.

Creative Hopelessness

Therefore, it is important to recognise the hopelessness about this struggle strategy of trying to ‘get rid’ of self-doubt and have a ‘better and doubt-free’ conceptualised self. Acknowledging this hopelessness can then help us to be open to learning different strategies to deal more effectively with self-doubt.

Promoting psychological flexibility through perspective taking and developing self-compassion

From an ACT perspective, there are three aspects of self-experience; Self as Content (Conceptualised Self), Self as Process and Self as Context.

Self-as-content

From this perspective, I am here-now and my psychological

content is here-now. There are coordinate relations (same as) between who I am and what I think (my self-doubt). My psychological content (self-doubt narrative) can become rigid and conceptualised and the function of this content transforms to the coordinated self which can also become rigid and conceptualised (I am my self-doubt). I become attached/fused to my content which makes it very likely that my content will exert some control over my over behaviour. This also reinforces the struggle and experiential avoidance as the psychological content (self-doubt) becomes something that I feel I have to believe or disbelieve. This perspective leads to rigid, inflexible automatic behaviours, narrow repertoire of behaviour, behavioural choices based on fusion and experiential avoidance.

When self-doubt is viewed as being a negative experience that functions as an obstacle to valued living...

Self-as-Process

From this perspective, I am here-now and my psychological content is here-now and experienced as ongoing and experiential. This is the ongoing experiencing and describing of my thoughts, feelings, behaviours etc. Experiencing my psychological content as fluid and changeable undermines psychological fusion to this experience and increases my repertoire of behavioural options.

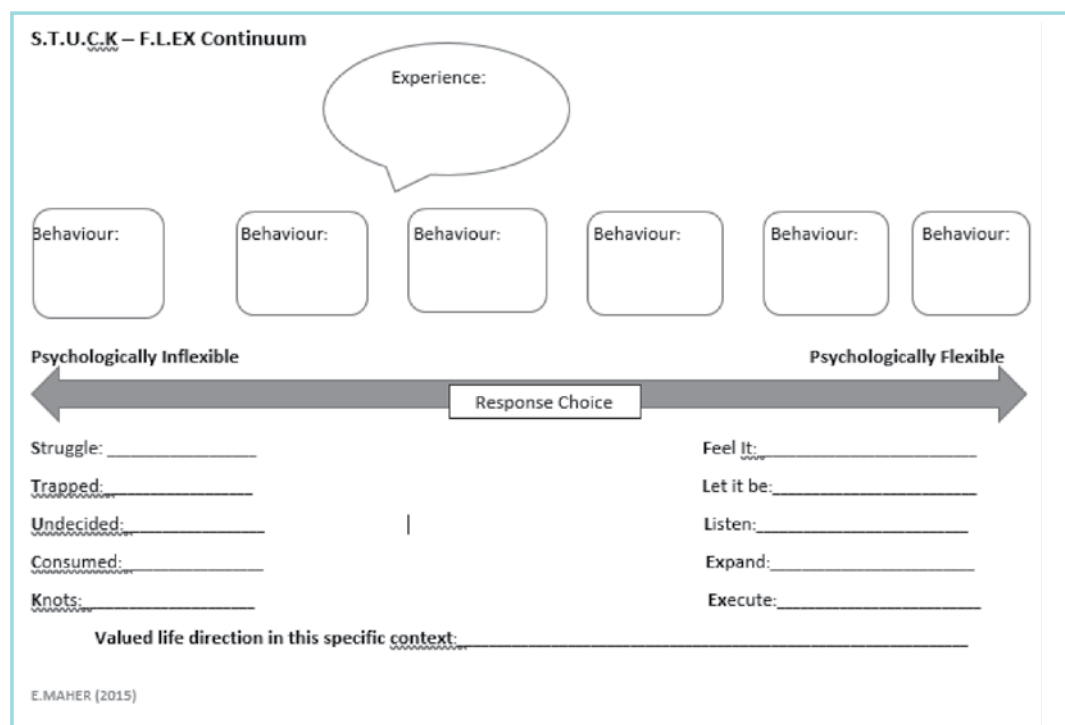
Self-as-Context

I am here-now and my psychological content is there-then. When an evaluation located in the perspective of I, HERE, NOW is discriminated as just an evaluation, it immediately acquires the relational functions of I, THERE and THEN (McHugh and Stewart, 2012). Therefore, the relational functions of I, HERE, NOW is a more stable perspective, a perspective of awareness with an experiential distinction between the psychological content (self-doubt) and the person experiencing it. This undermines the relational framing of the content (fusion to the literal meaning of the self-doubt story, and its coordinate frame with the sense of self), and promotes present moment awareness, acceptance and defusion (awareness of the self-doubt mind script without being hooked into this thought pattern and relational frames). This facilitates the perspective of being able to experience the self-doubt without being defined by it. A perspective from which we can offer this experience compassion, kindness, non-judgement, openness, and willingness. This leads to increased choice and behavioural

options, i.e. an expanded repertoire of behaviour.

Behavioural choices can then be assessed and selected based upon workability in living a values-based life, promoting values-based behavioural choices and actions.

Using the S.T.U.C.K to F.L.Ex Continuum to Promote Committed Action



STUCK – FLEX is a continuum that we move along dependent on context. We can use this to foster committed action that is workable in the present context and psychologically flexible.

We are not able to choose our internal experience, but have an ability to choose our behavioural responses. The behavioural choices and actions that we choose will depend on the context and the function of that behaviour in that particular context. STUCK responses to our self-doubt (struggle, trapped, undecided, consumed, tied up in knots) are unworkable as they move us away from values-based living and lead to increased psychological inflexibility. FLEX responses (feel it, let it be, listen, expand (make room), execute (choose and engage in workable behaviour) are workable as we can choose and engage in values-based actions.

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NZPsS Ethical Issues Helpdesk - A Personal View

Jack Austin



Past-President, Jack Austin has had a range of life and professional experiences which have shaped him—these include being

- An educational/ social psychologist for some decades;
- Executive Assistant to the C.E.O. Special Education Service and S.E.S. Board secretary;
- One of the team that produced the Code of Ethics;
- S.E.S. Area Manager, Wellington;
- Private Secretary for Special Education (some Labour years);
- President NZPsS;
- Private practice, now as Social Resources Ltd.;
- an optimist at heart.

Introduction

Ever since I started to train, learn, and then work in the broad area of social sciences, the issues presented by values, morality, and ethical action have fascinated me. The presentation of self in various contexts; the choices made in practice; the dilemmas surrounding “Why” and “Why not” have intrigued me. Is there a science of ethical practice, or does such practice rather relate to currently agreed standards? Social change occurs when the pendulum swings through the force of public and/or professional opinion. What constitutes ethical practice alters, develops, and comes to reflect the spirit of the societies framing, constructing and regulating that spirit

or ethos. From that perspective I think that it is time to review our *Code of Ethics*.

As psychologists we work in the light or shadow of an agreed code of ethics. I was fortunate to be a member of the working group that formulated/drafted that *Code of Ethics for Psychologists Working in Aotearoa New Zealand* (2002). These days, in a number of the forums in which I participate, I hear colleagues debate ethical decisions and argue about interpretations of this or that point. It is always timely to reflect on why we make the choices we do. Some matters in our *Code of Ethics* are black and white, but in other matters shades can and do exist. Perhaps integrity implies consciousness, and the reference point for that conscious awareness is primarily our *Code of Ethics*. It should be a living document: thus periodic reviews.

My initial question to a caller is “Are you insured?” as the answer to this colours my advice. If they are not insured, I encourage them to remedy that ‘oversight’ as soon as possible.

In line with that, when the helpdesk is asked for assistance or advice by a member, some responses are black and white, no and yes, but where the query lies in the shades, then my response is an opinion, and I try to make this clear. So too, I imagine, do the other committee members.

Helpdesk Life and Times

I’ve been in the role of convenor for 9 or 10 years now. Initially the Ethical Issues Committee was almost completely oriented towards providing comment on matters of ethics. However, as time has passed, and the existence of the Committee

has become more widely known, it has come to focus more on the provision of a service for members, and the helpdesk aspect has become gradually predominant.

In the years that I have been available as first stop or call, I’ve provided in the vicinity of 150 or more opinions some which necessitated multiple contacts. These ‘referrals’ are what any later comments are based upon. Ideally members approach National Office, who then refer on to an appropriate Ethics Committee member. Some calls come directly to me (not ideal), and some that I get, I then refer on. For instance, I have very slight Family Court experience, so I do not provide any opinion on the niceties of that area of practice.

At this point I want to note a principle that I have adopted in the provision of a helpdesk service, and one that I attempt to adhere to. Namely, that in the advice I provide or opinion I give, I always try to choose or recommend the most conservative path or action. With some matters, for example boundary issues, one can make a cogent argument for more than one course of action or viewpoint. My belief is that, as the conservative path is the most risk averse, in a member service, with an ethical or practice dilemma, a conservative approach is the appropriate stance to take. As well, being accountable for the advice given, it seems the most responsible.

Substance

The type of queries that I receive vary greatly, but I will indicate the main categories and some representative responses.

My initial question to a caller is “Are you insured?” as the answer to this colours my advice. If they are not

insured, I encourage them to remedy that 'oversight' as soon as possible. I then note that our discussion is confidential, in the same way that a supervision session is. In fact many of the helpdesk calls are akin to supervision, and in that context I enquire if they have discussed the matter at hand with their supervisor, and if not why not? Quite often the supervisor is not available, or there is a personal situation that the person considers could compromise their relationship (the supervisor is too 'close' to a colleague), or they work in a facility where there is an overlap between management and/or oversight and supervision. Where these situations are reported I suggest that the caller should think about establishing a more neutral/value-free supervision relationship. If one cannot have a full and frank discussion with one's supervisor, then it seems to me that to a significant degree that relationship is compromised.

Finally, I suggest that the person log the call/s and any agreed action, just as I will be doing. In respect of helpdesk comment, this allows for some accountability. In the instance that if appropriate I may follow up with a letter (e.g. to the employer). I file that as per usual casework procedure. I also take some helpdesk queries for discussion in my own supervision.

Ethical issues/helpdesk calls generally fall into several categories, sometimes more than one. These categories include:

Complaints – Someone has filed a complaint with either the Board or employer. I talk the caller through the process. I have chaired such processes for the Board, the Society, and in the Public Service. I stress the need to maintain professionalism, to tell the insurer, the supervisor and/or to contact a lawyer, depending on the nature of the complaint. When the

person asks if they should contact the complainant, I tell them "*definitely not*." I also act as a sounding board, and when the complaint is based on an ethical issue I try to talk that through in the context of the *Code of Ethics*. Again, I note that I am giving an opinion and the member needs to come to a decision according to their own judgement.

...many of the helpdesk calls are akin to supervision, and in that context I enquire if they have discussed the matter at hand with their supervisor, and if not why not?

Confidentiality Issues – These generally revolve around who is the client, and who receives copies of the report, especially if a disclosure has been made? I respond to these on a case-by-case basis, often with the object of arriving at a process from this point on. As with many helpdesk queries I emphasise the necessity of a paper trail as opposed to relying on verbal requests for information.

Employment Issues – Several times a year I am asked "*My employer (e.g. D.H.B.) wishes to see my case notes as part of my performance appraisal. Can I or should I pass these over?*" My answer is "*No, absolutely not*." In some instances an employer has taken this further; I have then provided the member with a letter for the employer.

In a different vein altogether, I am sometimes asked "*Can my employer make me sign out as a psychologist?*" This question usually comes from someone employed as other than a psychologist or in a part-time role. (For instance, a student guidance counsellor, or an assessor/psychometrician for a human resource (HR) firm. After discussing the nature of the referral and whether or not informed consent was in place, I advise the caller to make sure that they

are familiar with their job description and letter of engagement. I note that in my opinion such pressure from an employer is not proper, but does require a professional judgement call by the employee, as such situations can be varied and may potentially have flow-on consequences. Again, I stress the importance of a paper trail in bringing this to a conclusion.

The Provision of Reports to a Third Party

– This is an area where any advice I give is particularly cautious or conservative. Instances have been where a potential employer requests a copy of a report, or ACC. Sometimes these requests are verbal, or reported as having the permission of the client, or via a lawyer. My advice in these instances is not to supply the report, but to contact the client informing the client of the request. At that stage, even if the client gives verbal permission, my advice is to ask the client to write requesting that they (the client) receive a copy of the report. They can then provide it to whomever they wish. This keeps the provision of a report to a third party at arm's length from the practitioner. This can be useful, e.g. if the HR firm receiving the report does not recommend appointment for whatever reason, with the client later seeing the report as contributing to that decision.

Police and Court Requests for Files

– Reasonably often I am asked if such requests over-ride the ethics of confidentiality. The answer is yes, when a documented court order or police warrant is in place, then psychologists are required to provide the material that the order or warrant relates to or specifies.

Please note that this does not apply to a verbal approach only, but to a formal documented request.

There is a distinction to be made between a court order or police

warrant and a request from a lawyer, whether verbal or written. For an approach from a lawyer the request should be declined in the first instance, possibly until legal advice has been secured. It is in order to state that *“No response will be made to the request until appropriate advice has been acquired.”* A lawyer is not necessarily acting in the best interests of the psychologist or their client.

Conflicts of Interest – Questions presented in this area can be problematic as, similarly to much psychological practice, absolutes can be hard to find or apply. Conflicts of interest may also overlap with boundary issues. Particularly with queries of this type, I encourage the caller to discuss the issue with their supervisor or colleagues. If they do not wish to do so, I am curious as to the reason, but often it relates to availability when a quick decision is needed.

Some examples: *“I work part-time for Child and Adolescent Family Services. A client there wishes to pay me for additional sessions in my own practice. Should I go ahead with this arrangement?”* “No” is my reply.

Or, *“A client who is current has given me a Christmas present which is a voucher for a meal for two at a good restaurant. Can I accept it?”* Again, “No”. As well, there is a boundary issue in there. If the latter question had related to a piece of home baked Christmas cake or some flowers from the garden, I think I would have said yes. But where does one draw the line? Precision is a fine goal, but moments like this often require a judgement call, which is why gaining advice or comment from others can be of practical assistance. This is a core helpdesk function.

Boundary Issues – As with conflicts of interest, this is a complex area. Many of the same points apply in

respect of frank discussion with colleagues, and ensuring that due process has been worked through prior to reaching a decision.

Questions received in this area often relate to psychologists working in smaller centres. For instance, [a] *“What do I do about information/gossip I overheard at a party, about a family I’m working with?”* Or, [b] *“I’m on the school Board of Trustees. A client has just come on to the Board. Do I have to resign?”* Or [c] *“I’ve received a referral for the child of a near neighbour and I’m the only educational psychologist currently employed in the area. Am I obliged to accept the referral, especially as my son is friends with their brother?”*

The objective of this member service is to provide advice and opinion so that the judgements made by members using this service are ideally widely considered and well informed, and thus can be constructive for both practitioners and their clients.

These are different questions given their context, and given that there is no principle which can be applied to any and all situations with the confidence that the resulting decision will always be the correct one.

In attempting to answer queries such as these, I try to ensure that the caller has analysed the difficulty, has discussed it with their supervisor or colleagues, and is aware that the helpdesk provides advice, an opinion only, and that this opinion is just one factor in their arriving at their own conclusion as to a way to progress.

Answers given to the questions cited above were:

[a] Remember that one cannot be sure of the probity of gossip or informal remarks. I would avoid quoting what was overheard, but depending on its significance may approach the matter gradually and obliquely, if that is the

judgement come to after reflection. Sometimes it may be appropriate to consult with other local professionals (e.g. GP) who also work in a confidential ethos.

[b] Given my belief that involvement in our communities strengthens us all, my opinion here was that there was not a necessity to resign from the Board of Trustees. Rather, tread delicately, and if practicable discuss with the client the possibility of an onwards referral (being ‘easier’ on all parties).

[c] My personal belief is that no practitioner is obliged to accept a particular referral for whatever reason. In this matter the situation was complicated by the supervisor also being the manager/line control. As an aside, I think that the dual roles of supervisor/line control are to be avoided as a matter of principle. In this matter, after further collegial discussion, an Resource Teacher: Learning and Behaviour (RTLb) took the referral, to the satisfaction of all.

The above areas are indicative, but not all inclusive, of the types of queries that I have received as part of the NZPsS Ethical Issues Helpdesk. The objective of this member service is to provide advice and opinion so that the judgements made by members using this service are ideally widely considered and well informed, and thus can be constructive for both practitioners and their clients.

Please note that in all of the examples or views expressed here I have been speaking for myself and not for other Committee members. Committee members are senior practitioners within the NZPsS and come from varied psychology backgrounds including Family Court, DHB, community, organisational, clinical, Pasifika, Māori psychology and others. I would like to thank them for their involvement and support.

Psychological Resilience: Is this Construct of Benefit to Psychologists?

Dr Ian de Terte, Massey University & Susan Iacovou, University of Derby



Dr de Terte is a senior lecturer in clinical psychology at Massey University, Wellington. His research interests are psychological resilience, posttraumatic mental health, and high-risk occupations. His main research interest is the psychological resilience displayed by workers who are in high-risk occupations who are routinely exposed to traumatic events. He is also interested in techniques that will enhance an individual's psychological resilience. Dr de Terte's clinical interests are directly transferable from his research interests, and he has clinical interests in aspects of forensic psychology, intellectual disability, and sports psychology.



Dr Susan Iacovou is a Chartered Counselling Psychologist, UKCP registered psychotherapist, academic, author and educator with broad, in-depth experience of developing, teaching and managing both traditional and online degree programmes at Undergraduate, Master's and Doctorate levels. An experienced practitioner and researcher, Susan has published a range of books, chapters, journal and magazine articles on a wide range of psychology related topics. Her key research interests include the impact of active service on military personnel, existential perspectives on human experiences including anxiety and depression, the impact of posttraumatic stress on relationships and the applications of existential philosophy to counselling psychology. She is currently the Academic Manager for the Science programmes at the University of Derby Online Learning (UDOL).

Resilience is a term that is widely used today across all walks of life. For example, a sports commentator used the term recently when referring to a sports team, but what exactly is resilience? Is the term really useful? In the academic literature, resilience has been defined in two main ways. For some, resilience describes what happens when people bounce back or rebound from adversity. Nietzsche's and Hollingdale (1990) maxim neatly sums up this view – "That which does not kill us makes us stronger". Others describe resilience as the ability of an individual to maintain psychological wellness when confronted with adversity (Bonanno, 2004). Perhaps this is what Alain de Botton meant when he said "A good

half of the art of living is resilience" (Wegscheider-Cruse, 2016, p.39). We argue that both definitions are correct and there is no right way to deal with adversity. For example, some people have a psychological and physiological reaction to traumatic stress, but quickly bounce back from the distress while some individuals who are exposed to a traumatic event have no physical or emotional reaction or consequences following such an event and maintain equilibrium. The first author has primarily looked at psychological resilience in individuals who work in high-risk occupations, such as the military or the police where individuals in such occupations are routinely exposed to traumatic events while the second has examined

psychological trauma and post-traumatic stress disorder (PTSD) in military and civilian populations. Nevertheless, we argue that our concept of resilience is directly transferable to other professionals in areas such as health, business, or law. There are several criteria that are relevant to the construct of resilience before we discuss the concept.

First, the term resilience may have a negative impact when applied to people who have been exposed to adversity. For instance, people who were exposed to the Canterbury earthquakes during 2011 and 2012 were described as resilient (Gawith, 2013). Ex-servicemen in a study by the second author were also described in this way (Iacovou, in press). In

both examples, people who felt they were affected by their experiences, and were struggling with the effects of the earthquakes or the impact of their active service, did not seek help or support from mental health professionals because they felt that they should be resilient and that anything else was a sign of weakness. Arguably it could be considered normal that an individual who has been exposed to numerous earthquakes or to the violence of war, experience some form of traumatic outcome.

Second, the construct of resilience is dynamic in that individuals may deplete their resilience or build their resilience. For example, an individual may have a strong social support network that may become depleted during times of adversity. Or they may have friends whom they utilise during traumatic times, but may believe that he or she has overused this network and consequently has depleted the functioning social support system. In contrast an individual who has no social support network and may need to build the social support aspect of their resilience framework. Furthermore, we believe that resilience is dynamic because our experience shows that it can be taught via resilience training workshops – if it were static, this would not be possible and you would either have it or not have it.

Arguably it could be considered normal that an individual who has been exposed to numerous earthquakes or to the violence of war experience some form of traumatic outcome.

Furthermore, we believe that the construct of resilience is not one entity, but is made up of several interrelated constructs (e.g., compassion, self-care behaviours, and social support). We will say more about our view of resilience later in this paper, but before we do so it is important to highlight the multiple constructs within the multidimensional framework of resilience. Some individuals may have higher levels of certain elements of resilience when compared to others. For example, one individual may be optimistic, but have no social support network whereas another individual may have a strong social support network, but may not be very optimistic. Importantly, an individual may reduce their “deficits” in the areas of perceived weakness. Sometimes an individual may need the assistance of a professional to identify these purported weaknesses or deficits (explaining this process; however, is beyond the scope of this paper). As has been previously mentioned we view resilience from a multidimensional perspective that includes the constructs of optimism, social support, self-care, posttraumatic

growth, wellbeing, prevention strategies, motivation, stigma, sports participation, self-belief, humour, values, humility, self-compassion, mental toughness, coping behaviours, physical exercise, and survival behaviour. These constructs can map onto the three components of the three-part model of psychological resilience (3-PR) proposed by de Terte, Stephens, and Huddleston (2014). The 3-PR model of psychological resilience is based on the paradigm of cognitive-behavioural therapy and consists of the components of an individual’s cognitions, behaviours, and environment. The previously mentioned constructs can be mapped on to these components. These constructs can be enhanced directly to improve the overall resilience of an individual. There are also other less direct techniques that may lead to an increase in a person’s resilience including mindfulness, mental imagery, and behavioural strategies. It is beyond the scope of this paper to outline how to enhance an individual’s resilience either directly or indirectly, so instead we have decided to discuss briefly three constructs that contribute to the 3-PR model and how they could be of benefit to practising psychologists - social support, self-care, and self-compassion.

The construct of social support would map onto the environmental component of the 3-PR model because it is external to the individual and is related to their surroundings. Social support is typically made up of peer social support, supervisor social support, and social support from family/friends. With reference to practising psychologists, the process of clinical supervision could be likened to social support from peers and social support from supervisors, depending on where they work and on how clinical supervision is received. However, supervision is not the only social support mechanism for psychologists. For instance, whatever professional setting they are working in, psychologists would also have support from colleagues, family and friends, and management. There is a large body of scientific evidence (e.g., Norris et al., 2002) that illustrates how helpful social support is to people that experience traumatic events. Furthermore, Manning-Jones, de Terte, and Stephens (in press) have illustrated that social support is beneficial to mental health professionals who work with clients who have experienced trauma. Psychologists who have not got a strong social support network, which would include professional clinical supervision, would be well advised therefore to enhance this network as a protective mechanism.

The second factor that we would like to highlight is self-care. We would argue that this construct maps onto the behavioural domain and includes activities that create and maintain individual well-being such as meditation,

physical exercise, and healthy eating. Alternatively this factor has been labelled adaptive health practices (de Terte, 2012), and under this terminology would include things like relaxation, rest, and healthy eating. Research has illustrated the utility of looking after oneself as a protective mechanism in burnout, secondary trauma exposure, and direct trauma exposure (de Terte, 2012; Manning-Jones et al., in press). Regardless of the occupational setting in which psychologists practice (and there are a vast number of these areas) it is clear that looking after oneself would be highly beneficial to this group. When we work therapeutically with clients or patients we often encourage them to lead a more balanced life in line with their values and their ways of perceiving the world, but many of us are not very good at following our own advice. Adopting self-care practices in our own lives as psychologists may be a way of promoting a balanced life and the evidence certainly indicates that looking after ourselves provides protection in several domains. As the Roman parable states “cura te ipsum” or “physician heal thyself.”

There is a strong association between self-compassion and mental health.

The final construct we would like to discuss here is self-compassion or what has been referred to in the scientific literature as compassion (MacBeth & Gumley, 2012). We would describe self-compassion as an understanding of one's own inadequacies, shortfalls, and weaknesses coupled with forgiveness towards the self for having these weaknesses. There is a strong association between self-compassion and mental health. A recent meta-analysis illustrated this association in finding that higher levels of self-compassion were associated with lower levels of psychopathology

(MacBeth & Gumley, 2012). This construct arguably maps onto the cognitive component of the 3-PR model. What does this mean in practice for psychologists? The more forgiving or compassionate a practising psychologist is in their work the less psychological difficulties that may present in their own life. From training clinical psychologists, the first author sees a predilection of students or candidates striving constantly to be the best they can. However, perfection is never obtainable (and arguably makes us less empathic towards our clients). Being compassionate to oneself is a useful strategy to maintain our psychological well-being.

Adopting self-care practices in our own lives as psychologists may be a way of promoting a balanced life and the evidence certainly indicates that looking after ourselves provides protection in several domains.

The second factor that we would

In conclusion, we would like to reinforce three key messages. First the word resilience is an overused term and may have pejorative implications that prevent those who might seek support following trauma from doing so. We prefer the term protective factors, and by this we mean factors that promote an individual's wellbeing. Second, due to space limitations we have not been able to review all the scientific literature and in particular the research evidence that considers the protective factors for psychologists. However, we have highlighted three protective factors that we believe have the potential to create psychological wellness – to act as protective factors. These factors require to be tested through relevant research. Third, the protective factors of social support, self-care, and self-compassion should be integrated into a practising

psychologist's life. We encourage our clients to increase these factors, but we often neglect to integrate these factors into our own day-to-day living.

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A Sociological View of Psychology and Professional Boundaries

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Dr Edgar Burns is a kiwi sociology lecturer currently working between Bendigo and Melbourne in Victoria Australia. Previous experience includes working in government and running his own business, polytechnic teaching and research mentoring. From long-term research into professions and professionalism, he is currently writing a book with the working title *Theorising professions: A sociological introduction*.

Psychologists are experiencing their boundaries being invaded. This is partly by DHBs and other large organisations, such employers increasingly specifying scope of work and presuming to give directions regarding interventions. Many psychologists feel sandwiched between such pressure from above and proliferating therapists, counsellors and advisors of variable price, quality and expertise. This article brings a sociological perspective to this uncomfortable reality using key ideas of traits, division of labour, occupational boundaries and definitions, the market for psychological services and expertise, the notion of professional project.

Trait model of profession

Trait theory is the standard functionalist view (May, 2007) that psychologists and other professions hold about themselves. Professions are believed to be characterised by features like extensive training, expertise, autonomy, altruism, community benefit. Sociologists like Freidson (1970) and Johnson (1972) showed these traits were largely self-definitions of professions' self-worth. Traits do not, in fact, explain how professions operate, how they came about, or how professions succeeded and can succeed over time.

These idealised traits asserted by elite professions are closely emulated by aspirational groups. But trait thinking creates difficulties for professional groups like psychology acting in today's world because such traits do not help explain psychology's occupational position or boundaries and how these might change. The historical inadequacy of trait theory undermines relevant contemporary action. To better understand psychology's professional place today it is necessary to look *beyond* its boundaries.

Division of professional labour

In contrast to trait ideas psychologists likely carry around in their heads, Abbott (1988) describes a *professional division of labour*. Psychology sits among other professional, organisational and non-professional groups having to jockey for its position—resources, recognition, new opportunities. Legislation or qualifications can maintain professional boundaries only so far. In recent decades even medicine has to accept many allied professional groups in its space, and continues to adjust to constraints of managerial direction. The same applies to psychology.

Over a century or even decades, professions come and go, expand,

combine skills in new ways; may have core skills routinised. They gain or lose status and credibility; are perceived as doing quite specific functions. Psychological wellbeing practitioners, behavioural optometry or sociology's new *Society & Mental Health* journal illustrate innovation. Boundaries are created, asserted, maintained or undermined. Fluidity, not stasis, is the natural state of all professional boundaries, not just psychology's professional borders.

Definitions maintain boundaries and value

The ability to define client-profession interaction in positive ways, not core traits, is the hallmark of elite professions. While economists see professional boundaries as monopolistic, sociologists like Johnson (1972) and (Larson, 1977) saw the capacity to *define* the profession-client relationship as key in structuring professionalism. In some situations, clients define the interaction (construction firm-architect), sometimes the profession does (patient-doctor), sometimes government or a third party may define the relationship (welfare-social work), and sometimes the user/client and producer/profession contest fairly equally over which of them defines

value, cost and solutions from the interaction.

Over a century or even decades, professions come and go, expand, combine skills in new ways; may have core skills routinised.

Different parts of psychology fit all four of these variations. This is not about branding and professional image. A post-professional perspective sees a permanent shift to greater control by large organisations over professional work (Burns, 2007). This allows an expanded psychology workforce, but constrains autonomy: first, big organisations including government define their own needs only partly relying on psychology's opinions; second, competing 'helping' and management skills and provider groups may be cheaper, have other advantages than formal expertise, feel 'alternative'; third, alignment with mainstream thinking (e.g. wellbeing) and political sensitivities. This is actual socio-economic-cultural change, not merely fashion. Part of psychology's dilemma is its success to date.

Psychology in the professional sandwich

This professional squeeze is not just structural—it is also discursive (Foucault, 1981). Discourse is the power exerted by beliefs and assumptions. It adds to structural occupational advantage or nullifies it in public and government expectations. Though less tangible than regulations or qualifications, the long game of building 'occupational capital' (Bourdieu, 1986) needs to be psychology's template for action. This still does not guarantee success but can create a zone of preference for psychologists.

Trait professionalism was never true in the past and is even less relevant in

today's post-professional environment. How do you 'do' profession today: Be more ethical? Do more training? Be given more autonomy? These are things to consider but they are not the whole story by any means. The professional division of labour currently 'sandwiches' psychology, pinching it between elite claims and positioning from psychiatric specialties and corporate and government expectations, on one boundary, and the cornucopia of therapists, counsellors and qualifications, on the other side.

Nursing and veterinary work have achieved professional gains in recent decades within pressures of competition, de-professionalisation or commodification of professional services (Evetts, 2003, 2006). Psychology's success has latent consequences also. Contemporary decisional pivots are seen in debates like whether acceding to corporate demands for short therapy is a sell-out or an opportunity. This dilemma is repeated in other professions. Psychology recognising itself within a professional division of labour makes sense of this sandwich feeling and can lead to relevant action.

Psychology boundaries: erosion or revision

Many professional groups feel the same about moving from a simple profession-centric model. Even medicine and law have seen lower-level cadres added to their professional *fields* (Bourdieu, 1987), largely not at their initiative. Socio-economic modernisation means professional services as well as material commodities continue to be specialised or differentiated. Individual professions cannot stand against these changes, so need to strategise beyond defensiveness- co-option, subordination, usurpation (Witz, 1992- to find contemporary places

within them.

New opportunities, resources, even occupational negatives, for psychology include (1) biological- neurological-pharmaceutical applications, (2) accelerating technological change, (3) realising globalisation includes professional work, (4) changing costs and markets for drugs, mental well-being services, organisational advice, (5) new consumerist ideas- often media shaped- asserting priority of clients to shape their professional care (Rose, 2006). The new managerialism shaping this will change, but it will not disappear.

A post-professional perspective sees a permanent shift to greater control by large organisations over professional work.

Expertise versus the market for psychology

Psychology in the professional division of labour places it in a market for *psychological skills or psychological services*. On one hand the demand for mental health services is growing substantially. And on the other hand (the supply side), psychological skills are sought in management, consulting, planning, education, justice, health and administration of all kinds. A bigger field for psychological expertise becomes a more varied market. Like other professions, psychology can actively engage, or simply drift, to a new position in the market for its core expertise. It may seem unpalatable to talk about markets. However, as a collective professional group, it is psychology's *position* in the field not expertise by itself that maintains or erodes psychology's boundaries.

Demand and expertise feed each other of course in important ways, but it is not a simple correlation. Psychology is unlikely to be successful in the fields it works in as preferred provider

by insisting everyone should fit its existing trait template. Modern law comprises at least four different functions connected only via legal theory: corporate, business, family, criminal. Similarly, psychology has roles in corporate, legal, workplace, addiction, trauma, family, community and criminal spheres. Practical questions for psychology's future involve engaging these functions with intention, or simply letting the market position it.

To be about psychology, it must be more than just about psychology

As a profession, psychologists like most professionals implicitly start with themselves at the centre of the circle, their expertise radiating out to clients in various directions. Being 'client centred' does not challenge this whole-of-profession centrism. Organisational psychologist Seddon's (2005) alternative theory of group/entity process, applied to psychology itself, means starting instead with what clients want. What is the demand for psychology? What kinds or expertise are valued and what kinds not so much?

What psychology thinks counts as service may not be what clients seek. What works for consumers across a range of services? Clients may want more, but may be satisfied with less, or may want something different. This reverses the profession-centric-circle image. Placing clients at the circle centre in such thought experiments acknowledges where they see themselves. This is not about being 'nice', but a reality check for psychologists—the profession is simply one possible way individuals or organisations may seek to meet their diverse requirements.

Psychology might strategise in various ways: defending a small segment of a larger, expanding, field. Perhaps innovating new, practitioner genres, specialisms within psychology and universities. DSM 6 debates are part of this re-positioning. If specialist nurses can today prescribe, what innovations in psychology? The government function is significant; opening health horizons and organisational options means political discourse and medical voices asserting greater interest, control and influence. Wellbeing, integration and engagement are current watchwords any professional group needs to address.

The keys lie in connecting what psychology wishes to offer with what clients want, can afford, believe is of value, or is central to clients' thinking and feeling. With that consciousness psychology enables itself as a profession to better get to grips with change and what is possible in impacting or steering change. Adhering to, even excelling at the professional trait template, is a minimal part of a complex, shifting professional field impacting utilisation of expertise today.

Psychology's continuing professional project

Psychology can develop reflection for action using Larson's (1977) description of professional development as a two-part occupational project: a market project and a status project. The first aims to maximise financial rewards to the professional group and the second aims to enhance prestige and respect for the profession. Many professionals were offended by Larson's original naming of these processes and bypassing claims about professional traits. But new possibilities are opened up by applying these insights.

Like other professions, psychology can actively engage, or simply drift, to a new position in the market for its core expertise.

This better shows what is going on around psychology. First, maximising both financial reward and prestige is paralleled by similar efforts other occupational groups and entities are making. Second, through some achievement of success, psychology effectively moves itself to one part of the market/division of labour for psychological expertise, perhaps the upper end. This leaves space for other groups—or one segment of the profession—to service less financial, lower status parts of the market for psychological knowledge. Third, contingent possibilities are innovations or changes mostly outside the profession that may potentially be influenced by the profession as they occur in exercising collective occupational group agency.

The idea of professional project has a prospective aspect that cannot be determined by formula, but can be planned and engaged. Sociological concepts advanced here are tools to think with. The earlier ideas help create an outside-in perspective. The subsequent discussion of professional project indicates a route for managing psychology's professional boundaries.

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CONFERENCE WORKSHOPS 1 SEPTEMBER

Advanced ACT: Getting Experiential Without Exercises Presented by Matthieu Villatte, USA

ACT and other third wave therapies are distinct from other approaches to psychotherapy, in part, because they are experiential approaches. Despite an emphasis on the development and dissemination of experiential exercises, taking an experiential approach to therapy is not limited to an exercise based practice. Contextual behavioral science (CBS) offers an analysis of therapist and client behavior that allows for an understanding of experiential work based on Relational Frame Theory (RFT). I suggest that developing facility with RFT provides the foundation for therapists to do experiential work without resorting to experiential exercises. This workshop will provide an opportunity to practice, through a series of demonstrations and experiential role-plays, using RFT to 1) see opportunities for experiential intervention, 2) create RFT-based interventions in the moment, and 3) build RFT-based conceptualizations of the experiential therapy session. Full day workshop.

“Cut that Out”: Best Practices for Responding to Self-Injury Presented by Jennifer Muehlenkamp, USA

Using both lecture and interactive discussions, this workshop will provide attendees with practical knowledge and applicable clinical skills for working with youth who engage in nonsuicidal self-injury. The workshop will provide participants with a greater understanding of why youth self-injure, how selfinjury differs from but can also contribute risk for suicide, and when to become concerned about suicide risk. A significant portion of the workshop will provide a framework for approaching the treatment of self-injury along with specific intervention strategies that can be used in the therapy office and provided to parents to assist youth at home. Role plays, small group discussions, and case consultations will be employed as time allows. Full day workshop.

The problem with conflict..... **Presented by Sonja Macfarlane, NZ**

In this workshop, participants will interact with some key ideas relating to the notion of 'conflict' and 'resilience' and its psychological implications as a result of various experiences that humans encounter.

We will explore the realm of 'human conflict' generally, and look at various interpretations and perceptions – and the impact of these on how 'conflict' is understood, and may be expressed.

We will engage in an interactive quiz to explore our knowledge of some generally accepted theories about human development.

The impacts of unexpected 'conflict' on people will be explored in more detail with a particular focus on how 'resilience' may or may not be expressed.

Participants will interact in a range of scenarios in order to explore various 'conflicts' that exist on a daily basis for many young people in society. How might these conflicts impact on psychological theory and practice? Full day workshop.

Developing and Evaluating Health Interventions in Chronic Disease: Psychosocial care for people affected by cancer **Presented by Suzanne Chambers, Au**

This workshop will overview considerations for psychosocial interventions in chronic disease using the cancer setting as a case example. The workshop will cover pragmatic as well as theoretical and empirical issues and discuss the need for balance to develop a meaningful research agenda that has the potential for translation into practice. This will provide a forum for practitioner-researchers and researchers to discuss their experiences of intervention development and evaluation.

Learning Outcomes

- Identify key approaches to intervention in cancer from a pragmatic, theoretical and empirical standpoint*
- Describe principles of good intervention research*
- Understand challenges to research translation*

Half day workshop.

Ethics and Moral Engagement: How to Maintain and Strengthen Virtue in an Ethnically Diverse World **Presented by Janel Gauthier, Canada**

This workshop is intended to enable participants to identify situations in which psychologists may become, more or less consciously, morally disengaged from their base of ethics rules and of ethical principles. The identification of such issues is important in order to maintain oneself as an ethical psychologist and to assess motivations in resolving ethical dilemmas. Adding a mix of values from other cultures also complicates the decision-making substantially. Bandura's social cognitive theory of moral disengagement will be used to examine how internal moral control can be disengaged in everyday situations. Strategies for maintaining and strengthening one's ethical engagements will be identified, including emphasis on the ethical principles or virtue, ethical decision-making steps, peer consultation, continuing education, and understanding of the ethical principles and values presented in the Universal Declaration of Ethical Principles for Psychologists (2008). To explore these topics, the workshop will use small group discussion of questions related to lifelike vignettes. Full day workshop.

One on One - with Jodie Black



Jodie Black was invited as our 'one on one' contributor.

Jodie Black completed a Bachelor of Psychology with Honours at the University of New England, NSW Australia after being awarded a Country Scholarship. Jodie has worked as a psychologist in a range of rural and remote settings in country NSW, at times driving up to eight hours return from the central office to provide services. Jodie entered the field of mental health promotion on moving to New Zealand and later became the suicide prevention coordinator for the Southern District Health Board. Jodie currently works as a counselling psychologist at the Student Health Service at the University of Otago and manages the Otago University Healthy Campus web pages. Jodie is on the NZPS Ethical Issues Committee and is the current chair of the Otago-Southland branch.

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

I really enjoy the diversity of working within a university health centre. I get to meet a lot of wonderful students who will go on to do great things even if they have some significant road bumps along the way, or change their plans completely mid-route.

I also enjoy working within an organisation because it provides opportunities to strengthen supportive environments that promote mental health and wellbeing for both students and staff.

One event that changed the course of your career

Moving to New Zealand has definitely provided some opportunities I might not otherwise pursued. I was advised by New Zealand trained colleagues working in Australia that I may have some challenges in obtaining equivalent roles as a new migrant to New Zealand. So when I landed and started looking for work I cast a much wider net than I would have otherwise. I'd always been curious about what the health promoters in a previous office actually

did, so when a mental health promoter role was advertised in the week I arrived it seemed like a great opportunity to learn. I've really enjoyed the challenge of using my skills and knowledge to enhance public health approaches to wellbeing as well as widening my view of how psychologists can make meaningful contributions outside one to one interactions.

One alternative career path you might have chosen

When I decided to study psychology during my final year at high school it was with the aim to help people. Of the careers I was aware of, it seemed to provide the best mix of fit with my personality and new challenges. Now I've been in the workforce for a while I see there are a number of careers that would continue to let me pursue this goal.

One learning experience that made a big difference to you

Working in an understaffed, rural, community mental health team where we implemented a dialectical behaviour therapy informed programme challenged my knowledge and practice in a number of ways. As a team we felt that we needed to do "something" because providing the status quo to our clients was a very poor option. So with an experienced clinician, relatively young and under resourced staff we undertook the same relentless approach to problem solving that we asked of our clients.

The modality being implemented was significant, but more so was participating in the change process; consolidating the team and challenging the status quo to make the programme successful. It started to move my focus away from the micro-view of client experience to a service wide view.

It also led me to move away from the deficits model of clients and services to a strengths based model of “what can we achieve in spite of limited resources?” It has provided a new benchmark in putting the client at the heart of the services we provide, rather than continuing to do things the ways they’ve always been done

One book that you think all psychologists should read

“Oh the places you’ll go” By Dr Seuss. I only discovered Dr Seuss as an intern psychologist, but it is a book that applies to the child and adult, client and clinician alike because the journey never stops.

One challenge that you think psychology faces

As further strain is placed on health budgets in New Zealand there is a growing call for “generalist” health assistant roles. As the profession of psychology continues to improve rigour around its training and specialisation pathways we need to ensure we maintain our relevance to the clients and the sectors we work within.

One thing that psychology has achieved

A great understanding of what it means to be us, on an individual, societal and global level.

One aspiration for New Zealand psychology

To develop a more strengths based approach to health and wellbeing that has mental health as the corner stone. The World Health Organisation has long used the phrase “there is no health without mental health”, and it’s true. Dimensions of mental wellbeing are continually linked to positive outcomes across a range of measures. However mental health is still largely associated with those who are unwell, and the mental health professionals remains a siloed workforce.

New Zealand has an opportunity to lead in this pursuit. With the Te Whare Tapa Wha model of health, Taha Hinengaro is already recognised as one of the pillars of health. The challenge is how to translate this into action as what we do as psychologists and how we shape the systems around us.

One social justice issue psychology should focus on

Child poverty continues to plague New Zealand. There is well established research in the negative impacts on a child that grows up in poverty. Introducing a living wage that allows working families to live above the poverty line

is essential for the development of our children and the nation.

One big question

Why?

One regret

There are a lot of things I could have done differently, and maybe even found easier paths, but that would mean I wouldn’t be who I am and where I am now.

One proud moment

When I graduated from my B.Psych I took it largely for granted as so many of my peers were reaching the same milestone. But as I’ve got older I have realised it was something to be proud of. Previous generations of my family didn’t finish high school and very few were afforded the opportunities I had to gain an education. I was still sent out to find a casual job the week I was legally allowed to do so, but was told I could do anything I wanted, I’d just have to work for it.

One thing you would change about psychology

The psychology workforce is relatively small, but amazingly diverse. We often define ourselves by our specialisation but it would be nice to emphasise what we do in common and our aspirations as a whole workforce.

One piece of advice for aspiring psychologists

Don’t be afraid to step outside your comfort zone and take on a role because it sounds interesting. On the job training provides amazing learning opportunities for you as a professional, and as a person.

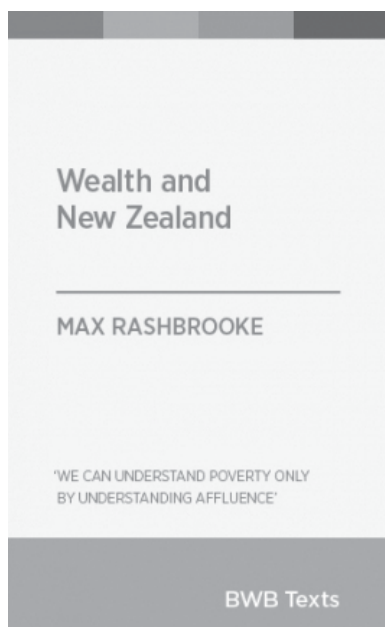


The main review in this issue is a very thought provoking and challenging piece by Quentin Abraham on Max Rashbrooke's 'Wealth and New Zealand'. Rashbrooke is a Wellington-based author, scholar, and journalist, and someone who writes and speaks passionately about inequality and its impact on the whole of New Zealand. In his review Abraham outlines some of the main points in the book and suggests why this should perturb psychologists in Aotearoa/ New Zealand. The second review is of a clinically-oriented text in the excellent Oxford Guides, this one is about mental contamination.

John Fitzgerald- Review Editor
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Wealth and New Zealand

Reviewed by Quentin Abraham



Questions about cuts to public spending and frozen psychologist posts are often met with 'the cupboard is bare' type metaphors which suggest we are overspent and we must manage our resources more effectively. Rashbrooke's analysis of the wealth of New Zealand challenges this perception.

In a concise, accessible book Rashbrooke examines the available data for New Zealand and concludes that assumptions made by the American economist Thomas Piketty also apply to our country – inherited wealth is the cause of rising inequality; wealth at the upper end is of a higher value so our store of wealth is heading towards 6 times the income we produce; our national income increasingly goes to wealth holders before being divided to wage earners.

Rashbrooke invokes the metaphor of the 'reservoir' to depict wealth and the 'flow of water' as the income. In recent times, the flow of these rivers has been diverted, emptying some reservoirs and filling others. So we see welfare benefits reduced as we pay less tax, the poor priced out of affluent neighbourhoods and banks, shareholders,

equity investors moving money offshore.

He presents some stark statistics. By 2010, the top 1% held 18.1% of our wealth and the top 10% held 53.5% of our wealth. By contrast the poorest 50% held only 3.8% of our wealth. Much of this wealth is held in property which is increasingly out of reach of the poor. Data from the Reserve Bank indicate 48% of assets are in housing and land reaching 60% if rental properties are included. Only the wealthiest 10% have non-housing assets such as investment properties, businesses and financial properties.

During 2004 to 2010 the top 10% increased their assets from \$259 to \$437 billion. The poorest 10% had negative net wealth (assets – debt) and increased their net debt to \$5.7 billion. He indicates that these disparities will continue to increase as house prices increase especially without a capital gains tax. It brings into question the effectiveness of our democracy and perceptions of ourselves as an egalitarian society.

There are marked wealth divisions in monetary terms between ethnic groups and according to gender. The average Pākehā wealth is \$125,000 compared to \$18,750 for Māori and \$8,500 for Pacific peoples. Women retire with \$60,000 less wealth than men as a result of fewer years in the workforce and lower rates of pay.

Rashbrooke proposes 5 responses:

1. Reducing income imbalances e.g. living wage, fixed ratio of the lowest to the highest earner.
2. Narrow the distribution of wealth e.g. employee profit sharing; reduce the risks of entrepreneurship.
3. Tax wealth and inheritance e.g. annual wealth tax.
4. Reduce the heat in the housing market; better renting regulation; increased housing supply; reduced tax subsidies for housing investors; lending restrictions and

effective alternatives for investment.

5. Improve employee profit sharing our democracy e.g. limits on donations to political parties.

Why should this matter to psychologists?

Principle 4 of our *Code of Ethics* requires us to be informed and proactive in our support of social justice. We may not be comfortable as psychologists to lose our 'neutral' positions challenging economic and political policy. However, psychology has never been value free.

We know that countries with less wealth inequity have better community, mental health, physical health, education and crime statistics. The wellbeing of everyone in our society would be improved if there was a more equitable distribution of wealth resources.

Rashbrooke notes that the reservoir of assets offers a sense of belonging and stability through tough times. Those who own a house can take risks to borrow and start a business. Those who have financial wealth have powerful, influential contacts, access to finance and access to the best educational opportunities. Unequal societies are less functional, less cohesive and less economically sound than their more equal counterparts.

Do we want to support a form of psychology that implores our clients to be 'grateful' or more 'mindful' whilst ignoring our responsibility to challenge structures that keep them in poverty at a risk to their mental health whilst others take the lion's share of the wealth of our country?

Current evidence indicates that countries who have adopted austerity measures are damaging their citizens. Those that had a strong citizenry and rejected austerity measures fared better. Psychologists in the UK are campaigning around five 'Austerity Ailments' -

1. Humiliation and Shame - Prolonged humiliation following a severe loss trebles the chance of being diagnosed with clinical depression. Shame and humiliation are endemic in experiences of poverty, which has increased during austerity.
2. Fear and Mistrust - Austerity has been driven through with a politics of fear and mistrust. Loss of trust underlies several forms of mental distress. Low levels of trust increase the chance of being diagnosed with depression by nearly 50%.
3. Instability and Insecurity - Job insecurity, which has increased during austerity, is as damaging for mental health as unemployment.
4. Isolation and Loneliness - Austerity has shut down

many crucial communal resources. Social isolation is poisonous for mental health and recovery; loneliness is as damaging to health as smoking or drinking alcohol.

5. Being Trapped and Powerless - Long term entrapping life experiences nearly treble the chances of being diagnosed with anxiety and depression.

In Aotearoa New Zealand there are individual psychologists contributing to policy making around child poverty and inequality. The New Zealand Psychological Society has contributed submissions on Child Poverty, Vulnerable Children and Children with Special Educational Needs.

Rashbrooke's book urges us to question our practice as psychologists. Can we do more to create a society that will enhance the mental health and wellbeing of all our citizens, proposing that the estimated at \$816 billion net wealth of our country is distributed more equitably?

(A fully referenced version of this review is available on request)

Wealth and New Zealand

M. Rashbrooke (2015)

Bridget Williams Books, 2015. ISBN 9780908321575

132 pp. Paperback. \$14.99

The Treatment of Mental Contamination

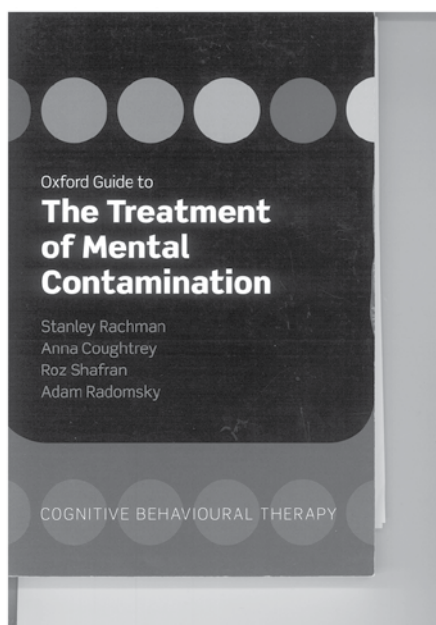
Reviewed by John Fitzgerald

This is another book in the excellent *Oxford Guides in Cognitive Behavioural Therapy* series. The series presents texts by internationally recognized scholars within the cognitive therapy field, and this book is no different. At just over 200 pages it is a little slimmer than other offerings in the series; however, it is still published to the same high standards, it is well written and an engaging read.

The book has a primary focus on *mental contamination* as opposed to *contact contamination*, although the latter is covered in some detail in order to provide both context and useful comparisons. The authors observe that contact contamination, the form most usually observed within obsessive-compulsive disorder (OCD), invariably results from physical contact with unpleasant or (perceived) harmful substances such as germs or dirt. It is this form of contamination which can, in more extreme cases, result in obsessive washing and cleaning behaviours. Mental contamination usually develops in people who

have experienced psychological or physical violation, and is unique to each individual. While there is often an overlapping experience of contact and mental contamination, both can exist independently.

In further explaining mental contamination the authors cite the literary example of Lady Macbeth's *mental pollution* resulting from her role in the murder of King Duncan, "Out, damn'd spot!" For the reader who prefers more contemporary examples these are liberally distributed throughout the book to illustrate points of case assessment, conceptualisation, and intervention. These case specimens are fascinating illustrations of the complexities of mental contamination, and the difficulty in finding an intervention which works. The authors also provide a number of helpful exercises to aid appreciation of mental contamination.



A majority of the book is taken with defining five sub-types of mental contamination, and detailing how these may be assessed and treated. The first types are *physical violation* and *psychological violation*. This distinction emphasises the important point that while events such as sexual assault can result in feelings of mental contamination, such feelings can also occur in the absence of physical contact. For example, the recognition that a stranger has been in your home while you were at work. After such an event an individual experiencing contact contamination may continually clean their home in the belief that if they touch something that the stranger touched they will be contaminated, a person experiencing mental contamination will stand in the room and think, 'it

looks clean, but I feel dirty'. The third sub-type is *self-contamination*, which are a result of one's own physical body, thoughts, dreams/fantasies, or actions. This form of contamination, according to these authors, is more often associated with guilt and/or shame. An example might be extreme feelings of being unclean after having a violent dream, or viewing pornography. The final two sub-types are related, and are *visual contamination* and *morphing*. The first refers to the idea that a person may experience mental contamination merely by seeing someone behaving in a way which is immoral, bizarre, unacceptable, etc., and morphing is when a person has a belief that they will take on or absorb the undesirable characteristics of a person that has been observed or touched. For example, a person can become a drug user simply by being in the room with another drug user or seeing someone use drugs. The exposition of each of these sub-types is fascinating and educative.

Despite being an experienced clinical psychologist the clear conceptualisation of mental contamination offered in this book is new for me, and while reading I was able to consider a number of past clients from a new perspective. It is not that the consideration of a cognitive response to trauma and challenge is new, but the development of the mental contamination concept is so well explained that it provides a credible and novel framework for re-formulation. I expect that researchers and practitioners who work with people experiencing OCD will be familiar with the ideas presented in this text. However, for practitioners who work with anxious individuals and see an occasional client with OCD this book will likely provide some new ideas to consider. The distinction between contact and mental contamination is also a useful one for clinical students to learn as, to some degree, it reflects the reality of many anxious individuals. I recommend this book to practitioners working with anxious clients, and I recommend the Oxford Guides series to a clinical psychology students and practitioners.

The Treatment of Mental Contamination

S. Rachman, A. Coughtrey, R. Shafran, & A. Radomsky (2015)

Oxford, UK: Oxford University Press.

ISBN 978-0-19-872724-8

Book supplied by Oxford University Press

Guest Editorial



Michele Blick
NZPsS Student Representative

Welcome to *Psychology Aotearoa*. The year is well underway and the summer holidays are a distant memory. Whether you are beginning your post-graduate studies or in your final year, the academic year is likely to fly by at a hectic pace.

It's time to give some thought to the NZPsS Annual Conference. This year it is in Wellington from Thursday 1st to Sunday 4th September. The theme is 'Psychology Without Borders: Mā te mahi kakama, kō atu'. The conference is an opportunity to listen to psychologists from a variety of backgrounds and perspectives. Formats include workshops, symposia, oral presentations and poster presentations. Check out the website for information about the keynote speakers. The conference is also an excellent opportunity to network with fellow students and professionals. This year the student rate is \$100 for three days.

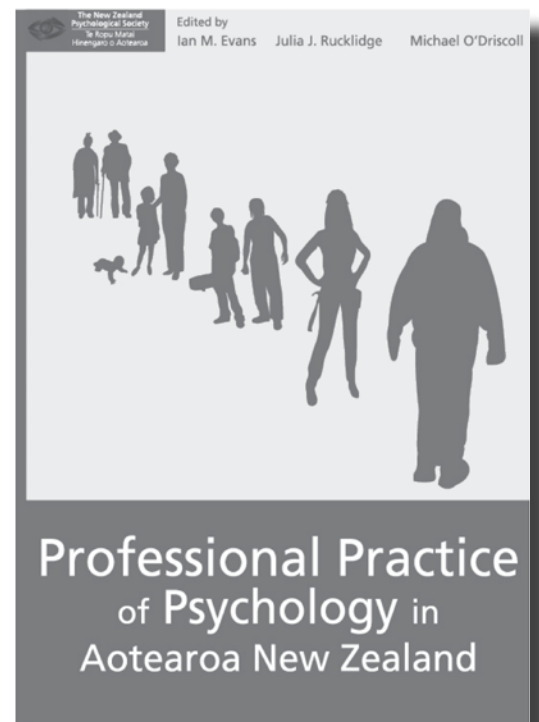
How about considering presenting at conference? The closing date for submission of abstracts is 1 June. If the thought of an oral presentation feels too daunting, how about considering a poster presentation? Posters are displayed throughout the duration

of the conference. There are no scheduled presentations but poster presenters are free to discuss their posters with interested delegates. Student subscribers presenting posters will be eligible for the Best Student Poster Prize.

Student Forum features the research of Tai Kake, recipient of the 2013 Karahipi Tumuaki – President's Scholarship. This award recognises research that is Māori-centred and of value to the Māori community. Tai's research has examined the cognitive neuropsychological functioning of Māori diagnosed with schizophrenia. There is a gap in the evidence base on schizophrenia in the Māori population and a need for research in this area given that Māori have an elevated rate of diagnosis of schizophrenia, delayed access to treatment, and poorer outcomes. It is concerning that there is evidence to suggest that certain ethnic groups with a diagnosis of schizophrenia are prescribed higher doses of antipsychotic and anticholinergic medications. The findings of Tai's research have important implications for medical and psychological support for Māori with a diagnosis of schizophrenia.

Best of luck with your studies this year. I look forward to meeting fellow students at conference.

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Cognitive Neuropsychological Functioning in Māori Diagnosed

Dr Tai Kake



Tai is of Ngāpuhi, Ngāti Hine/ Ngāti Hau descent. He grew up in South Auckland and his marae is Pehiaweri at Tikipunga, Whangarei.

Tai completed a

PhD at Otago University which examined neurocognitive functioning in people diagnosed with schizophrenia, with a particular focus on Māori. His background is mainly in mental health research, however he has also been involved in the evaluation of primary care, traumatic brain injury, and rheumatic fever programmes.

Previously Tai has worked in research and evaluation with the International Cochrane Collaboration, the Alcohol Liquor Advisory Council, and the Accident Compensation Corporation. He has also worked in the community with people with intellectual and mental health disabilities.

Tai has put his plans on hold for clinical psychology and is currently working fulltime as a Senior Research Advisor within the Ministry of Health in the Mental Health Service Improvement Group and Gambling Harm.

Tai enjoys working with health services.

He believes that researchers and health service providers can work together to develop innovative and culturally responsive solutions to the complex challenges faced in the sector.

Dr Tai Kake was awarded the Karahipi Tumuaki -President's Scholarship in 2013.

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Ko Kake tōku whānau

Ko Tai Riki tōku ingoa

No reira tēnā koutou, tēnā koutou, tēnā koutou katoa

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First and foremost, thank you to the participants in this study, to Menetta Te Aonui and Nick Garrett for their tautoko, and to the staff from Counties Manukau DHB and Capital Coast Health DHB Māori mental health services. Thank you to the New Zealand Psychological Society (in particular, Dr Moana Waitoki and Dr Pamela Hyde) for awarding me the Karahipi Tumuaki scholarship and thereby inspiring me to publish this research. Arohanui ki a koutou katoa.

Objectives:

The primary focus of the present study was on examining cognitive neuropsychological functioning in Māori diagnosed with schizophrenia. This study also examined associations between cognition, medication, substance abuse, duration of illness, duration of untreated psychosis, and symptoms of psychosis in the schizophrenia group.

Background:

A series of New Zealand studies indicate that Māori may have an elevated rate of schizophrenia (Bridgman & Dyal, 1996; Kake et al, 2008; Linscott et al, 2006). Such findings highlight the importance of having a strong evidence base on schizophrenia in the Māori population, however there is very limited evidence on key clinical features of schizophrenia in this ethnic group to inform decision-

with Schizophrenia

making.

International studies (Heinrichs & Zakzanis, 1998; Kahn & Keefe, 2013) report significant cognitive impairment in people with schizophrenia across several cognitive functions. The cognitive impairment found in schizophrenia is considered a primary feature of the illness (Heinrichs, 2005; Kahn & Keefe, 2013) and is associated with poorer community, social, and vocational outcomes. However, very few of the above studies have involved indigenous populations and ethnic minority groups. This gap in the evidence base is especially concerning for groups such as Māori who have an elevated rate of diagnosis of schizophrenia, delayed access to treatment, and poorer outcomes. The primary objective of the present study was to provide evidence on cognitive neuropsychological functioning in Māori diagnosed with schizophrenia using clinical measures that assess a range of cognitive functions.

The present study also examined associations between cognitive impairment and medications used in the Māori group diagnosed with schizophrenia. International studies have found that higher doses of antipsychotic and anticholinergic medications routinely prescribed to people with schizophrenia are associated with lower cognitive performance in this group (Keefe et al, 2007; Minzenberg et al, 2004; Ogino et al, 2014). It is important to examine such associations in ethnic groups such as Māori because of concerns that members of such groups diagnosed with schizophrenia may be prescribed higher doses of such medications (Guilera et al, 2009; Kuno et al, 2002; Walkup et al, 2000). There is little published evidence on the average doses of antipsychotic and anticholinergic medications prescribed to Māori diagnosed with schizophrenia in New Zealand. One study (Wheeler et al, 2008) found Māori with schizophrenia were prescribed significantly higher doses of antipsychotic medications than European people with the illness, although the average dose was within the clinically acceptable range.

The present study also examined associations between duration of illness, duration of untreated psychosis, and cognitive functioning in the Māori group diagnosed with schizophrenia. Current neurodevelopmental models of schizophrenia (Davis et al, 2014) propose a neurodegenerative phase with worsening cognitive functioning over time as the illness duration increases. The 'Neurotoxic Hypothesis' (Rund, 2014) suggests that

prolonged exposure to repeated psychotic episodes without adequate antipsychotic treatment can cause damage to the brain and impaired cognition. Consistent with this hypothesis, some studies have found evidence of worsening cognitive performance as the duration of illness or the duration of untreated psychosis increases (Fuller et al, 2002; Reichenberg et al, 2005). However, other studies have found no evidence (Barder et al, 2015; Heinrichs & Zakzanis, 1998; Rund, 2014). It is important to examine such associations in Māori diagnosed with schizophrenia because this ethnic group may be at greater risk for delayed access to adequate treatment for mental health disorders such as schizophrenia (Bridgman & Dyal, 1996; Oakley Browne, Wells & Scott, 2006).

The present study also examined the association between substance abuse and cognition in Māori diagnosed with schizophrenia. International studies (Henquet et al, 2005) indicate a strong association between schizophrenia and the misuse of substances such as alcohol, cannabis, nicotine and illegal drugs. The effect of these substances on cognition in schizophrenia appears to range from beneficial to detrimental (Bahorik et al, 2014; James et al, 2013; Potvin et al, 2008). Currently there are no published studies on substance abuse amongst Māori diagnosed with schizophrenia.

Finally, the present study examined the associations between the positive and negative symptoms of schizophrenia and cognition in Māori diagnosed with schizophrenia. International evidence (Dibben et al, 2009; Savilla et al, 2008) indicates negative psychotic symptoms have a small degree of association with cognitive impairment in schizophrenia, but in general cognitive impairment is relatively independent of psychotic symptoms (Nieuwenstein et al, 2001). There have been very few attempts (Ihara et al, 2003) to examine psychotic symptom-cognition relationships in different ethnic groups diagnosed with schizophrenia, and there have been no such studies involving Māori participants.

Method: An initial consultation process involving kuia, kaumātua, tangata whaiora representatives, and staff from Māori mental health services in South Auckland and Porirua/Wellington took place before any research procedures were carried out. The participants with a diagnosis of schizophrenia were recruited from mental health services while the 'control' participants (without

a diagnosis of schizophrenia) were recruited from the above regions using the Māori electoral roll, or from Te Wananga o Aotearoa, or the Anglican Church (tikanga Māori branch). As far as practicable, the participants were matched on age, cultural identity, gender, handedness, premorbid cognitive ability (NART), socio-demographic variables, substance use, and years of education. All participants were assessed on eight neuropsychological tests of attention, executive ability, motor, premorbid ability, verbal/non-verbal memory, and verbal fluency (English/Māori versions; Cooper, 1997). The Positive and Negative Syndrome Scale (PANSS) was used to assess symptoms of psychosis in the schizophrenia group. Information on cultural identity (Te Hoe Nuku Roa; Durie et al, 1995), duration of illness, duration of untreated psychosis, medication, and substance abuse was also collected from participants.

Results: 54 adult Māori diagnosed with schizophrenia and 54 adult Māori 'controls' participated in the study. The proportions of iwi affiliations of the participants in both groups were similar, and were representative of the general Māori population.

The average scores for the schizophrenia group were significantly lower than the control group on all the neuropsychological tests, except on one measure of attention. The effect sizes were moderate to large, 0.78 for motor function; 1.3 for executive ability, verbal fluency, and visual memory; 1.6 for verbal learning; and 1.8 for verbal memory. These differences remained after adjustment for multiple comparisons and covariates. A higher dose of antipsychotic medication, and a higher anticholinergic load were associated with greater verbal memory impairment ($r = -0.38$). A longer

duration of illness was associated with greater impairment of verbal memory ($\rho = -0.48$), verbal learning ($\rho = -0.41$), and visual memory ($\rho = -0.44$).

Conclusions: The results for the group with a diagnosis of schizophrenia indicate a profile of generalized cognitive impairment, and with greater impairment of verbal memory. The cognitive impairment in the schizophrenia group was independent of psychotic symptoms, but was associated with a higher antipsychotic dose, higher anticholinergic load, and longer duration of illness. These findings have implications for clinical prescribing practices, service provision, and rehabilitation for Māori diagnosed with schizophrenia.

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