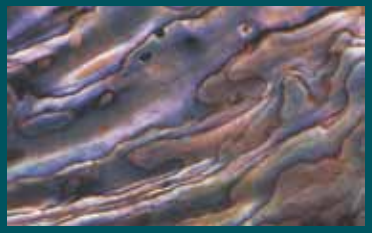
The New Zealand
Psychological Society
Te Rōpū Mātai Hinengaro o Aotearoa

Psychology Aotearoa

VOLUME 6 NUMBER 2 WHIRINGA-Ā-RANGI 2014




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

Being part of *Psychology Aotearoa*

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

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

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The New Zealand
Psychological Society

Te Rōpū Mātai Hinengaro o Aotearoa

The New Zealand Psychological Society is the premier professional association for psychologists in Aotearoa New Zealand. Established as a stand-alone incorporated society in 1967, it now has over 1500 members and subscribers. The Society provides representation, services and support for its New Zealand and overseas members.

Psychology Aotearoa is the Society's member-only periodical published twice a year. It contains articles and feature sections on topics of general interest to psychologists including the teaching, training and practice of psychology in Aotearoa New Zealand, research and new developments in psychology, application of psychology to current and social and political issues.

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Printed by Metroprint

ISSN 1179-3961 (Print)
ISSN 1179-397X (Online)

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Contents

President's Korero—Kerry Gibson

I came away from the annual conference in Nelson with a renewed awareness of the privilege of being part of an organization that allows me to discuss and debate with colleagues and to feel part of a professional community. I thought that the conference papers this year were particularly stimulating and provocative: Do we need to think differently about the way that we conduct research; about the extent to which we really take on our bi-cultural responsibilities; about how psychological ideas can be used for both good and bad in society; about how we need to change to manage the effects of economic policies on health and well-being and the enormous challenges that climate change will bring? This kind of critical thinking about contextual challenges and our own practices can be daunting but also potentially invigorating and enlivening for our profession. I left the conference feeling excited to be involved in the development of professional psychology in this time and place.

During the course of this year, I have been fortunate to be part of a group of Auckland psychologists (largely in the health sector) who have been meeting to talk about the 'future of psychology'. We were drawn together because of our shared concerns with some of the challenges currently facing psychologists and a desire to be proactive in our response. Many of the challenges we identified relate to the budget constraints in health and social services and having just heard the election results I fear there is more to come. In the current context, psychology is sometimes considered 'expensive' as other professions are seen to be able to perform similar roles at less cost. This view combined with the increasing dominance of biomedical explanations of psychological problems represents, I believe, one of the most serious threats to psychology in its relatively short professional history. Challenges like these can prompt a range of 'threat' responses from our profession including increased efforts to 'prove our worth' to the powers that be. We may, for example, be tempted to demonstrate how we can cut corners and costs regardless of the evidence base to the contrary or try to align ourselves more closely with the increasing popularity of psycho-pharmacological interventions. But while it is important to be more assertive about the value of psychology, we also need to keep a firm eye on why we do what we do. For most of us psychology is not simply a way to earn a living (there are many easier ways to do this). We do it because we are primarily concerned with people's wellbeing and, by necessity, with the social conditions which enable or undermine this. We need to find ways to engage with and influence policy makers to ensure the future place of psychology – but we need to do this from a platform which is strongly informed by our ethical and social responsibilities.

While many of the challenges we face as psychologists come from outside of our ranks - and we need to engage these - some of the most debilitating threats to our future I believe are inside psychology itself. The tendency to division dilutes our capacity for effective action and the likelihood we will be taken seriously by others as a political force. As a profession psychologists are quite often divided. There is sometimes competition between universities, different local strategies within service organisations, differences in the approaches of our discipline areas and divisions between the bodies that represent us. For a small country, it seems to me, there are rather too many schisms. Diversity can be extremely productive – but we need to temper this with the need to stand together for common interests in this time when contextual challenges are likely to affect us all. We need also to be wary of adopting a guild mentality that sets our own profession against others who work alongside us and make sure we are all working together for a common good[1].

The 'future of psychology' group hopes to engage other psychologists in talking about and enacting solutions to these things – at least in the health sector. We have now facilitated two workshops to talk about these issues with our colleagues both of which seemed to generate considerable energy and enthusiasm. While this initiative was not developed as a project of the New Zealand Psychological Society and has the advantage of involving a broad cross section of psychologists – the Society will be actively involved in supporting and furthering these efforts. It would be good to see similar discussions in other areas of psychology as well. The experience of connection and opportunities for collective discussion and action are the best antidotes to powerlessness. As the President of the Society I undertake to work hard to provide forums for members to meet with one another and to ensure that we as an Executive maintain good connections with our branches,

1 I am grateful to Clifford van Ommen for making this point in a response to our discussion piece in *Psychology Aotearoa* earlier this year. Bellamy, A., Feather, J., Gibson, K., Howard, F., Lamprecht, I. (2014). *Psychology in Aotearoa 2020: Where are we going*? *Psychology Aotearoa*, 6 (1) 14-17.

with institutes and with other organisations.

I am very fortunate to be inheriting the leadership of the Society in its current state of good health. We have some 1500 members including an increasing number of new students. Our existing branches are thriving while others are regenerating and developing. This situation is largely due to the excellent work of the previous presidents under whom I have served on the executive: Peter Coleman, Frank O'Connor and Jack Austin as well as the wonderful office staff led so ably by Pamela Hyde in her role as executive director.

I am looking forward to the next two years in my role as President.

'He waka eke noa'

Kerry Gibson

Editorial

Tēnā koutou colleagues,

Six months has passed already and we have a new edition of *Psychology Aotearoa* with a fresh set of interesting readings for you. The annual conference has provided a lot of stimulus for those of us that went and I concur with Kerry Gibson's comments that it was a very interesting and engaging conference. Many of the keynotes and papers succeeded in challenging some of our existing frameworks.

Some of the keynote addresses have been published in this edition. Michael Daffern talks about the perils of practicing psychology in terms of encountering aggression, violence and other threats. We are reminded that one can become complacent or worse still, suffer from burnout which in turn can make us more susceptible to such violence. Michael emphasises the need to attend to our wellbeing, provides an overview of violence in the workplace and helpful tips to minimise the risk.

Andrew Munro's keynote entitled 'Minding the gap: the growing gap between evidence and claim' reminds us of the dangers of falling prey to the seductive nature of research wherein researchers are under pressure to make big claims yet there is increasing fragility of the evidence base. Andrew's keynote walks us through the challenges in the translation from the research process to the application by the practitioner. This is a serious concern to practitioners who are frequently subject to organisational policies which support only a simplistic notion of what 'evidence-based' actually means but which do not reflect the complexities of the research processes themselves. Encouragingly he has some recommendations for our profession on how we should respond to this gap.

Harlene Anderson's keynote has some synergy with Andrew Munro's in that she had us rethinking psychotherapy in her description of her therapeutic practice - collaborative dialogue. Her eloquent presentation conveyed her deep respect for the client's experience and the careful attention she pays to engaging in a collaborative dialogue. Harlene shared her three 'Perspective-Orienting Assumptions' and engaged us in considering how these could influence our work. The first of these was to question the nature of 'knowledge', and maintain scepticism of "the authoritative claims of the expert" and their research findings. Secondly, she urges us to resist generalisations influenced by dominant discourses, meta-narratives and universal truths. Thirdly, we are encouraged to privilege local knowledge such as the expertise, values, and wisdom of ordinary people. Harlene goes on to explain how she upholds these ideas when she engages with her clients. She presents an example which brings this process alive nicely.

Moving to other features, we present part two of Damian Terrill and Neville Robertson's "There's no cloud of shame on me…" an account of Māori men's experience of bicultural prison-based psychological rehabilitation. This part of the qualitative study offers some insights into the experience of three men within a bicultural therapy model and illustrates the potential for different research methodologies to shine a light on different aspects of participants' experience.

Our *Inter-disciplinary Perspective* is provided by Professor Karen Witten, who originally trained as a clinical psychologist but then forged an alternative career in public health research. Her research still aims toward improving wellbeing of people, but more to do with policies and practices that influence the wellbeing of population groups,

particularly policies that contribute to inequitable health and social outcomes. Karen's account of her work provides an interesting study of how a psychologist's focus can intersect with those in the policy environment.

Kerry Gibson's *one on one* interview also provides insight into someone who has wellbeing as a central orienting value. Kerry describes how she came to be caught up in psychology which gave her a way to further her passion for a social justice agenda. Her upbringing in South Africa during a time of transition has provided fertile ground for her to develop the commitment she has to provide leadership in our field where we share similar values. We look forward to hearing more of Kerry's ideas in the future.

Clifford van Ommen also shares the background of a highly political environment in South Africa in the 80s. In his response to Bellamy et al's paper (in the last edition) on the future of psychology he proposes that psychology in Aotearoa is at a crossroads where our choices involve either colluding with those in power (e.g. with regard to policies, decisions and practices in the health sector) or decide a different course of action where we take a stronger role speaking out against policies that don't work for our clients and ultimately may serve to oppress them. He warns against engagement in 'guild type' arguments and debates, that is, trying to demonstrate our relevance and importance as a profession to those in power. Rather he suggests we should pursue alliances with other professional associations to strengthen our voice and position.

An example of just the path van Ommen is warning against is presented in our international article by Professor Russell Hawkins. He gives us an overview on the recent changes in Australia with respect to some guild protection: psychology training, credentialing and supervision. Russell explains the changes with regard to differential rebates for different scopes of psychologist who can provide services within Medicare, and the impact of the new competency standards for the profession which include those for supervision. The discussion presents the advantages of these moves alongside the challenges of implementation. This is a valuable insight for us in New Zealand.

Significant debate surrounds a number of other issues featured in the other papers in this edition. For example Joshua Myers and John Fitzgerald's second paper on the DSM-V urges mental health oriented psychologists to focus upon our tool of formulation and evidence based practice to determine our interventions rather than a classification system. They continue their description of the changes to the manual and the critique surrounding it.

Gwenda Willis' personal account of her brave engagement in a heated public debate with the sensible sentencing trust is a great example of speaking out in the public domain. This is a good example of the perils of practicing psychology where commitment to our values can lead us into challenging public roles. Her presentation on the pros and cons of a public register for sex offenders was well reasoned and convincing, but not to the sensible sentencing trust who attempted to discredit her approach and her person. Although a stressful encounter, Gwenda provides a note of encouragement, her commitment to her values of a safer society combined with sound reasoning and research evidence as well as support from fellow professionals no doubt helped in this challenging campaign.

And if you haven't had enough of contentious social, cultural or political issues, there is a fascinating book review to read about child poverty. Quentin Abraham reviews Boston and Chapple's, "Child Poverty in New Zealand". Quentin echoes Clifford's warning, that without such analysis about the causes of poverty, we are in danger of unwittingly supporting structures that maintain disadvantages when we offer behavioural and parental programmes in schools and communities. He urges us to use the knowledge derived from such a useful publication to bolster our entry into more debate addressing poverty and inequality both locally and nationally. In the *Student Forum* two intern psychologists, Chris Stanley and Matt Hegan with the Ministry of Education (MOE) in Tauranga are interviewed by Peter Stanley about the realities of their workplace experience. This will be of interest to students but also others who want a very interesting insight into the internship experience. Charlene Neuhoff, student prize winner at conference, shares her interesting insights into taking psychology into the business world and Matthew McDonald shares a very interesting poster on hippocampal functioning and autobiographical memories.

In this edition, through the papers themselves I once again find myself drawn into a number of the difficult but stimulating debates within our society, particularly where our professional involvement intersects with policy and politics. I find myself asking: what political actions do we as a profession need to be taking? How can we have more of a voice in these agendas? What can we do to build our competence in this arena?

Fiona Howard

Co-Editor (f.howard@auckland.ac.nz)

NZPsS 47th Annual General Meeting 2014

The following is a brief summary of the AGM held on 31 August, 2014 at the NZPsS conference in Nelson. Forty-two members and three students attended the meeting. There were eight apologies. Quentin Abraham opened the meeting with a karakia timatanga.

Minutes and Reports

The 2013 minutes were accepted. Matters arising included a discussion of the Psychologists Board complaint processes. The President Peter Coleman and Executive Director Pamela Hyde outlined the Society's actions on this issue including, the new "member welfare" section on the "Members Only" section of the NZPsS website and the survey on support for members undergoing complaints.

Reports were accepted. Peter Coleman spoke to a power point of the Society's activities over the past year and thanked members for their highly valued contribution to their peers in their work with the Society. There was a round of applause for all branch, institute and special interest group chairs for their excellent work.

Elected Fellows

Elected Fellow, Jack Austin was congratulated at the meeting and thanked for his longstanding work for the Society both at national and branch levels as was Joanne Cunningham for her dedicated work on behalf of the Society.

Election of Officers

Peter Coleman stood down as President and welcomed Dr Kerry Gibson as the New President. Kerry thanked Peter for his energy and commitment to the President's role. Iris Fontanilla stood down as Director of Professional Development and Training and was thanked for her contribution. Quentin Abraham was elected President Elect, Dr Rose Black as Director of Social Issues, Dr John Fitzgerald, Director of Professional Development and Training, John Eatwell as Director of Professional Issues and Dr Jackie Feather as Director of Scientific Affairs. Dr Waikaremoana Waitoki and Dr Erana Cooper remain as Directors of Bicultural Issues.

Remits

There were three remits put to the meeting. The Waikato Branch put forward a remit asking the NZPsS to work with the Board to establish an independent evaluation of the continuing competence programme involving all stakeholders. After a discussion for and against the remit followed by a vote, this remit was not carried.

A remit was put forward to alter the Rules to enable students to elect their representative on the Executive. This remit was carried.

Marg O'Brien from Nelson put forward a remit which asked the NZPsS to recognise the need to actively encourage psychologists to promote a wider understanding of the human and psychological dimensions of climate change, to audit the NZPsS' own environmental impacts and to work with government agencies to ensure they understand the potential roles for psychology in understanding and changing behaviour in relation to human adaptation to climate change. This remit was carried.

A vote of thanks

The meeting ended with a vote of thanks to the Executive, the National Office staff and all those members who contribute to the Society in a myriad of ways as chairs, presenters at conference, presenting professional development etc.

Who's who in the NZPsS

NZPsS Executive

President- Dr Kerry Gibson
President –Elect- Quentin Abraham
Directors of Bicultural Issues- Dr Waikaremoana Waitoki, Dr Erana Cooper
Director of Social Issues- Dr Rose Black
Director of Scientific Affairs- Dr Jackie Feather
Director of Professional Development and Training- Dr John Fitzgerald
Director of Professional Issues- John Eatwell
Kaihautū- Professor Angus Macfarlane

National Office Staff

Executive Director- Dr Pamela Hyde
Executive Officer- Vicki Hume
Membership Administrator- Donna Macdonald
Professional Development Coordinator- Heike Albrecht

Branch Chairs

Auckland- Alison Kirby
Waikato- Dr Carrie Barber
Bay of Plenty- Dr Peter Stanley
Central Districts- Dr Barbara Kennedy
Wellington – Dr Ruth Gammon
Canterbury- Branch currently being revitalised
Otago/Southland- Brian Dixon

Institutes
Institute of Clinical Psychology (ICP)- Chris Dyson
Institute of Community Psychology Aotearoa (IComPA)- Dr Jane Furness
Institute of Health Psychology (IHP)- Iris Fontanilla
Institute of Educational and Developmental Psychology (IEDP)- Fiona Ayres
Institute of Counselling Psychology (ICounsPsy)- Dr Elizabeth du Preez
Institute of Criminal Justice and Forensic Psychology (ICJFP)- Rajan Gupta

CONGRATULATIONS to New Life Member

The NZPsS Executive confirms and congratulates those members who have completed thirty years of membership and have become life members of the Society or those who have been members for at least twenty years and have been granted life membership in accordance with Rule 10.1 of the NZPsS Rules, having made an outstanding contribution to the Society over an extended period of time. Congratulations to Gary Poole who has written about his psychology career journey.

Gary Poole

A series of seemingly random but related and connected events altered my career course. Born in Canada, and later principally raised in the USA by maternal grandparents, I was initially set on a course to take over the family business. First completing two years in management at the University of Tampa, I switched to psychology and criminal justice on a whim transferring to South Florida when Charles Spielberger was there. On to post graduate work in clinical psychology on a scholarship in Baltimore. Returning late from a term holiday, I was dismayed to find that all the choice clinical internship placements had been taken and I was left to work in an alcohol and drug centre located in an urban ghetto. It turned out to the best thing that could happen as I was privileged to have met my first mentor, Dr Gloria Phillips, an African-American clinician working in disadvantaged communities.

In 1978, I left a possible academic career, family and friends to accept a two year assignment in the Peace Corps working in northern Malaysia during the Cambodian crisis where I met my wife Anne. What we were seeing in refugees would later come to be known as severe post-traumatic stress. After that, 5 years in Hawaii as divisional director of Hawaii State Hospital learning something about cross-cultural ways of thinking and working.

Disillusioned with Reagan America, we immigrated with our first child to New Zealand in 1982 and it felt like coming home. A first assignment in computer evaluation systems for the Ministry of Health led on to a senior management job with what was then Presbyterian Social Services or PSSA in Auckland and Northland. It was halcyon years for that NGO and I had the privilege of initiating diverse new services such as the Genesis Child & Family Centre in Whangarei, the Wilderness Experience Outdoor programme, alcohol and drug services, and building aged care complexes in Kerikeri and Tauranga. Later I went on to work with the DHB in child health services.

After 2001, I went back into refugee and international aid work accepting a leadership assignment with the IRC humanitarian agency on UNHCR funded health projects in three provinces in Afghanistan. Difficult and personally transformative times, our team built a hospital in remote northern Badakhshan. Coming back home to New Zealand, I was appointed CEO for RASNZ, the refugee health agency in 2007. An old friend describes me as a 'high-tech nomad.' Not sure about the tech bit. I've enjoyed being a member of the NZPsS, and participating in conferences and training with colleagues and good friends over the years.

Climate and Health Action

New Zealand doctors believe that they have a role in improving population health and reducing inequalities. Public health specialists Rhys Jones and Alexandra Macmillan note that climate change is widely accepted as amongst the biggest threats to health as evidenced by the statements from many of the world's leading medical and health professional associations. They argue therefore that climate change as a health issue falls within doctors' job descriptions. They consider that there are practical ways of considering patients' health and climate change and gaining win wins for climate and health. They are not suggesting that patients be exhorted to reduce their carbon footprint but they can for example be encouraged to build their physical activity into their daily routines such as cycling or walking to work. This increases the patient's physical activity and reduces the use of motor vehicles and greenhouse gas emissions. They suggest also that doctors could go a step further and become more active in advocating for example for infrastructure for safe cycling and walking to facilitate healthy choices.

Source: New Zealand Doctor 27 August, 2014 p19

Freeing the play "instinct"

In the June edition of *The Psychologist* Jon Sutton reports from the "Idea Conference" in Bullund, Denmark at which Professor Peter Gray, (Department of Psychology, Boston College) talked about 'freeing the play instinct' in children. Gray referred to evidence suggesting that children's sense of control over their lives has decreased over the past 35 years which he linked with declining opportunities to play. Gray noted that play is how children take control of their lives, solve their own problems, regulate their emotions and learn to get along with peers. Gray argues that in the first half of the 20th century children were freed from the workplace by labour laws but in the 1950s adults took over children's non-labour activities and hobbies and replaced them by classes. He suggests that children need the optimal self-education context were they learn how to learn rather than learning based on storing facts and assessment.

Source: 'Play is not a four-letter word' Jon Sutton the Psychologist Vol 27 (6) 2014, p 393

Desisting and persisting- male intimate partner violence

Can violent men change? Researchers from Coventry University- Kate Walker, Sarah Brown and Emma Sleath have been researching the psychological processes involved in desisting from violent behaviour and what separates men who persist in violence and those who are able to make a positive change. Using in-depth interviews of desisters (men who had not been violent for a year or longer), persisters (who were still violent) as well as people who had witnessed or even survived violent relationships, Walker has analysed how desisters make changes. The interviews indicated the importance of triggers and transitions which include, fear of losing a partner, newfound religion, fear of prison, losing or threat of losing children. These triggers may not themselves result in permanent change but they may start the process of realisation for the desister that their behaviour needed to radically change. The research suggested that there were no differences between the desisters and the persisters in how violent they had been in the past. As a result of their findings, the researchers have devised a cycle of change conceptual model – Phase 1 rationalising violence, Phase 2 the desister focused more on the consequences of the violence and negative emotional responses. Desisters felt guilty for much longer whereas persisters were not dogged by their guilt. Desisters felt more concern about the consequences of their actions on others and more fear e.g. about not seeing their children. Only desisters talked about shame. These factors appear to act as drivers for change. Finally in Phase 3 successful desisters could deal with violent triggers and self –identified as a non-violent person. The researchers conclude that violent men can change but not overnight. They conclude that they may benefit from treatments that focus on speeding up autonomous resolve which helps violent men fully understand the implications of their actions.

Source: 'Male intimate partner violence-persisting and desisting'. the Psychologist Vol 27 (7) 2014, p 491

"Good health is not a simple narrative about personal responsibility."

Counselling psychologist, Jason Purnell is leading a research project with colleagues at Washington University in St. Louis and Saint Louis University called "For the Sake of All," which explores factors beyond medical care, such as limited economic and educational opportunities, that negatively affect the health and well-being of African-Americans in the St. Louis metropolitan area.

Purnell notes that behaviour is contextual and includes interpersonal contexts such as families, and larger contexts involving communities, society and policy. Purnell cites research showing that behaviour contributes to 40 percent of early deaths, and social conditions, such as housing,

education and community connectedness, contribute 15 percent compared with lack of access to medical care, which only contributes 10 percent. Purnell wanted to test an hypotheses about the contribution of social factors including access to education, poverty and racial segregation to deaths among African-Americans in St Louis. In doing so he aimed to inform the public about the social determinants of health and how they contribute to health disparities, highlight promising strategies and recommend policies and programmes to improve health. His meta-analysis of studies linking social factors with mortality and local health data found that one in six deaths among African-American adults in St. Louis could be attributed to poverty and lack of education. On a more positive note Purnell concluded that targeted investments in areas such as early childhood development and providing economic opportunities for low-income families could improve health outcomes.

Source: Psychology: Science in Action – APA website http://www.apa.org action/careers/health/jason-purnell.aspx

Milgram and Ethics

Professors of psychology, Alexander Haslam from the University of Queensland and Stephen Reicher from the University of St Andrews in the UK looked at Milgram's obedience studies and Zimbardo's 'blind conformity' research and replicated some of the Milgram studies in an ethical manner. They also identified the ethical issues involved in Milgram's psychological studies and noted the things that they considered should never happen again. For example, in "Milgram's experiment participants thought they were involved in a learning study and the electric shocks came as a complete surprise presenting an unenviable dilemma for them. Informed consent was clearly not a feature of this experiment. Nor was the ethical principle that participants should not be exposed to short-term harm. Milgram noted that he "observed a mature and initially poised businessman enter the laboratory smiling and confident who was reduced 20 minutes later to a twitching stuttering wreck". Evidence for whether long-term harm occurred as a result of the Milgram experiments is mixed. Ensuring that the study did not cause "social harm by endorsing forms of belief that legitimise discriminatory or harmful acts towards others" was not adhered to. Milgram told participants that what they had done had advanced scientific understanding and in doing so promoted a belief that it is acceptable to inflict suffering for a cause such as science.

Source: 'Just Obeying Orders?' Alexander Haslam and Stephen Reicher. New Scientist 13 September, 2014, No290, pp28-31

NZPsS Professional Development Programme presents
ONE-DAY WORKSHOP:

Improving outcomes with 'resistant' clients and enhancing motivation to change

Dr Matthew Berry

9.00am to 5.00pm

Auckland
Date: 17 April 2015

Wellington
Date: 20 April 2015

Christchurch
Date: 23 April 2015

This interactive workshop draws from the presenter's experience working with drug and alcohol populations, and describes principles and interventions that may also be helpful for clinicians working with similar ego-syntonic disorders such as OCD, mania, eating disorders, and some self-harming behaviours.
Six common causes for this type of presentation are described, along with a range of strategies that may assist in resolving each type for the client's best outcomes. These include skills from Miller and Rollnicks' latest (2012) version of Motivational Interviewing, as well as strategies drawn from other therapeutic approaches.
The seminar will also describe a three-dimensional model that helps clinicians to formulate the process of change with ego-syntonic behaviours, and set goals accordingly.

For more information go the NZPsS events page on our website: www.psychology.org.nz or contact Heike: pd@psychology.org.nz

DSM-5 and the practice of psychology – Part 2: The major changes and their implications.

John Fitzgerald & Joshua Myers

Dr John Fitzgerald is director of The Psychology Centre in Hamilton and a registered clinical psychologist. He obtained his qualification in clinical psychology from the University of Birmingham (England) in 1988 and has been in New Zealand since 1992. He completed his PhD thesis at the University of Waikato in 2002. He supervises students/ interns from the Waikato University Clinical Programme and a range of other health practitioners, and maintains an active clinical caseload. His current areas of research interest include: cutting and deliberate self-harm; monitoring change and measuring outcomes in mental health; professional ethics; family resilience and suicide risk; and psychological interventions in primary care based mental health service. He is a Fellow of the Society and editor of the Society's Journal.

Dr Joshua Myers is a consultant clinical psychologist and supervisor working at The Psychology Centre (TPC) in Hamilton. He is also an Honorary Lecturer at the University of Waikato in the School of Psychology. He completed his clinical psychology training at Indiana State University (U.S.). After spending a decade in private practice in Florida where he worked with a range of clients from children and adults to court-ordered forensic evaluations, Joshua moved to New Zealand in 2010. While initially working in forensics at the Waikato DHB, he changed roles to work as a supervisor, instructor and clinician at TPC in 2012. In addition to his supervisory and other clinical responsibilities, Joshua's research interests include; ethics in clinical practice, therapeutic relationships and client attrition from psychotherapy.

This is the second in a short series exploring the DSM system of classification, its impact on our work as psychologists, and on the society in which we live.

In part I of this article (Fitzgerald & Myers, 2014) we briefly considered some of the difficulties that marked the development and release of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) by the American Psychiatric Association (APA, 2013a). Since its origins in 1952 the DSM system has had a powerful influence on the mental health landscape throughout the Western world. It has been used to shape the research agenda, set the basic criteria for manuscripts published in many of our journals, the format of our clinical assessments, and inform the frameworks that guide interventions. Because of this the release of a new DSM is important, even if we question the need for, and motivation behind, the new version. Psychologists will need to consider how changes are likely to impact on the wider health system because they may eventually change the nature of the clients that we are meeting with, the treatments that our clients have already been offered, and the interactions we have with our professional colleagues. Indeed, some of the changes may have far-reaching implications for the structure and funding of health and educational systems. In what follows we will present some of the more significant changes and consider what impact these might have on the practice of psychology in Aotearoa/ New Zealand.

The APA released a document entitled, *Highlights of changes from DSM-IV-TR to DSM-5* (APA, 2013b) and others have published similar summaries (Reichenberg, 2014). Additionally, Section I of the DSM-5 contains general comments on the structural changes to the diagnostic framework. Most notable of these changes is the removal of the multi-axial system of diagnosis. Also of interest is an attempt to move to a dimensional system and an ordering of material which is intended to reflect a lifespan progression. The "NOS" diagnoses have been replaced, and there are only three main sections in the 947 page document. Old sections have been combined and new chapters created in a re-organization of the heart of the document (Section II) which now contains 19 main chapters.

Several major changes in each chapter are outlined below:

1. **Neurodevelopmental Disorders**

There are changes to the nomenclature to Intellectual

Disability (ID) and an emphasis on adaptive functioning and cognitive capacity. That is, an IQ score below 70 may no longer be seen as the primary criteria for eligibility.

The amalgamation of Autistic Disorder, Asperger's Disorder, Childhood Disintegrative Disorder and Pervasive Developmental Disorder into a single dimension entitled Autism Spectrum Disorder (ASD) was well publicised prior to release of the DSM-5. Additionally social communication and restricted repetitive behaviours are both required, making it more difficult to meet the ASD diagnostic criteria.

Several significant changes have been made to the ADHD criteria with the strengthening of the cross-situational requirement, a loosening of the requirement that symptoms be present prior to the age of seven, and the reduction of the symptom threshold for adults.

2. **Schizophrenia Spectrum and Other Psychotic Disorders**

A range of disorders and presentations within this category are now more clearly organised on a schizophrenia spectrum with diagnosis on the spectrum being according to the number and degree of deficits. It also is notable that delusions no longer need to be "bizarre" and schizophrenia subtypes have been eliminated from the system.

3. **Bipolar and Related Disorders**

The DSM-5 places a greater emphasis on "change in activity and energy" which appears to be less stringent criteria than the previous "elevated mood". A clarification of the "mixed episode" diagnosis allows for a Bipolar I diagnosis to be made on the presentation of depression with the history of mania or vice versa, rather than requiring co-occurrence. Additionally, an "Anxious Distress modifier" can be applied to any mood disorder to indicate a co-occurrence of anxiety that does not rise to the level of an independent diagnosis.

4. **Depressive Disorder**

The *Highlights* document enthusiastically claims that it contains several new depressive disorders including Disruptive Mood Dysregulation Disorder (DMDD) and Premenstrual Dysphoric Disorder (promoted from Appendix B of DSM-IV). DMDD essentially takes on the role of classifying what previously was Bipolar Disorder in children, inclusive of those up to the age of 18 who exhibit persistent irritability and frequent episodes of "behavioural dyscontrol".

A significant change to the Major Depressive Episode diagnosis involves a reduction in the bereavement exclusion from two months to two weeks.

5. **Anxiety Disorders**

The DSM-5 Anxiety Disorders section no longer includes Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder or Acute Stress Disorder (each now having its own chapter), and Panic Disorder and Agoraphobia are no longer linked, with each having independent criteria.

Previously, Separation Anxiety Disorder was categorised as a disorder usually first seen in children. However, it is now included in the Anxiety Disorder domain without an age of onset prior to 18 requirement.

6. **Obsessive-Compulsive and Related Disorders**

The DSM-5 creators established this new chapter given the reported frequent occurrence of OCD in developed countries around the world. The related disorders identified include OCD, Hoarding Disorder, Excoriation Disorders, Substance/Medication- Induced OCD, and Body Dysmorphic Disorder.

7. **Trauma- and Stress-Related Disorders**

The DSM-IV criteria for Acute Stress Disorder requiring that the traumatic events lead a person to experience intense "fear, helplessness, or horror" have been eliminated. Adjustment Disorders have been re-conceptualised with the primary emphasis being placed on a stress response occurring in the context of exposure to a distressing event, rather than simply being seen as a residual category for individuals who exhibit significant distress but who do not meet the criteria for another disorder.

As with Acute Stress Disorder, the emphasis in PTSD is focused on the circumstances under which an individual experiences a traumatic event rather than their subjective reaction to it. The avoidance/numbing cluster of symptoms has also been divided into two distinct groupings, and some additional behaviours have been added to the arousal/reactivity cluster. Additionally, criterion A has been expanded to include "threats" and "indirect" experiences. The diagnostic threshold for PTSD in children and adolescents has been reduced. Finally, Reactive Attachment Disorder has been divided into two distinct childhood disorders, Reactive Attachment Disorder and Disinhibited Social Engagement Disorder.

8. **Dissociative Disorders**

The criterion for a disruption of identity that meets diagnostic thresholds has been expanded to include the observations of others as well as self-report.

9. **Somatic Symptom and Related Disorders**

This new chapter covers the disorders previously referred

to as Somatoform Disorders. The number of Somatic Symptom Disorders has been reduced with the removal of Somatization Disorder, Hypochondriasis, Pain Disorder and Undifferentiated Somatoform Disorder. Comment is made that the new Somatic Symptom Disorder can be better conceptualised as a spectrum.

Finally Conversion Disorder has been medicalized, with the addition of 'functional neurological symptom disorder'. The criteria have been modified to require a neurological examination in recognition that psychological factors may not be demonstrable at the time of diagnosis.

10. **Feeding and Eating Disorders**

All eating-related disorders including difficulties experienced in childhood are covered in this domain. The criteria for the diagnosis of Anorexia Nervosa requiring amenorrhoea has been eliminated, taking into account that at least some of the people experiencing this problem are male and a number of the females will be taking a contraceptive pill. The only change for Bulimia Nervosa is a reduction in the required minimum average frequency of binge eating and inappropriate compensatory behaviour from twice to once weekly. Binge Eating Disorder has moved from the appendix in DSM-IV to the main text and has undergone a change in frequency similar to Bulimia (from twice weekly to once weekly over a 3-month period).

11. **Elimination Disorders**

This new chapter was created to house diagnostically unchanged Enuresis and Encopresis which were displaced by the removal of the disorders of infancy, childhood and adolescence section of DSM-IV.

12. **Sleep-Wake Disorders**

The primary move here has been to reconceptualise Sleep-Wake Disorders as being primary disorders in their own right rather than being secondary to other mental health or medical conditions.

13. **Sexual Dysfunctions**

The DSM-5 sees the inclusion of gender-specific sexual dysfunctions, for example, for females a combined disorder of Sexual Interest/Arousal Disorder has been added. No rationale is provided for why this disorder is considered gender-specific.

14. **Gender Dysphoria**

Gender Dysphoria is a new diagnostic class in DSM-5 with a name change from Gender Identity Disorder. This appears to be in response to an inappropriate grouping of gender identity disorder with sexual dysfunction and paraphilias in the DSM-IV.

15. **Disruptive, Impulse-Control, and Conduct Disorders**

This grouping of disorders is new in DSM-5. Four changes have been made to the Oppositional Defiant Disorder criteria. The first provides for grouping of symptoms to reflect that ODD has both emotional and behavioural aspects to its presentation. The second change removes the Conduct Disorder exclusion. Third, guidance is provided regarding the typical frequency of behaviours to meet diagnostic criteria. Finally, the pervasiveness of symptoms across settings is given increasing importance as an indicator of severity.

In DSM-IV Intermittent Explosive Disorder was associated primarily with physical aggression. This has been expanded to include verbal aggression and non-destructive/non-injurious physical aggression. Behavioural 'explosions' are now more clearly defined with respect to frequency, impairment, and negative consequences.

16. **Substance-Related and Addictive Disorders**

Gambling Disorder is now included as the only non-substance-related disorder within this section. The inclusion was based on research which suggests that gambling, like addiction to substances, involves activation of the brain's reward system.
The DSM-5 has removed the diagnostic separation of substance abuse and dependence, and polysubstance disorders are to be replaced by specifying each individual substance disorder. Cannabis and Caffeine Withdrawal Disorders have been included in the DSM for the first time. Tobacco Use Disorder has similar diagnostic criteria to those of other substance use disorders.

17. **Neurocognitive Disorders**

Dementia and Amnesic Disorder are now subsumed under the new diagnostic entity of Major Neurocognitive Disorder (NCD). It is recognised that milder forms of NCD exist which can be diagnosed as Mild NCD. It is noted that the threshold between mild and major NCD is arbitrary and specifiers can be added for known causes.

18. **Personality Disorders**

The criteria for individual personality disorders contained within Section II of the DSM-5 has not changed from DSM-IV-TR, although an alternative dimensional approach to diagnosing personality disorders is included in Section III, and there is suggestion that the two can be used in parallel despite their numerous differences.

19. **Paraphilic Disorders**

The document observes that paraphilic behaviour is not necessarily a mental disorder on its own. This has prompted a distinction between paraphilia and Paraphilic Disorder, with the latter involving behaviour that must cause distress and impairment to an individual or another person, causing harm or risk of harm.

This is, of course, only an overview of changes we find most relevant, important and interesting in this document - with many additional DSM-5 diagnostic specifiers and criteria not detailed here. While a number of the changes incorporated into the DSM-5 appear non-contentious there are some changes that have caused confusion and substantial debate.

What do we think about this?

The most striking thing about this document is that for many diagnoses (barring ASD), the DSM-5 criteria have become more inclusive than their DSM-IV-TR correlates. The most obvious implication of this is that a greater number of people will meet criteria for a diagnosis and thereby become eligible for treatment.

If such greater inclusiveness accurately reflects the line in the sand between "healthy" and "unhealthy", then clearly our perspectives should change to match this changing reality. However, the need for and basis of this greater inclusiveness and the decision-making behind it have been called into question in several recent scholarly articles (Banner, 2013; Welch et al, 2013; Zimmerman, 2012).

In fact, in an article on the DSM-5 field trials, Allen Frances explains that not just the line in the sand, but the sands themselves may have shifted with this incarnation of the DSM. Frances explains that previous DSMs expected inter-rater reliability for diagnostic field trials be at the 0.6 (kappa) level or higher, but this was changed for DSM-5. Now kappas of 0.6 to 0.4 are being used and are now deemed "good" and 0.2 to 0.4 are deemed "acceptable" (Frances, 2012).

A greater rate of diagnostic inclusion could possibly be seen as helpful in an American healthcare system where third party payers have a reputation for excluding treatment from individuals without a diagnosis. However this may not accurately reflect how the rest of the world wishes to categorize mental health. This certainly calls into question the accuracy of recoding from a DSM to an ICD nomenclature if these two systems do not define mental health equally as broadly. This is potentially relevant in New Zealand where the Ministry of Health utilizes ICD coding and DSM-based diagnoses are regularly recoded. Now through the course of shifting lines and sand we are potentially getting muddied water.

Having reviewed the main changes above, we find ourselves agreeing with the views expressed in the response to the release of the DSM-5 published by the British Psychological Society's Division of Clinical Psychology (DCP, 2013). That is, that the DSM is clearly moving towards an overly inclusive theoretical position which privileges biological factors in the genesis of mental health difficulties, and medical factors in their resolution. The way that behavioural addictions, Binge Eating Disorder, Mild Neurocognitive Disorders, Disruptive Mood Dysregulation Disorder (DMMD) and others disorders have been included moves difficulties with substantial psycho-social features into a medical-psychiatric framework. Amendments to criteria such as that made to the grief exclusion for Major Depressive Episode achieve the same result. If DSM-5, like its predecessors, is used as a guide to what research is funded and published, then we can expect a rapid expansion in funding for medically (predominantly neurologically) oriented research into problems such as DMDD, with preference being given to randomised controlled drug trials. This broadening of the diagnostic scope of the DSM could have the result of further marginalising psychological explanations of mental health challenges and limit the resources available to innovate psychological practice.

What can we do?

Our response should be at once informed and multi-faceted. When faced with a discussion of the DSM-5 we should be ready to raise concerns and engage in informed dialogue about our view of the current DSM-5 system. Helpful discussion points can be found in BPS position statement (DCP, 2013) and a similar document published by the New Zealand Psychological Society (NZPsS, 2014). Highlighted in these documents are limitations in validity and reliability of diagnoses, interpretations presented as facts, restrictions in clinical utility and functions and an inherent ethnocentric (Western) worldview, among other concerns.

When required to utilize these nomenclature systems because of the environments we work within, we should advocate for and apply approaches that emphasize best practice in diagnosis. Allen Frances (2013) points to several, including:

- Be sure to know the client well and the context in which symptoms occur.
- Rely on multiple sources of information.

- Revisit diagnoses given by self and/or others.
- It is often safer and more accurate to under-diagnose when uncertain.
- Take extra time to make the best effort at accurate diagnosis.
- Inaccurate diagnoses can lead to great harm and we should first do no harm.
- The provider-client relationship should be emphasized for enhanced client understandings.
- Client discussions leading to diagnosis should be collaborative explorations.

Finally, we should be prepared to discuss and apply what we do uniquely well as mental health practitioners including using formulation to guide our understanding of client concerns and employing an evidence base to assess and adjust our interventions and strive for improved client outcomes. By focussing our work in this way we maximize the chances of attaining the individual solutions that really matter for our clients. Competent and ethical psychologists are in a unique position to reach this end regardless of labels or systems of nomenclature.

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At the meeting of the Institute and Branch chairs with the Executive at National Office ...

Where to Psychology in Aotearoa? Choosing Between Histories

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Clifford van Ommen is Director of Massey University's Centre for Psychology in Auckland. He is a member of the South African Clinical Neuropsychology Association and the International Society of Theoretical Psychology and an editorial board member for the journal *Theory and Psychology*. Clifford's two primary current research projects are on the immigration experiences of South Africans, and the history of psychology in Aotearoa New Zealand. Prior to immigrating to this country, he worked as Senior Lecturer at Rhodes University in South Africa. During this time Clifford coordinated the Counselling Masters and Research programmes, taught across undergraduate and Honours programmes, and trained and supervised Masters' students. Prior to 1998, he worked as a clinical psychologist in a drug rehabilitation centre and EAP. He completed his doctorate on neuroscience and embodiment in 2010 and published an edited book, *Interiors*, on the history of psychology in South Africa with Desmond Painter in 2008.

This piece aims to contribute to the discussion, 'Psychology in Aotearoa 2020: Where are we going?' initiated by Bellamy and colleagues in the May 2014 issue of *Psychology Aotearoa*. This, in my opinion, is an important development and deserves our ongoing support and investment.

Psychology has a complex history; there is much written about its sycophancy to those in power, whether in industry, the state, the military, or medicine. This eagerness to demonstrate the discipline's utility and flexibility and to thus build its professional credentials has done much to bring about its ubiquitous presence in contemporary society. But there is also a parallel history that runs counter to the narrative of accommodating the needs of the current hegemony; a history that demonstrates a capacity for reflexivity, reinvention and resistance. I would like to argue that we, the profession of psychology, are now at a point in time where we will have to choose between which of these histories we would like to contribute to.

The relevance debate is an ongoing and vital debate which extends well beyond the borders of Aotearoa.

Psychology has a complex history; there is much written about its sycophancy to those in power, whether in industry, the state, the military, or medicine.

Similar debates, for example, were held in South Africa, especially in the 1980s and 1990s, as the profession struggled to understand its complicity in the violence, oppression and struggle that marked the country in which it continued to forge an identity. Given my newness to Aotearoa, I will draw heavily on these experiences in highlighting some concerns. The 'relevance' question requires some unpacking, since we need to ask who determines what counts as relevant actions for our profession. Too easily the parameters of this debate are sculpted by powers beyond our own and too easily do we accept these limitations as given and unchallengeable. Of course those in power will describe constraints and developments as inevitable, natural, logical, reasonable, and so forth. It is important to be wary of such characterisations for they are both ideological (aimed at naturalising a particular version of the world) and rhetorical (aimed to silence, reduce resistance, and promote an agenda). In South Africa in the 1980s, psychology (in a debate I encountered as a fresh faced first year) was a profession divided as many increasingly saw that what they were undertaking as a form of 'band aid therapy', where the difficulties they were witnessing in their clients and fellow citizens were the result of a violent and oppressive social structure (Dawes, 1985). The interventions offered were thus misguided, limited, and ineffective.

Not only was this social system inflicting ubiquitous harm but it was reducing the profession to an accomplice – often through psychologists claiming to be apolitical which is, of course, a profoundly political statement. In other words, in seeking acknowledgement of its relevance from those in power,

the profession was being an active participant in its own (ethical) destruction and in the oppression of those it sought to understand, assist and protect. In South Africa this was unsustainable and led to the rupture within the profession as alternate, often multidisciplinary, overtly political and activist associations were formed separately from the existing conservative professional society.

… those in power – pursuing an illusory austerity line of argument - are not interested in our profession and have no investment in protecting it.

I believe that psychology as a profession in Aotearoa finds itself in a similar, although far less overtly violent, situation. I would like to argue that the emergence of the Bellamy and colleagues' debate is indicative of a crossroads for the profession; it can either continue to accommodate the injunctions and manipulations from those in power and in the process be complicit in its own dismantling (until what we are left doing leaves us feeling completely alienated from our own work) and the neglect of those in need, or we can decide on a different course of action, one where the profession determines its own identity and speaks out against the decisions, policies and practices that fail to serve and ultimately oppress an increasing number of the people of this country. The latter path is of course the far scarier one to pursue. But what is the alternative if we trace the current process into the not-so-distant future?

There are traps to watch out for in this process: One is to get invited into and becoming preoccupied with guild type arguments and debates, that is, trying to demonstrate our relevance and importance as a profession to those in power. There are two problems with this; those in power – pursuing an illusory austerity line of argument - are not interested in our profession and have no investment in protecting it. They are not socially minded; rather their economic reductionism represents a simple exploitative strategy, especially when it comes to mental health, of how to achieve more for less. We should not be fooled by the there-is-no-money argument which then leaves us divided against our fellow health disciplines in scrambling for ever decreasing pieces of the pie. Bluntly stated; there is enough money (or rather wealth), it is just increasingly in fewer and fewer hands as an ever increasing majority have to cope with less and less. This is not a matter of scarce resources; it is a matter of ideology where we are witnessing the effects of a neo-liberal form of social engineering which has been making its way across the globe since its first institution in Chile after the 1973 coup removed their democratically elected government (Harvey, 2005). We can play along with this rationality but must then make peace with the fact that our profession will continue to be compromised and will increasingly have its role determined by those outside the profession. Such forms of social engineering will however, as in South Africa, only change with the rise of multiple points of resistance both within and beyond psychology.

This leads to my second point concerning the dangers of guild protection debates (e.g., issues of competency, specialisation, regulation, and training); as a social engineering project the effect of this neo-liberal (economic reductionist) ideology affects all professions, not only our own. In other words, if we choose to resist it must proceed in solidarity and discussion with other professional associations. This struggle is not unique to psychology but, I believe, will be found across all health professions. These governmental strategies are being applied to all professions and therefore there is a shared discomfort and outrage to draw from. Our concerns are not only our own but shared with many. Given this we must not become caught in professional boundary protection debates but should rather pursue alliances with other associations. If we are as good in conceptualising holistically as we claim to be, then surely our conceptualisation points us in this direction?

We should not be fooled by the there-is-no-money argument which then leaves us divided against our fellow health disciplines in scrambling for ever decreasing pieces of the pie.

The questions to answer are; how are we actively and passively complicit in our own demise and the increasing misery of the people of this country and how do we choose to respond? Individual action will not suffice, collective action is essential. Ironically, if we remain quiet, accommodating, and self-involved we will experience the same alienation, unhappiness, poverty, and ill health as those we claim to serve. Finally, these actions and strategies should be our own, devised within the uniqueness of our local context; drawing from wisdoms, insights and ideas elsewhere but not subservient or naively accepting to these, that is, we need to sculpt Kiwi solutions for all of Aotearoa's people.

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Bringing Psychological Research Into Public Dialogue About Preventing Sexual Reoffending.

Gwenda M. Willis

Gwenda Willis is a clinical psychologist and senior lecturer in the School of Psychology at The University of Auckland. Her research and clinical interests are in criminal justice/ forensic psychology, with a focus on understanding and preventing sexual offending and strengths-based approaches to offender rehabilitation and reintegration.

Sexual violence infiltrates news headlines on an almost daily basis. People want to know how to keep their children safe. People want to know how they can be assured that someone with a history of sexual offending will never offend again. Many psychologists hold specialised knowledge about the individual, relational and societal influences that support the perpetration of sexual violence and most importantly, how to prevent repeat sexual crimes. Such information is typically lacking from media reports of sexual crimes, which often perpetuate myths about sexual offending (e.g., that all sex offenders are incurable "monsters" or "beasts") and leave the public with little knowledge about prevention. Sexual violence is a community problem with community solutions, and engaging the public is crucial in efforts to eradicate sexual violence. In this brief article I share two very different experiences of public engagement, and conclude with some thoughts on effective strategies for engaging the public on a highly emotive topic.

A Pre-Election Public Debate

How do we keep our children safe from sex offenders? That was a question at the centre of a recent public debate organised by the Sensible Sentencing Trust (SST). SST believes a publically accessible online register of convicted sex offenders is a solution. Their recently launched website www.protectthatchild.co.nz states "The public have a right to know who these offenders are to protect themselves and their families from risk." More than a decade of research into the (in)effectiveness of public registers in the United States demonstrates that a public register will not protect communities from sexual violence. Worryingly, a public register might compromise community safety. I was invited to offer an academic voice to the debate.

The debate was held on a wet and windy day in mid-July 2014, at Auckland Grammar School's Centennial Theatre. The weather didn't deter a crowd of staunch SST supporters. Dotted amongst them were members of Just Speak, MPs, students and other interested members of the public. Pictured below, my fellow panel members were Kim Workman (Rethinking Crime and Punishment), Ian Tyler (retired UK Detective Chief Inspector), Derryn Hinch (Australian broadcaster), and Anne Marie (survivor of sexual abuse). The debate lasted three hours and was chaired by Wellington based lawyer and former ACT List MP Steven Franks. Each speaker presented their views for 15 – 20 minutes each, interspersed by questions and comments from fellow panellists and the audience. Emotionally charged debate encapsulated what time was left.

Sensible Sentence Trust's draw card and main weaponry for the debate was Australian veteran broadcaster and media personality Derryn Hinch. Derryn Hinch, introduced as a "man of his convictions," has spent time in prison for breaching name suppression orders in his campaign for a national publically

accessible register of convicted sex offenders in Australia. Our opposing views were reflected in newspaper headlines in the lead up to the debate: "Heavyweight help for Sex Offender Campaign" and "Kneejerk Reaction Could Increase Reoffending" (both appeared in the *New Zealand Herald* 12 July 2014). In my 20 minutes, armed with empirical research and a commitment to preventing sexual violence, I outlined why public registers of convicted sex offenders would not keep our children safe from sexual abuse:

Public registers are too late. Public registers are a reactive response to horrific crimes. They are too late to protect children and adults who have already been harmed. Approximately 80% of men in prison for sexual offences against children in New Zealand are first time sex offenders – meaning they would not have been on a public register had there been one.

Public registers only include convicted sex offenders. The majority of sexual crimes are not reported to Police, and of reported crimes, many do not result in a conviction.

Public registers are poorly targeted. If we're serious about keeping our children safe, we need to take a serious look around us. Children are at a far greater risk of sexual abuse from people they know and trust. In one large New Zealand study, 85% of sexually abused women were abused by a male family member. Abusers typically have established relationships with victims, yet registers target the people living amongst us who we don't know. It must be acknowledged that there are a minority of convicted sexual offenders who are at a heightened risk of reoffending. These are the people we hear about in the media; they include the minority of repetitive offenders who target stranger victims. These are the individuals we have reason to be concerned about, and where carefully orchestrated public notification may be warranted.

Public registers do not reduce rates of reoffending. Numerous studies in the United States have analysed reoffending rates before and after the introduction of public registers, and the overwhelming majority of studies have found no differences in rates of reoffending. Alarmingly, public registers might unintentionally increase the risk of reoffending through blocking ex-offenders' access to stable housing and employment. Research shows that ex-offenders without somewhere to live, without people to be accountable to, and without employment opportunities are at a heightened risk of reoffending.

Taxpayer dollars can be better spent on empirically supported sex offender management strategies. I spoke briefly about empirically supported approaches to reducing sexual reoffending, including specialised treatment programmes that adhere to principles of effective correctional interventions (i.e., risk, need, and responsivity) and comprehensive release planning processes including attention to housing, pro-social support, and employment needs.

My attempts to highlight a shared goal of preventing sexual offending were met with staunch disagreement from Derryn Hinch and confrontational demands that the public "had a right to know" about who is living amongst them. There was a lot of anger in the room and reasoning was difficult.

Post-Debate Reflections

I came into the debate believing that the panellists and audience all shared the same goal of eradicating sexual violence. It seems I was mistaken, and that Derryn Hinch and his supporters placed the public's "right to know" ahead of the goal of community safety. Feeling safe seemed to be more important than actually being safe. Public registers create a false sense of security, which is perhaps more appealing than actually addressing the reality of sexual violence in our families and communities. Some psychologists might refer to this as externalising responsibility.

I was grateful to the Sensible Sentencing Trust for having me speak at their debate, and for encouraging public dialogue on an important issue. I would later learn that my participation had given some audience members something to think about, which is perhaps all I could expect in an environment where people opposing public registers would have struggled to have their voices heard. Indeed, a prominent Labour MP walked out when several audience members and panellists spoke over her.

A Different Experience: Public Engagement through Theatre

A couple of weeks after the debate I was sitting in an audience following a production of the New Zealand plays *Portraits* (Stuart McKenzie and Miranda Harcourt) and *Verbatim* (William Brandt and Miranda Harcourt), based on real cases of violence and sexual violence and developed through interviews with offenders, their families, and their victims' families. The plays are a form of docu-drama – they are performed by talented actors and actresses but every word is real. The following review captures the ambience of the plays:

> *Verbatim and Portraits are confronting. They make you think. And think about things you may not want to*

consider, like what was going through offenders' minds at the time of their horrific crimes. It's rare to feel empathy for offenders when reading crime news reports. Putting the stories in a theatre opens up new complexities. The real strength of these two plays is their authenticity. Words have been taken straight from real people's mouths and you can feel that honesty in the lines. Fear, shame and anger trip up in painful laden repeated words and redundancies. (For the full review see http://metromag.co.nz/culture/stage/theatre-review-verbatim-portraits/)

Following each production, the cast, crew and guest speakers form a panel on the stage, reflect on the works, and invite audience questions and discussion. I was a panel member at earlier performances during which thought provoking discussions about sex offender treatment and management unfolded. At this particular performance, a man in the front row of the audience raised his hand to speak. He told his story of going to prison for murder, and subsequently turning his life around. He spoke with courage, compassion and honesty. Like the content of the plays, his account gripped the audience's attention and challenged many people's views of ex-offenders and their capacity for change.

Concluding Thoughts

A necessary precursor to rational, informative discussion about highly emotive topics is creating an environment in which facts and research are palatable. Correcting misperceptions through the provision of information on its own is unlikely sufficient to influence affectively laden attitudes. Sharing stories and engaging audiences on an emotional level have power to create the environments necessary for reasoned discussion.

and our clients have stories, and these stories can help all people (professionals and the lay public alike) understand the complexities of the lives affected by sexual abuse. Our clients' stories can challenge the prototypical sexual offender depicted in the media. Even our own stories can help those outside the field understand how we are all ultimately fellow travellers to prevent sexual violence.

Regardless of the specific field we work in, at times proposed policies and legislation will conflict with psychological theory and research. Participation in public forums therefore becomes an important yet challenging part of our role. Notwithstanding attacks to my professional integrity during the debate and in blogs afterwards, I believe it was a task worth tackling, but not without a fair amount of preparation and collegial support.

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Gerald Monk, USA
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more to come, check our website for regular updates:
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"There's no cloud of shame on me": Māori men's experiences of prison-based psychological rehabilitation - Part II

Damian Terrill & Neville Robertson

Damian Terrill is an independent researcher with interests in culture, identity and organised crime.

Neville Robertson is a senior lecturer in community psychology at the University of Waikato.

Damian Terrill and Neville Robertson explore the role of bi-cultural practice in the delivery of psychological treatment within a New Zealand correctional setting.

Abstract

Bi-cultural practice is of paramount importance for New Zealand-based practitioners. In Part I, we presented an overview of the circumstances surrounding bi-cultural practice in the broader context of colonisation and correctional policy. We briefly reviewed some of the literature which currently informs treatment approaches within prisons. We identified an over-reliance on quantitative research and a lack of studies of Māori men's lived experience of treatment regimes. In Part II we make a modest effort to address this lack by presenting a study of three Māori men who underwent the Special Treatment Unit – Rehabilitation Programme (STU-RP) in a New Zealand prison. Bi-cultural practice was of particular importance to these men. Amongst their many reflections, they explained how a specific bi-cultural therapy intervention played a prominent part in each of their treatment experiences, most notably in the development of a robust therapeutic alliance. We follow this up by drawing upon our collective encounters as Pākehā (New Zealand European and first generation European immigrants respectively) working in bi-cultural settings to outline some considerations which may assist other practitioners in reflecting upon and developing their own bi-cultural awareness.

Keywords: prison; rehabilitation; colonisation; bi-culturalism; Māori; qualitative.

In part I, we reviewed the context surrounding bi-cultural practice in the New Zealand correctional system. We highlighted the apparent drive to quantify, measure and interpret psychotherapeutic intervention through an ostensibly Western scientific lens, and identified a clear and present need for ongoing research into bi-cultural matters. In Part II we offer further empirical insight into the field of bi-cultural inquiry by examining the perspectives and experiences of three Māori men who undertook the Special Treatment Unit – Rehabilitation Programme (STU-RP) within a New Zealand prison. Acknowledging the inherent subjectivity of our approach, the sensitivities which are sometimes attached to discussion about cultural justice and the intangible, sometimes ambiguous, nature of the material discussed, we recognise that our perspectives will not be met with agreement by all readers. However, it is our intention to inspire debate by contributing a much-needed person-centred discourse to scholarship in psychology which is often heavy on decontextualised statistics but light on more human narratives.

In the still-dominant drive to quantify human behaviour, we urge the critical reader to remain mindful that behind every data point is a person, and that every person no matter how troubled, marginalised or overlooked, brings a unique contribution to understanding the complex social and cultural systems in which we are all embedded. As Bhabha and Parekh (1989) observe, a society can only develop its true public culture when its minority cultures are empowered with the confidence and public space to undertake meaningful dialogue with the dominant cultural group. We maintain that the prison system is, unfortunately, a significant setting for just such an endeavour.

Background

The overarching objective of this discussion is to provide a detailed insight into the impact of an intensive rehabilitation programme upon three Māori inmates deemed to be at high-risk of re-offending. Participants for this study were recruited from an overall cohort of "high-risk" male offenders who had either completed, or were due to complete the STU-RP, a full-time, residential rehabilitation programme located in a low-medium security classification unit of a New Zealand prison.

Whilst each of the participants in this study are Māori, the Unit is open to men of all ethnic backgrounds. That is, the Unit is not a designated Māori Focus Unit (MFU), but it embraces certain aspects of tikanga (correct procedure, custom) such as waiata (song, chant) and karakia (incantation, prayer), displays various forms of Māori artwork and incorporates into some of its programmes specifically Māori models (e.g.,Te Whare Tapa Whā (Durie, 1998)) and processes (e.g., whakawhānaungatanga (establishing relationships)). The Unit is staffed by psychologists, programme facilitators and custodial officers from a range of cultural backgrounds. The majority of the staff members are Pākehā (or Anglo/European), many of whom are overseas-born.

Established in February, 2008, the STU-RP is a mainstream rehabilitative psychological intervention. It is defined by Lammers (2009) as an intensive, group-based criminogenic rehabilitation programme delivering CBT and DBT-based treatment. According to Kilgour and Polaschek, the STU-RP "aims to address the complex offence-focussed needs of male offenders with a high risk of general and violent re-offending" (2012, p.3). The STU-RP is a full-time programme lasting nine months, with participants living and working in an environment described as a Community of Change (CoC) (Department of Corrections, 2009).

The CoC ethos accords with the treatment philosophies of the therapeutic community which include fostering personal-responsibility, a focus on the whole person, a structured routine, a flattened hierarchy and harnessing group processes to achieve therapeutic goals (Campling, 2001; Sacks, Chaple, Sacks, McKendrick & Cleland, 2012; Ware, Frost & Hoy, 2009). The Unit's CoC emphasises community participation, communalism and shared decision making (Department of Corrections, n.d.). The CoC is considered central to the Unit as it encourages community participation between prisoners and staff with the intention of 'help(ing) them (participants) learn how to live communally' (Department of Corrections, 2009). Consequently, the CoC forms an integral part of the rehabilitative and re-integrative processes.

It is important to note, however, that the practicalities of communalism and shared decision making in a custodial environment have been actively challenged. For example, Woodward (2002, as cited in Lammers and Whitehead, 2011) observed how therapeutic communities have the potential to create confusion within a custodial setting. As a corollary, Lammers and Whitehead describe the therapeutic community of the Unit in which they are based as hierarchical. Within this format, custodial staff and therapists adopt the role of guides to change, with the community itself formulating the method of change.

The STU-RP consists of 250 hours of treatment, with participants receiving twelve-hours per week of group-based therapy which is complemented by individual treatment as necessary (Lammers, 2009). To be considered for treatment, participants must be aged twenty-years or more, have been sentenced to a term of imprisonment of two-years or greater and score 0.7 or above (equating to "high-risk") on the Departmental static risk assessment tool (RoC*RoI) (Bakker, Riley & O'Malley, 1999). They must also have at least one violent offence in their criminal history. Once accepted onto the programme, participants are divided into treatment groups of approximately ten; however, this can change as participants can be exited from the programme at any point for breaching prison regulations (Lammers, 2009).

Treatment consists of a series of interrelated modules, many of which are modelled on the Medium Intensity Rehabilitation Programme (MIRP). These include

1. Whakawhānaungatanga – Getting to know one another/Developing a working culture.
2. Offence Mapping/Inga ra o muri/ The old script.
3. Te taha hinengaro: Looking at thinking/changing thinking.
4. Te taha hinengaro/Managing feelings/Ngākau, deep seated emotions/Whatumanawa – particularly anger/riri and managing impulses.
5. Te taha whānau – Relationship Skills and
6. Mai ki te po ki te ao mārama: From the world of darkness to the world of light - safety planning: Putting it all together (Department of Corrections, 2006).

Inmates also had the opportunity to engage in bi-cultural therapy. This was offered on a weekly basis for a period of approximately two-hours and enabled participants to work alongside a local kaumātua (respected elder) in activities such as whakairo (carving), waiata, te reo (Māori language) and other Māori cultural practices.

Within the STU-RP, group therapy sessions are delivered in an interactive manner, with facilitators using a variety of learning activities (e.g., art, role plays and group discussions). In addition to their classroom-based activities, participants are required to complete self-directed homework tasks which are designed to elicit further

reflection and encourage the ongoing development of the skills and techniques discussed in the classroom (Lammers, 2009). Upon completion of the STU-RP, graduates participate in a post-treatment assessment and attend a maintenance group (Kilgour & Polaschek, 2012).

Method

Having obtained ethical approval from both the Department of Corrections and the University of Waikato, the lead author held rapport building meetings with potential participants to introduce himself and explain the ethical requirements of this study. Six participants were recruited. This paper focuses upon three Māori offenders: two had completed the programme ("Jerry" and "Al"), while the third ("Jay")[1] was expelled from the programme after being found in possession of a cell phone in contravention of prison regulations. They were all versatile, recidivist offenders deemed high-risk of re-offending by Departmental risk assessment tools and were serving terms of imprisonment for offending involving violence. Their ages ranged from 22 to 40.

In recognition of the cultural differences between the lead author (Pākehā) and the Māori participants, cultural supervision was sought with the Unit's Bi-cultural Therapy Model (BTM) facilitator, a local kaumātua. The kaumātua highlighted the necessity to commence and close each interview with karakia. He expressed the need to be mindful of differences in communication styles (both verbal and non-verbal) and to remain sensitive to the intricacies of Māori protocol at all times.

In addition, interviews were conducted with three staff members; two were programme facilitators, and one a custodial officer. All three were Pākehā. These interviews provided valuable insight into the delivery of treatment in the STU as well as staff-offender interactions in the everyday running of the STU. The staff interviews also provided an opportunity to clarify points raised by the offender participants. Each of the participants was interviewed face-to-face on at least one occasion for up to two-hours. Follow-up meetings were conducted as necessary.

The interview data were subjected to systematic content analysis to identify and extract those themes and patterns that most accurately described the participants' experiences. Data were alternately expanded and compressed in a manner described by Frost (2004). As the data were accrued conceptual relationships between data sets were proposed (compression). The credibility of the relationships were then scrutinised by reflecting them back to the interviewees (offenders and staff) through the process of expansion. This procedure was repeated until no new categories were identifiable (compressed) (Frost, 2004). The analysis was conducted from the perspectives of a postmodernism and social constructionism.

1 Pseudonyms

Findings: Ngā pakiwaitara nō ngā herehere (Narratives from prisoners).

While the interviews canvassed a wide range of issues related to the STU-RP and its impact on the participants, in this paper, we will focus on just one theme, the importance of bi-cultural therapy.

Māori cultural paradigms are reflected in various ways in the day-to-day practices of the Unit. For example, CoC meetings are opened and closed with karakia, te reo is used frequently in signage and everyday greetings, and waiata are incorporated into group sessions. STU-RP participants are given an opportunity to broaden their cultural knowledge through participation in specialist bi-cultural therapy modules delivered by BTM facilitators. Those who elect to do so are encouraged to explore their cultural identity. The participants spoke favourably of these aspects of the culture of the Unit; however, for two of the three, its effects were especially potent.

Jerry and Jay had previously been held in specialist Māori Focus Units. Both men spoke positively about their time in those units and saw the BTM as an opportunity to build on what they had already learnt. Jerry commented

> *I thought it (Bi-cultural Therapy Module) was quite good … yep… I come from a Māori Focus Unit before I come to this unit. So it just sort of enhanced what I already knew. You know, it extended my vocabulary and in the Māori language and yeah, yeah, I learn more about the area that I am in. Yeah.*

The importance of place and understanding local culture was reflected in a similar comment by Jay.

> *It (BTM) brought back memories … whereas, I was down Taranaki they had Taranaki protocols. Here they are Tainui protocols. Different: yeah, lot different so it was "Oh yeah, choice" you know, some more – um – skills and knowledge.*

These comments speak to the rehabilitative value of acquiring specific cultural knowledge and skills which are generally seen as outside of the scope of the dominant CBT paradigm. For example, references to understanding local kawa (protocols) remind us that a sense of place, is, for many people, an important part of health and wellbeing (Frumkin, 2003). Growing fluency in te reo gave Jerry

pride and a sense of accomplishment. In this light, BTM can be considered to be making a small but significant contribution to ameliorating some of the harms colonisation has inflicted on Māori offenders and their whanau, hapu and iwi – and to reducing the risks of these men re-offending.

Jay described how he benefited from a robust therapeutic bond with the BTM facilitator, whom he called "matua" (father, or, by extension, an esteemed older man).

> *I found him available … I enjoyed his company, his good character and he was kind. (He) came across as passionate with the fatherly role, the matua role. I loved him, loved him.*

Here, Jay expresses a connection beyond the scope of a conventional Western therapist-client therapeutic alliance: Jay "loved" matua. Matua's availability, passion, warmth and compassion, could, from another perspective, be considered to breach some of the boundaries a Western therapist would be expected to observe (Britt & Kalders, 2007). Matua is not Jay's father in the literal sense but his relationship with Jay provided a degree of paternal nurturing. Jay's commentary emphasises the "who" of "treatment". It suggests the value of person and deep personal connection over technique and presumed objectivity. In doing so, it presents a direct challenge to the "science" of CBT.

As Tamatea and Brown (2011, p.177) have noted, specific cultural possibilities are opened up when an offender comes to regard a practitioner as matua. Here, the opportunity to use te reo was one such possibility. Like Jerry, Jay reflected on the role of te reo. Being able to converse in te reo with a man he felt understood him was a transformative experience for Jay.

> *…cause I love my language you know and there's nobody else I can talk to in it in there … I could come in and it would sort of take me back into that therapeutic surroundings again, and then I'll forget I'm actually incarcerated sometimes, until I walk along by the gate "Oh hey"! 'til I see the green uniforms and it reminds me.*

It is apparent Jay experienced a deep cultural connection in the conversations he shared with matua, and that he felt a robust sense of psychological wellbeing in matua's presence, sufficient, in fact, to allow him to forget, albeit temporarily, that he was in prison.

But while prison was not the place he wanted to be, for Jay, the Unit did at least sometimes provide a sense of community and opportunities for mastery.

> *I think everybody moves in a group, there's no capital – you know. Everyone's a (community) … That's part of being a Māori … I lived in a (community). … While I've been incarcerated (I began) finding my language (I)… get up and do mihi (greetings), pōwhiri (formal welcome) … There's no cloud of shame on me.*

Jay's reflections would suggest that his experiences of community in his upbringing enabled him to establish connections within the CoC of the Unit. They also highlight the importance of mastering te reo and of public "performance" in Jay's development. Traditionally, notions of whakamā involve personal reticence – expressions of shame through non-verbal means, 'to "speak" by not speaking' (Metge & Kinloch, 2001, p.29). By being able to mihi and to play a role in powhiri, Jay has been able to move out from under the "cloud of shame" cast by his offending.

Further discussing his therapeutic interactions, Jay went on to describe how matua encouraged him to examine his thoughts, feelings and behaviours on a daily basis and learn from his insights. This appeared to be an important learning experience for Jay:

> *…making sure I'm getting out of my comfort zone … and take on other challenges or learning out of things …*

For Jerry, an important part of bi-cultural therapy was developing self-respect, something he linked to reducing his likelihood of re-offending.

> *Um, it sort of give me a sense of um, um, you know – respect for myself and um, yeah just try and respect others. If you respect yourself you tend to respect others as well. When it comes to, just yeah, um you know – if I am going to offend with someone I'm not really respecting them other people and that.*

That is, he appeared to have discovered the importance of first respecting one's self in order to respect others. He recalled how Te Taha Hinengaro (mental focus) component of Te Whare Tapa Whā model, was particularly useful in facilitating this.

> *…there was Te Taha Hinengaro - just looking at the way we think and that … on the first module we had um, they introduced Te Whare Tapa Wha. That was like our four cornerstones. Yeah, it's like our thoughts, our spiritual wellbeing, our physical, respecting our physical self and just keeping them all in balance, because, you know, when… ones out of balance it sort of affects the person, yeah.*

Jerry described the discomfort he feels when he becomes aware of a discrepancy between his spiritual,

physical and psychological wellbeing. He observed that by focusing upon the influence of his thoughts, feelings and actions across all levels of existence he will be better able to self-regulate upon release.

In comparison to those of Jerry and Jay, Al's engagement with the BTM was notably short-lived. Al explained how the scheduling of the BTM intervention clashed with his recreation time and that he chose to go to the gym rather than attend the BTM sessions:

> *I started it (Bi-cultural Therapy Model) at the beginning when I first got here, but I stopped about six-weeks into it … the afternoon's sort of the only time you can get to go to the gym. So um I just used that same time as the BTM and I'd just rather keep fit… Some people prefer to learn Tikanga Māori, but um it's a personal thing.*

It seems unfortunate that Al found himself in a position whereby he felt he must choose between physical fitness and the psycho-physiological wellbeing that others discovered in the BTM - something which for them formulated a crucial part of their overall therapeutic experience.

CONCLUSION

Depriving an individual of his or her freedom is a serious affair, not only for the individual, but also for the family and community to which that individual belongs. As the literature discussed in Part I shows, the imposition of a British-derived criminal justice system, along with the devastating impact of colonisation generally, have left a legacy of significant disparities. Māori have a disproportionately high level of imprisonment. Māori detainees have an elevated risk of developing psychopathology. Upon release, Māori remain at a high risk of re-conviction. These circumstances require us to consider the ways in which criminogenic rehabilitation can be delivered to Māori inmates in a way which will enrich their therapeutic experience. To do otherwise, would be to abrogate the Crown's responsibilities as embodied in Articles II and III of Te Tiriti o Waitangi[2].

The path to enduring change is a delicate one, fraught with complexity. The first steps along it must be taken tentatively, guided by a willingness to learn and founded in a determination to understanding. Surely there can be no better opportunity to learn about the rehabilitation of imprisoned Māori than from Māori detainees themselves. Jerry, Al and Jay provided unique perspectives of some of the cultural factors affecting rehabilitative treatment. They brought their experiences to life through their detailed disclosures of the intricacies, complications, learning opportunities and emotional upheavals which intersected and interceded one another to characterise prison life for them at the time.

It is apparent that cultural identity was of central importance to all three men. Here identity was achieved in part through performance: for example, te reo, waiata, mihi and powhiri. It was also achieved through relationship: for example, Jay's close relationship with matua and the priority he placed on learning the kawa of the tangata whenua when he was transferred to a prison in a different rohe). Jerry and Jay found in Te Whare Tapa Whā model, something far more profound than a simple paradigm for self-monitoring. Supported by the advances made in terms of their language, their enhanced connections with the land and the comfort of robust therapeutic bonds, Jerry, Al and Jay discovered a means of understanding self-identity that was sensitive enough to nurture the subtleties of their cultural persona, yet broad enough to develop their overall social schema.

In particular, this research has highlighted the value of the BTM. Each of the participants had engaged with it to varying degrees and all reported positively on their experiences. The consistently upbeat nature of this feedback would suggest that the BTM holds considerable value for the STU-RP participants: the greater one's exposure to BTM, the more relevant it became. Moreover, the sense of security and support established (through matua) in the delivery of the BTM had a notable impact on the psychological wellbeing of the participants (Jay in particular). It is unfortunate that alternative timetabling arrangements could not have been made to enable Al to experience the benefits of completing the BTM in addition to those associated with physical fitness. It is disconcerting to observe how a rehabilitation programme participant found himself in a position where he had to sacrifice the holistic benefits of physical, spiritual, psychological and familial wellbeing (Durie, 1998) associated with the BTM, for the opportunity to engage in physical recreation. Future criminogenic interventions may wish to consider the timetabling of their activities so that their participants may engage in the full remit of activities and interventions.

The culturally-specific insights identified as salient by Jerry, Al and Jay shed light upon the fragmented, isolated manner in which they perceive their existence in the social world.

2 Although it is beyond the scope of this article, a more complete discussion of the implications of Te Tiriti for the criminal justice system is needed. Such a discussion would raise questions about the meaning of Article I (the so-called kawanatanga clause) and the implied limits on the Crown's power in relation to tangata whenua. See *Ngapuhi Speaks: He Wakaputanga of te Rangatiratanga o Nu Tireni and Te Tiriti o Waitangi, the Independent Report on the Ngapuhi Nui Tonu Claim* (2012: Te Kawariki & Network Waitangi Whangarei.)

The resultant existential naivety perpetuates a continuously revolving vicious cycle of isolation, offending and imprisonment. For Jerry, Al and Jay offending behaviours can be perceived as intimately connected to an existential crisis anchored in the loss of cultural identity. Seen in this light, interventions which address cultural needs, such as a BTM, are likely to be particularly efficacious. To further advance the health outcomes of Māori it is critical for the progress gained in matters of bi-cultural understanding to be allied with equal opportunities in the wider public forum.

Through deep, reflective conversations, this research has generated insights not usually available in conventional Western correctional research which tends to value detachment, objectivity and non-transparent measurement over engagement with participants. We believe that research such as ours has a vital role to play in the evaluation of prison and other correctional programmes. Although very little has been written around the experiences of imprisoned Māori, particularly those undergoing intensive rehabilitative therapy, the weight of academic literature (Friendship, Blud, Erikson & Travers, 2002; Friendship, Blud, Erikson, Travers, & Thornton, 2003; Landenberger & Lipsey, 2005; McGuire, 2002; Polaschek, Wilson, Townsend & Daly, 2005) supports the view that prison-based CBT-styled interventions are effective in reducing recidivism. However, our research raises an interesting question: if these three men do indeed go on and live non-offending lives, to what extent can that positive outcome be attributed to the CBT programme and to what extent can it be attributed to the BTM – or to other experiences within the Unit? This is not a trivial question. Unless we understand much more about the lived experience of inmates undergoing treatment programmes, we may make incorrect attributions about the effectiveness of our interventions. We may waste time and effort on things which don't make a difference – or are counter-productive – for at least some participants. We may fail to maximise those aspects of our programmes that really do make a difference. By throwing light on the lived experience of programme participants, qualitative research has an important role to play in criminal justice research.

None of this will come as a surprise to readers familiar with the literature on programme evaluation. Over the last 40 years, programme evaluation has moved a long way from an unquestioned hypothetical-deductive paradigm borrowed from the tradition of agricultural field trials (Patton 1978). That paradigm relied almost exclusively on quantitative measures, experimental or quasi-experimental designs and statistical analyses (e.g., Posavac & Carey, 1980). It was a paradigm concerned only with the assessment of outcomes.

Modern evaluation, on the other hand, emphases multiple methods, engaging with stakeholders (including programme participants), and, in particular, the importance of studying programme processes – along with programme outcomes (American Evaluation Association, 2004; Guba & Lincoln, 1989; Lunt, Davidson & McKegg, 2003). The folly of studying only programme outcomes and ignoring programme processes is now well-understood. Without studying programme processes, including participants' experiences, the programme remains what Patton has called a "black box" (1978, p.129). We cannot see what goes on inside and simply assume that what we think is happening is in fact the case. (See Patton (1986, pp142-144) for an interesting example of the black box in criminal justice research). Qualitative research has a vital role in unlocking the black box.

Despite the much-needed depth of insight and richness of detail offered by qualitative research it continues to be marginalised in criminal justice research. Accordingly, the primary objective of this paper was to document Māori men's perspectives of rehabilitation within the context of a New Zealand prison-based Special Treatment Unit Rehabilitation Programme and consider some of the implications for how therapy is delivered to them.

The study raises interesting issues about the conduct of research across cultural difference. The cultural gap between the interviewer, a non-Māori British immigrant, and the Māori participants is palpable. The inherent cultural dissonance may have engendered an undercurrent of estrangement, distancing the offender participants and interviewer in unspoken scepticism, or given the perils of colonisation, an air of hierarchically-driven mistrust. Conversely, approaching the interview process as an outsider, untainted by the biases of familiarity, may have carried some important benefits. It provided the offender participants with an opportunity to speak candidly (without fear of redress) to an external person; someone not only detached from the penal system, but from their wider socio-cultural network. Whichever way one views this difference, it is important to understand the enormous contribution made by the cultural supervisor. Cultural supervision provided much-needed insights into the practicalities associated with the interview process, and guidance as to the general spirit in which the process needed to be

framed. We strongly recommend such supervision to other non-Māori researchers who may be contemplating similar research.

An obvious limitation of this research is the small number of participants. It would be unwise to attribute these findings to broader groups. The findings are offered as tentative explanations: they require further research in order to assess how widely they are shared (and among who).

The richness of the overall data could have been enhanced by the inclusion of naturalistic observations as these would have enabled the interviewer to witness some of the events described by the participants and facilitators. Although a great deal of data was obtained through one-to-one interviews the collection of these additional data would have enabled more effective triangulation of the information acquired. Therefore, their inclusion in future projects of this nature is recommended. Such triangulation is well-recognised as best-practice in evaluation research.

In conclusion, the rehabilitation of offenders remains a fascinating, complex area of academic enquiry which is continually evolving to reflect the equally dynamic, broader cultural zeitgeist which encompasses it. It is hoped that this research will offer an insight into some of the challenges facing those individuals who are engaged in the rehabilitation of Māori offenders. In particular, it reminds us of the limitations of some mainstream therapies which tend to be overly individualistic in focus and pay little attention to the cultural context in which offenders live their lives. It also points to the importance of providing a milieu in which offenders can strengthen their engagement with Te Ao Māori and ensure that they develop a positive identity as Māori so that "There's no cloud of shame on me".

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We feature papers based on the keynote presentations at the conference from Michael Daffern, Andrew Munro and Harlene Anderson

The perils of practicing psychology: Aggression, violence and other threats to wellbeing

Michael Daffern

Michael Daffern is a clinical psychologist who has worked in mainstream adult psychiatry, forensic mental health and correctional settings. He is currently professor in clinical forensic psychology with the Centre for Forensic Behavioural Science at Swinburne University of Technology. He is also principle consultant psychologist with the Victorian Institute of Forensic Mental Health (Forensicare). His research concerns personality disorder and the assessment and treatment of violent offenders and offender rehabilitation more generally.

Violence in the health care sector constitutes almost a quarter of all incidents of workplace violence (Nordin, 1995); it can have profound personal and professional impacts. Violence in the health care sector is dissimilar to 'horizontal violence' (violence perpetrated by one employee towards another); psychologists and other health care workers are sometimes assaulted, threatened or otherwise harmed by people for whom they are attempting to assess or treat. Unfortunately, despite potentially significant personal and professional impacts, the issue of violence against psychologists is rarely studied; this limits our understanding of the phenomenon and our capacity to generate informed preventative strategies that might limit harm.

This paper encourages psychologists to consider issues pertaining to aggression, violence and other threatening behavior. It highlights the need to consider, and it briefly explores causal factors, preventative strategies, as well as some considerations for what to do in, and after, a critical situation. Space does not permit an exhaustive review; the purpose of this paper is to stimulate discussion so that safety in the workplace can be enhanced. This is a precondition for psychologists to be present and engaged with their clients so that productive work can occur.

What do we know about workplace violence?

The precise prevalence and nature of aggression and violence against psychologists is unclear; there is very little research on the topic. Further, like much research on aggression and violence, the extant literature uses varied definitions, which limits prevalence estimates. Hyde (2014) suggests that a focus on 'aggression' and/or 'violence' restricts our understanding of the problem; she notes that a range of behaviours can adversely impact psychologists' wellbeing. Accordingly, Hyde (2014) prefers the term 'threats'; this encompasses behaviours that are (1) personal (e.g., direct challenges to our personal, physical and psychological integrity – e.g., being threatened by a client), (2) professional (e.g., attacks on our professional behavior, false complaints), (3) familial (direct threats towards our families or our families concerns about our work), or (4) directed towards colleagues.

The precise prevalence and nature of aggression and violence against psychologists is unclear; there is very little research on the topic.

The experiences of psychologists are typically subsumed within studies of violence towards mental health professionals more generally. This presumes that the nature of psychologists' work is similar. However, differences exist and the accumulated knowledge regarding violence towards other mental health practitioners may not generalise to the experiences of psychologists. For instance, violence against nurses within mental health units typically follows the denial of a patient's request or a nurse's demand for some sort of patient activity (Daffern, Howells & Ogloff, 2007). Psychologists do not commonly engage in these workplace interactions; as such, the nature and functions of threatening behaviour towards psychologists may differ.

The impact of threatening behaviour

There are various consequences to threatening behaviour. Psychological harms suffered vary and can include: reduced emotional wellbeing and stabilty, anger, disappointment, a sense of personal vulnerability, reduced motivation, nightmares, intrusive images, hypervigilince, irritability,

sadness and depression, feelings of hopelessness and demoralisation, and poor sleep (Hyde, 2014). Physical harms range from fatigue to death. Threats may also adversely impact our professional performance; they may reduce efficiency or render us incompetent. Some psychologists may become suspicious of their clients or become careful and selective about the clients they see. Pope, Tabachnick & Keith-Spiegal (1987) found that many psychologists reported working when they perceived themselves to be too distressed to be effective.

The causes or threatening behaviour

Understanding the causes of violence is critical to risk assessment and violence prevention. Certain symptoms of mental disorder appear to increase violence propensity (e.g., active positive symptoms of psychosis such as persecutory delusions or violent command hallucinations). However, an exclusive focus on client-centred factors likely impedes our understanding. Broadening our attention beyond client-centred factors to include consideration of environmental facilitators and protective factors and interactional factors permits a more comprehensive understanding of threatening behaviour; it also encourages the development of various preventative strategies. Such an approach is consistent with contemporary models of aggressive behaviour (Anderson & Bushman, 2002) that emphasize the importance of studying multiple interacting factors, including characteristics of the client, psychologist, and the setting.

An example of interactional and psychologist related causal factors is psychologist burnout. Burnout, which is sometimes a consequence of exposure to aggression, might actually increase vulnerability to aggression (Winstanley & Whittington, 2002). The emotional exhaustion that is experienced by people who suffer burnout may lead directly to an increase in depersonalization as a coping mechanism; this may manifest as negative behavioural change toward patients (which may be experienced by the client as indifference) that tarnishes the therapeutic relationship and thereby increases the risk for aggression.

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Minimising the risk

The extant literature includes several recommendations to prevent violence: (1) training in aggression management, (2) establishing a safe working environment (e.g., working in a safe location, not working alone or in an isolated location), and (c) conducting a risk assessment and instituting a risk management plan. Risk assessment should focus not only on client factors (several structured risk assessment measures exist that facilitate a comprehensive appraisal of violence risk), but also factors pertaining to the psychologist (personal factors the psychologists brings to the work that might increase violence risk, such as poor therapeutic skills or a domineering/authoritarian approach), and treatment/task related risk factors (some work tasks increase violence risk such as working with mandated clients or with people in conflicted relationships, particularly when issues of access and protection of children are being considered).

In their discussion of stalking of health professionals Pathé, Mullen & Purcell (2002) list the following preventative strategies: (1) preserving privacy and security (remember, once you permit access to your personal details you can't ask the client to forget them and you also can't control where that information goes-a trusted client may share your personal information with somebody whom you have a troubled relationship); (2) establishing and maintaining clear boundaries and addressing the patient's attempts to undermine these; (3) informing colleagues and other relevant parties if the client engages in threatening behaviour; (4) transferring the client's care, and (5) considering legal action (stalking is a crime and so is threatening to kill). More generally, when working with high-risk clients, psychologists should try to (1) be clear, direct, open, respectful and honest; (2) remain alert, firm and consistent; (3) work actively to promote engagement, and (4) support the client's autonomy. Outlining expectations and standards of behavior, and the consequences of same, may help create a fair and transparent process.

If threats occur during a psychological treatment session then a key question is whether to attempt to respond therapeutically or to terminate the session and escape the situation.

The prevention of boundary crossings and violations, which may result in conflict, is supported by regular high-quality professional supervision. Supervisees may benefit from supportive supervisors who are open and direct about the potential for threats; this may encourage reflection and problem solving. Inexperienced psychologists may gain particular benefit from discussion pertaining to practical privacy and safety issues (e.g., whether they should list their phone number). Frequent reviewing and exploration of ethical and clinical challenges is important. It may be helpful to acknowledge the

possibility of personal issues arising (e.g., feeling attracted to a client); it may also be wise and helpful to acknowledge that we sometimes experience strong negative emotional reactions to our clients; we may be fearful or upset by the behaviour our client reports. Supervision may permit proper processing of our responses so that we can establish and maintain a collaborative, empathic and respectful relationship. Additional peer mentoring may be helpful when the supervisor is a senior psychologist who holds line managerial responsibilities or personal qualities that impair openness (psychologists often report that peer supervision is helpful following threats (Ting et al., 2008).

In the critical situation

If threats occur during a psychological treatment session then a key question is whether to attempt to respond therapeutically or to terminate the session and escape the situation. Working therapeutically with a client in a high-risk state may be valuable if the client's behaviour is analogous to their other threatening behaviours; such therapeutic work may be more potent than working with distal problem behaviours that are recalled in session (for further discussion of this therapeutic approach see Function Analytic Psychotherapy (Kohlenberg & Tsai, 1994) or the Offence Paralleling Behaviour Framework described by Jones, 2004). The priority when considering whether to respond therapeutically with the threatening client is the safety of both the psychologist and the client. If psychologists choose to work therapeutically then it is important to try to remain calm, confident and assertive. Avoid confrontation and request the client discontinue their problem behaviour. If possible get a colleague to join the session to help; this can increase confidence and safety. If it is not safe to remain in the session to work therapeutically, then minimise interaction with the client, schedule a break or postpone the session, and leave the situation (Hyde, 2014).

Although psychologists are ultimately responsible for their own professional behaviour, supervisors play a critical role in the practice and wellbeing of their supervisees.

After the incident it is important to make detailed notes and seek support and supervision. Be mindful of the need for self-care and consider referral of the client to another psychologist. It may be wise to obtain personal therapy. Seek consultation to learn from the incident so that strategies can be developed that might lessen the likelihood of a similar incident occurring again. As a result of consultation, develop a safety plan for future work.

Conclusion

The wellbeing of psychologists is occasionally threatened by client behavior. Although psychologists are ultimately responsible for their own professional behaviour, supervisors play a critical role in the practice and wellbeing of their supervisees. They help shape professional practice and can provide emotional support and practical advice that can enhance safety. Supervisors should encourage discussion of issues pertaining to client threats; they should also be open to discussions concerning supervisees' personal responses to their clients so that issues pertaining to boundaries and safety can be discussed. Unless this is raised: (1) psychologists may fail to take proper preventative action to avoid harms, (2) they may violate boundaries that alter the nature of the relationship they share with clients, thereby increasing risk, (3) they may not seek help when they are victimized because they feel they will be negatively evaluated, or that they should be able to cope. We should not be reluctant to seek support; remember, we need to be in good condition to remain present and helpful. Despite supervisors' best efforts, some supervisees may not accept invitations to discuss personal reactions to clients or reflect upon and implement strategies that increase personal safety; it may be that peer support networks are a useful adjunct.

Finally, despite what appears to be occasional exposure to threats to our wellbeing, many, if not most psychologists continue to enjoy their work and cope well. The inherent value of our work likely acts as a protective factor, as does a high value within our profession on supervision. Nevertheless, we should reflect on our practice to ensure we minimise threats to our wellbeing.

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Mind the Gap: the growing gap between evidence and claim

Andrew Munro

Andrew Munro is a business psychologist based in the UK with over 25 years of international consulting experience across the corporate and public sectors. He also advises other consultancies in the design and implementation of applications in personal, team and organisational effectiveness. His work has led him to realize that a shift in thinking was needed to ensure that psychological theory, methodology and insight would have a practical impact. He established AM Azure Consulting to provide expertise, experience and support to the reality of client problems rather than insist on pre-packaged solutions. AM Azure had worked on a number of assignments including innovation within the higher education sector, senior team development in the Police Service and career development in the UK Civil Service.

The challenge

From its beginnings as a science in the late 19th century, psychology has engaged in a battle for "scientific respectability as well as with the forces of pseudo-science."[1] If the battle with pseudo-science shows little sign of lessening, the battle for scientific respectability has become more intense. Why is the gap between claim and evidence widening? What are the dynamics of this gap to explain why claims are becoming exaggerated, and what are the difficulties in building a coherent evidence base to support claims for efficacy? How might the discipline and profession respond to this gap?

Arguably this challenge also reflects the ongoing tension between the world of academic theory and research, and the domain of the practitioner engaged in the implementation of pragmatic solutions. The falling standard of evidence is now being exploited by the practitioner who can point to the lack of a credible and authoritative consensus, and continue happily to cherry pick from a questionable evidence base. At the same time the need for instant solutions to big problems may now encourage researchers to take short-cuts and over claim from the conclusions of research findings.

The increasing pressure to make big claims

Firstly psychologists are entreated to be **relevant** to the challenges facing society, organisations and individuals. This is psychology having a voice on the issues of the day to make a contribution to individual well-being as well as to the state of our institutions and society more generally. It is the need for relevance that for example prompted the claim that a resilience programme directed at over 1 million soldiers could tackle post traumatic stress disorder, substance abuse and suicide rates, despite the controversy over the evidence base[2].

Secondly claims must be **authoritative** to provide clear direction. Claims that attempt to reflect the messy uncertainty of context, cause and consequence will be lost in a complex world. Attention spans are short; a message must be unwaveringly confident and clear to provide reassurance of a claim that if we do X we will achieve Y. Philip Tetlock[3] points out the paradox in which the confidence of the authoritative expert is negatively correlated with the predictive accuracy of the claim.

Thirdly, claims must be kept **simple** in a noisy world. At best, theories meet the three criteria of simplicity, accuracy and generalisability. There are unfortunately few theories within psychology that meet all three criteria to deliver powerful elegance. The big claim is attracted to simplicity and generalisability, a combination that represents an easy solution which can be explained quickly with the promise that it works anywhere and everywhere. Accuracy is being sacrificed for universal appeal.

Finally, a claim is made in **competition with aggressive rivals**. In a world in which psychological science is competing against an array of other disciplines, including the frauds and charlatans, it is argued that psychology can't get too squeamish about the claims it makes. The profession must play hardball to hold its own in an aggressive world.

A combination of the importance of relevance, the need to be authoritative, simplicity in a noisy world, and competition against aggressive rivals has created any permutation of confusion, suspicion and cynicism. To paraphrase GK Chesterton, if no claim can be believed, any claim can be believed. Meaningful claims

with potential to shape informed interventions are being overwhelmed in the general clamour, and limited resources are misdirected towards flawed interventions with minimal, or even worse, adverse outcomes.

The increasing fragility of the evidence base

Evidence should as Carl Sagan suggested "winnow the deep truths from the deep nonsense". Unfortunately, just as claims are becoming more extravagant, our evidence base is looking increasingly fragile and vulnerable. Lee Jussim[4], social psychologist, recently asked the questions: How much of the product of our field can we really believe? And how can we tell what to believe and what not to believe?

If the battle with pseudo-science shows little sign of lessening, the battle for scientific respectability has become more intense.

Evidence building **always has been difficult**, and there is no reason to think it is getting any easier. There are puzzles and there are wicked problems. Science is good at puzzles; psychology has to apply the scientific method to the wicked problems. The sheer number of potential causal variables, at different levels of explanation, their interactions, the impact of non-linear relationships and multiplier effects make for a daunting enterprise.

If building an evidence base within the complexity of this field is tough, it is being constrained further by the **impact of flawed methodology**. Five problems can be highlighted:

1. The **focus of research** may be skewed towards the quirky, the unusual and the "gee-whiz" factor. No doubt this can be a dynamic of innovation, but it is not one that lends itself to the steady accumulation of a robust evidence base. It also makes for the cherry picking of the sensational and controversial much loved by the media.

It is questionable that we are looking at the important issues in the first place.

2. The **design of research**. We sample from the convenience of the WEIRD, sampling from western, educated from industrialised rich democratic countries, and go on to draw sweeping conclusions from this highly select group. Questionable research practices - to finesse our data-sets and analyses and reframe our hypotheses - have become prevalent in the field. In this happy world, statistically non significant results become significant, nearly all theory supported, all measures validated and our interventions are successful.

3. **Analysis**. Our evidence base is overly reliant on statistical inference which it now seems has often been wrong-headed[5]. Research conclusions are drawn from statistically under-powered studies which are generating a substantial proportion of false positives. This is evidence based on questionable interpretative practices.

4. **Publication bias** to select studies that report positive findings is well documented, and not new. Which editor wants to publish papers with the conclusion "nothing's happening; now please move on"? Other issues include the accuracy of abstracts of articles. James Coyne[6] has questioned how well abstracts in fact do summarise the conclusions from research, arguing that the common strategy of "best foot forward" over-states the findings and distorts the evidence base.

5. **Replication**. Greg Francis[7] points out that replication should remove many of the problems of statistical inference. An effect is found, that effect is reported again, and again, by a different research team, and confidence in the robustness of the finding increases. Unfortunately, a reproducible result may actually be quite a rarity[8]. John Ioannidis states that "in the absence of replication the vast majority of psychological research = unchallenged fallacies."

The way forward

For anyone with a sense of the history of psychology there must be a sense of déjà vu: we have been here before. Paul Meehl[9] commenting on the need for change within psychology 20 years ago remarked: "one has the uneasy feeling that, if all of this had been possible, it would have happened more than it has by now."

Claims that attempt to reflect the messy uncertainty of context, cause and consequence will be lost in a complex world.

Incentives within the field remain the fundamental problem. If a change in practice is going to happen it will need a fundamental rethink of how reward systems operate.

Max Plank famously suggested we have to wait for the "science to progress one funeral at a time." It may be a slow process to shift incentive systems.[10]

But there are reasons to be more cheerful in 2014.

A generation of psychologists, weary of the recent state of play are looking for improvements in practice, with social media providing a platform for the free exchange of information and ideas to accelerate innovation. The pressures for **greater transparency** in real time are shaping an expectation of more openness; openness of research aims, pre-registration of experimental plans, and the

willingness to make methodology and data accessible for others to review. Social media is also facilitating greater collaboration to build evidence based on bigger sample sizes.

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Transparency provides a stick as well as a carrot. The growing application of data forensics makes it easier to spot the "too good to be true" finding based on any research irregularities. The risk of the exposure of bad practice is now high. No doubt there is a potential downside to this transparency, and the danger of a shift to an atmosphere of negative psychology. Here fearfulness constrains genuine creativity and creates mistrust that is suspicious of others' efforts and outputs.

Encouragingly for the future of psychology the **end of ideology** might be in sight. The fruitless debates about, for example, nature vs. nurture or person vs. situation are largely coming to an end. It took us several decades to get out of this ideological cul de sac and acknowledge that biology matters as does our life situation and experience, and social and cultural worlds. Psychology has suffered from the reluctance of the academic left and right to accept what was blindingly obvious to the general public. There is now a better understanding of the **impact of context** and the importance of theory building that accommodates and integrates situational factors on behaviour.

There is also the rediscovery of the **importance of individual differences**. The neglect of individual differences in research design resulted in modest effect sizes. One size fits all interventions were limited in their impact. There is now the appreciation of Carl Jung's insight that "the shoe that fits one person pinches another; there is no recipe for living that suits all cases."[11]

Psychology is coming to terms with the limitations of generalisability to be cautious about claims of universal explanation and prediction. Accuracy within context seems a better strategy to ensure claims are consistent with evidence.

Kevin McConkey[12] draws on the image of the "unhappy person" from David Lodge's book *Therapy*, in turn adapted from the philosopher Kierkegaard. The unhappy person is never present to themselves; they think of the past or the future. McConkey suggests this is a useful parallel for psychological science. "We can find things that were better back then or will be better in future."

But above all it [psychology] should keep moving in the present with a combination of humility, courage and wisdom to make progress.

The unhappy person recognised that "after many false starts, various battles, and some failures, the best way to move toward the future was to quit worrying about it, and to simply keep moving." Psychology of course must build on its past and learn from it. It should also set ambitious aims of future possibilities. But above all it should keep moving in the present with a combination of humility, courage and wisdom to make progress.

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Rethinking Psychotherapy: Collaborative-Dialogue [ii]

Harlene Anderson, Ph.D [iii]

Dr. Harlene Anderson is an international leader in the development of postmodern collaborative-dialogic practices, and applies her approach to therapy, organization development, education, research, coaching and consultation. She offers personal and business consultations and coaching internationally, nationally and locally, as well as workshops and keynote talks at conferences and meetings. Her books include *Conversations, Language and Possibilities* which has been translated into Chinese and seven other languages and co-edited *Appreciative Organizations, Collaborative Therapy: Relationships and Conversations that Make a Difference , Innovations in the Reflecting Process, and Narrative Collaborations*. She is the founding editor of the *International Journal of Collaborative Practices* and the International Certificate in Collaborative Practices program and is a founder and board member of the Houston Galveston Institute, the Taos Institute and *AccessSuccess* International. .

Consistent with the theme of the NZPsS 2014 conference, "Psychology in a Changing World," a persistent, seemingly simple yet complex question is: "*How can our practices have relevance for people's everyday lives in our fast changing world, what is this relevance, and who determines it?"* The collaborative-dialogue approach that evolved over the years, beginning with the family therapy research project at the University of Texas Medical School in Galveston, Texas in the late 1950s, is one response to this question.

Today, citizens of the world express disillusionment and frustration with rigid institutions and being treated as numbers and categories. To one extent or another, they demand systems and services that are more flexible, respectful and relevant to their defined needs. In response, we must be ready and willing to question whether our psychotherapy traditions are in sync with our contemporary world and if not to create ones that are. Relative to this demand, the Mayor of Nelson said, we must develop "user friendly services" and plenary guest Darrin Hodgetts suggested, we must "re-humanize" our practice.

Historically, though a large percentage of my practice has always included what are commonly called "treatment failures" or "revolving door clients", I was curious what clients distinguished as the special nature of therapy and therapists that made a difference? I interviewed clients about their experiences of successful and unsuccessful therapy, and what I learned from the clients significantly influenced the development of my collaborative-dialogue practice.

Contextually, collaborative-dialogue shares common ground with a growing international community of therapists who draw from postmodern and hermeneutic philosophy and social construction and dialogue theories: variously referred to as postmodern, conversational, dialogical, discursive, open dialogue, reflecting and social construction therapies. At this conference, Ruth Gammon and colleagues' "wraparound services" join this community.

Three Perspective-Orienting Assumptions and the Challenges they Invite

What I learned from clients influenced a search for a vocabulary to help me understand my experiences and those reported by clients. Along with colleagues I was drawn to the body of abstract assumptions mentioned above. A common dominant thread among these is the notion of knowledge, language and dialogue as relational, participatory, interpretive and inherently transforming. This is a move away from the more traditional ways of thinking about language as representational and knowledge as discoverable. Here I mention three features that these assumptions invite:

1. Maintain a skeptical and questioning attitude regarding knowledge as fundamental and definitive,

[ii] This article is an abbreviated version of a workshop and plenary given at the New Zealand Psychology Society Annual Conference in Nelson, New Zealand, August 29 and September 1, 2014 respectively. For fuller descriptions of the ideas and practices overviewed in this article see: Anderson, H. (2012). Collaborative Relationships and Dialogic Conversations: Ideas for a Relationally Responsive Practice. Family Process. 51(1):8-24 and Anderson, H. (1997). Conversations, Language and Possibilities: A Postmodern Approach to Psychotherapy. New York: Basic Books.

[iii] Co-founder and Board of Directors: Houston Galveston Institute and Taos Institute

such as knowledge of inherited and established dominant discourses, meta-narratives, universal truths or rules. We are born, live and are educated within knowledge systems and traditions that are often taken for granted or unwittingly bought into and reproduced. This does not suggest that familiar knowledge should be abandoned: any knowledge can be useful.

What I learned from clients influenced a search for a vocabulary to help me understand my experiences and those reported by clients.

The call is to withstand the seductiveness of our inherited psychotherapy traditions and be ready to break away from them as well as the potential "narrowness of disciplinary thinking." These traditions include, for instance, the notions of objective reality, instructive interaction, linear and circular causality, subjectivity and subject-object dualism, transference and counter-transference and the encapsulated self-contained self. In this conference for instance, Andrew Munro suggested that we maintain skepticism of "the authoritative claims of the expert" and their research findings; and Neville Blampied suggested the same of "research methods and results that are based on the fallacy of the average man". Canadian psychotherapist Colin Sanders refers to such attitudes and actions as "poetic resistance." Importantly, the philosophical and theoretical discourses on which collaborative practice itself is based are also open to scrutiny.

2. Avoid generalizations influenced by dominant discourses, meta-narratives and universal truths are often generalized and applied across peoples, cultures, situations or problems. Being led by pre-knowledge (e.g., theoretical scripts, predetermined rules) can create categories, types and classes of people, problems and solutions that can inhibit ability to learn about the uniqueness of each person or group of people and their circumstances. Social psychologist John Shotter refers to this risk of familiarity as the "re-discovery of sameness." In other words, familiarity and labels can risk depersonalizing and overshadowing the uniqueness of a person. In other words, it can tempt us to fill in the gaps and proceed based on our assumptions rather than learning from the person we are talking with and thus limiting our and their possibilities.

The call is to beware of the seductiveness of generalizing knowledge and its possibility-limiting nature of seeing and finding what you are looking for and the risks associated with each. In this conference Ainsleigh Cribb-Su'a's story of the twelve year old who was brought into her clinic in handcuffs illustrates Sanders's poetic resistance: upon seeing the boy in handcuffs she asked the guard to take off the cuffs. She saw a young boy, not a threat to her life. This gesture was a small part of the beginning of what would be a positive and creative therapeutic relationship in which she learned so much about the boy from his own first-person narrative and thus was able to understand his words and actions differently than described in the stories that others had about him as an evil and psychotic person. When we learn about the distinctiveness of each person's life directly from them and see the familiar or what we think we might pre-know in an unfamiliar or fresh way, we maximize the possibility of co-creating futures that are unique and fitting to them and their circumstances.

3. Privilege local knowledge- such as the expertise, truths, values, habits, narratives and wisdom- of ordinary people (e.g., a family, school classroom or business board room) who have first-hand knowledge of themselves and their situation is important. This would include what is called indigenous or ancestral knowledge. Local knowledge formulated within a community to address their self-defined needs can therefore be more relevant, pragmatic and sustainable for that community. Local knowledge, of course, always develops against the background of dominant discourses, meta-narratives, and universal truths and is influenced by these conditions. It is not suggested that it is or can be otherwise or that this background should be or can be avoided.

The call is to be ever mindful of the value of local knowledge: the need for local understandings, actions and solutions is critical to being able to hear what the other judges important for you to hear and to suspend pre-knowing which can interfere with hearing. This contributes to outcomes that are more fitting to the person and their situation and therefore their sustainability.

Practical Implications of the Perspective-Orienting Assumptions

In thinking about how to translate these assumptions to therapy or to suggest their practical implications, I began to think that they informed the notions of *collaborative relationships* and *dialogical conversations*.

Collaborative relationship and dialogical conversation refer to the *metaphorical space* and the *polyphonic process* in which transformation is generated. In other words, transformation occurs in the dynamics of the relationship and the conversation.

The essence of a collaborative relationship entails the way in which

we orient ourselves to be, act, and respond "with" another person. It refers to a kind of connection in which the other feels what they have to offer is appreciated, valued and not judged. Consequently, they feel invited to join us in a joint engagement that I call a shared or mutual inquiry. As an aesthetic and not a technical process, it is one that invites and requires a sense of participation, belonging, ownership, accountability and responsibility for all participants.

According to Russian philosopher and literary critic Mikhal Bakhtin we are dialogical beings who engage "with" each other and ourselves out loud and silently in a search for meaning and understanding. This includes any way we try to communicate, articulate and express ourselves - including words, signs, symbols, gestures, etc.

In practice, dialogue involves a shared or mutual inquiry: jointly responding (e.g., commenting, examining, questioning, wondering, reflecting, nodding, gazing and etc.) as we talk about the issues at hand. In therapy dialogue requires the capacity to try to understand the other person from their perspective not ours. Dialogic understanding is not a search for facts or details but an orientation and a process. It is an (inter) active way of being that requires participation through responding to connect with and learn about the other from them, rather than to pre-know and -understand them and their words from a predisposition such as a theory. In this sense, it is neither directive nor passive.

The call is to withstand the seductiveness of our inherited psychotherapy traditions and be ready to break away from them as well as the potential "narrowness of disciplinary thinking."

Collaboration and dialogue go hand-in-hand; each informs and is critical to the other. In other words, the kinds and quality of the relationship we begin to develop with the other influences the kind and quality of the conversations we can have with each other and vice versa.

When people inhabit a metaphorical space and are engaged in a polyphonic process in which imagination and creativity are invited as they begin to talk with and hear themselves, each other and others in new ways that permit the construction of something that has not existed before. The newness that develops can express itself in an infinite variety of forms in understanding and action such as enhanced self-agency and freeing self-identities. But we are still left with the question of the practical implications: what to do.

The Philosophical Stance

The philosophical stance is the *heart and spirit* of collaborative practice: it refers to *ways of being and becoming* that involve a posture, an attitude and a tone that communicates to the other the special importance that they hold for me. Each person is a unique human being and not a category of people. I want to recognize and appreciate them, and I want to show that I believe that what they have to say is worth hearing. The stance reflects ways of being and becoming *with* people that includes thinking, talking, acting and responding with them rather than to, for, or about them. *With* is the significant word: a "withness" process of orienting and re-orienting oneself to the other person. The stance and its *withness* relationships and conversations invite and encourage the other to participate on a more equitable basis. Therapy becomes more participatory and mutual and less hierarchical and dualistic.

The stance becomes a natural and spontaneous expression of a value, belief, and worldview that does not separate professional from personal. Congruence is important. I once heard psychotherapist and theologian Roy Bowden introduce New Zealand psychiatrist and professor of Māori Studies Sir Mason Durie at a conference. Looking at him he said: "I looked but I could not see the difference between you as a psychiatrist and you as a person." I thought 'what a compliment'. In other words, Bowden and I are talking about *humanbeingness* and maintaining it across contexts and relationships contrary to performing a role.

Interconnected Features of the Philosophical Stance: Action-Orienting Sensitivities of a Conversational Partnership

The beliefs and attitudes- ways of being and becoming- that flow from the philosophical assumptions I discussed a moment ago become orienting sensitivities from which practitioners through this stance invite the other to *connect, collaborate* and *create* with others. They become authentic, spontaneous and natural actions, not techniques or pre-structured steps. I refer to this engagement as a *conversational partnership*. I usually discuss seven features, though because of limited space I will elaborate on one: mutual inquiry.

Mutual Inquiry

Practitioner and client form a *conversational partnership* characterized by a joint activity of "shared" or *mutual inquiry*. It is an in-there-together, doing with process in which two or more people put their heads together to puzzle over and address something. The practitioner invites the other person, or persons, into this mutual inquiry by

taking a curious learning position and being interested about their circumstances in ways they have not been able to do before– with themselves or others.

A host/guest metaphor. Inviting another into the kind of relationship and conversation that I am talking about entails what French philosopher Derrida suggested as unconditional hospitality, an ethical position. I use a host/guest metaphor with my students to highlight the importance of unconditional hospitality- as an important aspect of the subtleties and nuances of how our greetings and meetings begin to shape the tone, quality and possibilities of how we will be and what we will do together, and consequently the potential for a more equitable relationship.

I emphasize that being a hospitable host and guest go hand-in-hand. The therapist is simultaneously, a temporary transitory host and guest in the other's life, both a foreigner in the other's life as the other is in theirs. Hospitality is not only important in the initial meeting and greeting but must be continually attended to.

A story ball metaphor. I use a "story ball" metaphor to further discuss the invitation with my students. When I first meet a client and they begin to talk, it's as if they have brought a special gift to me--a story ball with selected intertwined narrative fragments of their life story and current circumstances. They present the gift, gesture to hand the story ball to me

> As they put the ball toward me, and while their hands are still on it, I gaze at it and I gently place my hands on it but I do not take it from them. I begin to participate with them in their story telling, as I attentively and carefully look at and listen to the aspect that they are showing me. I try to learn about and understand their story by responding to them: I am curious, I pose questions, make comments and gesture. I am the learner, the client is the teacher. In my experience, this therapist learning position acts to spontaneously engage the client as a co-learner; it is as if the therapist's curiosity is contagious. In other words, what begins as one-way learning becomes a two-way, back-and-forth process of mutual learning as client and therapist co-explore the familiar and co-develop the new, shifting to a mutual inquiry of examining, questioning, wondering and reflecting with each other.

It is important to keep in mind that as Professor and Director of the University of Western Australia Centre for Aboriginal Medical and Dental Health Helen Milroy (an advocate for a just world) once said, "A gift must be given freely." I do not ask nor tell the client what to give me. It is their choice.

My responses- whether questions, comments, gestures and etc.- are informed by and come from inside the conversation itself; they relate to what the person has just said or done. They are not informed by my "truths" about them such as what they should be talking about or should be doing- truths derived, for instance, from theoretical maps, clinical experience or personal values. My responses are my way of participating in the conversation and are offered from a continual learning position to ensure that I understand as best I can. My aim is to encourage the back-and forth process that I call mutual inquiry and to engage with me in a new curiosity about themselves. Through the process of mutual inquiry the client begins to develop meanings for themselves and the people and events in their lives that permit expanded or new agency. In other words, the newness comes from within the inherently transforming dialogic process.

Through this joint activity, the relationship and conversation begin to determine the process or method of inquiry. The method does not define the relationship and the conversation but just the opposite. That is, client and practitioner create from within the moment-to-moment unfolding of the present relationship and conversation, not from outside it or ahead of time. The practitioner does not control the direction of the conversation or story telling but participates in it. Together, client and practitioner shape the story-telling, always a re-telling that is at the same time a new-telling

Practitioner and client form a conversational partnership characterized by a joint activity of "shared" or mutual inquiry

that yields a richness of novel freshly seen possibilities and previously unimagined futures.

When working with a family, a business team or an organization's membership, I think of each person as coming with his or her own story ball. I want to make room for and show the importance I place on each one. It is not unusual for members to have different and sometimes competing story versions. This is part of the collective storytelling. I am interested in exploring and understanding each version. I do not strive for a consensus of story versions, past, present or future. Differences and tension are important aspects of dialogue and hold the richness for possibilities to emerge.

It is important for the practitioner to facilitate listening and speaking and to make ample room for each. In my experience, in the dialogic process that I am referring to, as one member of

a family speaks and the others listen, all parties begin to experience a difference in the story tellings and re-tellings. When a speaker has the room to fully express his or herself without interruption and the others have equally full room for listening, all begin to have a different experience of each other and what is said and heard. When you are able to fully listen without, for instance, sitting on the edge of your chair preparing a corrective response, you have the opportunity to begin to hear and understand things in other ways.

A Client's Reports of After-Session Transformation and Action

I find that clients are far more resourceful and inventive than we sometimes give them credit for. I want to be careful to trust them and not get in their way. Their after-therapy session thinking and acting is often unpredictable and surprising. Here is a surprise feedback from a consultation session that I conducted during a workshop at a university graduate program.

The woman I talked with had a long-standing family conflict that she continued to be plagued and distressed by. The conflict involved an uncle she dearly loved, his wife whom she detested to put it mildly and her deceased grandmother who was the "glue" in the family and for whom the woman felt a responsibility to carry-on a family tradition that had always been her grandmother's role. She sought consultation because an important family holiday was approaching. She dreaded the holiday because she did not want to continue the family ritual of an obligatory dinner much less with the obligatory family guests. She felt in a moral bind and decision dilemma and was filled with guilt, anger, frustration and bleakness regarding the situation. She wanted to invite her uncle for the holiday dinner but neither wanted to invite nor not invite his wife. She said that she needed to make a decision about what to do (e.g., what action to take and how).

I listened to her story, participated in its telling with questions, comments, etc.- all part of our mutual inquiry. Running through her story fragments, from the beginning and throughout her talking about the current situation and its history, was her adamancy that she would not waver in her conviction that she would not under any circumstances do anything that might be, or appear to be, a conciliatory gesture toward her uncle's wife. I heeded her position and did not in any form or fashion, overtly or covertly try to get her to do so.

She asked me directly, "What should I do?" I had the sense that she would object to any suggestion I might offer she would find objectionable as I felt that we had touched the edge of several options in our talking, and that she had indicated in one way or another that they did not fit or interest her. That is, I think there was a gap in what she wanted me to understand and how I understood. Put simply, perhaps I was not getting it. In retrospect, I think that what I was not getting was the intensity of her emotions and convictions. But, of course, I would have to ask her.

I told her that I had two or three ideas of possible ways she might handle the situation with her uncle and his wife that we could discuss. I was careful to keep in mind that she wanted to continue to have a good relationship with her uncle and was not seeking an amenable relationship with his wife.

I offered my ideas and we discussed them. She gave reasons why none of them, nor any variation we came up with, would work. To her, all sounded like offering an olive branch to the uncle's wife and trying to repair that relationship which she did not want to do. Neither was my purpose, nor did I intend that one or any of them would be suitable for her. They were offered in response to her request, as a way to continue talking about her situation, and explore possible options. No, I did not think that she was a negative person nor the like, but rather that she like any client knows their life and circumstances better than I do. She left our session without any answers, but generously thanked me and said that it was good to talk about her problem. She said that she now felt that she would be able to find a solution but had no idea when, what or how.

About a month later, I received an unsolicited email from her. She wanted to tell me what happened after the consultation session. Here are her unedited words:

> *"It has been a month since we met in … I have had a dinner gathering with my Uncle. I finally did not suggest to him whether to bring his wife to the dinner or not. I cannot explain why but it seems that I suddenly realized this: It should be my Uncle who decides whether to bring his wife with him, not me.*
>
> *The result was: He came alone to the dinner, without anyone asking him to do so. I think I will not worry about this issue any more, not because I trust my Uncle "will do the right thing" but I have changed from within. Now I feel like I can just let it be. I believe even if my Aunt joins our gathering, I will still be able to handle the situation without problem.*
>
> *I really cannot figure out why my attitude changed but*

I welcome this change. I think the interview you did with me in the workshop was the turning point. Thank you very much for everything you said and did in the workshop, which definitely enhanced this change."

Several months later I received this unsolicited brief note:

Tell you what, the Mid-Autumn Festival is approaching and this is the second most important gathering time for the Chinese (the most important is the Chinese New Year). I will meet my uncle for a family dinner without hesitation this time. Thanks again for the interview in the workshop.

How did this happen? I would not want to speak nor speculate for the woman. Understanding the transformation from the process of dialogue, however, I suggest that I did not do anything to cause the change. Her change is an example of what can happen in a dialogic process when there is a space, an occasion, for people to recount and discuss their story fragments in ways that the telling and the perceiving are influenced by the process itself.

Reflection on the Example

What a client comes to therapy to address may change for many reasons: the new meaning and understanding may dissolve the idea or experience that a client had of a "problem", may allow them to have a sense of different actions they might take, or may lead to the carrying out of new actions. The change or transformation does not necessarily have to be in thought, action or in any other shape that might be preferred by a therapist. What is important is that it is a newness that the client has participated in constructing and that it has relevance for them.

The woman above had a "carry-over" conversations with herself though they were not planned in the session. I do not doubt that she has found, or will find, a different way to be in relationship with her uncle and his wife, ones filled with less tension and anguish and perhaps even with some contentment and the sense of family that she lost with her grandmother's death. Of note, in her email there was a shift in how she referred to her uncle's wife, referring to her as "my aunt."

Each client creates their own unique carry-over, their own germination of what began for each in the session. Each creates a next step that is spontaneous, natural and fitting to their circumstances and needs, and in my experience, it will be sustainable (to the extent that anything dialogic can be sustainable) because they did it. I call this process that begins in the session and continues afterwards each in its own unique way and each fitting to a client's ever changing life: dynamic sustainability.

In conclusion, collaborative – dialogue is an inherently transforming process that is a means to unpredictable and spontaneous novel ways of being, thinking, speaking, acting and relating. Dialogue is a relational activity and as family therapist and writer Lynn Hoffman and social psychologist John Shotter suggest, it requires a withness-thinking-acting versus an aboutness-thinking-acting. To paraphrase philosopher Ludwig Wittgenstein, dialogue allows each of us to find ways to go on from here. So, perhaps this is what is helpful in dialogue: we find ways to go on. Or, as some clients have reported: a sense or a hope that it is possible.

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Kristy Arbon
Kristy Arbon is Administrative Director of the Center for Mindful Self-Compassion (www.centerformsc.org). She has practiced meditation and mindfulness, mainly in the Buddhist tradition, for 25 years and has made a conscious decision to focus her work toward easing suffering.
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Anna Friis
Anna is a health psychologist working in private practice. Following a high-paced previous career, and with a master's degree examining the effects of stress, she has a particular interest in helping people find balance and ease within their lives and workplaces. She is currently researching the health benefits of self-compassion as part of a PhD at the University of Auckland and is a devoted practitioner of yoga and meditation .www.annafriis.com
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The New Zealand Psychological Society
Te Rōpū Mātai Hinengaro o Aotearoa

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An Interview with Professor Karen Witten

Karen Witten is an Auckland-based social scientist with an interest in urban neighbourhoods and how their design and infrastructure influences the social relationships, transport choices and well-being of residents. She trained as a clinical psychologist at The University of Auckland and worked in mental health services before making a career shift into public health research. Her PhD is in Urban Geography. She is a Professor of Public Health at the SHORE & Whariki Research Centre, Massey University, Auckland.

You are both a geographer and a psychologist. How did you come to combine these two fields of study?

I have worked in interdisciplinary environments for so long that I no longer see clear boundaries between disciplines. In the past I was a clinical psychologist but now, as a social scientist and researcher, I draw from whatever disciplinary theories and methods are useful to understand cities and how neighbourhoods influence the wellbeing of different population groups. Geography is useful as cities and neighbourhoods are inherently spatial - where you live in a city determines your access (or not) to a range of material, social and cultural resources – resources that can impact on your health and wellbeing. Probably the hardest aspect of morphing from a psychologist to a more broadly based social scientist was discarding the individual focus of a psychologist's training to see people as part of city and neighbourhood systems.

Can you tell us about your areas of interest and research?

I'll mention three projects. *Kids in the City* is a fascinating study exploring children's use and experience of urban neighbourhoods. The kids, 9-12 years, live in inner city apartments, medium density dwellings and suburban locations in higher and lower deprivation neighbourhoods. We are investigating how neighbourhood characteristics (physical and social) influence parenting practices particularly around the restrictions placed on children's freedom to play and get around unsupervised. The children wore a GPS and an accelerometer for seven days so we could track where they went and how much physical activity they did. Children also became neighbourhood reporters as they took an interviewer on a Go-along walking interview to places they liked and disliked near their home. The wider context for the study of course is children's declining freedoms, low levels of physical activity and increasing rates of obesity, but also to understand the likely consequences for children as Auckland intensifies.

Traffic safety is a major concern for children and parents and in a second study, *Future Streets*, I am one of a team of researchers conducting a street redesign intervention in Mangere. The team, which includes expertise in transport engineering, ergonomics, economics, epidemiology, and physical activity, is measuring the safety, health and economic impacts of the intervention. A unique aspect of the study is the level of engagement we have had with Mangere residents - to understand how they use and experience their neighbourhoods, safety hotspots and their ideas for change. As well as monitoring changes in traffic speeds and volumes and driver behaviour before and after the street redesign we are surveying residents about their safety perceptions, social connections, transport mode use and physical activity. Goals of the intervention include slower traffic, an increase in walking and cycling to local destinations, and strengthened neighbourhood networks through the serendipity of street encounters.

Lastly, *Resilient Urban Futures* is a study examining the social, environmental and economic outcomes of different forms of urban development - the compact city vs the low density city. I am supervising a number of PhD students investigating housing typologies and residential choice and the process of community formation in higher density developments. The research is a collaboration between social scientists and environmental scientists. This study is led by another ex-clinical psychologist, Philippa Howden Chapman who has taken a similar path from psychology through public health to an interest in inequalities,

housing and things urban.

How do you go about researching the interaction between the design of urban environments and for example, social relationships, transport choices and the well-being of residents?

My research is always interdisciplinary and multi method – using quantitative, qualitative and spatial methods. *Kids in the City* is a good example. To understand children's use of the city they wore GPS and accelerometers, as mentioned earlier, but to gather experiential data we also interviewed children as they walked around their neighbourhoods and in school-based focused groups. Their parents were surveyed by phone but also interviewed face to face and in groups about their neighbourhood connections, perceptions and parenting practise. The built environment, for example dwelling density and access to services and amenities, is measured and mapped using Geographical Information Systems. As a team we start with the research question/s and then think through how they are best investigated. If we don't have the methodological skills we collaborate with colleagues who do. It's a very rewarding way to work as your understandings are constantly being stretched and over time you build up a kete of eclectic methods and approaches.

Can you give some examples of how urban design impacts on the wellbeing of residents?

- New Zealand adults living in higher density neighbourhoods that have a mix of houses, shops and workplaces are more physically active for both transport and for recreation than those living in lower density residential only neighbourhoods.
- Well-designed public spaces become anchor points in community life, meeting places and sites of social connection –e.g. streets, courtyards, parks, playgrounds.
- The school gate is often a gathering place for parents, a place they converse, share information and experience a sense of community. Seating at the school gate can formally acknowledge this role.

What in your view would be the primary issues that urban designers need to consider in relation to the wellbeing of residents?

Design cities for people not cars and prioritise pedestrian use over car use. Also, consider children needs for outdoor communal play space close to all dwellings. Children live everywhere so places for play are needed in all streets and neighbourhoods, including the inner city.

Are their cultural and gender and socio-economic issues which need to be considered in relation to urban design?

Yes of course. People like to feel safe and have a sense of belonging where they live, work and play and urban design can influence whether people feel 'in place' or 'out of place', welcome or unwelcome, safe or not safe.

A very tangible example of gender difference is that to feel safe cycling women have a stronger preference than men for separated cycle lanes.

Access for parks is particularly important in lower socioeconomic areas. In the *Kids in the City* study children in lower socio economic areas went to the park for informal play far more often than children from affluent area whereas children in wealthy neighbourhoods attended paid sports-related activities at four times the rate of their peers in poorer neighbourhoods.

How has your background in psychology assisted you in your work?

Psychology provides good basic research training. Also psychologists are concerned about people's wellbeing. This is still central to my research, but the focus is not the individual but policies and practices that influence the wellbeing of population groups, particularly policies that contribute to inequitable health and social outcomes. Regarding other aspects of psychology training - other people would need to answer this not me – I can no longer discern where disciplines begin and end.

What could psychologists (academic researchers or clinicians) take more into consideration when addressing physical or mental health problems?

The wider social and policy environment that impacts on the physical and mental health of their clients – although I'm sure many do!

One on One - with new NZPsS President Dr Kerry Gibson

Kerry Gibson was invited as our 'one on one' contributor.

Kerry is a member of the Institute of Clinical Psychology and the Institute of Counselling Psychology. She has many years of experience in academic teaching as well as hands-on experience as a clinical supervisor and a practitioner. In addition to her clinical focus, Kerry has strong interests in the fields of community psychology, organisational psychology and health psychology and contributes to these areas through her academic writing and work with community-based organisations. Kerry is a senior lecturer in clinical psychology at The University of Auckland.

One aspect of your role that you find really satisfying

It's hard to pick just one. I lecture on the clinical programme at The University of Auckland and I guess I chose a university role because it allows for the mix of teaching, research and clinical work which I so enjoy. I work with a great team as well so I really consider myself very lucky. My work with the New Zealand Psychological Society is a good complement to my 'day job' as it allows me to keep in touch with the broader issues affecting psychologists and their clients.

One event that changed the course of your career

Probably that I kept my best friend company as she waited in the queue to register for undergraduate psychology which led to me signing on for PSYCH 101 as a filler in my Journalism degree! More seriously though, starting my career as a psychologist and academic during the height of the anti-apartheid protests in South Africa showed me that it was impossible to address psychological issues outside of a social justice agenda. As dark as these days were, they gave me the sense that things that were wrong in the world could be changed and that, as a psychologist, I could play a role in that.

One alternative career path you might have chosen

I was going to be a journalist and possibly a writer. I enjoyed my very brief career as a journalist but found I kept wanting to help the people I was interviewing! That's when I made the switch to psychology. I confess though that I still enjoy the writing side of my job.

One learning experience that made a big difference to you

There are so many it's hard to single out one. I will say though that one of the most pivotal experiences I had was the relationship with my PhD supervisor, at the University of Cape Town. He taught me the value of having a supervisor who fundamentally believes in you. I have tried to remember that in my own relationships with students.

One book that you think all psychologists should read

There are many academic books that have influenced me but I would still want to credit my love of psychology to reading novels. Research and theory tell us about key ideas – but there is nothing like one of the great novels to help you understand the subtlety and complexity of human beings and their relationships with one another.

One challenge that you think psychology faces

There are a great many challenges at the moment. Probably the biggest is the increasing dominance of bio-medical thinking in relation to the psychology of human beings. While I share the excitement that many people feel about advances in brain research, I worry about the potential for biologically reductionist explanations to gain popularity and draw attention away from the many social problems that help to create human misery. I admired the way that the BPS Division of Clinical Psychology took up this issue in the media and also the statement our own Society put out in response to the DSM-5.

One thing that psychology has achieved

There are so many things here but from my own fields of interest I would say the way that psychology has drawn attention to the abuse of children and helped to inform better parenting practices.

One aspiration for New Zealand psychology

I would like there to be greater unity in our ranks. There are so many important issues for us to focus on to

improve the lives of our clients – but we can't do this effectively if we are divided amongst ourselves. I would like to see researchers and applied psychologists working more closely together, to see the diverse discipline areas in psychology seeking common ground and our organisations working together. For a small country, New Zealand psychology seems to have far too many splits and divisions!

One social justice issue psychology should focus on

It seems so time wasting to service the ambulance at the bottom of the cliff and not engage with the social problems that create psychological distress. Child poverty is a major culprit here and the Society has been very active in addressing this in the last year or two. I think we also need to give some serious attention to climate change which is likely to exacerbate the existing social inequities which impact on people's well-being.

One big question

The chicken or the egg?

One regret

I regret not being braver in my youth. I was afraid of what people might think if I spoke my mind. I hope I am getting better as I get older. Perhaps I should apologise in advance!!

One proud moment

My son turned 21 earlier this year and I am so proud to see him become the lovely young man he is.

One thing you would change about psychology

That's a difficult question. My answer would perhaps be 'everything and nothing'. I hope that psychology continues to evolve, to question its assumptions, to develop new ways of thinking and practicing. But it is this potential for change that is precisely what I love about working in psychology.

One piece of advice for aspiring psychologists

Feel passionately about what you do and think critically. Sorry –that was two pieces of advice.

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- Psychology in popular culture
- Celebrations
- Book/article reviews
- News items
- Member network news
- Overseas issues

Reviewed article

Training and Supervision in Professional Psychology in Australia

Russell Hawkins

Russell Hawkins is a Professor of Psychology and the Director of Professional Programs in Psychology at James Cook University (JCU) where he teaches clinical psychology. He was previously seconded to JCU Singapore as the Associate Dean Psychology and Director of Psychology Clinical Programs there. His Singapore experience included 4 years as Course Coordinator for the Master of Arts (Applied Psychology) program (Nanyang Technological University) and Head of the National Institute of Education Psychology Clinic. In Singapore, he served as the Chair of the Singapore Register of Psychologists and as a Council member of the Singapore Psychological Society as well as on the Research Committee for the Singapore Children's Society. Prior to that he was the Program Director for the Master of Psychology (Clinical) program at the University of South Australia. Primarily a Clinical Psychologist, he has also been a member of the Australian Psychological Society Colleges of Forensic Psychology, Organisational Psychology and Health Psychology. He worked in a hospital chronic pain clinic for more than 20 years and also has long experience running a private practice in psychology.

His research interests include clinical supervision, child protection and child abuse prevention, resilience, human sexuality, rural and remote mental health, acute and chronic pain, hypnosis, clinical psychology, counselling psychology, forensic psychology and aviation psychology.

Russell frequently visits NZ to fly helicopters.

Abstract

This paper provides an overview of various regulatory, registration, accreditation and professional matters affecting professional psychology in Australia. A number of significant changes which have occurred in recent years are outlined, including a clear shift towards competency based approaches to training and supervision. Alternative routes to registration as a psychologist are briefly described together with references to an associated controversy. Australia is also facing economic threats to the viability of university based psychology training programs which means that meeting high quality standards and a adopting competency based approach while nonetheless controlling costs will be challenging.

Keywords: Registration, competency, clinical supervision, training, accreditation, Australia

Complexity and Change in Professional Psychology in Australia

This paper commences with an overview of some of the regulatory, registration, and accreditation agencies affecting professional psychology in Australia and then the various paths toward registration as a psychologist and an accompanying controversy are introduced. Distinctions between different categories of psychologist drawn by the health reimbursement scheme (Medicare) are discussed and current data about the numbers of registered psychologists are provided.

The Australian Health Practitioner Regulation Agency (AHPRA) is a relatively new agency based on law which came into effect in July 2010 and which governs 14 health professions. Health professions in Australia are thus now regulated by nationally consistent legislation and earlier, substantial, state based differences in standards have been removed.

The Psychology Board of Australia (PBA) works in partnership with AHPRA to protect the public and guide the profession and its functions include: registering psychologists; developing standards, codes and guidelines for the psychology profession; handling complaints; assessing overseas trained practitioners who wish to practice

in Australia; and approving accreditation standards and accredited courses of study. As a sub unit of the AHPRA the PBA is also a recently created Australian authority. The PBA liaises with the New Zealand Psychologists Board on such matters as trans-Tasman regulation issues and the International Project on Competence in Psychology.

The Australian Psychology Accreditation Council (APAC) has a mission to ensure that education and training in psychology is conducted to the highest possible standards, so that graduates of APAC-accredited programs are competent to safely practice as a registered psychologist. This is the agency that accredits university based training programs (on a 5 year cycle).

The Australian Psychological Society (APS) is the largest professional association for psychologists in Australia, representing over 21,000 members. It includes nine Colleges representing a range of different areas in psychology. The APS is committed to advancing psychology as a discipline and profession. The Australian Clinical Psychology Association (ACPA) is a relatively new organisation that represents those psychologists who hold an accredited Masters or professional Doctorate degree in clinical psychology.

Psychology in Australia is a fast changing profession. In 2006, the national health insurance system (Medicare) introduced rebates to patients for a portion of the fees charged by psychologists. The rebate amount a client or patient is entitled to depends on the category of psychologist. Treatment by a clinical psychologist currently results in a rebate around 50% higher than that for a registered psychologist. University training programs have subsequently received fresh demand from practicing psychologists without Masters degrees wanting to become qualified as clinical psychologists. Universities also experience high demand from undergraduates for places in postgraduate training programs. Many potentially suitable candidates are unable to obtain a place in these programs which have small quotas. There has been divisiveness about the status of different types of psychologists (Cresswell, 2010) and debate about the virtues of different routes to registration.

Hunt and Hyde (2013) have described the current standards for psychology registration and compared these with international requirements. They suggested that Australia "has the largest but least trained workforce of psychologists in the developed world" (p. 113) and that many psychologists registered in Australia would not be eligible to practice elsewhere. This is because Australia offers more than one route to registration. The first route, which is relatively uncontroversial, requires at least an APAC accredited Masters degree in an applied field of psychology such as clinical psychology or counselling psychology following an APAC accredited undergraduate four year sequence in psychology. The second route is commonly known as the 4+2 route. It involves the same initial four year undergraduate degree but is then followed by two years of supervised practice (almost an apprenticeship model) without any further university based training. In 2013 the Psychology Board of Australia provided guidelines for a new 5+1 program (Psychology Board of Australia., 2014a) which might be thought of as part way between the 4+2 route and a Masters degree. It involves a fifth year of tertiary level study (practica and coursework) followed by a supervised practice internship and leads to registration as a psychologist. The majority of universities in Australia do not yet offer this degree.

Regardless of the route taken towards registration, the undergraduate degree provides knowledge about the science of psychology but does not focus on practice, thus mastery of the applied skills of practice must be achieved during the two years of supervised practice or Masters level training. Whether this separation of background knowledge and applied skills training into undergraduate and postgraduate training programs is the best model for producing practitioners is debatable. Other health disciplines do not find it necessary to impose such a separation.

In 2006, the national health insurance system (Medicare) introduced rebates to patients for a portion of the fees charged by psychologists. The rebate amount a client or patient is entitled to depends on the category of psychologist.

Arguably the status of the 4+2 trained psychologist is similar to the role of a psychology assistant in the United Kingdom or in those US and Canadian states where this role exists – nonetheless in the Australian system this route leads to full registration as a psychologist (Hyde, 2013).

Since July 2010, graduates with a Masters or professional Doctorate degree in Australia have been, after a further period of supervised practice (one year for applicants with an accredited professional Doctorate and two years for applicants with an accredited Masters degree), able to apply to become endorsed in one of various areas (clinical psychology, counselling psychology, forensic psychology, clinical neuropsychology, organisational psychology, sport and exercise psychology, educational and developmental psychology, health psychology, and community psychology). It is only endorsed clinical psychologists whose

patients are eligible to receive the higher Medicare rebate and who are generally seen as more properly qualified by the critics of the 4+2 route to registration (although even here critics would point to a grand-parenting process which operated at the time the new laws were introduced (2010) and which gave some people an endorsed status without them holding recognised post graduate qualifications in clinical psychology (Hyde, 2013)).

PBA data for June 2014 show that in Australia there were 31,717 registered psychologists. Of these 10,274 psychologists were endorsed in one of the nominated areas and a significant majority of these (6,716) were endorsed clinical psychologists (Psychology Board of Australia, 2014b).

Competency Developments in Australian Psychology

Two major forces have recently made a significant impact on training models for psychology and advanced the competency based movement. These forces are first, the re-emergence of the Australian Quality Framework (AQF) in July 2011 as an important influence on professional training programs in psychology at tertiary institutions and second, the new competency standards for clinical supervisors and clinical supervisor training providers announced by the PBA (April 2013).

The Australian Qualifications Framework (AQF) is the government agency which regulates qualifications in education and training. The AQF has ruled that from January 2015 all new enrolments in training programs must meet the new AQF requirements. In practice this means that across the country universities are reviewing their degrees to ensure future compliance. Changes will be required to various aspects of current professional training programs in psychology. Revised definitions of what constitutes particular levels of training have practical implications. For example, many universities currently offer a post graduate, three year, Doctor of Psychology (DPsych) program which provides students with coursework, supervised practica experience and a thesis. Currently the thesis involves around one year of full time work while the coursework and practica take two years. The new AQF rules will not allow the title Doctor to be granted for anything less than two years of research thesis activity so universities will either drop this degree from their offerings or modify their existing three year DPsych degrees to become four year degrees including a two year thesis.

A key aspect of the new AQF rules is the focus on competency. The AQF standards not only require training programs to provide a list of behavioural competencies to be demonstrated on graduation but also require a clear account of how graduate competencies are linked to specific assessment items at the level of each individual subject within a training program (a much more fine-tuned approach to competencies). While the AQF is the official regulator of standards it will likely cooperate with professional accrediting bodies (in this case the APAC). The APAC is currently undertaking a major review of the accreditation standards for the psychology profession in Australia.

Until recently, the supervision of students undertaking practica as part of professional training in psychology has been managed by universities and other higher education providers (who were, though, subject to the APAC accreditation standards). This management included the capacity for universities to deem appropriately experienced people to be suitable as supervisors. This often meant that selection was based on the potential supervisor's years of experience and perhaps his or her reputation to some extent. In rural and remote locations expertise shortages have often limited the availability of suitable people to serve as supervisors. Until 2010 supervision processes were handled on a state by state basis, which lead to significant differences in the rules and standards across the states. In some states there were no training requirements at all to become a supervisor. Under the new rules which took effect from July 2013, supervisors in higher education based programs must be approved by the Psychology Board of Australia, following forms of training which must also be approved.

The future of professional training programs in psychology in Australia is under threat, part of which is attributable to the cost burden of the high standards insisted on by the APAC accreditation processes.

In 2013, the PBA announced the new Guidelines for supervisors and supervision training providers (Psychology Board of Australia, 2013). They cover standards for Board approved supervisor qualifications; Board approved supervisor competencies, and Board approved supervisor training. Previously approved supervisors who applied to the Board were able to continue as supervisors and will have five years to complete new training requirements. Anxiety is evident in various sectors as the implications of some of the new rules and policies become apparent. Psychologists generally applaud the improved recognition of the importance of good quality training for supervisors and support a competency based approach but many have serious concerns about the implementation of the new policies.

Outcomes Following New Supervision Competencies Rules

Responses to a PBA supervision policy consultation paper (Psychology Board of Australia, 2011) included various concerns. Cost emerged as a key focus and many submissions noted that the cost to become a PBA approved supervisor would serve as a disincentive and that many people may simply not be willing to undertake the process because of this. In spite of these concerns, recent data show that in March 2014 there were 8,476 Board approved supervisors listed with the Psychology Board of Australia (Psychology Board of Australia, 2014c).

There was a concern in some of the submissions into the PBA supervision consultative process that it is premature to decree what the competencies related to supervision should be. This is well supported by the research literature (Gonsalvez & Calvert, 2014; Olds & Hawkins, 2014). While the introduction of competency standards for student training programs and supervisor training programs in Australia is a useful development, it will be beneficial if the standards are flexible enough to allow for revisions as clearer definitions, conceptualisations and greater consensus on professional competencies in psychology emerge.

The Risk Context for Professional Training in Psychology.

The future of professional training programs in psychology in Australia is under threat, part of which is attributable to the cost burden of the high standards insisted on by the APAC accreditation processes. Voudouris and Mrowinski have highlighted the plight faced by postgraduate training programs in Australia generally (Voudouris & Mrowinski, 2010). They reported that there had been a net decrease of 49 professional psychology programs across Australia in five years. This is likely an economic response by universities to the costs faced by postgraduate programs.

As an example, the university where the author is the Director of Professional Programs in Psychology closed down all of its postgraduate forensic psychology programs including its Master of Psychology (Forensic) and Doctor of Psychology (Forensic) degrees. In spite of these programs attracting strong student demand and employer support they were deemed too expensive to continue. Voudouris and Mrowinski (2010) have quantified the financial costs to universities:

> The average shortfall in postgraduate professional programs funding reaching Schools and Departments was $619,197 per School per annum and the average shortfall in funding per EFTSL per year was $8,426 (Voudouris & Mrowinski, 2010, p. 22).

The cost burden is very much influenced by accreditation rules which, for example, currently prescribe a staff:student ratio of 1:8. This ratio is far lower than ratios typical of other university programs (e.g., in undergraduate psychology) and is thus seen by managers as expensive. Similarly the mandated ratio of supervision hours to student face to face clinical activity (1 hour of supervision for every 7 hours of clinical work) is also very expensive in terms of staff time. The APAC standards are under review and it is possible that some of the existing limits may be liberalised.

In summary there have been multiple developments in professional psychology training and supervision in Australia in recent times including a clear focus on a competency based approach. Some controversy remains regarding the various routes to registration in this country and tertiary institutions are concerned about the costs of professional training. Voudouris & Mrowinski (2010) asserted that "the first task is to assist the [Australian] Government and other planners to understand how urgent it is to address the funding shortfall in professional postgraduate training if decline is to be arrested" (p. 23).

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We have one book review this time on the important social justice issue of child poverty.

If you are interested in reviewing a book but don't have anything specific in mind, just a general area of interest, please let me know because we are receiving more unsolicited books from publishers than we have in the past. Alternatively, if you are interested in reviewing a specific book we may be able to source a review copy for you.

John Fitzgerald- Review Editor
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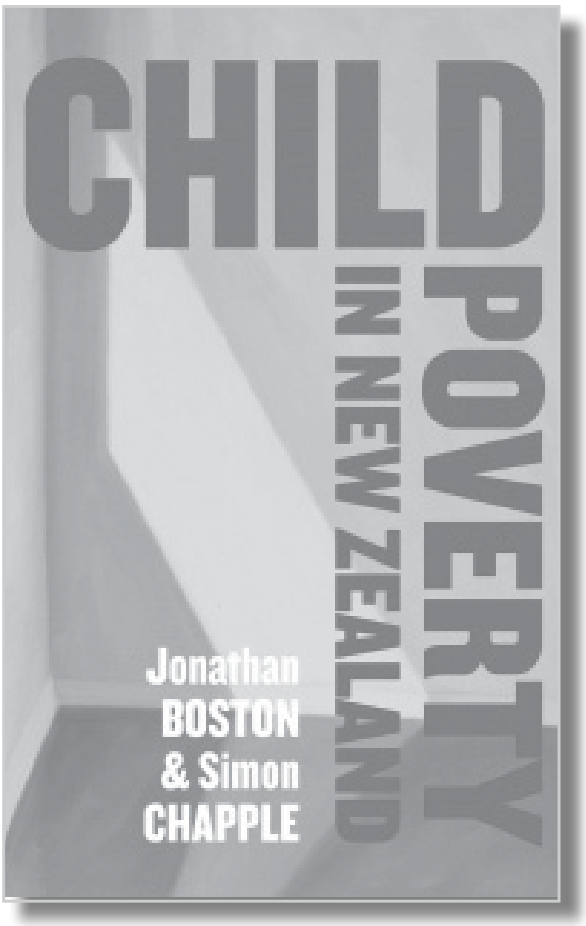
Child Poverty in New Zealand

Reviewed by Quentin Abraham, NZPsS President-Elect

This is an ambitious book that has attempted to gather the empirical evidence in a non-partisan manner about child poverty in our country. The 12 chapters are organised into 3 sections.



Part I Why Child Poverty Matters

Part II How Best to Reduce Child Poverty

Part III Mitigating the Impacts of Child Poverty

As psychologists we are often called to help mitigate the impacts of poverty by helping poor families function better, access their education and live successfully within their communities. However, principle 4 of our Code of Ethics (2012, p25) calls on us to uphold our responsibility not just to respond to our clients symptoms but to actively improve the systemic, societal processes that impoverish our clients' wellbeing.

The authors do not state why they chose to address poverty rather than inequality but they note that in surveys of our citizens there is more concern about poverty than inequality. They address directly many contentious issues, examining the policy mix for centre or left leaning governments, including a range of factors that affect income support and parental employment.

This balanced approach may encourage a wider audience, as it will be more difficult to dismiss the evidence they provide as liberal scaremongering. However, I welcomed the times when they stated their opinions openly. For example, although generally very cautious about simple solutions, they state "With appropriate changes to our tax benefit system, we could halve child income poverty virtually overnight in New Zealand." (p. 49). The less dispassionate and reasoned part of me wants to shout, "Let's do it". In fact it was hard to be reminded of the derisory sums of money families are paid to support their children, the hideously complex systems and the unfair policies such as not paying beneficiaries the Child Support collected from a non-custodial parent i.e. an extra tax for the government.

There is a detailed chapter, gathering real world research, which concludes that a low income in childhood has a

causal effect on children's outcomes; that the size of the effect is significant and it is not a consequence of poor parenting, school quality or neighbourhoods. This is important evidence to challenge current perceptions, as a recent New Zealand survey found that although 80% thought child poverty was a problem, 40% thought it was caused by bad parenting choices (Child Poverty Action Group, 2014).

As psychologists we might have views about the chapter dedicated to financial incentives, especially reforming the "In Work Tax Credit" (IWTC) to encourage more participation in the workforce. I was not aware that parents required incentivising as the authors suggest. Indeed, Singley (2003) reviewed research and found the majority of beneficiaries and low-income families generally held positive attitudes toward work, including low paid work. There are barriers to work but many are not within the control of the poor. Borland (2014) cites research where he estimates that 95% of the change of work in/out flow in Australia was due to the economy and the availability of work. Later, Boston and Chapple concede that policy reforms credited with reduction in the number of unemployed between 2000 to 2008, could have been attributed to a stronger economy, particularly as single parents were able to find work more easily.

Not surprisingly given the debate about the extent and types of poverty in New Zealand/Aotearoa, Boston and Chapple discuss a range of measures to monitor effective intervention programmes. I have some sympathy with this view. However, they note themselves, that much of government policy is not evidence based and that measured targets can be misused distorted and result in goal displacement e.g. a reduction in the number recorded as beneficiaries but no increase in the number who have more income or in work. We will need to engage the hearts and minds of our citizens, policy makers and politicians to make meaningful changes to poverty and inequality. For this reason I would be cautious of framing poverty only in monetary terms. The authors propose that the money spent on poverty is treated as a capital expense rather than an operational expense to provide a more favourable accounting environment and therefore release more funds. However, what happens if our 'investment' in poor children fails to deliver dividends? Can we value our children for their own sake? He taonga ā tātou tamariki.

It seems unethical to remain silent when we discover that in 1990 the Domestic Purposes Benefit was 45% of the net average wage and it has decreased to 27% net average by 2010 (p.132). Effectively beneficiaries have been allocated less in real terms over a 20 year period. Can we as psychologists only work with a referred behavioural difficulty when the young person lives in a crowded, cold home, with hungry people, stressed parental relationships, lacking the materials to participate socially and not challenge the status quo?

This is a well-researched, fully referenced and wide ranging book that is specific to poverty in Aotearoa/New Zealand. It helps us to understand some of the literature beyond our own domain of practice and addresses the debates that influence Treasury and politicians. Inevitably with such a complex and contentious topic there are times when it is a little dense or confusing with cross references to other chapters. Fortunately this is often rescued by good chapter summaries.

I do feel better informed about the range of thinking regarding poverty in Aotearoa/New Zealand. As a profession we risk being accused of promoting our own profession by servicing 'poorly performing schools', 'poorly performing neighbourhoods' with behavioural and parental programmes and so may unwittingly maintain structural disadvantages. As psychologists I hope this book will go some way to helping us enter into robust debates, work collaboratively with other disciplines to address poverty and inequality at a local and national level.

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Child Poverty in New Zealand

J. Boston, J., & S. Chapple (2014)

ISBN 9781927247860

296 pp. Paperback. $49.99

Review book provided by Bridget Williams Books

Editorial

Kathryn Jenner
Student Forum Editor

Hello and welcome to the end of what I am sure has been a frantic year of study – I don't know how it happens but every year time goes faster and faster and we find ourselves here in November saying "how is it nearly Christmas already!"

We held a very successful conference in beautiful Nelson at the end of August and received fantastic feedback on the programme and events that were part of the programme and we have also decided on our conference venue for 2015 – this will be in Hamilton at the University of Waikato from 28-31 August. So if you attended this years' conference and can see yourself presenting next year, keep an eye out on our webpage for when we call for abstracts in 2015 for this annual conference – it is a fantastic opportunity to present your research and to network with other students and professionals from around the country. We had a number of student presenters this year including Jacinda Shailer from Massey University, Alison McKinlay from Massey University, Rebekah Graham from the University of Waikato, Samantha Brennan from the University of Waikato, Nadia Mysliwiec from AUT, Mihiroa Gillies from University of Canterbury, Leah MinKyung Oh from the University of Waikato and Matt McDonald from the University of Otago. As you can see these students represent the length and breadth of the country, coming from most of our major universities and it will be exciting to see where these successful and motivated students take their careers to next!

One of these students, Matt McDonald was the winner of the poster competition at the conference and has submitted his poster for *Student Forum* this month, which is about the ability of the brain to reconstruct autobiographical memories using Multiple Trace Theory. We are also lucky to have Charlene Neuhoff who is an intern at Instep Limited who has prepared a report based on her experience as an intern student and the paradoxes she noticed in communication between what people want and what others may be providing in terms of communication. Grounded in her real life experience as an intern psychologist this will be valuable reading for many of us. Chris Stanley and Matt Hegan who have recently completed an internship at the Ministry of Education have also provided a summary of their experience in the government educational psychology setting. These are both timely articles as many of us head into summer internships in our various fields and learning from the experiences of others in the same or similar situations can surely only serve to help us make the most of our own internships.

Thanks so much to all of our contributors this month and also a huge thank you to the student volunteers who helped to make the conference such a success: Lin Li, Anna Lee, Shubhangi Kaushik, Katie Maher, Matt McDonald, Rebecca Grattan, Gabrielle Cornelius and Sandy Tsai – we are very grateful and look forward to seeing you back next year!

I hope you all have a wonderful Christmas and New Year – take a well-earned break from study and enjoy some sun in one of our country's wonderful summer spots. If you are interested in contributing to our next issue, please don't hesitate to get in touch!

Kathryn Jenner

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Two internships with the Ministry of Education

Peter Stanley (Intern supervisor), Chris Stanley, and Matt Hegan (Intern psychologists).

Peter Stanley

Chris Stanley

Matt Hegan

Dr Peter Stanley has worked in four Government services for children with special needs: the Department of Educations' Psychological Service, the Special Education Service, Specialist Education Services, and the Ministry of Education (MOE). In addition to working as a psychologist and supervisor within these services, he has held roles as a Centre Manager, Business Development Coordinator, and Director of Whatuora Research Centre. Until recently he worked with MOE as a psychologist and Intern supervisor in Tauranga.

Chris Stanley studied psychology at the University of Waikato, and he has a Master of Applied Psychology in applied behaviour analysis. He began his internship with the Ministry of Education, Special Education, in Tauranga in July 2013. After working in a Behaviour Team he moved to Whakatane where he currently works with children with high and complex needs. He has previous experience working with children diagnosed with autism.

Matt Hegan studied at the University of Otago, and he has a Master of Science (Psychology) and a Diploma for Graduates (Education). After working in secure residential care with Child, Youth and Family Services, he began his internship in October 2013 with the Ministry of Education, Special Education, in Tauranga. He is currently with the Ministry's Intensive Wraparound Service in Central North.

Two intern psychologists with the Ministry of Education (MOE) in Tauranga were interviewed about the realities of their workplace experience. The findings of the research are obviously limited by the methodology but for these participants the experience of becoming a psychologist with MOE exceeded their initial expectations and hopes, and it has contained some surprises and some challenges. The interns also report on some of the skills and understandings they have developed in assessment and best psychological practices. As well, the participants discuss the satisfactions in their work, and they give advice to others contemplating an internship with MOE.

Peter: *Chris you are coming up now to the examination at the end of your internship period, and Matt you have completed nine months of your internship. Thinking back to the week before, or the night before, you began as an intern psychologist, what expectations or preconceptions did you have of the role?*

Chris: I think my expectations were pretty simple; that the problems we would be dealing with would be clear cut; that it would be as simple as a quick assessment, put an intervention in place, and we would begin to see changes in problem behaviours within a few weeks. Quite simply, I didn't know what I didn't know. It turned out that it was a lot more complex than that. There are a lot of variables to deal with, like managing staff in schools; and how families deal with children, and how they maintain behaviour. Working through these issues was much more difficult, and

not quite what I was expecting.

Peter: *And for you Matt?*

Matt: I thought that the title would give it away, and that Special Education was about helping kids at school who are struggling academically. I would be learning how to do assessments for children with learning difficulties and essentially ticking boxes. To be honest, I was a little hesitant because I didn't want to tick boxes and label kids. As it turned out, I was in for a big surprise.

Peter: *That's really helpful. Chris, let's now focus on your first couple of weeks.*

Chris: I found it quite exciting. I remember meeting with the management of schools, and parents, and discussing behaviour as well as doing some classroom observations. It was such a nice variety of experiences. I really enjoyed it.

Peter: *Was it the same for you Matt?*

Matt: In the first week I was very surprised at how diverse the role was. I found that I was working in three different contexts; in homes, in schools, and also with community organisations. I was surprised because I thought that I would be working either in the office where clients came in, or in schools doing assessments. But no, I was doing observations and interviews with parents and teachers and other significant people around a client, and so that was a pleasant surprise. I was also overwhelmed by the number of acronyms that are part of the professional conversation, and trying to get my head around working for such a big organisation.

Peter: *Yes, well we can all empathise with the acronyms. You're going nowhere in MOE if you don't know the difference between RTLB and SENCOs, and SEAs and SLTs!*
You two have done some solid academic studies. Chris; you completed the Waikato University's Master of Applied Psychology programme and Matt you have a Master of Science in psychology from the University of Otago. Was all of that study helpful and useful?

Chris: I have found the study increasingly more useful as time has gone on. Really, it wasn't until I got into the real world and was working that I saw just how useful applied behaviour analysis is. Determining the function of children's behaviour takes away the guess work. The solid grounding that ABA gave me means I can provide effective interventions and produce results. As well, I am able to track changes in behaviour using data with interventions in place. That's been very helpful.

Peter: *And Matt?*

Matt: How relevant is the academic approach? Very relevant, although I don't think it's the complete answer. Training in psychology in the scientist practitioner model is incredibly valuable, and behavioural analysis concepts are extremely relevant. But I like what Skinner had to say about education - that an education is what survives when what has been learnt has been forgotten. For me, that means that although I might have forgotten things, I have the ability to learn them again, and I have the scientific mindset to delve deeper, to evaluate things, and not just take things at face value. I think the complete answer to being a good psychologist is also to have creativity, flair, and interpersonal skills. I'm not saying that I have these things, but I can see that the good psychs do have them. That side of it can't be taught, and I think that's what sets the good psychs apart.

Peter: *Thank you very much. Okay, here you are working at the Ministry, working in special education, and working with teachers, parents and other agencies. What surprised you in your work?*

Chris: I found the biggest surprise was the level of authority that we work at. We work with the upper management of schools, principals and deputy principals; but also with staff at Child, Youth and Family Services, and with other professionals from other organisations. We have the potential to change the lives of children and those changes can be good or bad, depending on how we work. We have the power, for want of a better word, to advise parents to enrol their child at another school, if that's seen as best practice. We may refer a child on to Child and Adolescent Mental Health Services and that can potentially lead to a child taking medication. I guess it was a surprise to me to know that we had this 'power' with respect to children's lives.

Peter: *Surprises for you Matt?*

Matt: I was surprised at how much autonomy there is in the role. We are able to assess a situation and to make recommendations covering a broad spectrum of needs. There's no prescribed route to get somewhere; but we have the autonomy to look at what needs to be done, to be creative, and to try and design things as part of a team, because it is a very team oriented role. We don't work according to a conventional professional client model, because there is a strong team emphasis. As a member of the team, I don't have all the answers but I can help with certain things using the strong evidence base that we have in psychological science. Putting it together means that sometimes we can need to gently emphasise what the research says about certain situations but, as well, we need to take into account what the family or client wants, and that might not always be what we are advising.

Yes, the autonomy really surprised me. But what also surprised me was how poorly our role is understood. Some

people refer to MOE just because they want money for teacher aide hours. While that might be part of an answer, it is unlikely to be the only way to address a problem. As I say, people don't quite know what we do at the Ministry of Education and just because we have Special Education on our cards doesn't mean that we only deal with academic concerns.

Peter: *Okay, you two have spent quite some time now working with the Ministry and in special education and I am just wondering if there have been some specific challenges for each of you in your professional work?*

Chris: Probably the biggest challenge I found was working through other people. From an environmental perspective, the teacher has control over the child's behaviour in the classroom, as do children's parents in the home, and so we are working with these people. There's potential for conflict in people's values and beliefs. In addition, we're bringing a lot of knowledge of behavioural principles that we're really familiar with, and presenting this to parents and teachers who do not necessarily understand these principles, and who look to other explanations for the child's behaviour. That's a couple of challenges to implementing an intervention, and then there's the practical side of it as teachers have a lot of work to do already with so many children in their classes, and parents have a lot on at home. Implementing interventions can be difficult and challenging.

Peter: *And challenges for you Matt?*

Matt: Yes, similar to what Chris has found. It can be a challenge moving a conversation beyond money, and teacher aide hours, and into a practical discussion about the evidence-based interventions we can do at home and in the classroom. That's a challenge and that's something I'm still learning how to do. Also, I think a big challenge arises because our service is free. That's good because it means that we are accessible to a wide range of people. But I also think it results in a lack of motivation sometimes when people are not paying for a service, and there can be a lack of boundaries as well. For example, I had one parent ask if I would help her child with mathematics' tutoring. This really surprised me as I had been working in the home and the school, and the mother had decided not to implement the basic positive behaviour strategies in the home that we had discussed. She seemed to think that I was someone that the government paid to do whatever she asked, which in this case was to provide free tutorage.

Peter: *Chris, what have been the major areas of skill development over the course of your internship?*

Chris: The major skill development for me has to be working with others collaboratively, and especially with other professionals. We work with other organisations, like Child, Youth and Family Services and the District Health Board. Also within the organisation, we work with occupational therapists, physiotherapists, speech language therapists, and people from a lot of other disciplines. I've found working with others and knowing where my line of work ends, and not crossing over, has been a big learning curve.

Matt: Yes, the same for me. It's developing and nurturing relationships with other professionals and with families. And sometimes that means running with resistance. What you've taught me Peter is that often we need to just be there and to develop a relationship with the family, or whoever we're working with, even if they're not implementing the interventions or the suggestions that we're there to provide. We stay and we're there for the long term, ready to revisit our suggestions when asked, and that is something that I think is unique about the Ministry. And that's what the research shows too. Many psychological models talk about the importance of the therapeutic relationship and 'buy in' from the client. I just never realised that this can sometimes take quite a long time.

Peter: *One of the things I've seen in my experience supervising Interns is that they have to learn that it's a journey with parents and teachers. Working collaboratively with the important people in kids' lives like this really raises the bar. It also has all sorts of implications, including ethical aspects, and it's quite different from conventional ideas of professional practice or case management. The other thing I have seen Interns struggle with is learning to implement applied behaviour analysis procedures, and other psychological strategies, in real life. It can be quite a challenge to translate text books and journal articles into the real world. But like collaborative practice, it's a good challenge because it's at the heart of what we do.*

Chris and Matt, what have been areas of personal and professional satisfaction for you?

Chris: As Matt has already said, I also enjoy the autonomy of the job. I create my own weeks, so I book in appointments for observations and interviews and I can also set aside an afternoon to catch up on paper work if needs be. So I enjoy that aspect. There are a lot of professional development opportunities to attend such as Non-violent Crisis Intervention as well as the Psych Forum. I really appreciate the little things as well, such as the Ministry's fleet of cars. I've got a work phone and my psychologist registration costs are covered, and I think these things make a difference to job satisfaction. And lastly, I enjoy having

the room to implement interventions without having to stick to a rule book. For instance, I've been able to do acceptance and commitment therapy with the parent of one child and give that a good go whereas in other roles that freedom may not necessarily be there.

Matt: I think a major satisfaction is when you're working with the adults around a child and they realise that it's not the child that's necessarily the problem. It's actually an environmental issue and they can help change what's happening by using some evidence-based strategies at home or school. It is very satisfying when you revisit the family or school and see change occurring in a positive direction and that you are making a difference. Yes, there is some good professional development available as Chris talks about. For instance, I've been able to get some training in acceptance and commitment therapy, which is something I would like to get more into, and that's been paid for by the Ministry. It's a part of being required to provide best practice; and that means reading the most up to date research, learning about new techniques or interventions, and applying interventions that are evidence based.

Peter: *Matt, could you please comment on the role of psychological assessment in your work?*

Matt: We work in an ecological model so we start off by trying to get a good idea of what's going on with the client, their environments, and what's needed. This usually means interviews across multiple settings, whether it's teachers, parents, police, and whoever else is involved. Then there are observations, with functional behaviour analyses. As well, there are a range of cognitive and psychological assessments that can help back up our observations and provide further data, such as the WISC, PVVT, BASC, ABAS, Piers-Harris, or any number of behavioural checklists if that's what's needed. We try our best to collect good data to plan the best interventions possible.

Peter: *That's good. Thanks Matt. Chris, would you like to respond to the place of assessment in your work.*

Chris: I rely heavily on gathering data and, for the most part, I depend on behavioural assessments. However, since coming into an ORRS (Ongoing Resourcing) team and working with students with high and complex needs I have found a place for psychological assessments such as WISCs and the Vineland to get a measure of levels of cognitive and adaptive behaviour functioning, and to see if those levels have changed. From these instruments I will bring in ABA assessments again to record instances of behaviour.

Peter: *We could have a lot longer discussion about assessment because I think the amount of assessment that we do in natural settings is a point of difference for us as psychologists. As well, we tend to be uneasy about diagnosis, and this can be another point of contrast; but our reservations arise from working in homes and classrooms where we see the formative interchanges between children and parents and between students and teachers. Actually, it would be interesting to know where you two are now at in terms of your understanding of best psychological practice in working with children.*

Matt: When the Government commissioned the Church Report we were given quite a comprehensive review of best practice interventions for children who are presenting with behaviour difficulties. And it came out really clearly that a successful intervention needs to work across both home and school environments. That is something that really informs our work and we do work in both of these settings. Often it's a matter of making sure that there is clear communication across all of the settings, and we assist in getting everyone onto the same page. I think the other thing that really stands out from the Church Report is the importance of early intervention and trying to get to the root of the problem as early as possible.

Chris: As Matt said, the Church Report is a very good guide to best practice. When you are dealing with a child with challenging behaviour in a school setting, so often if you dig deeper and interview the parent, you find that that behaviour has come from the home setting. Solely putting interventions into the school just won't get anywhere near the effectiveness of an intervention that covers both settings. My experience with the Ministry to date has allowed me to pursue comprehensive and consistent interventions of this sort and that's made for some very effective behaviour change.

Peter: *Chris, what advice would you give to someone who is contemplating an internship with the Ministry of Education?*

Chris: Since moving into the ORRS team I've found that caseloads can get up to around forty clients. If you break that down to a week, there's only so much that you can do for each child. It's a bit different in a behaviour team where you could have 15 cases. Even so, be prepared for that, and that you won't get really quick changes. As well, it is important to realise that you've really got to be able to get on with all types of people and especially when you're working through others. There are schools where the staff don't change, and they have been there for quite a long time. If you get off on a bad foot with a staff member in one

of those schools it can have lasting effects. So that's something to consider as well.

Matt: If someone is contemplating the Ministry it is important to get a good feel for the environment first and to see if it's a good fit for them. The Ministry has been really good for the interns I've seen. Usually there's a fairly gentle introduction with days of observation, and discussions around what the work looks like, and this is important. In my experience, MOE supports you with really good supervision. And that includes a designated supervisor, but also peer supervision as well; and the support that you receive allows you to be effective, and to implement best practice. It's a role that will stretch you, but you will also be supported to intervene in many different situations. You can make better money with other organisations but the Ministry has some distinct advantages that outweigh that. The autonomy of the role is such a bonus, and this personal responsibility also encourages me to make sure I am listening to the goals of the client and their families and not just imposing my views. Furthermore, our commitment to professionalism and best practices, along with the supervision, probably means that I am less likely to suffer from burnout.

Peter: *Matt and Chris, thank you very much.*

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Reference

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Acknowledgements

The support is acknowledged of John McGovern, Service Manager, and Nicky Hampshire, District Manger, Ministry of Education, Bay of Plenty East. Thank you also to Susan Keys, MOE Shared Services Whakatane, for translating the audio tape.

Different Audience, Different Story, Same Facts.

Charlene Neuhoff

Charlene Neuhoff is an Intern Psychologist currently in placement at Instep Limited, BSSNZ Corporate Psychology and the Mental Health Foundation's Working Well programme. Charlene is interested in psychology as it is applied to people at work, and she is particularly drawn to what makes people feel well, be productive and get along well with one another. At Instep, Charlene's work involves data collection, specialist referral, and on-going case management of employees using the service. At BSSNZ Charlene provides workshop facilitation, analysis, logistics and evaluation support for fitness for work training and consultancy that addresses areas such as resilience, fatigue, AOD risk management, and mental health in the workplace. Charlene was a joint winner with Mihiroa Gillies for the NZPsS best student paper presented at the 2014 NZPsS Conference in Nelson.

Psychologists have to present complex information to diverse audiences. We often need to communicate similar information to audiences with very different characteristics and needs. Do we know what format of communication is expected of us or desired? Could we communicate more effectively and increase the impact we have as a profession? Training in the science of our discipline taught me how to produce work suitable for the academic world. Learning to practice psychology in the corporate and public sectors taught me that in these contexts academic format is not the best fit; I needed to learn how to convey the same psychological information in different ways for different audiences.

The following article is a distillation of key reflections taken from my experience of learning to take psychology into the business world. It is the condensed version of some rather painful lessons. These lessons helped me to close the gap between what clients wanted from me as a psychologist and what I was delivering. This article also includes the results of a micro-research project. The project was undertaken to shed light on some of the questions I started to ask as a result of my

experiences. What kind of communication do our clients/ employers actually want, and more broadly what do they wish psychologists knew?

Translating Psychology into Business Speak.

One of the first lessons learnt: keep it simple. Can I blame a manager for staring blankly at a thirty page report that could have been written in three? Diligent efforts to communicate detailed information can lose a business audience. There is a trade-off between simplicity and comprehensive coverage. Certainly, those looking for technical detail need to be able to find it. But I learned that those who want to avoid the detail will. If I want my message to be understood, I need to encapsulate its core in plain language that will make sense to the intended audience.

Keep it simple

"The suprachiasmatic nucleus (a small group of nerve cells in the hypothalamus) controls the sleep wakefulness cycle"

"There is a sleep centre in the brain that acts as a master clock for the body"

The second lesson learnt: be confident. Academic communication is characterised by qualifiers and non-committal language; rightly so. Yet in the business sector I found that this style did not translate very well. We need to be accurate; avoid lies or over-claiming, and yet excessive use of words such as 'possibly, maybe, and appear to be' is unwelcome and unhelpful.

Be confident

"Based on the evidence, it is likely that most employees navigate construction sites and operate machinery. As such fatigue may be of additional concern"

"Employees often navigate construction sites and operate machinery which makes fatigue of additional concern."

The third lesson learned: no in-text references. We have mastered the skill of reading material punctuated by references. Many other people have not. I found that when referencing is non-negotiable footnotes appear to be more digestible than parenthetical citations.

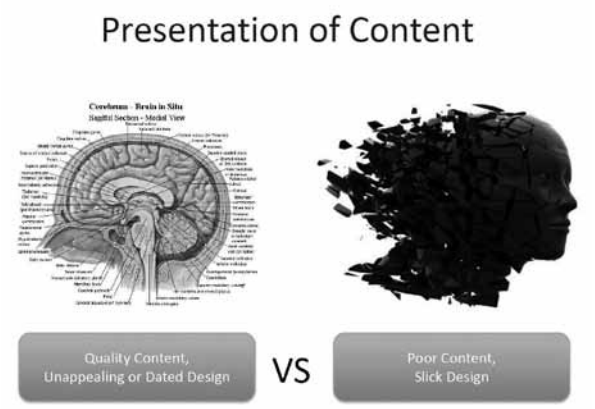
Ditch in-text references

"The GDR method (Heid et al., 1985; Braunbaum et al., 1984; Led et al., 1995) is not ideal for capturing short-lived[1] stages of sleep (Marsden et al., 1991a)"

"The GDR method is not ideal for capturing short-lived stages of sleep"

The fourth lesson: seniority and verbiage, an inverse relationship. The higher up you go on the corporate ladder the less information they seem to want. When reporting to the board or senior managers, a low page count, clear summarised messages, and simple graphs are preferred. When reporting to line managers or supervisors, clear messages and simple graphs are important, but it is they who value further detail and case examples.

The fifth lesson learned: aesthetics matter. As psychologists, our high expectation for quality content can mean that the "look and feel" of our work is neglected. After all, written after our degree is the word *psychology* not *graphic design*. *But in the business world these things matter*. The "shop front" of psychology tends to be characterised by well packaged, attention grabbing, poor quality content. Therein lies the need to make good information just as accessible and pretty.



What do the people holding the purse strings want from us?

Learning how to communicate with different audiences through trial and error was traumatic. So I decided to do a risky thing and ask some important people what they actually wanted from psychologists. The result was an informal micro-research project to aid the development of my practice. I approached three groups of people: a clinic of general practitioners, an EAP provider and a handful of CEOs/business owners. These people were chosen for their position as gate keepers of income, funding and client referrals for psychologists. Using the safety of my intern title to full advantage I asked them:

"In your dealings with psychologists and the work they produce, what do you actually want? With this is mind what do you wish psychologists knew?"

Due to time constraints, content analysis was not performed on the responses. But the following is a list of the recurring themes and key messages that rose to the top for each group.

General Practitioners

1) Summarise, summarise, summarise. *"Please end a report with a three (no more) line summary. We don't have the time to read through the hour long discussion and history you took and had with the client. Unless for legal purposes, keep it in your notes and give us the short (very short) version"*

2) Send stuff electronically. *"Do check if there is an electronic method of sending reports to your referrers. Most practices have them and appreciate this method. On my side it means a simple click can file the report in the patient's folder. Ask our practice managers about this."*

3) Unless it's an emergency don't phone during consulting hours. *"When you call and ask to speak to the doc about your mutual patient we feel obliged to take the call in case it's urgent. I'm always unimpressed if it isn't. There is often another patient sitting in front of me who according to Murphy's Law is probably your patient's grandmother, boss, neighbour. Rather, leave a short message with the practice nurse. She will write in it the doctor's book. Maybe not satisfactory but best we can do."*

4) Please ask GPs (in a short note) if there is something you want done. "If there is something you would like the GP to check/do, don't be afraid to ask. For example, you may say *"as per the patient history I assume thyroid function is normal, but could you please reassure that this has been recently checked"*. A short note is more likely to be noticed."

5) Want referrals? Come in and say hi. *"Do introduce yourself to your local GP practices. Putting a face to a name helps. Try a few times to get through the concrete. We are bombarded with people/specialists/reps/newmeds, but eventually a new face and name sticks. Forget teatime...It doesn't exist! You will be competing for medical rep space. Book ahead with the practice manager for best results."*

"Come and ask us what type of patients we don't like spending time with. If you specialize in them profess a massive interest in these patients (i.e. I have a special interest in chronic fatigue, pain, depression, and obesity). We will think of you when they come our way. P.S. thank you for taking these people on!"

6) Doing a series of consults? Don't send a report for every one. *"If doing a series of consults on a patient in short order (unless there is a directive/query) a summary at the end of the series is best. No need to spend your or our time with a report every time. Trees need saving."*

Employee Assistance Programme (EAP) Staff

1) Acknowledge that you are a business. *"To us you are a business charging for services. Please make sure your high standard extends to ALL areas of your business (i.e. timely and accurate invoicing, up to date profiles, CVs and websites). Attention to this is critical to your success with us. We see this side of your service more often than we see a therapeutic outcome. If these things are sloppy on a regular basis we make the assumption that this may be reflective of your clinical work"*

2) EAP providers don't like surprises. *"We love being gobsmacked by what psychologists do in their spare time - but you will quickly find yourself cut off the Christmas card list if we get a nasty surprise. Finding out a client has been seen ten times without authorisation, or that a psychologist has appeared in the NZ Herald under the heading 'EAP Advocate' at court will freak us out."*

3) Before you set up shop, ask us at EAP where they don't have many people and go there. *"Psychologists who ask us where they are most needed often reap big rewards. For example, currently we have hardly anyone on our books practicing in <location specified>. The one or two people based there get a rather lucrative monopoly on referrals"*

Business Owners and CEOs

1) Use the language of the client, not yours. *"Save the heavy psych terms for your psych friends. If your audience is white collar, blue collar, or a business, alter your language for your audience"*

"Remember, some expressions used by psychologists can have different interpretations – I remember being confused over

what a psych meant by engagement. The terminology of your profession may not mean the same thing to me as it does to you"

2) Please be business savvy. *"I appreciate when you explain the problem to me in simple terms (not academic)" "PLEASE offer me a solution. Don't just tell me what's wrong"*
"Tell me how much a thing will cost. Dollars and time"

3) In reporting, metrics and simple graphs are really helpful. *"As a business owner, it's the language that speaks volumes to me. Benchmarking with other companies/ industries/countries…more of that please. When I see my company is doing poorly in relation to someone else's I get competitive. I will want that to change."*

5) Psychologists = Perfectionists. *"Your work is always very thorough, but this is sometimes not necessary. 'Good enough' work can be preferable - especially when time is short or it will mean a higher output of work overall."*

6) You are truly valued. *"You do great work; I can always count on a very high standard."*

"Psychologists are a safe pair of hands. When an employee presents with multiple issues (perhaps a mixed bag of clinical /workplace related issues) I want a psychologist looking after that person"

A bitter pill to swallow? Or a nugget of gold?

Personally, I found some of the responses a little confronting. Yet within these honest opinions are some valuable suggestions that may make for better business relationships, better communication, and opportunities for psychologists to have greater impact.

I believe we can be encouraged by the results. It would appear that we have a reputation for producing detailed/quality work and taking on difficult cases. At the same time there is no denying the dissonance that appears to exist between what we sometimes deliver and what is desired or even useful.

What clients want from us as a profession is an important question to ask. Psychologists in NZ are increasingly being asked to do more with less. Can we afford to do work that is undervalued and perhaps missing the mark? Overall the people I asked seemed to truly value what we offer as psychologists. Could we be doing more to increase the impact we have and market our services better? The answer appears to be yes.

Hippocampal Functioning & Autobiographical Memories: A Neuropsychological Test of Multiple Trace Theory

Matthew McDonald

Matthew McDonald is a student at the Department of Psychology, University of Otago. He is completing concurrent study towards a PhD and a Postgraduate Diploma in Clinical Psychology. Matthew's research interests include the changes in autobiographical and prospective memory abilities throughout the lifespan and positive health and well-being outcomes for older people. His doctoral research is supervised by Professor Robert Knight. Email: mattm@psy.otago.ac.nz

Matthew McDonald's poster (see next page) was the winner of the NZPsS Best Student Conference Poster prize for 2014.

Hippocampal Functioning & Autobiographical Memories: A Neuropsychological Test of Multiple Trace Theory

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Multiple Trace Theory

- Evidence from both lesion and fMRI studies suggest that the hippocampal complex is a critical component for memory processes, and especially for the retrieval of recent episodic memories.
- One theory of memory consolidation, *Multiple Trace Theory (MTT)* posits that the hippocampus is always involved in storage and retrieval of richly detailed episodic memories, regardless of the age of the memories, and that only semantic information can be retrieved independent of the hippocampus.
- It was hypothesised that if *MTT* is correct, the recall of rich detail in both recent and remote autobiographical episodes would be predicted by an older adult's abilities on a source memory task (a hippocampal function) whereas recall of semantic autobiographical information would be more related to other processes, such as executive functioning.

Neuropsychological Testing of Older Adults

Participants

80 adults aged 55 to 89 years of age ($M = 70.49$ $SD = 8.96$). Participants reported no medical or neurological conditions.

Assessment

We administered the following tests:

- Modified Verbal Autobiographical Fluency (VAF) Test- interview to assess recall of recent and remote autobiographical memories. Verbal questions "zoom in" from semantic information i.e. dividing life into many 2 year+ periods (VAF1) & recall of regular activities (VAF2), to the recall of specific episodes (VAF3) and one autobiographical episode in rich detail (VAF4). Interviews were recorded, and coded for details by an independent coder.

Figure 1: Example of "zooming in on a memory" VAF 1 to 4

- Source Memory Task- a computer-based task for memory of the source list of pictures of everyday items. Hits and misses were analysed using Process Dissociation and Signal Detection methods to give estimates of two key memory processes: conscious recollection (R), and automatic processing or familiarity (d').

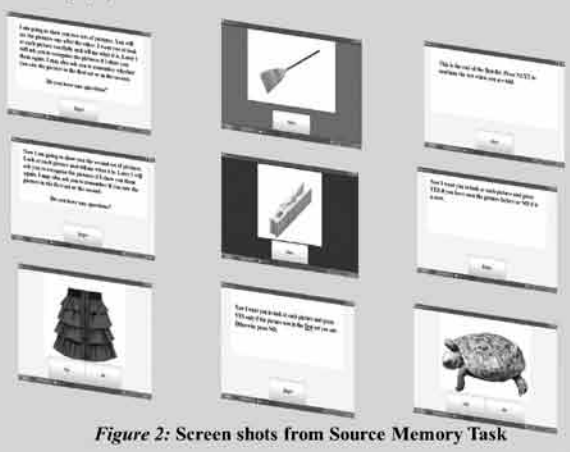

Figure 2: Screen shots from Source Memory Task

- Digit Span Forwards and Backwards- working memory ability.
- Controlled Oral Word Association Test (FAS version)- verbal fluency.
- Trail Making Test (TMT)- psychomotor processing speed, working memory.

Procedure

- Data were analysed using forward stepwise regression analyses.

Recall of episodic detail was predicted by verbal fluency, recollection & familiarity. Semantic information was predicted by executive functions

Table 1. Summary of Results from a Series of Forward Stepwise Regression Analyses to Predict Autobiographical Memories (VAFs)

Dependent variables	Independent variables (measures)	R^2 change (p)	Total R^2	Independent variables (measures, education, age)	R^2 change (p)	Total R^2 (p)
VAF1 overall	Digit Span	0.085**	0.085**	Age	0.166**	0.166**
VAF2 remote	TMT	0.223**	0.223**	TMT Age	0.223** 0.061**	0.288**
VAF2 recent	FAS	0.166**	0.166**	FAS	0.166**	0.166**
VAF3 remote	FAS d'	0.103* 0.074**	0.176**	Educ	0.111**	0.111*
VAF3 recent	FAS	0.117**	0.117**	FAS	0.117**	0.117**
VAF4 remote	FAS d' R	0.087* 0.058* 0.084**	0.230*	Age	0.132	0.132**
VAF4 recent	No predictor variables			Age	0.118**	0.118**

*$p<.05$ **$p<.01$

- As shown in *Table 1*, before age and education were included in the model, two measures of remote autobiographical episodes (VAF3 remote & VAF4 remote) were both predicted by verbal fluency (FAS) and source memory (R & d'). Both remote and recent semantic information (VAF1 & 2) were predicted by executive functions.

Conclusions

- Our hypothesis was partially supported. The recall of rich detail in remote autobiographical episodes was predicted by source memory abilities and the recall of both remote and recent semantic information were predicted by executive functions. Contrary to our hypothesis, detail in recent autobiographical episodes was not predicted by source memory.
- A key tenet of MTT is that the hippocampus remains involved in the retrieval of remote episodic memories, and that other brain areas are important for semantic recall. Our results do suggest that the integrity of the hippocampal complex corresponds with an increased ability to recall detail in remote memories, and that the frontal lobes (executive functioning) are associated with the ability to recall semantic information.
- However, given the weak predictive value of both the source memory task and executive functioning tasks it is likely that other psychological factors play key roles in performance on the verbal autobiographical fluency task. Factors such as individual differences in personality could be considered in future research.
- Methodological limitations include: this study is correlational research so conclusions regarding causation are not possible. Participants showed ceiling effects on the source memory task and this could have resulted in an under estimation of their recollection abilities.

Acknowledgements

- The authors acknowledge the receipt of the University of Otago Doctoral Scholarship for funding of this research.

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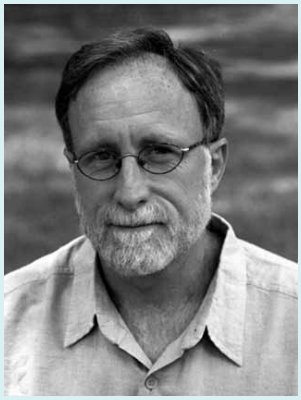

Understanding current diagnostic systems: Problems and Prospects in the revisions

Presenter: Greg Neimeyer

4 March 2015 in Auckland, 6 March 2015 in Wellington
9 March 2015 in Dunedin, 10 March 2015 in Christchurch

Dr. Greg J. Neimeyer is professor of psychology in the Department of Psychology at the University of Florida where he currently teaches the doctoral course on Psychodiagnosis (DSM-5 and ICD) and has served both as Director of Clinical Training and as Graduate Coordinator. A Fellow of the American Psychological Association, he is also a recipient of its Award for Outstanding Contributions to Career and Personality Research. Dr. Neimeyer has published over 200 articles and 10 books, with an emphasis on aspects of professional training and development. A former Chair of the Executive Board of the Council of Counseling Psychologists in the United States, Dr. Neimeyer has also been elected as a Fellow to the Academy of Distinguished Teaching Scholars. Dr. Neimeyer currently divides his time between the University of Florida, where he has maintained a practice in the Family Practice Medical Residency Training Program, and Washington, D.C., where he directs the Office of Continuing Education in Psychology at the American Psychological Association.

Workshop description
The Diagnostic and Statistical Manual of Mental Disorders (DSM) has undergone substantial revision across its sixty years of evolution, with the latest version (DSM-5) continuing that tradition in substantial ways, including its articulation with the ICD-10 and (forthcoming) ICD-11. The discontinuation of the multi- axial system, the addition and deletion of specific disorders, the regrouping and reclassification of familiar disorders, and significant changes in the names, nature and criteria associated with various disorders all mark the fifth edition of the DSM as a substantial revision of the diagnostic system. In addition to receiving a detailed overview of the primary changes and rationales
associated with those revisions, participants will also gain familiarity with the ICD-10 and experience in utilizing several novel inclusions in the DSM-5, including the new cross-cutting diagnostic dimensions and the new Personality Disorders assessment, the PID-5, and its potential relationship to the Psychodynamic Diagnostic Manual (PDM).

Workshop Overview and Disclaimers

The Top 10 Most Significant (and Controversial) Changes

DSM History and ICD History and Contemporary Context

DSM-5 Revision: Process and Organization
- Section I: DSM Basics
- Section II: Diagnostic categories, criteria and codes
- Section III: Emerging Measures and Models

Specific Revisions and Reorganization of Disorders
- Neurodevelopmental Disorders
- Schizophrenic Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma and Stress-Related Disorders
- Dissociative Disorders
- Somatic Symptom Disorders
- Feeding and Eating Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Substance-Related and Addictive Disorders
- Personality Disorders and the PDM
- Neurocognitive Disorders

Back to the Future: The DSM and the ICD

For more information please go the NZPsS events page on our website: www.psychology.org.nz or contact Heike at: pd@psychology.org.nz