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Editorial 2

Articles

Real Men *Do* Cry 3
Vinyak Dev, Pam Low & James Loh
Working With the Gut-Brain Axis 12
Karen Faisandier
Cognitive Analytic Therapy (CAT) in Groups 23
Rachel Hodge
Distinct or Overlapping: Reviewing the Role of Central Concepts in Contemporary Models of Suicide 29
Andre Mason

Literature Review

Metacognitive Training (MCT) Group for Adults with Psychosis Based in a Specialist Mental Health Service 36
Wade Stent

Commentary/Poetry

Māori Identity, Old Solutions and New Problems 41
Emerald Muriwai

Opinions/Reflections

To Therapy or Not to Therapy 46
Tamara Smolinksi
Evolution of Group Supervision 48
Nicola Crook
Zooming in and Zoning out: A Reflection on why we get Fatigued When Using Telehealth 52
Liesje Donkin

Reports and Reviews

Review of Sleep DownUnder 2019 56
Reviewed by Kimberly Falconer

Book Review: A Conversation With my Country. Where We've Come From. Where we can go 58
Reviewed by Peter Stanley
Book Review: Irreversible Damage: Teenage Girls and the Transgender Craze 60
Reviewed by Peter Stanley

NECC Training Timetable 63

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The Specialist Organisation for Clinical Psychologists

Tatangi mai ana te tātarakihi, he wera kei te haere.
The audible murmuring of the cicada signifies a hot day.
The natural world communicates information giving indication.

Editorial

Dear Colleagues

This journal's theme, 'Evolutions of therapy: new approaches to old problems', seemed a way to build on the changes and challenges we have faced over the last 12+ months with the pandemic. Many of us have had to think outside the square to continue to help and support our clients, colleagues, family, friends and even ourselves with the changes that have occurred around the world. This required some quick changes and adaptations to novel problems we had not faced before, such as many of us trialling video call-based therapy.

At a broader level there are notable changes occurring around the world and in the field of psychology, which with technological advancements seem to be happening at a quick rate. Reflecting on these changes seemed important. Whether it has been incorporating recent advancements into our practice, building on our own existing knowledge or sharing things that may be new to us and old to others.

However, as one of the pieces in the journal notes, sometimes we also need to look back to move forward, and often, we may already hold some of the answers we may seek through new or novel things. Evolutions of therapy or even within therapy can often be well supported by the past or a better understanding of those old learnings, which may help with new problems. This is important to remember, and a good reflection to have about our own continued learning and development as to whether we are missing out on the old knowledge or our own identity by always seeking the new.

Regards,

Liesje & Wade

Real Men *Do* Cry

Vinyak Dev, Jame Loh & Pam Low

Men constitute 49.7% of the New Zealand population (Statistics New Zealand, 2019), despite 105 males being born for every 100 females (Statistics New Zealand, 2018). In most parts of the world, morbidity and mortality rates among men tend to be substantially worse than those among women (CMS Office of Minority Health, 2017; Population Reference Bureau, 2008). Men also access healthcare services less than women (Cameron et al., 2010; Saunders, 2000), are more likely to incur physical injuries (Sorenson, 2011; Udry, 1998), tend to have their abuse ignored and be under-reported (Barber, 2008; Drijber et al., 2013) and are more likely to commit suicide (Ministry of Health, 2017; United Health Foundation, 2019). To compound these trends, men also tend to have lower educational achievement and higher drop-out rates than women (Hjorth et al., 2016; Ministry of Education, 2020), greater rates of incarceration (Ministry of Justice, 2020) and greater homelessness (Demographic Data Project, 2018; Statista, 2018). However, these gender-based inequities have received little national, regional or global acknowledgement or attention from policymakers or providers (especially in a healthcare context) (Baker et al., 2014).

There are various reasons underlying the systemic health-related disparities observed between men and women. In addition to biological sex differences (particularly gene-, hormone-, reproductive anatomy- and metabolism-related differences), these reasons primarily include men: a) having greater levels of occupational stress and hostility, and exposure to physical and chemical hazards; b) engaging in behaviours associated with male norms of risk-taking and adventure (including substance abuse and poor diet); c) having lower social support; d) having greater levels of shame and stigma associated with support-seeking behaviours (especially in a healthcare context); and e) being less likely to report the symptoms, or report less (and minimise) symptoms, of their disease or illness (Harvard Men's Health Watch, 2019; Population Reference Bureau, 2008; UCL Institute of Health Equity, 2014; United Health Foundation, 2019).

In addition to individual factors, systemic factors also contribute to exacerbating men's morbidity and mortality rates. These factors include longer appointment wait times; lower access to relevant assistance and information; lower care coordination; lower likelihood of being screened for obesity, hypertension, diabetes, cancer, eye problems and kidney problems; lower likelihood of being monitored for the use of high-risk medications; lower likelihood of having an ambulatory or preventive care visit; delayed hospitalisation for cardiac arrest; lower likelihood of receiving mental health support and of being treated with antidepressants; and delayed treatment for chronic obstructive pulmonary disease and rheumatoid arthritis (CMS Office of Minority Health, 2017; Mesa, 2018; Saunders, 2000). Other factors such as lower socioeconomic status, lower education level, employment type and affiliation with minority cultural groups (particularly minority ethnic and sexual groups) may also exacerbate men's morbidity and mortality rates relative to women, while also contributing to a poorer quality of life (Astbury, 2001; Cherepanov

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et al., 2010; Haas & Lane, 2015; Moen & Chermack, 2005; Orielle & Irwin, 2010; Rieker & Bird, 2005; Stringhini et al., 2017; White et al., 2020).

In the New Zealand context, this specifically applies to Māori and Pasifika men with lower socioeconomic status, particularly in relation to their access to primary healthcare services (Hefford et al., 2005) and cardiovascular disease-related support (Tukuitonga & Bindman, 2002). These inequities can primarily be attributed to explicit or implicit discrimination, nurses and community health workers carrying a disproportionate burden of care, and cultural and diversity training not being mandatory for employment (Ellison-Loschmann & Pearce, 2006; Sheridan et al., 2011). Gender-based healthcare-related inequities faced by men in New Zealand also extend to other domains, particularly: education, where 79.0% of males complete high school relative to 85.0% of females (Ministry of Education, 2020); homelessness, where 83% of homeless people in New Zealand are men (Statista, 2018); and corrections, where 79% of those who are incarcerated are men (Ministry of Justice, 2020). Additionally, court sentences tend to be systematically harsher for male convicts (Jeffries, 2002; Jeffries et al., 2003), and men find it more difficult to find employment opportunities post-prison than women (Morrison et al., 2018). These trends tend to be particularly worse for Māori and Pasifika men (Jeffries, 2002; Ministry of Education, 2020; Ministry of Justice, 2020).

A way in which the inequities faced by men can be addressed, their shame and stigma in accessing support services (especially the healthcare system) reduced and their risk-taking and male-norm-based behaviours moderated is through gender-specific psychotherapeutic support groups or '*Men's Groups*' (Reddin & Sonn, 2003). While the term is used broadly in the literature to describe psychotherapeutic support groups for men that vary in their frequency, duration, focus, use of modalities and intensity, the overarching aims of such groups tend to be consistent; that is, to cultivate greater levels of introspection, self-awareness and insight, emotional awareness and expression, emotional regulation skills, communication and interpersonal skills and emotional support, *and* to foster a sense of community (MacNab, 1990; Reddin & Sonn, 2003). Furthermore, such groups have also typically been shown to improve men's physical health, ability to be aware of others' boundaries and assert personal boundaries, develop leadership skills, be better equipped to integrate and fulfil their (especially emotional) needs, engage in helpful story-telling, feel belonged, accepted and related to (i.e., have a greater sense of emotional safety), and resolve gender-role uncertainty and conflict (Chambers & Martin, 2002; MacNab, 1990; Reddin & Sonn, 2003).

Given the predominance of women in home, healthcare, childcare and educational contexts, much of the socialisation process that men undergo as children is under female supervision (MacNab, 1990). This is in direct contrast with the trend observed in most hunter-gatherer societies, whereby boys are plunged from a maternal environment into a world of adult masculine identification through various initiation ceremonies (MacNab, 1990). In doing so, boys naturally transition into their adult masculine roles with a clear sense of identity—a trend that appears to be missing in modern societies (MacNab, 1990; Reddin & Sonn, 2003). Thus, in leading to the aforementioned outcomes, especially a greater sense of emotional connection, purpose in life and feeling of being belonged, accepted and related to, Men's Groups can contribute strongly to cultivating a strong sense of identity that a lot of men appear to be missing these days.

In light of these trends, a series of Men's Groups were implemented in a primary care setting in Auckland, New Zealand, to determine whether they would lead to significant improvements in participants' health and well-being. Specifically, the study sought to: a) evaluate the effectiveness of Men's Groups in reducing participants' subjective levels of physical and psychological distress, and b) explore participants' subjective experiences of the process.

Methods

The study employed an observational, cross-sectional design. Data were gathered from three Men's Groups that occurred over the course of 2020. These Men's Groups were psychotherapeutic support groups that involved one 2-hour session per week for 6 weeks. Each group had a dynamic structure and involved psychoeducation and discussions on topics that arose naturally. A rough outline of each session across the three groups is provided in Table 1, with the topics that were only covered in one of the three groups italicised.

Participants either self-referred using information provided on posters, pamphlets and social media, or were referred to the programme by their respective primary healthcare providers (specifically, general practitioners, health coaches, health improvement practitioners, nurses or therapists). The groups were advertised to healthcare professionals and patients as groups 'that provide the skills and personal attributes necessary for men to be able to successfully navigate through the world, to thrive, and to feel fulfilled in who they are and in what they can be'. Enrolled participants completed a baseline questionnaire and a follow-up questionnaire after completion of the programme. Convenience sampling was used to recruit participants.

Table 1

Outline of the Men's Group Course Sessions

Session Number	Outline
1	Introductions and whakawhanaungatanga; *discussion on the impacts of COVID–19* and on the issues currently faced by men; group outline and expectations; discussions on the tension scale, mood scale, *attention scale* and *the dual model of grief.*
2	Check-in and reflection on the week using the tension scale or the mood scale; discussions on positive male role models, definitions of masculinity, 'drama' and 'healthy' triangles, importance of being vulnerable at times and the importance of taking responsibility.
3	Discussion on what makes a good listener and Imago dialogue; practicing listening skills using roleplays; learning how to provide validation and normalisations.
4	Discussion on the overarching goals and values for the next 5 years, importance of vulnerability and transparency in relationships, emotional regulation and processing skills and techniques, distress externalisers versus internalisers, three chairs metaphor (i.e. observer, bully, 'your 8-year-old self'), validations that 'your 8-year-old self' would have appreciated, and *the influence of upbringing on coping styles.*
5	Assertiveness training; discussion on non-violent communication; review of the three chairs metaphor (i.e., observer, bully, 'your 8-year-old self').
6	Reflections on personal journey and learnings in the group; provision of feedback to one-another; review of the concepts learned and discussed in the group.

Measures

The primary measures (i.e. anxiety, depression and physical distress) were assessed using the Patient Health Questionnaire (PHQ) battery of questionnaires, based on the Primary Care Evaluation of Mental Disorders (Spitzer et al., 1999).

Anxiety. Anxiety-related symptoms were assessed using the Generalised Anxiety Disorder 7-item scale (GAD–7) (Spitzer et al., 2006). This questionnaire assesses the frequency of symptoms (e.g. 'feeling nervous, anxious or on edge' and 'trouble relaxing') of generalised anxiety on a scale from 0 ('not at all') to 3 ('nearly every day'). It possesses good internal and test–retest reliability, and good criterion, construct and factorial validity (Löwe et al. 2008).

Depression. Depression-related symptoms were assessed using the PHQ–9 (Kroenke et al., 2001). This 9-item questionnaire assesses the severity of depression using items such as 'little interest or pleasure in doing things?' and 'feeling tired or having little energy?'. All items are rated on a scale from 0 ('not at all') to 3 ('nearly every day'). The measure has good psychometric properties (Kroenke & Spitzer, 2002) and is widely used in general practices in New Zealand.

Physical distress. Physical distress was assessed using the PHQ–15 (Kroenke et al., 2002). This 15-item questionnaire was derived from the full PHQ and assesses the frequency of physical symptoms (e.g. 'stomach pain', 'back pain' and 'dizziness') experienced by patients on a scale from 0 ('not at all') to 2 ('more than half the days' or 'nearly every day'). This measure also has sound psychometric properties (Kroenke et al., 2002).

Analytic Strategy

Consistent with our exploration of whether physical distress, anxiety and depression (i.e., psychological distress) would reduce over the span of the Men's Groups, paired-samples *t*-tests were conducted to compare participants' scores for these measures before and after the Men's Groups.

Qualitative data were analysed using basic thematic analysis, whereby participants' responses were visually scanned for any recurring themes, which were then recoded and combined as five major themes. Qualitative data were gathered through semi-structured interviews with participants within a week of the final session. The interview used questions such as, 'how was your experience of the group?', 'what would you tell others about the group?', 'what worked well for you?', 'what could be improved?', 'what are you taking away from the group?' and 'any other feedback?'.

Results

Quantitative Results

As seen in Table 3 and Figure 1, participants (N = 20) in the Men's Groups experienced a marginal reduction in physical distress (M = 2.80, standard deviation [SD] = 5.99; $t(19) = 2.09$, $p = .050$). Significant reductions were observed in levels of psychological distress: depression (M = 7.60, SD = 7.03; $t(19) = 4.84$, $p < .001$) and anxiety (M = 6.20, SD = 6.50; $t(19) = 4.27$, $p < .001$).

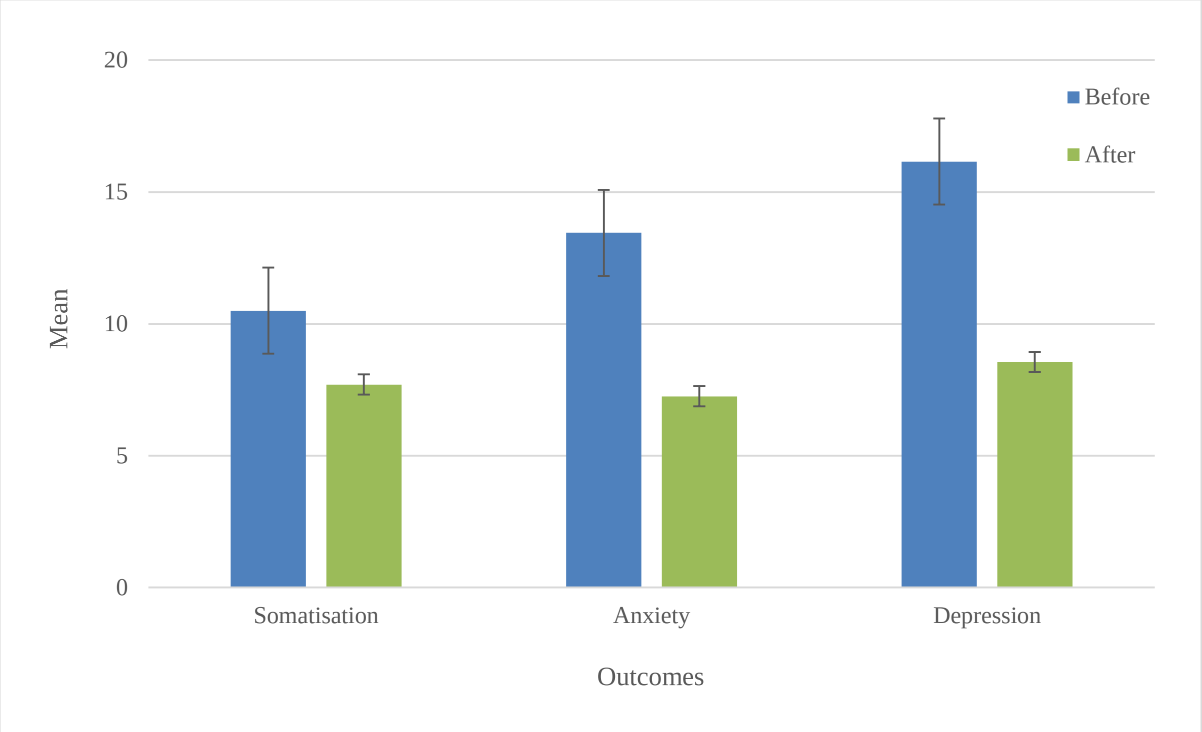
Table 3

Differences in Participants' Physical and Psychological Distress Before and After the Men's Groups

(Before – After)	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		*t*	df	Significance
				Lower	Upper			
Physical symptoms	2.80	5.99	1.34	0.00	5.60	2.09	19	.050
Anxiety	6.20	6.50	1.45	3.16	9.24	4.27	19	.000*
Depression	7.60	7.03	1.57	4.31	10.89	4.84	19	.000*

Figure 1

Before-and-After Comparisons of Physical Symptoms, Anxiety and Depression



Qualitative Findings

Thematic analysis revealed five major themes in relation to participants' experiences of the Men's Groups. As highlighted below, these themes captured increased sense of connection, improved self-management skills, greater assertiveness and boundary setting skills, increased hope and self-efficacy and greater internal peace and insight.

Increased sense of connection. Most participants described feeling an increased sense of camaraderie and connection in being a part of a Men's Group. Many also reported noticing improvements in connecting with others. For example, 'taught me skills to create better connections with people', 'taught me skills to be better in society' and 'talking about all these things in a group of similar-minded guys felt better than having session with my therapist'. One way the group achieved this was by helping its members experience the benefits of sharing their vulnerabilities with other group members. One participant stated that he enjoyed the 'camaraderie of being with the boys', which helped him practice these skills with his friends and family outside of the group. Specific comments included: 'it has taught me to be able to share my thoughts and feelings with my partner and to look after my two children better' and 'my care and sympathy for others is a whole lot better'.

Improved self-management skills. Cultivating better self-management (especially emotional regulation) behaviours and taking self-accountability for emotions was another common theme. For example, comments from two participants were: 'I have been able to understand my feelings and emotions a lot better' and 'I still suffer from depression and anxiety, but I have more effective tools to deal with it now'. Another participant noted that Men's Group 'improved me managing my moods and interactions with others', presumably through an ongoing focus on discussing healthy versus unhealthy coping and emotional regulation strategies, and providing psycho-education on more adaptive strategies.

Greater assertiveness and boundary setting skills. Group members were provided the skills necessary for healthy, assertive communication. These skills were reflected in several of their responses; for example, one member learned 'how to make my boundary and realised that I am not a useless person'. Another stated, 'I've improved so much through this group—I've become more assertive and a much better listener. Thank you dear brothers. I've loved this'.

Increased hope and self-efficacy. A somewhat recurring theme of increased hope for the future also emerged in the feedback provided by the participants. Specific comments included: 'given me hope to carry on a new journey towards my new start in life', 'increased confidence, gave new sense of hope', 'given new sense of optimism for life' and 'increased self-esteem'.

Greater internal peace and insight. Some of the men felt that there was an increase in their sense of internal peacefulness in being a part of Men's Group, citing benefits such as 'personal growth; inner peace' and 'brought a sense of peace in self, reflects at home and it all is relevant in the teachings here'. Others described having developed an increased sense of self-awareness and insight. For example: 'it helped me to understand thoughts and feelings' and 'changed my life; better now; more reflective too.'

Alternatively, in terms of constructive feedback, some participants reported feeling as though the room in which the sessions took place was too small and 'a bit cold'. Another participant believed that it would be better to have 'separate courses for different mindsets anger versus depression' (i.e. externalisers versus internalisers); however, others disagreed and mentioned that they preferred to have both range of issues covered in the same group.

Discussion

Consistent with the corresponding literature, Men's Groups were found to be successful in improving participants' health and well-being, specifically in reducing their levels of physical and psychological distress, and leading to improvements in their subjective sense of connection, hope and self-efficacy, internal peace and insight, along with self-management, assertiveness and boundary setting skills. Despite a relatively small sample size, this study was also one of the first to demonstrate Men's Groups as being an effective intervention in contributing to men's health and well-being in the New Zealand context.

Given the inequities faced by men in New Zealand, it is important to explore and implement interventions that seek to manage these inequities on a societal and policy levels, and also to explore and implement interventions at an individual 'grassroots' level. One such intervention was explored in this study and proved valuable in leading to significant physical and psychological improvements among participating men. It is important to note that significant reductions in psychological distress levels were reported at the end of each Men's Group, *despite* participants reporting greater levels of self-awareness and insight. Generally, men tend to minimise their levels of distress and have lower symptom reporting than women (Kroenke & Spitzer, 1998; Ladwig et al., 2000), particularly in relation to psychological distress (Kroenke & Spitzer, 1998). Therefore, despite minimising their distress initially, and then developing greater awareness of and insight into it, they still reported a significant reduction in their distress. This provides further weight to the viability and utility of Men's Groups in improving men's health and well-being.

According to the qualitative data acquired during this study, the changes observed in participants' physical and psychological distress levels may be attributable to them developing a greater sense of connection, self-management, assertiveness and boundary setting skills, hope and self-efficacy and internal peace and insight. These attributes and skills gained over the course of the Men's Groups were consistent with those commonly reported by participants in other Men's Groups (Chambers & Martin, 2002; MacNab, 1990; Reddin & Sonn, 2003).

It is important to emphasise the considerable improvements observed across the psychological distress variables among participants in this study, especially given that men's psychological distress tends to manifest differently than women, which leads to difficulty for some health professionals in noticing and assessing the signs of mental health issues and providing the necessary support (Te Hiringa Hauora, 2020). This is further exacerbated by the 'hard culture' (Reddin & Sonn, 2003) among men in Australia and New Zealand that leads to stronger identification with rigid gender norms, and promotes stoicism, restrictive emotionality, self-reliance, status and success-seeking, aggression and fear of intimacy (Reddin & Sonn, 2003). These attributes further exacerbate men's psychological well-being and hamper their ability to seek and access necessary support. Therefore, the fact that participants in the Men's Groups in this study could not only 'open up' in the groups and correspondingly shed some of the 'hard culture' they had been socialised in, but also experience significant improvement in psychological well-being provides further support to the utility and effectiveness of Men's Groups in meeting men's needs in our society.

Despite contributing to the literature in demonstrating Men's Groups as a viable intervention in reducing physical and psychological distress among men, there are important limitations of this study that need to be considered. These limitations were broadly a result of measurement issues that related to the study's reliance on self-report data. This potentially introduced several biases, including, social desirability, self-presentational and recall biases. Ideally, further research could employ more objective and culturally sensitive measures of symptoms and psychological factors. Further research could also experiment with specific group dynamics and evaluate the effectiveness of Men's Groups separately for various demographic groups, especially for older adult and adolescent males who may benefit the most from such groups.

Overall, despite the limitations and relatively small sample size, this study was one of the first to demonstrate Men's Groups as a robust intervention to improve men's physical and psychological health, and their sense of connection, hope and self-efficacy, internal peace and insight, along with self-management, assertiveness and boundary setting skills in a New Zealand context. In doing so, this study provides an effective solution for the management of several inequities unique to men and paves the way for more men's needs-focused interventions to be implemented and evaluated cross-culturally.

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Working with the Gut-Brain Axis

Karen Faisandier

The *Evolutions of Therapy* theme of this journal is an apt one for discussing the role the gut-brain axis within mental health and pathophysiology more broadly given the link between physical and mental health. In late 2020 I presented a talk called *The Best of Both Worlds* to local clinical psychologists about my work running an integrative practice. This practice strives to bridge psychology and nutrition and services adults who are experiencing psychological concerns that overlap with chronic physical health concerns (e.g., hormonal health problems, gut health problems, autoimmunity). This opinion piece presents ideas covered in this talk, supported by nutrition and mental health literature as well as material from both integrative medicine and clinical nutrition. It is also informed by practice-based evidence. Namely, this is the gathering of evidence during clinical work with individuals, which can be useful in therapy innovation and to complement group data (Blampied, 2001).

In the 17th century, the philosopher Descartes proposed that the mind was separate from the body, which became known as Cartesian dualism (Bullmore, 2018). Dualism lives on today in both our training of health practitioners and the approach used in our public healthcare systems and services. Psychologists are trained to specialise in the thoughts, emotions and behaviour of humans, whereas medical doctors and psychiatrists focus on the physical and biological. To date, these healthcare professionals have not been trained in the role of the gut or dietary intake in health problem prevention or treatment (Kris-Etherton et al., 2015). In addition, nutrition and gut-health specialists have not typically been trained in psychological knowledge or skills. A consequence of this mind-body divide and exclusion of nutrition is that people may see multiple practitioners to address various symptoms on their health and mental health journey, but their gut-health and diet may be overlooked as a contributing or causal factor. Today, our understanding of the gut-brain axis coupled with the rise of complex and long-lasting health

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presentations suggests the need for health practitioners, including psychologists, to become less dualistic.

This article will present changes to the chronicity of health concerns people are experiencing and proposed causes, describe current thinking on the gut-brain connection and implicated systems and discuss thoughts on incorporating gut health and nutrition into psychological practice.

Chronicity of Human Health Problems

According to the Global Burden of Disease (GBD) study, humans have become more chronically sick (GBD 2018 Risk Factors Collaborators, 2018). This is unlike earlier times in history where our species faced more acute health problems or accidents. Humans now live longer thanks to medical advances for symptom management or resolution, but these years are spent gradually developing health conditions in increasing numbers. Chronic health expressions such as cancer, type-2 diabetes, heart disease, hypertension, obesity, autoimmunity and dementia are all on the rise. Of these non-communicable problems, mental health concerns like anxiety and mood disorders along with substance use disorders (SUDS) are the purported leading cause of disability worldwide (GBD 2016 Risk Factors Collaborators, 2017; Jacka, 2019). Similar findings were found in the New Zealand Ministry of Health (MOH) *Longer Happier Lives 2020* report, where non-communicable diseases were found to account for 81.8% of our country's disability in 2017. Of these, mental health concerns were considered a high-level cause and accounted for 8% of disability, while neurological disorders (e.g., headache and dementia) and SUDS comprised 7% and 2% of disability, respectively (MOH, 2020).

High comorbidity has also been found between mental and physical health concerns, and this has been raised as a human rights issue as it coincides with social issues and inequality (Firth et al., 2019). There is a greater risk for comorbid obesity, diabetes and cardiovascular disease in people with psychotic disorders, SUDS and anxiety and depressive disorders (Firth et al., 2019). Anecdotally, many people live with chronic health problems that do not reach a threshold for a formal diagnosis (e.g., metabolic health problems) and experience unpleasant physical symptoms (e.g., exhaustion, 'brain fog') that cause them significant distress or impairment. This lack of clear diagnosis or treatment pathway can often result in anxiety, and eventually despair and loss of hope for improvement. Medications may be used that manage symptoms but do not always address the cause and can bring unintended adverse effects. One commonly prescribed example is the proton pump inhibitor omeprazole. This medication is for heartburn or gastroesophageal reflux disease and involves switching off stomach acid production; however, with chronic use, it may reduce absorption of vitamin B12, magnesium and iron and can increase the risk for bone fractures (Wilhem et al., 2013). This is an example of a dualistic approach that does not address the reason for low stomach acid production that could potentially be achieved through an understanding of gut health and nutritional factors.

Is the Modern Lifestyle Making us Sick?

Modern Food

The global industrial and agricultural revolutions of the late 1800s initially allowed humans easier access to food, but progressively changed traditional ancestral diets to a standard Western diet, which is predominantly packaged and processed, refined-carbohydrate heavy, nutrient-devoid and potentially inflammatory (Jacka, 2019; Price, 2010). In modern societies, food can be consumed at any time of day, night or season, with minimal effort required to source (Selhub et al., 2014). These shifts differ from past traditional practices around the world, where humans would hunt, gather and forage for seasonally available produce (Price, 2010). Food nutrient content itself may have also declined. For example, a comparison of 20 fruits and vegetables over a 50-year period (1930s–1980s) found significant reductions in levels of seven of eight key vitamins and minerals, including calcium, magnesium, copper and sodium in vegetables, and magnesium, iron, copper and potassium in fruit (Mayer, 1997). Proposed causes for this finding include reduced soil quality, importing, storage and ripening systems, high-yield plant breeding, and the use of fertilizers and pesticides over traditional methods such as manure and compost (Mayer, 1997).

Such deviation in food growing practices coupled with further revolutions in urbanisation, transportation and technology have resulted in many humans becoming overfed but undernourished; humans are also more sedentary and overfat or obese with an epidemic of metabolic health problems (Chaput et al., 2011). The leading risk factor for early death from a variety of causes previously mentioned (e.g., heart disease, type 2 diabetes) in developed countries is reported to be poor diet (GBD 2016 Risk Factors Collaborators, 2017). One in every five deaths was associated with poor diet, and the collaborators recommended that coordinated global efforts target food systems and policies in order to improve diets (GBD 2016 Risk Factors Collaborators, 2017).

Modern Medicine

This past century also saw a pharmaceutical revolution that discovered medication treatments for health problems; for example, the first antibiotic (penicillin) in 1928 (Anderson, 2017). This was extended to include psychopharmacological offerings in the 1950s. This shifted the focus of mental health treatment onto medication therapies and may have contributed to waning interest in researching other ways to support mental health, including nutritional considerations (Rucklidge & Kaplan, 2013). Since then, rates of psychotropic medication prescribing have continued to rise, with 13.7% of New Zealand adults being prescribed antidepressant medication in 2015 (Mulder et al., 2017). According to PHARMAC data, there was a 50% increase in antidepressant and antipsychotic prescribing reported between 2007 and 2017 (Mulder et al., 2017). Despite this increase and the growing mental health workforce, the prevalence of mental health concerns has not reduced and more people than ever before are referred for mental health support (Mulder et al., 2017).

Modern Lifestyle

The Western lifestyle has also deviated from traditional traditions of physical work, close-knit communities that eat and play together, and sleep patterns governed by sunrise and sunset (Price, 2010). Anecdotally, many members of our society now work long hours in mostly sedentary jobs while juggling family and relationship demands. They wake up with caffeine and rush throughout the day in sympathetic nervous system mode as they juggle competing work and family demands. By evening they are physically tired but mentally wired, and wind down with alcohol or other drugs, sedative medicines or screen binges. Often the last thing they prioritise is good nutrition, sufficient time to relax, quality sleep and physical movement. Technology has increased the need for modern work to be indoors and screen-based, involving long periods of concentration with incoming alerts (emails, notifications, phone calls) dividing attention. Workplace or self-expectations often result in evening or weekend work affecting time for relaxation or connection at home. Screen use and incoming notifications during the evening can impair both sleep quantity and quality through disrupting circadian biology. Collectively, these excesses of brain stimuli and insufficiencies of physical or restorative activities can result in chronic stress activation for many people.

Chronic Stress Activation

General adaptation syndrome is a three-stage model of stress described by neuroendocrinologist Hans Selye and is based on the idea that the human body seeks homeostasis or balance (Selye, 1978). The first stage is the alarm, which is when the human nervous system responds to an acute stressor through the hypothalamic-pituitary-adrenal (HPA) axis (McEwen, 2002). The sympathetic nervous stress system activates and releases corticotrophin-releasing hormone from the hypothalamus, which signals other hormonal reactions and results in increased glucocorticoid production (McEwen, 2003). This cascade ideally enables a survival response and return to homeostasis.

If homeostasis is not achieved, the second stage is a resistance stage, which involves longer-term activation of the sympathetic nervous system (McEwen, 2013). During the alarm stage of stress, cortisol acts as an initial anti-inflammatory hormone; however, the opposite becomes true in the resistance stage (McEwen, 2013). Glucocorticoids become desensitised, which reduces their inhibitory effects on inflammation (Marieb & Hoehn, 2019). In modern society, stressors that drive a resistance stage are not always life-threatening or imminent but are imagined or perceived threats. Stressors can also be bodily experiences that are often out of conscious awareness, such as low-blood sugar, dehydration or food sensitivities (Haas with Levin, 2006).

The third stage of stress is exhaustion, where the body is drained of physical, emotional and mental reserves, and enforces rest and recovery by reducing the individual's capacity to respond to stress (McEwen, 2013). This can present much like depression and is a method to achieve homeostasis, as rest and recovery is required in order to re-balance (McEwen, 2013). Chronic stress can have detrimental effects for the gut-brain axis and impacts via various pathways which may perturb good mental health.

What is the Gut-Brain Axis?

The gut-brain axis is bidirectional from the brain-down and the gastrointestinal tract (GIT)-up and is connected via the vagus nerve. It also interacts with the endocrine and immune systems, which are all relevant when exploring the relationships between physical and mental health. This section provides a short description of the GIT and each interactive system for context and introduces the concept of inflammation.

GIT

The GIT is the tract from the mouth through to the anus through which food is taken in, digested, nutrients absorbed and waste expelled (Marieb & Hoehn, 2019). It includes various digestive organs and houses the gut microbiota, which mediate the gut-brain axis communication from gut to brain, largely through the many various types of bacteria (as well as yeasts, protozoans, viruses and fungi) (Anderson, 2017). The unique combination of our microbiota influences our thoughts, emotions and behaviour (Anderson, 2017; Foster et al., 2017). The composition of the microbiota literally changes with every meal and so can be rapidly impacted (for better or worse) with every food decision (Anderson, 2017). The GIT can be detrimentally affected by stress, sugar, trans fatty acids, alcohol and other drugs as well as medication use, environmental toxicants and inadequate sleep or movement (Marx et al., 2020).

Nervous System

The entire nervous system plays a role in the gut-brain axis including the central nervous system, somatic and sensory nervous systems, autonomic nervous system and enteric nervous system (Foster et al., 2017). The enteric nervous system or 'second brain' is the GIT's own nervous system that is layered around the intestines and constantly communicates to the brain, largely through gut microbiota (Anderson, 2017). The autonomic nervous system is also of particular importance with its two arms: 1) the sympathetic *fight-or-flight* response and 2) the parasympathetic *rest-and-repair*. This system communicates rapidly using neurotransmitters and the vagus nerve (Anderson, 2017; Bullmore, 2018). Chronic maintenance of a sympathetic response is associated with GIT impairment as digestion and absorption of nutrients is impaired and intestinal lining integrity compromised (Marieb & Hoehn, 2019).

Endocrine System

The endocrine system helps maintain immune and metabolic balance enlisting endocrine glands that communicate across the body using hormonal messengers via the blood system (e.g., adrenal, thyroid and reproductive hormones; Anderson, 2017; Bullmore, 2018). It is an integral component of the stress response (McEwen, 2013). This system is hugely impacted by chronic stress, which can manifest in impairments to thyroid functioning (e.g., hypothyroidism), adrenal dysfunction (e.g., lasting exhaustion), circadian rhythms (e.g., sleep disturbance) and deranged sex hormone functioning (e.g., period problems) (Marieb & Hoehn, 2019).

Immune System

The immune system uses pro-inflammatory and anti-inflammatory hormone messengers (among others) via the blood system to ward off perceived pathogens and can become overactive during chronic stress and with regular exposure to inflammatory triggers (e.g., food antigens, toxicants, pathogens) (Anderson, 2017; Bullmore, 2018). The immune system can develop autoimmunity when it confuses self from non-self and mounts an attack on its own host (Bullmore, 2018). A key aspect of the immune system is that it is the GIT itself that houses the largest immune organ (gut-associated lymphoid tissue), which produces up to 80% of immune cells (Rudzki & Sculc, 2018).

Inflammation

Inflammation is the process whereby hormones called cytokines are activated and circulate in the blood stream in response to an immune challenge (Bullmore, 2018). The presence and degree of inflammation can be measured through biomarkers in the blood; for example, interleukin 6, tumour necrosis factor alpha and C-reactive protein (Jacka, 2019). It used to be thought that pathogens were protected from entering the brain via the blood brain barrier (BBB); however in the 1990s, researchers discovered that this barrier could become permeable (Bullmore, 2918; Kelly et al., 2015). Much like the process of intestinal permeability, colloquially referred to as *leaky gut* where tight junctions in the GIT lining are compromised, it is now understood that the BBB epithelial tight junctions can be opened by these inflammatory factors in the blood (Bullmore, 2018). There is a strong relationship between intestinal permeability and brain permeability; if one epithelium has become permeable then the other is also permeable (Yeoh, 2018).

Inflammation, Diet and Mental Health

One outcome of a persistently permeable intestinal and brain barriers can be chronic inflammation, with the phenomenon of *sickness behaviour* (Bullmore, 2018). This refers to the following symptoms that overlap with diagnostic criteria for depression. These indicators include fatigue, melancholy, social withdrawal, feeling physically slowed, disturbance to sleep and appetite and brain fog (Bullmore, 2018). In previous times, sickness behaviour was potentially adaptive to humans as a short depressive response to an inflammatory challenge was advantageous to survival (Anderson, 2017; Bullmore, 2018). Genes that made humans more likely to survive would help to kill off infectious germs, conserve energy and ensure that infection was not spread to others (Bullmore, 2018). In modern times, this response can become chronic driven by systemic inflammation, but the relationship is bidirectional and the question has been asked, 'what causes the inflammation in the first place?' (Berk et al., 2013; Jacka, 2019).

A variety of factors impact on the process of inflammation. One that has grown in interest and is potentially controllable includes an individual's food intake (Marx et al., 2020). As people need to eat every day, their dietary choices can either drive systemic inflammation at a chronic level or offer anti-inflammatory benefits. The mechanisms of actions for the role of diet in mental health have been described as 'complex, multifaceted, interacting' with inflammation, oxidative stress, epigenetics, mitochondrial dysfunction, the gut microbiota, tryptophan-kynurenine metabolism, the HPA axis, neurogenesis and obesity, making it into a non-exhaustive list of possible modulating pathways (Marx et al., 2020). Gut dysbiosis, when the microbiota itself becomes unbalanced and provokes an immune response, is an important contributor to developing inflammation, anxiety and depression (Anderson, 2017; Rogers et al., 2016). For comprehensive reviews of mechanisms by which the gut and nutrition can influence mental health, please see Berk et al. (2013), Foster et al. (2017), Kaplan et al. (2015) and Marx et al. (2020).

One of the reasons that the Mediterranean diet has perhaps been found to be effective as a therapy for major depression is because it reduces inflammation (Jacka et al., 2017; Parletta et al., 2019). This diet removes inflammatory foods (e.g., trans fatty acids, high fructose corn syrup, ultra-processed foods and refined carbohydrates) and increases anti-inflammatory foods (e.g., polyphenols in fruit and vegetables, omega-3 fats) (Jacka, 2019). The Western diet tends to be high in omega-6 fatty acids, which often come from processed sources (e.g., fried or processed foods) and promote inflammation, whereas omega-3 fatty acids help to offset this and can be found in fish, flaxseeds and walnuts, or supplemented with good quality fish oil (Bernstein, 2016). The key omega-3 fatty acids for brain health are eicosapentaenoic acid and docosahexaenoic acid, which help make up the structure of the brain and support brain nerve cell communication (Bernstein, 2016). The recommended ratio of omega-6 to omega-3 is 4:1 but may be as high as 25:1 in the Western diet (Bernstein, 2016). The Mediterranean diet brings the balance of omega-3 and omega-6 closer to the ideal range.

While this diet is found to be efficacious as a treatment for depression, anecdotally it may not be sufficient for individuals with co-existing chronic health problems including irritable bowel syndrome or autoimmunity. This is because potential food sensitivities are included such as gluten and dairy, and oligosaccharides such as beans, legumes, garlic and onions that can drive an inflammatory response for some individuals. In these cases, further dietary assessment and intervention should be pursued with gut and nutrition experts.

Incorporating the Gut-Brain Axis in Clinical Practice

Clinical psychologists are scientist-practitioners who use a biopsychosocial framework. Psychologists look broadly, keep up with new literature and make rule-outs before formulating. However, nutritional science has not been part of the training; therefore, this is a current gap in our collective knowledgebase. When diagnosing any psychological disorder, the Diagnostic and Statistical Manual of Mental Disorders 5 (American Psychiatric Association, 2013) stipulates that the symptoms should not be attributable to the physiological effects of a substance or to another medical condition. Yet in practice, do we know how and do we rule out gut health and nutrition related factors in psychological presentations? Given the potential for inflammatory cytokines to cause depressive symptoms, do we consider the role of systemic inflammation as a potential cause or contributing factor during psychological assessment? If we were to do so within a clinical psychologist scope of practice, what would that look like?

With a small amount of upskilling, psychologists could provide basic gut-health and nutritional assessment and recommendations, with more advanced interventions requiring further professional development or liaison with nutritional specialists. The following section will touch on various aspects that I think have potential for psychologists to consider incorporating into their practice (if they are not already).

Switching off Chronic HPA Axis Activation

Psychologists understand that the mind can become a chronic driver of stress via the HPA axis to maintain sympathetic nervous system activation, which can impact food motility, erode the integrity of the gut lining and ultimately cause dysbiosis of the microbiota. Therapies including mindfulness and relaxation skills (e.g., diaphragmatic breathing or progressive muscle relaxation) can help optimal digestion and absorption of nutrients. The range of psychological interventions psychologists use to help individuals with chronic stress or anxiety presentations can help them switch into parasympathetic mode. This can allow the nervous, endocrine and immune systems to resume homeostasis, with beneficial effects on health and mental health.

In addition to interventions for stress, anxiety or depression, psychology offers therapy options for recovery after traumatic experiences that perpetuate gut-brain dysfunction (e.g., loss of appetite, nausea, deranged metabolism) and inflammation via the HPA axis. This can include therapies for acute stress or posttraumatic stress disorder, such as the teaching of grounding and emotional regulation skills, exposure therapies, eye movement desensitisation and reprocessing therapy, somatic therapies, trauma-sensitive yoga and therapies to help integrate insecure attachment experiences. Addressing these areas may improve bodily stress by calming the nervous system, enabling safety and connection, facilitating digestion and absorption and reducing inflammation.

Psychoeducation

Clinical psychologists are specialists in motivational and behavioural change, and thus offer a specialised skill set that nutritionists often lack in helping individuals who want to apply nutritional or lifestyle changes. Psychologists are also educators and communicators of science through psychoeducation and the provision of resources; this is an area that I believe our profession could help people to understand the role of nutrition and their gut in their psychological functioning. During assessment, psychologists could ask about and factor in an individual's dietary pattern in their formulation. Simply asking about a typical day's food intake for a client can be revealing in the context of their presentation. In more complex gut-health cases, psychologists could facilitate referrals to nutrition or gut health specialists. Broad spectrum micronutrient and whole-of-diet approaches are basic level interventions that could be discussed with clients and have growing research support as legitimate mental health treatments.

Mediterranean Diet

A modified Mediterranean diet has been investigated as a treatment for major depression, with encouraging outcomes that have been replicated (Jacka et al., 2017; Parletta et al., 2019). This diet may lower inflammation and reduce depression (Jacka et al., 2017; Parletta et al., 2019; Marx et al., 2020). This diet was developed by a dietician and includes real food rather than processed foods and specific phytochemicals (e.g., polyphenols in blueberries and curcumin), omega-3 fatty acids, organically sourced poultry and red meat, fibre and a range of good gut-bacteria promoting foods (e.g., legumes) (Jacka et al., 2017). It also includes a variety of micronutrients that have also been researched in mental health treatment outcome studies (Blampied et al., 2020). To learn more about the Mediterranean diet, there are a number of online resources available at Deakin University's 'Food and Mood Centre', as well as in the book *Brain Changer* (Jacka, 2019).

Micronutrients

Over the past decade, outcome studies have evaluated the use of micronutrients (a broad combination of vitamins, minerals and amino acids) as a treatment for stress, anxiety and depression (Blampied et al., 2020; Rucklidge & Blampied, 2011; Rucklidge & Kaplan, 2013). Micronutrients taken as a daily supplement have been researched as a treatment for many presenting issues, especially attention deficit hyperactivity disorder, stress, anxiety and depression (Blampied et al., 2020). Although these have been researched as a stand-alone treatment, micronutrients are generally recommended as supplementary to a healthful diet. Micronutrient research is currently focused on specific clinical trials for diagnosed mood and anxiety disorders, as well as comparative trials against current frontline treatments in order to clarify what works best for whom, and under what circumstances (Blampied et al., 2020). The website www.hardynutritionals.com provides practitioner tools, resources and free training on use of their products, which have been the focus of micronutrient research to date.

Single-Micronutrient Treatments

There is substantial literature that explores the use of single nutrients (e.g., the B vitamins, magnesium, iron and zinc) for mental health concerns; however, these studies reported mixed results and had methodological limitations (Popper et al., 2017). Anecdotally, use of a single nutrient supplement in isolation of other interventions would likely be an insufficient treatment approach for most mental health concerns, unless it was specifically caused by a clear deficiency (e.g., depression caused by iron deficiency). However, use of supplements may improve some chronic health or mental health symptoms (e.g., fatigue, brain fog, sleep disturbance) and enhance outcomes for many individuals. They can often also support physical health and resilience to make dietary and lifestyle changes or therapy work easier to do.

An example is magnesium. Magnesium is an essential mineral that is a co-factor for many other enzymes and can dampen down HPA axis activity by slowing stress hormone secretion (Greenblatt & Grossmann, 2016). Magnesium supports muscle relaxation throughout the body including in the GIT, aids energy production, relaxation and sleep quality, and can help with mood and hormonal health (Haas with Levin, 2006). Magnesium is found in plant foods grown in magnesium replete soil and is depleted through soda, caffeine and alcohol use as well as chronic stress and impaired GIT absorption (Haas with Levin, 2006). Magnesium deficiency or insufficiency cannot reliably be assessed using blood tests but can be detected based on symptoms such as stress and anxiety, constipation and muscle spasms (Greenblatt & Grossman, 2016). This can be supplemented on a daily basis for stress, anxiety, depression or unrefreshing sleep, using approximately 300 mcg of magnesium citrate, aspartate or glycinate (Haas with Levin, 2006).

As each individual has unique genes, biochemistry and presenting problems, supplements affect different people differently, and the same results may not be extrapolated from one person to the next (Haas with Levin, 2006). For safety, contraindications should always be considered, such as medications or health conditions that mean various supplements should not be used (Haas with Levin, 2006). In my opinion, the provision of single micronutrients represents an area that requires more advanced professional development, including knowledge of nutrition and biochemistry, or liaison with nutrition specialists.

Psychobiotics

The innovative use of psychobiotics (probiotics for mental health) is also an upcoming area. Human studies investigating mental health outcomes using specific probiotic strains indicate that this could become a mental health intervention of the future (Jacka, 2019). Much more research is required in this area however, as opposing results have also been found (Romijn et al., 2017).

Prebiotics, or food for healthy gut bacteria, could also be part of the future of psychobiotics (Anderson, 2017). Probiotic fermented foods were part of traditional diets that are not as regularly consumed in the Western diet (Anderson, 207; Price, 2010; Selhub et al., 2014). The Mediterranean diet encourages fermented foods such as cultured yoghurt or sauerkraut, kefir, and prebiotic foods (e.g., onions, garlic and leeks), which can improve gut health through increasing bacterial diversity and supporting a healthy microbiome (Anderson, 2017). At the most basic level, inclusion of fermented foods could be recommended as they may have positive effects for the microbiota and mental health.

Overall, these non-exhaustive ideas could be simplified into brain-down (psychology) interventions and gut-up (nutrition and lifestyle) that overall aim to lower chronic stress and systemic inflammation and improve the health of the gut microbiome. Lifestyle factors that relate to inflammation and mental health have not been focused on here; however, they are equally as important in gut-brain work and can include movement, sleep patterns, relaxation and pleasure, as well as the capacity for connection. This approach offers additional methods that people can employ to support their mental health either in isolation of or alongside therapy or medication if they choose that.

Future Directions for the Gut-Brain Axis in Psychological Practice

The complexity and chronicity of many of today's health problems requires that health professionals innovate. The notion of bringing the gut-brain axis into psychological practice has been discussed in this opinion piece through targeting psychological factors, gut-health and nutrition. These ideas represent a field that is in its infancy in terms of practical clinical guidance for psychologists; it will be up to our evolving profession to establish best practice over time.

Our profession needs to now reflect on *how* we can develop competency in nutrition and the gut-brain axis as it pertains to mental health. And to establish *what* this competency would look like for our profession? Would it form part of the psychology training curriculum, involve later professional development, include liaison with nutrition experts or become its very own scope of practice?

In the interim, there are practical and safe options with sufficient evidence in which psychologists could upskill and use with clients who are suffering now. Psychologists could provide psychoeducation about the gut-brain axis, make recommendations and provide resources around dietary change using the Mediterranean diet, incorporate adjunctive supplementation, target gut health through stress and anxiety reduction and develop relationships with local practitioners when referral to a nutrition or gut-health expert is indicated.

Although nutrition and gut-health have not been included in our psychology training, we cannot treat these as separate from mental health. So many people are suffering with health concerns induced or exacerbated by their gut health and diet. Some of these concerns will manifest psychologically but a psychology-only approach may be inadequate. As the public are already self-experimenting and seeking guidance to implement diet and lifestyle changes for their mental health, why could this advice not come from psychologists? Our profession could play an integral role in helping our communities to make sense of the gut-brain axis and its role in mental ill health assessment and treatment, and even more ideally, prevention.

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Cognitive Analytic Therapy (CAT) in Groups: Reflecting on the Service Development and Application of a Pilot CAT Group at an Adult Mental Health Service

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This article is an edited and anonymised version of an essay submitted in 2019 to the Association of New Zealand and Australia Cognitive Analytic Therapy as part of an accreditation process. Rachel Hodge became an accredited CAT Practitioner in 2019 and was supervised through this process by Emma Bosworth (an accredited CAT practitioner and supervisor). Rachel Hodge and Emma Bosworth co-facilitated this group.

'The group is something more than the sum of its parts'

Cognitive analytic therapy (CAT) is an integrative therapy that was developed in the 1980s by Anthony Ryle in answer to the difficulties of providing psychological therapy for individuals in the UK National Health Service (NHS) (Ryle & Kerr, 2002). One of the main benefits of CAT was to provide effective but brief psychotherapy to these clients, as access to therapy was a precious resource. Broadly, in the psychological literature and clinical practice, groups are also used to address this same issue. CAT is a therapy that lends itself to the group model. This essay is both a literature review on CAT and its application in groups, and a reflection[1] from the perspective of a pilot group ran by an adult community mental health team called 'Relationships: Understanding Your Relationships with Others and Yourself Better'.

CAT is a time-limited, collaborative, integrative therapy informed by theories such as cognitive theory and psychodynamic psychotherapy (Denman, 2001). It is a deeply relational approach, both in its view of human development and in its practice of psychotherapy, and is used individually, with couples, groups, families and within systems. At the core of CAT is the idea of reciprocal roles, a simplified way to understand the fundamental importance of how we relate to each other.

CAT Groups: A Comment on the Theory and Literature

Group psychotherapy is increasingly being used to address resource issues around the world and in New Zealand District Health Boards (DHBs). Some research suggests that group therapy is at least comparable with individual therapy (Ryan et al., 2010; Toseland & Siporin, 1986). CAT is

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[1] Reflections will be indicated through the use of *italics*.

one of the models adopting this strategy. As a therapy, CAT recognises that how we relate to others and ourselves will have a marked impact on our mental health problems. One of the main aims of therapy in general is increased self-reflection on one's difficulties; however, the aim to increase awareness of recurrent problematic relational patterns is specific to CAT. Thus, conducting psychotherapy in a group setting creates an opportunity to work relationally with people in a different way to working individually with just a therapist. It can provide the context within which the important work can be done.

A question often posed is how does CAT as a model lend itself to the group context, practically and theoretically? We know groups can help reduce feelings of stigma, loneliness, isolation and shame (Sidell & Wells, 2018) and address a number of psychological problems (Yalom, 2005). Previous theoretical work by Irvin Yalom (Yalom, 2005) outlines eleven therapeutic factors (see Table 1) that have a core relational grounding, and CAT is a psychotherapy based on a relational understanding of human development (Hepple, 2012). Therefore, given CAT's theoretical grounding in relational, social and cultural development of the self, it is well positioned to be applied for group work. Group analytic theory also helps this theory. Corbridge, Brummer and Coid (2018) reported that group analysis allows learning from the experiences of the group, with the tools of CAT offering additional scaffolding. In fact, Sidell and Wells (2018) broadly outlined the benefits of peers being a more valid source in learning and that modelling by peers is helpful in learning adaptive strategies. Specifically, CAT's framework allows for the identification and revision of here-and-now re-enactments of early unhelpful reciprocal roles (RRs).

Corbridge, Brummer and Coid (2018) suggested that there is increasing evidence for group-based CAT for people with severe and enduring mental illness. However, at present there is a limited evidence base. Despite this, Sidell and Wells (2018) proposed that CAT groups are likely to be able to help a wide variety of people with complex disorders to gain understanding of their problems and achieve this in a more efficient and less confronting manner. In their 2018 study, Sidell and Wells researched the views and opinions of therapists with CAT groups, specifically looking at what therapists felt CAT groups offered and individuals gained that one might not get from other psychological interventions. Their outcomes suggested positive opinions (see Table 2), describing an environment of a supportive and safe containment. They suggested that this meant that individuals can access 'deeper seated and more challenging aspects of their problems, allowing for "real time" examples and active commentary on their problematic relational styles' (p. 105). Because of CAT's strong focus on process, experiences and observations, the relational patterns within the group can be used in a very live way to facilitate reflection and understanding for all.

While there is a limited formal evidence base for CAT in groups, some informal findings and reflections are available (Duignan & Mitzman, 1993, 1994; Maple & Simpson, 1995; Calvert et al., 2015; John & Darongkamas, 2009). Key findings include: written and diagrammatic reformulation of patient's problems (sequential diagrammatic reformulation [SDR] or a visual diagrammatic reformulation of one's relational patterns and their outcomes) when shared in the group served to help the group process, participation, containment and commitment; written and diagrammatic reformulation of a patient's problems also helped individuals generalise their difficulties into the 'real world', and improved interpersonal functioning and general well-being.

The structure and process of CAT groups has varied across available studies. Sessions were often about 90 minutes, and the length varied from 10, 12 or 16 sessions to 1 year. Group numbers were typically 6–10 participants, with limited exclusion or inclusion criteria. Some groups had an open format whereas others were closed, some were inpatient and others were outpatient. There was also variability in whether an individual session occurred first to introduce the model and create an individual map (SDR), whereas others focused more on the development of a shared group map in session. This variability in CAT groups thus far may be attributable to the limited research, or because of CAT's focus on process factors.

Development of the Pilot Group

The Canterbury DHB (CDHB) Adult Community Psychiatric Services (ACPS) works with the top 3% of the most enduring and severe mental health problems in its community. As with most DHBs, it is a busy, under-resourced service and psychology is a scarce resource. A number of service developments are in place to attempt to manage some of these difficulties, including offering psychological groups. However, other than the MindSight service (a service for individuals with severe borderline personality disorder), all groups offered are skills-based and non-process groups. No groups are specifically interpersonally focused. Because CAT is a relationally focused therapy that can be used with a broad range of individual and psychological problems, it was understandable to start to think about integrating a CAT group into the adult mental health services in Christchurch. Using it in a group format means there are more relationships available to observe and learn experientially from. Furthermore, CAT had also recently been included in the UK national guidelines for treatment of personality disorder in the NHS (Sidell & Wells, 2018) and had been used in a group format in Wellington by Nicola Crook in a DHB-specialist service for personality disorders in 2018 and 2019. Sidell and Wells (2018) suggested that over and above cognitive behavioural therapy groups, CAT groups can often help individuals gain a thorough understanding of their problems, identify and adjust problematic relational patterns, and experience real life examples as they see this play out within the group. I argue that introducing a CAT group in the CDHB ACPS would benefit clients and staff.

Reflections on the Pilot Group

Following is a reflection on the CDHB pilot group, using available theory from both the CAT literature and more general group psychotherapy literature (Tables 1 and 2). Traditionally, group psychotherapy in New Zealand (and elsewhere) has relied heavily on the work of Irvin Yalom and there are beneficial overlaps with some of CAT's core relational concepts. Therefore, Yalom's (2005) eleven therapeutic factors, which allow change within groups, are reflected on here[2] (see Table 1). Also used to help reflect on the group is Sidell and Wells' (2018) analysis on therapist opinions of what CAT groups offer (see Table 2).

Table 1

Reflecting on the CDHB Pilot CAT Group using Yalom's Eleven Therapeutic Factors (Yalom, 2005) in the Context of CAT Concepts

Instillation of Hope	Instilling and maintaining hope is crucial to help clients both stay in therapy and have faith in the therapeutic model.	*We talked about CAT as a model and the benefits of groups in general during early sessions to instil hope. Also noted to help instil hope were group members' encouragement, validation and understanding of each other in the first session.*
Universality	Many clients have a heightened sense of uniqueness about their problems, perceiving they are isolated in their distress.	*Our CAT group achieved this in the first session and was referred to multiple times over the sessions (e.g., being able to talk about suicidal thoughts without feeling judged). In fact, this may have been one of the most powerful outcomes for the group.*
Imparting Information	While not historically part of early interactional groups, more recently groups can include didactic	*Our group was intended to be process-based; however, we decided to include initial*

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[2] Full brief of group psychotherapy literature is outside of the scope of this essay. Please see Yalom's (2005) 'The Theory and Practice of Group Psychotherapy' for a more in-depth review.

	instruction needed for the success of the group. Some groups are specifically psychoeducational in nature and are only didactic.	*psychoeducation about the CAT model.*
Altruism	Members of the group are said to also gain through giving, and not only in receiving help. Corbridge, Brummer and Coid (2018) suggested that this factor allows group members to help each other by gaining, receiving and offering support, and that this can help facilitate new healthy RRs.	*As sessions progressed the group developed new roles such as 'Helping to Helped', describing how they felt supported and cared for as well as experiencing themselves in providing this.*
The Corrective Recapitulation of the Primary Family Group	Most clients who come to a group have had inadequate or unsatisfactory early relational experiences in their family. The group can be a place for re-enactments of these experiences that can be worked through and repaired in the group setting. In CAT terms, this could be seen as not colluding into old unhelpful RRs by being aware when they are triggered and trying out new healthier RRs.	*Frequent examples of this occurred in the group; the use of mapping the relational patterns playing out within the group helped group members identify what was happening and together to explore more helpful responses, reflecting their goals established at the start of the group.*
Development of Socialising Techniques	Social learning is an important therapeutic factor in all groups. CAT groups can experience new relational roles with others in the group through observations and experiences, and lead to the alteration of social behaviour.	*As the sessions progressed and relationships became more secure, both facilitators and clients were more able to challenge group members when 'stuck' in old RRs/patterns and recognise when using new healthier ones.*
Imitative Behaviour	In therapy, clients may over time end up thinking and talking like their therapist. In a group, a member may imitate not only the facilitators but also other group members.	*Group members were noted to change at times their responses, reflecting more in line with facilitators' responses.*
Interpersonal Learning	Humans are inherently social beings where we construct our self-regard from the reflected appraisals of others. The group setting is a social microcosm in which the maladaptive behaviour of members is triggered and feedback from others is received. Therefore, the interpersonal learning in this context can aid insight, help work through transference, and help have corrective emotional experiences.	*As the sessions progressed, group members were able to express their social (intimacy) needs which created challenges when perceived as too much by the other. Mapping as a group in a compassionate way enabled this to be explored openly, and thus working through possible ruptures in adaptive ways.*
Group Cohesiveness	The relationship in individual therapy is essential for a positive outcome. Group cohesiveness is the equivalent to a positive therapeutic relationship. For the purpose of his book, Yalom (2005) broadly defined group cohesiveness as 'the result of all the forces acting on all the members such that they remain in the group, or more simply, the attractiveness of a group for its members'.	*Group cohesiveness was seen to develop at session one through the process of collaborative RRs that constituted 'group rules'.* *A threat to the group cohesiveness occurred at session six where a group discussion was held about the benefits and possible downsides of the development of friendships with group members. Members were able to show perspective taking and listen to others' views, eventually identifying that the group was a safe place to discuss and problem solve tricky interpersonal issues that one may typically be left confused about.*
Catharsis	The open expression of affect is vital to the group therapeutic process; without it the process becomes an intellectual one.	*Affect was important during group and was allowed its space. For example, one group member often was tearful and although another appeared to have little affect; that group member acknowledged a competence at shutting down emotions. Identification of this helped the exploration and expression of feelings.*
Existential Factors	Although often forgotten, existential factors are some of the biggest learnings in the group setting. Issues such as responsibility, basic isolation and recognition of our own mortality and how this might impact how we live our life are included in factors that are related to our existence.	*The concept that ultimately there is no escape from some of life's pain was discussed in the group. A sense of basic isolation was an issue for all, facing life alone was explored with the group, as was the fear of an uncertain future.*

Table 2

Reflecting on the CDHB Pilot CAT Group using Sidell and Wells' (2018) Analysis on Therapist Opinions on what CAT Groups Offer

Accessibility	That because RRs unfold within a group dynamic they are more easily understood and more difficult aspects of them can be discussed.	*Key roles became apparent from the first session, allowing early identification of relational patterns and consequences of this (e.g., a gesture of help from one member triggered the dependency needs and longing for idea care by another). This allowed working through of these roles in the group.*
Support	That group members can be more direct and frank with each other, where the therapist cannot.	*This issue occurred for example when a friendship developed in the group, where one member was able to directly address the 'pros and cons' of this to the other members with the developing friendship.*
Safe	That CAT groups are safe and containing, which facilitates group dynamics and allows individuals to discuss feelings that may not have felt able to previously.	*A group member showed increased insight not previously seen in individual therapy, likely due to the combination of feeling safe and contained, feeling understood by other group members and being able to see in the moment the dynamics playing out with other group members.*
Relational	That because CAT is a relational model, positive relational experiences can be fostered and thus integrated into new RRs for individuals.	*Relational patterns were triggered quickly, in the first session, leaving lots of time to reflect, revise and integrate new roles with group members. For example, all group members reported experiences of feeling understood and not judged.*
Observation	Observing other individuals in similar experiences benefited one's own journey.	*One group member reported hearing another member's difficulties had helped them gain perspective and gratitude to the positive things they still had in their life.*
Mapping	Group mapping allows for the triggered RRs to be seen in 'real time'.	*Group mapping of the members' RRs was done on several occasions, allowing them to see how their individual relational patterns were playing out together, and to provide new helpful roles to use instead.*
Beneficial for the Therapist	CAT groups were seen as unique and rewarding experiences for the therapists.	*Co-facilitating this group has definitely been rewarding. Being able to see RRs play out in the various relationships has been interesting and excellent for my learning.*

Final Reflections

Emma (group co-facilitator) *and I took some years to get this group started. We wanted to add to the current group options run in the CDHB and specifically allow for something to help those who had enduring relationship difficulties. We thoroughly considered the structure, aims and potential issues when running groups, both through available literature and consulting with other clinicians who had run groups. Despite this, we still encountered difficulties not predicted and reflected that we learned as we progressed, including debriefs at the end of each session. For example, group members struggled with understanding the CAT model and managing group cohesiveness. More teaching about the purpose and nature of the group was needed. We found co-supervision and external supervision helpful for challenges along the way. However, debriefing at the end of each session is important; we did not do this consistently as we progressed, and I wonder how this might have helped members' reflection processes and abilities. Managing the different zone of proximal developments (ZPD) for group members was a challenge due to differing ZPDs. Despite difficulty in retention (starting with five, ending with three) overall, the group was considered beneficial for all involved. Data collected showed general improvements. The CORE Outcome Measure for all but one member improved (they reported they did not want to end therapy) and all members improved on their interpersonal functioning.*

Key to CAT model and practice is the use of 'CAT tools' or letters, maps, the therapeutic relationship and a focus on endings, and we found these important and useful tools of our group. Letters of reformulation (the retelling of a client's story using the CAT framework and theory) and goodbye (part of CAT's focus on endings) were used to *good effect. Maps/SDRs were used, which is an important tool of CAT where the therapist and client co-create a visual diagrammatic of one's relational patterns which include RRs as well as unhelpful relational patterns and the outcomes of these. While we did not develop a formal group map, we regularly used the tool of 'mapping the moment' to help make sense of here-and-now relational experiences (mapping out the interactions happening in the here-and-now of the group). And of course, as with most therapy, the therapeutic relationship was very important. We saw re-enactments play out with group members and ourselves regularly, using supervision to identify triggered patterns and to avoid collusion. We saw that for many group members, ending was difficult. As is standard CAT practice, ending was an encouraged topic as we approached the end. Our final session was unexpectedly cancelled due to strike action; however, we were able to have a 'good enough' ending at session 15, writing a goodbye letter together.*

This CAT group allowed me to reflect on how and where I am in the assimilation of CAT principles into my professional practice. I can see that I use the CAT principles and theory of thinking relationally and systemically about clients and their problems and as I function within teams in my work. I was drawn to CAT initially to 'fill the knowledge gap' of knowing how to use the therapeutic relationship effectively and helping to understand people in a more relational manner. Thus, CAT provided a framework to enhance formulations, and work relationally and with a process-focus in session. It was rewarding to hear the group members report benefit in further understanding themselves and their relationships, and how this impacted their quality of lives. It is hoped that this essay may be evidence of more informal support for the benefit of using CAT in a group setting.

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Distinct or Overlapping: Reviewing the Role of Central concepts in Contemporary Models of Suicide

Andre Mason

With the development of ideation to action frameworks, contemporary models of suicide recognise that the factors associated with the emergence of suicidal ideation are distinct from those associated with suicide action (i.e., an attempt). Although these theories have meaningfully advanced our understanding of suicide, each one argues that different factors are central to the emergence of suicidal thoughts. To further advance our understanding of suicide and translate this understanding into clinically useful strategies, it is critical to understand the overlap and distinction between contemporary models. This narrative review explores five key factors: defeat, entrapment, hope, hopelessness, and perceived burdensomeness. Based on current evidence, we offer two inferences. First, similarities between perceptions of perceived burdensomeness and defeat indicate that there may be some degree of overlap between these concepts. Second, hopelessness, hope, and entrapment may interact to predict both greater variation in suicidal ideation over time and the transition to active suicidal thoughts.

Building on decades of research, contemporary theories of suicide tend to be consistent with an ideation-to-action framework (Klonsky & May, 2014; Klonsky et al., 2018). Pioneered by the interpersonal psychological theory of suicide (Joiner, 2005; Van Orden et al., 2010), we now have the fluid vulnerability theory (Rudd, 2006), schematic appraisal model of suicide (Johnson et al., 2008), integrated motivational volitional model of suicide (O'Connor, 2011; O'Connor & Kirtley, 2018) and three step theory (Klonsky & May, 2015). In general, these models propose a range of factors that could lead to the emergence of suicidal ideation and in turn, facilitate the progression from ideation to an attempt. Despite the expanding evidence-base for these factors, it is important to evaluate and clarify how they contribute to and possibly interact in the emergence of suicidal thoughts.

Each of the above theories posits an array of factors thought to contribute to the emergence of suicidal ideation. In doing so, they emphasise and combine different factors and consequently, overlook the importance of other factors. Moreover, they may introduce a new term or concept that is conceptually similar to one used in another model, thereby increasing the breadth and complexity of suicide-related terminology without a corresponding increase in clinical utility. Although interesting, such scholarship may contribute to a continued lack of advancement in our ability to predict suicidal ideation and behaviour (Franklin et al., 2017). Indeed, to the author's knowledge, only one study has attempted to provide an overview of these related theories and factors, and found that the core components from multiple theories may explain a greater amount of variance than any one theory alone (De Beurs et al., 2019).

Given an important goal is to translate theory into effective prevention and intervention strategies for suicide, the present narrative review evaluates the similarities, overlap and differences between defeat, entrapment, hope, hopelessness and perceived burdensomeness. In doing so, we hope to identify areas through which suicide-related literature can continue to expand and improve the ability to predict risk of suicidal thoughts and behaviours.

Perceptions of Defeat and Entrapment

A central tenet of the integrated motivational-volitional and schematic appraisal models of suicide is that feelings of defeat and entrapment lead to the emergence of suicidal ideation

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(Johnson et al., 2008; O'Connor, 2011; O'Connor & Kirtley, 2018). The processes of defeat and entrapment were thought to provide an evolutionary basis for mental health problems (e.g., depression: Gilbert & Allan, 1998). That is, developed within the context of social rank theory (Price, 1972), defeat can be defined as a sense of failed or diminished social rank (Gilbert & Allan, 1998; Taylor et al., 2010). Similarly, entrapment is conceptualised as a desire to escape, alongside the belief that the individual is unable to so due to internal (e.g., feelings of guilt, shame) or external circumstances (e.g., lack of interpersonal relationships) (Gilbert & Allan, 1998). Suicidal thoughts are thought to emerge when an individual believes that they are unable to escape their feelings of defeat.

There is strong evidence that defeat and entrapment play integral parts in the emergence of suicidal ideation (Siddaway et al., 2015). However, the nature and extent of the relationship between defeat and entrapment is contested (Forkmann et al., 2018). While evidence through the lens of the integrated motivational-volitional model considers defeat and entrapment as distinct, albeit highly related concepts (Tucker et al., 2016), other research posits that defeat and entrapment are best considered together as a single latent variable (Griffiths et al., 2014; Johnson et al., 2008; Li et al., 2016; Taylor et al., 2009). To examine this, Taylor et al. (2009) had university students complete the Gilbert and Allan (1998) defeat and entrapment scales. Exploratory factor analysis revealed that responses were best explained by a single latent variable representing a perception of loss and failure without belief of possible improvement. Supporting this single factor approach, longitudinal research has demonstrated that a combined defeat/entrapment variable, but not entrapment alone, predicted suicidal ideation (Taylor, Gooding, Wood, Johnson, et al., 2011).

Although there is empirical support for a single factor approach to defeat and entrapment, there is a growing body of research opposing the shift to treat defeat and entrapment as a single variable (Dhingra et al., 2016; Forkmann et al., 2018; Tucker et al., 2016). Indeed, across both online community and clinical samples, network-based analyses suggest that defeat and entrapment are distinct yet highly related factors (Forkmann et al., 2018). Furthermore, structural tests (e.g., structural equation modelling and network analysis) of the integrated motivational-volitional model revealed that defeat and entrapment had unique relationships with suicidal ideation (De Beurs et al., 2019; Dhingra et al., 2016; Wetherall et al., 2018). For example, in one study, although defeat predicted entrapment and entrapment predicted suicidal ideation, defeat did not directly predict suicidal ideation itself (Dhingra et al., 2016). In contrast, findings from the Scottish Wellbeing Study suggested that while defeat and entrapment were predictive of suicidal ideation and/or attempt, only defeat independently increased the risk for ideation and attempts relative to controls (Wetherall et al., 2018).

Rather than overlapping as a single latent variable or having a direct effect on suicidal ideation, entrapment may *mediate* the relationship between defeat and suicidal ideation. Indeed, among students who had recent experiences of suicide ideation, factor analyses revealed a two-factor solution between defeat and entrapment (Tucker et al., 2016). Furthermore, although defeat was directly related to suicidal ideation, entrapment was neither directly nor indirectly related to suicidal ideation. Instead, the relationship between entrapment and suicidal ideation depended upon moderating factors such as hope. In addition, a longitudinal test of the integrated motivational-volitional model found that while defeat and entrapment were significant predictors of suicidal ideation at baseline, only entrapment remained significant at the 1-month follow-up and neither variable remained significant at the 6-month follow-up (Branley-Bell et al., 2019). However, before the addition of entrapment into the model, defeat significantly predicted suicidal ideation across all three-time points. Given that mediation analyses revealed an indirect effect of defeat on ideation at baseline, and at the 1-month follow-up, the lack of significant results for defeat in the full model was thought to be explained by entrapment mediating the effect of defeat on suicidal ideation.

A further consideration when exploring the role of entrapment in suicidal ideation is the distinction between internal, external, and total entrapment. Internal entrapment can be considered the perception of being unable to escape from one's own thoughts and feelings, whereas external entrapment refers to the desire to escape from one's situation or present circumstances (Gilbert & Allan, 1998). Although few studies separated entrapment into its subscales (see Taylor et al., 2011 for a review), evidence suggests that internal entrapment is more strongly related to suicidal ideation (De Beurs et al., 2019). Furthermore, although both internal and external entrapment have been shown to independently prospectively predict suicidal ideation, only internal entrapment mediated the relationship between defeat and suicidal ideation (Owen et al., 2018). One argument suggested that internal entrapment was more closely associated with defeat. Although some, particularly those in favour of a combined defeat-entrapment variable, would argue that this close association is indicative of overlap, an alternative argument may be that the entrapment component is better conceptualised as a variable that prolongs and limits the escape from feelings of defeat.

A Need for the Added Consideration of Hopelessness?

Despite evidence for the importance of defeat and entrapment in suicidal ideation, meta-analytic findings suggest that behaviours beyond these constructs are needed to explain the specific phenomenology of suicide (Siddaway et al., 2015). One such construct could be hopelessness. Global hopelessness, defined as negative expectations about the future, has long been associated with suicide (Taylor et al., 2011). For example, it is a central component of Joiner's (2005) interpersonal theory and Klonsky and May's (2015) three step theory. Rather than exploring the role of all three factors, many studies focused solely on the role of defeat and entrapment (Branley-Bell et al., 2019) or hopelessness (Dhingra et al., 2019). Of the studies that considered all three, the findings have been mixed (e.g., Gooding et al., 2016; Littlewood et al., 2016; Panagioti et al., 2012).

Studies emphasising the importance of defeat and entrapment suggest that they have a unique effect on suicidal ideation over and above hopelessness. For example, in a university student sample, defeat and entrapment fully mediated the effect of appraisals of social support and problem-solving ability on suicidal ideation, regardless of whether hopelessness was accounted for (Johnson et al., 2008). Similarly, in a sample of 73 individuals who had experienced posttraumatic stress disorder symptoms, defeat and entrapment accounted for 69% of the variance in suicidal behaviours, but depression and hopelessness were not significantly related (Panagioti et al., 2013). Although these findings support the assertion that specific negative appraisals may give rise to increasingly severe perceptions of defeat and entrapment and contribute to the development of suicidal thoughts and behaviours, both studies combined defeat and entrapment as a single latent variable. However, when treated as distinct constructs, there is evidence that hopelessness may be an important predictor of suicidal thoughts and behaviours (Gooding et al., 2016; Littlewood et al., 2016). Thus, it is possible that combining defeat and entrapment into a single factor may mask the contributions of other suicide-related factors.

Models that retain defeat, entrapment and hopelessness as unique factors show a range of pathways through which they may contribute to the emergence of suicidal ideation. For example, after controlling for comorbid depression, nightmares were indirectly associated with suicidal ideation via two pathways; through defeat to entrapment to hopelessness, and through defeat to hopelessness (Littlewood et al., 2016). Furthermore, in a highly vulnerable sample of male prisoners, hopelessness, general psychiatric symptoms and personality disorders predicted suicide probability, whereas defeat and entrapment did not (Gooding et al., 2016). A possible explanation for the mixed findings is that the factors contributing to suicidal ideation are context specific. Thus, a combined defeat and entrapment variable may oversimplify any emerging pathways, thereby limiting the ability for researchers and clinicians to accurately predict risk for suicidal thoughts and behaviours.

The Respective Roles of Hope and Hopelessness

As constructs, hope and hopelessness originate from different conceptual foundations. Hope theory (Snyder, 2002; Snyder et al., 1991) defines hope using goal-related elements, namely the capacity to set goals, identify pathways to achieve the goals and find sufficient motivation to achieve the goals. According to Snyder's (2002) hope model, the capacity for identifying pathways and pursuing them emerges during early childhood. However, if this capacity is thwarted, an enduring lack of hope may hinder a person's ability to identify and achieve alternative routes, thereby escaping their perceptions of defeat. Empirically, hope moderates the relationship between entrapment and suicidal ideation (Tucker et al., 2016). That is, as hope increases, the association between entrapment and suicidal ideation decrease until eventually, in the presence of high hope, entrapment is no longer significantly related to suicidal ideation.

With respect to hopelessness, Beck et al. (1974) conceptualised hopelessness as more global in nature and reflecting a general negative expectation about future outcomes. Since its conception, hopelessness has been strongly associated with both depression and suicide. Although it remains central to modern theories of suicide such as Joiner's (2005) interpersonal psychological theory of suicide and Klonsky and May's (2015) three step theory of suicide, some of the research reviewed above demonstrates argues that hopelessness ceases to explain variance in suicidal thoughts and behaviours above and beyond defeat and entrapment (e.g., Panagioti et al., 2013).

In considering the role of hopelessness in Klonsky and May's (2015) three step theory, it is plausible that the conflicting evidence results from differences in terminology. The three step theory posits that 'if someone living in pain has hope that the situation can improve, the individual likely will focus on obtaining a future with diminished pain rather than on the possibility of ending his or her life. For this reason, hopelessness is also required for the development of suicidal ideation' (Klonsky & May, 2015, p 117). Rather than being two ends of the same spectrum, hope and hopelessness have subtle but important differences (Huen et al., 2015). While hope is conceptualised as goal-directed, hopelessness concerns negative expectations about the future. Thus, rather than hopelessness, a lack of hope may be more fitting as it is a more succinct description of the process through which suicidal thoughts may emerge in the perceived absence of escape routes.

Furthermore, modelling hopelessness as a global variable may mask the underlying constructs. Hopelessness is typically conceptualised as a unidimensional construct. However, in the context of suicide, it may be more valuable when split into two components: lack of optimism and pessimism (Horwitz et al., 2017). Originally thought to represent a combination of both factors, studies have shown that the lack of positive future thought is a better predictor of suicide than a preponderance of negative thoughts (Horwitz et al., 2017; O'Connor et al., 2008). For example, Horwitz et al. (2017) demonstrated that adolescents' lack of positive expectation about the future, rather than a negative orientation *per se*, predicted future suicidal behaviours. Similarly, O'Connor et al. (2008) demonstrated that for adults who had been hospitalised following suicidal self-harm, specific future thought was protective against future suicidal behaviour whereas negative future thought was unrelated to either current or future suicidal behaviour.

Specifying hopelessness as a lack of optimism may be particularly pertinent when considered through the lens of the interpersonal psychological theory of suicide (Joiner, 2005; Van Orden et al., 2010). Recent evidence suggests that in contrast to the theory itself, perceived burdensomeness is a stronger predictor of suicidal ideation than thwarted belonging (Becker et al., 2020; De Beurs et al., 2019; Ma et al., 2016). Moreover, beyond perceived burdensomeness alone, the interaction between perceived burdensomeness and hopelessness explains additional variance in suicidal ideation (Christensen et al., 2013; Elledge et al., 2019). Among adolescent psychiatric inpatients (aged 12–19 years), lack of optimism (absence of positive future thought) but not pessimism (negative future thought) predicted suicidal ideation. Furthermore, only the interaction between perceived burdensomeness and lack of optimism was found to distinguish active and passive ideation. Thus, the perceived inability to maintain reciprocally beneficial relationships alongside a lack of positive future thought may drive the emergence of active suicidal ideation.

Implications

In their present form, contemporary models of suicide lack the clarity required to directly inform clinical practice. Although they offer an overview of factors that clinicians may want to be aware of and of pathways and interactions between factors that may be meaningful, they are as argued by Millner et al. (2020), all verbal theories and consequently contain inherent levels of imprecision which limit their ability to predict suicidal thought and behaviours. It is therefore important that future research continues to strive towards greater clarity and predictive power so that these theories can be translated into effective intervention and prevention strategies for suicide.

Striving towards these aims, the present narrative review suggests that some of the previously identified factors related to suicide, which are considered integral components in the emergence of suicidal ideation, are perhaps more similar than previously thought. Beyond the debates surrounding the merging of defeat and entrapment into a single construct, parallels can also be drawn between the defeat by entrapment interaction outlined in the integrated motivational-volitional (O’Connor, 2011; O’Connor & Kirtley, 2018) and schematic appraisal (Johnson et al., 2008) models of suicide, and the perceived burdensomeness by lack of optimism interaction within the interpersonal psychological theory of suicide (Joiner, 2005; Van Orden et al., 2010). If defeat is conceptualised as a sense of failed ability to contribute, then it is possible that it contributes to perceived burdensomeness. Indeed, previous literature suggests they are two highly related concepts (Branley-Bell et al., 2019; Dhingra et al., 2016) and that although perceived burdensomeness is strongly related to suicidal ideation, defeat is strongly related to other factors yet weakly related to suicidal ideation, thereby suggesting an indirect effect (De Beurs et al., 2019). Moreover, perceived burdensomeness appears to have a unique effect beyond entrapment on suicidal ideation (De Beurs et al., 2019; Forkmann & Teismann, 2017). Thus, future research may not only benefit from exploring the relatedness between defeat and perceived burdensomeness, but also from positioning perceived burdensomeness as a core component in the emergence of suicidal thoughts and behaviours.

Further, by integrating concepts from contemporary models of suicide, it is possible that aspects of entrapment, hope and hopelessness could be shown to intertwine and account for even greater variance in suicidal ideation. The present review has identified that defeat and entrapment, particularly internal entrapment, uniquely contribute to suicidal ideation, even after accounting for hopelessness (Griffiths et al., 2014; Owen et al., 2018). Once hopelessness is added into the path analyses rather than being treated as a control variable, it too appears to contribute to the emergence of suicidal thoughts (Littlewood et al., 2016). Given the contradictory findings and recent suggestion to separate hopelessness into two dimensions, suicide-related theory should consider the possible overlap between these constructs.

It is possible that when feelings of internal entrapment are combined with a lack of optimism, they may form a sense of entrapment suitable to explain short- and long-term variance in suicidal ideation. Although the integrated motivational-volitional model considers the possibility of this interaction by positioning hope as a motivational moderator, treating these factors as a 'perception of chronic entrapment' may help to provide a longer-term perspective. Already, studies have shown that hope significantly moderates the relationship between entrapment and suicidal ideation (Tucker et al., 2016) and that entrapment lacked long-term predictive utility beyond approximately 4 months (Branley-Bell et al., 2019; Owen et al., 2018). Given that one explanation for the lack of predictive capacity was that people's circumstances may change, altering their sense of entrapment (Branley-Bell et al., 2019; Taylor, Gooding, Wood, Johnson et al., 2011), it is plausible that considering hope/lack of optimism alongside entrapment may add explanatory value over a longer time period.

Conclusions

Contemporary models of suicide argue that various combinations of defeat, entrapment, hope, hopelessness and perceived burdensomeness are central to the emergence of suicidal ideation. While these constructs have meaningfully advanced our understanding of suicide, they have also increased the vocabulary of factors related to suicide. Based on the evidence reviewed, we suggest that these suicide risk factors may at times overlap, and together represent an underlying construct that the individual concepts can only partially acknowledge. Primarily, feelings of defeat and perceived burdensomeness may form an initial step in the emergence of suicidal thoughts before interacting with factors that create the impression that these negative feelings will endure, thereby opening the possibility for suicide as a means to escape. In conclusion, through developing a greater understanding of these underlying concepts, it may be possible to offer insights that not only improve suicidal risk assessment but also increase the overall effectiveness of intervention and prevention strategies more generally.

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Metacognitive Training (MCT) Group for Adults with Psychosis Based in a Specialist Mental Health Service: A Pilot Study Research Proposal

Wade Stent

This literature review is related to a research proposal for implementing a group-based metacognitive intervention for adults with psychosis in the Canterbury District Health Board. It is an area where I saw there was a notable gap within our current service delivery, and where I thought we needed 'new solutions for old problems' or a way to engage a population that was being under-served by our health system.

Schizophrenia and Psychosis

Schizophrenia is often characterised as one of the more severe mental health disorders and one of the most recognisable psychotic disorders. Symptoms can include hallucinations (experiencing

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things that are not present, most commonly voices or auditory based), delusions (strong fixed beliefs), disorganised thinking or thought processes, flattened emotional expression, decreased motivation, social withdrawal, cognitive impacts or a varied mixture of these (American Psychiatric Association, 2013). Approximately three-quarters of those with a diagnosis of schizophrenia experience delusions and/or hallucinations (Balzan et al., 2014). Lifetime estimates indicate that between 0.3% and 0.7% of the population are affected by schizophrenia (McGrath et al., 2008; van Os & Kapur, 2009). Although rates in the general population are low, there is a low rate of improvement; only 20% of diagnosed individuals are reportedly doing or functioning well, with even fewer recovering, and approximately 50% having a lifelong impairment (American Psychiatric Association, 2013; Lawrence et al., 2015).

There are significant morbidity and mortality impacts associated with schizophrenia, which are accentuated by the low rates of remission. It is associated with a decreased life expectancy of 10–25 years, which has been linked with obesity, smoking, poor diet and an increased rate of suicide (Laursen et al., 2012; McGrath et al., 2008; van Os & Kapur, 2009). In New Zealand, people with a psychotic disorder have been shown to have an age-adjusted mortality rate three times higher than the general population, which includes a 1.8 times increased risk for cardiovascular disease and cancers (Galletly et al., 2016). These physical health impairments have been correlated with all mental health disorders and are associated with higher rates of smoking, medication side effects on cardiovascular health, discrimination, lack of appropriate medical treatment and social deprivation (Galletly et al., 2016).

Furthermore, because of the nature of some of the difficulties and symptoms of schizophrenia, there are often poor functional outcomes, such as lack of social engagement or distrust within relationships, high unemployment rates (up to 85%; Owen et al., 2016) and high societal and economic costs because of social deprivation, medical care and psychiatric care (van Os & Kapur, 2009; Landa et al., 2006; McGrath et al., 2008). The symptoms of schizophrenia or psychosis can impact the ability of those with schizophrenia to access support and intervention for their health in a broad sense, which exacerbates or prolongs these difficulties. Impairment for this population is further compounded by the prevalence of comorbid psychiatric difficulties. Comorbidity is relatively common in schizophrenia, with rates of about 29% for posttraumatic stress disorder, 15% for panic disorder, 23% for obsessive compulsive disorder, 50% for depression and 47% for substance abuse difficulties (Buckley et al., 2009). These rates are much higher than rates found in the general population. Therefore, having the disorder puts individuals at a high risk for other difficulties and complications beyond what they experience related to psychosis alone.

Symptoms of psychosis are not exclusive to schizophrenia and lead to similar difficulties across a number of other disorders. For example, psychotic symptoms are a diagnostic feature in schizophreniform disorder (where individuals have been experiencing symptoms for more than 1 month and less than 6 months), schizoaffective disorder (involves symptoms of schizophrenia and mood disorders with bipolar or depressive subtypes), brief psychotic disorder, delusional disorder and psychotic disorders not otherwise specified. These disorders have been more recently referred to as disorders on the ‘schizophrenia spectrum’, allowing broader conceptualisation and research in the field of psychosis because of the overlapping presentations (World Health Organization, 2019).

Other conditions can present with psychotic symptoms or psychotic-like symptoms; however, these tend to be of briefer duration and may be related to mood states or levels of stress. Psychotic symptoms can also be present for some individuals with bipolar disorder, depression, dissociative identity disorder, and some personality disorders. Additionally, psychotic symptoms can present for some people in times of acute stress, or symptoms of other disorders can appear similar to psychosis, such as re-experiencing of trauma within chronic and complex forms of PTSD, particularly if intense and vivid.

Interventions

The first-line intervention for clients with psychosis is generally medication, particularly if core symptoms are severe and significantly interfere with functioning. Antipsychotics are effective in the treatment of schizophrenia and other psychotic disorders; however, 30%–40% of people only experience a partial response (Zink et al., 2010), and approximately one-third of those with schizophrenia do not respond at all (Smith et al., 2009). With such high costs to individuals experiencing psychosis and high rates of partial/no response to medication, it is important for research to continue investigating ways to help those for whom standard interventions may not work or only have limited success.

There has been an increase in research on psychological treatments to complement medication-based treatments, particularly for those with only a partial response. There is a growing evidence base for psychotherapies in improving symptoms and broader functioning for those with psychosis, as per the below referenced meta-analyses. These include cognitive behavioural therapy for psychosis (Wykes et al., 2008), cognitive remediation therapy (Wykes et al., 2011), acceptance and commitment therapy (Wakefield et al., 2018), and metacognitive-based approaches (Morrison et al., 2014; Moritz & Woodward, 2007). Many of these are adaptations of well-established therapies for working with those who have or are experiencing psychosis. Despite growing research in the area, there remains variability regarding access to psychological therapies for people with psychosis in the community (van Os & Kapur, 2009). This can be attributed to costs, waiting times, other service needs or a focus on prioritising the stabilisation of symptoms with medication before considering complementary interventions (Smith et al., 2009). Additionally, it may be hard to engage some clients with more severe experiences of psychosis, as their beliefs or experiences may discourage engagement with others and may impact on insight into their difficulties or ability to engage in some modes of therapy. These factors may be why many of the psychological therapies noted above are often for individual delivery, which may help with providing people input and working around some of the difficulties in trusting others.

There has been a small shift towards the use of a broader all-encompassing approach including both psychological and pharmacological approaches, particularly in early intervention services for psychosis. Research supports that this type of approach contributes to significant long-term maintenance of improvements (Jackson et al., 2019). These services only cater for those in their first presentation of psychosis and are usually time-limited (often approximately 2 years), whereas for most with schizophrenia, difficulties persist. Based on the low rates of remission, there is also a more chronic group of clients for whom numerous approaches do not lead to much change or improvement. As such, there still exists a need for additional effective for those who may be more chronic in their presentations and may not have responded to typical interventions (Moritz et al., 2014).

Metacognition Training (MCT)

MCT is an intervention that builds on evidence linking delusional beliefs with difficulties with theory of mind, specific thinking styles, cognitive biases and the associated disrupted appraisals of daily events or how people make sense of these (Moritz & Woodward, 2007; Garety & Freeman, 2013; Moritz et al., 2014). It has been observed that these thinking patterns may lead to further impacts around social withdrawal, distrust of others, feeling unsafe and possible impacts on lack of insight into difficulties (Lysaker et al., 2010). These thinking patterns become the focus of treatment in MCT, with clients being encouraged to reflect on their thinking patterns and biases. MCT focuses on increasing participants' awareness of these cognitive biases and aims to 'plant the seeds of doubt' about certainty of thoughts through non-delusional based scenarios and practical exercises (Moritz et al., 2014). MCT addresses cognitive biases and emotion management strategies. The daily impact of these unhelpful strategies are discussed through the use of typical examples, before moving into reflecting how this may be related to psychotic symptoms. Particular focus is given to how an escalation of biases, such as overconfidence and jumping to conclusions, can exacerbate symptoms as well as unhelpful responses. It is emphasised that these thinking patterns are deviations from normal functioning, rather than being psychosis-specific, which has been suggested to normalise some discussions around thoughts or certain experiences to facilitate engagement (Moritz et al., 2017).

Throughout the development of MCT, Moritz and colleagues focused on ease of implementation with those with more chronic presentations and aimed for high acceptability by clients to encourage greater engagement. Lack of acceptability is a factor that may make engagement in other therapy modalities harder because of not having such a focus on engagement and acceptability, particularly with more severe and chronic individuals with psychosis. MCT has been well researched for almost a decade (Garety & Freeman, 2013; Eichner & Berna, 2016; Liu et al., 2018). Meta-analyses have shown that an MCT group-based intervention had a small to medium effect on delusions and positive symptoms (Hedge's $g = -0.38$, Liu et al., 2018; Hedge's $g = -0.28$, Eichner & Berna, 2016), with these effect sizes maintained at follow up (6 months Hedge's $g = -0.35$, Liu et al., 2018). Much of this research is based on the group format of MCT; however, an individualised variant is also available with similar results. It has been found that the group-based format may not be suited for those with high levels of suspiciousness (van Oosterhout et al., 2014) or more severe delusions, who may be more benefit from structured individual work (Eichner & Berna, 2016). It is important to note that the effect of MCT appears to be complementary to standard medication interventions, as participants in most studies were already on antipsychotics (Andreou et al., 2017). However, there have been some non-significant results found in a meta-analysis of MCT (van Oosterhout et al., 2016). That meta-analysis critiqued study methodology such as blinding, intention-to-treat analyses, lack of statistical power and publication biases as contributing to what they found to be small to non-significant effect sizes when studies were analysed together.

MCT has the added benefit of being regularly updated based on new research findings. This has included the addition of sections on self-esteem and stigma following participant requests. Furthermore, the intervention itself is freely available online, which helps with improving the ease of access for clients and clinicians, something the development team has maintained since its conception. This ease of access has allowed multiple translations and variations to be made and kept freely available. MCT is available in over 15 different languages and 36 different regional variants, such as traditional versus modern language versions or country specific treatment packages even where a language is shared. Adaptations of content is encouraged provided the core principles remain, such as the focus on cognitive biases. Treatment effectiveness of the MCT package has been maintained when adapted in these ways, and implemented in different languages or cultures, as found in published research on Chinese, Korean and Portuguese applications (Lam et al., 2015; Park et al., 2020; de Pinho et al., 2020).

Proposed Study

A pilot study is proposed using group MCT for adults with psychosis in a specialist mental health service. This use of MCT is justified based on this literature review reporting a need for improved treatment for this group and the growing evidence base for MCT, with reasonable effect sizes in this hard-to-treat group, ease of implementation and acceptability by clients. The proposed research will focus on determining the feasibility and preliminary estimates of effectiveness of MCT in an adult outpatient community service in New Zealand. To our knowledge, this will be the first time this treatment approach has been researched in New Zealand and as such, is important to gauge whether this treatment is transferable to this context.

As outlined above, schizophrenia and psychotic symptoms have severe impacts because of the associated symptoms and impairments, including secondary impacts on physical health and well-being. It is important to trial new and novel approaches to aid those with ongoing impairments, especially where individuals may not have responded to other interventions. It is hoped that the promising results of MCT in international settings can be replicated for clients in New Zealand and will lead to more treatment uptake and support for this population. If successful, this may increase ease of access for psychological therapy to those with more complex presentations, rather than interventions remaining largely medication based alone. Finally, the pilot study will garner information about adjustments that may be needed within the New Zealand context, such as bicultural or multicultural options.

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Māori Identity, Old Solutions and New Problems

Emerald Muriwai

Part commentary, part poetry reflection on the proposal to continually search for new solutions to old problems from the perspective of a Māori intern psychologist. For Māori, many of the issues that arise in therapy are bound by one thing, tuakiri or identity; the old solution to the new problems we face.

My critique of looking for new solutions for old problems;
is the
side-stepping
of the glaringly obvious.
it is a ticket of convenience
to keep looking outwards
when many of the old solutions
were devoured the minute you told me my culture
was new.

When working with Māori therapeutic approaches must start by honouring identity. Identity in te reo Māori is referred to in one way as tuakiri (literal translation 'beyond the skin'), acknowledging

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that who we are is extends beyond the physical. We have many modern ‘problems’, which are an echo of our colonised experiences and our shared histories with all who call Aotearoa home. From an academic perspective, we understand that the measurement of Māori identity has long been a contested space due to the lasting impacts of colonisation. Spanning 30 years, the work of Māori academics has solidified the significance of Māori identity in regard to health and wellbeing outcomes (e.g., Durie, 1997, 2004; Lawson-Te Aho, 1998). Work of this nature is often described as ‘the interface between Māori knowledge, and Western science’ (Rata, 2012, p.20). While this marriage of mātauranga Māori and Western method has been fruitful in developing detailed psychological profiles of Māori (e.g., Houkamau & Sibley, 2010, 2013; Kukutai & Webber, 2013), these developments ultimately favour a tuturu (essentialist) concept of what it means to be Māori (Moeke-Maxwell, 2003, 2005). As ‘scientist-practitioners’, we as clinical psychologists seek to understand the context of tangata whai i te ora’s issues. When talking with Māori, we begin in a complex, contested and colonised space.

My critique of looking for new solutions for old problems;
is that we all have whakapapa
and yet
I find myself teaching others
who it is to be them
sharing my mother tongue
which is actually my third language
because no matter what,
we believe in you and your ancestors.

In te ao Māori, identity and whakapapa exist in an inverse hierarchy, which positions te tai ao (the natural environment) as first and ingoa (name) last. As detailed in the hauora layers model below and in the broader practice of pepeha (tribal sayings, introductions), identity is recognised firstly with reference to the te taiao and ngā atua (Māori gods) from which we descend (Mutu, 2005; Murton, 2012). The ‘formulaic saying’ (Mutu, 2005) of who we are or our ‘geographical self’ (Murton, 2012) varies for Māori and is influenced by proficiency and access to te reo Māori, mātauranga Māori and whānau histories. Indeed, a ‘continuum model’ (Moeke-Maxwell, 2005) of Māori identity replicates the colonial lens by differentiating Māori by how colonised or tuturu they are perceived to be. Therefore, it must be acknowledged that distinct urban Māori identities (Borrell, 2005; Rosenblatt 2002) and multi-ethnic ‘hybrid’ identities (Moeke-Maxwell, 2005; Webber, 2008, 2012) form other, meaningful expressions of Māori identity.

Figure: Hauora layers; a conceptual model from kōrero with Dr Ihirangi Heke

My critique of looking for new solutions for old problems;
it's actually pretty easy.
to flip your brain upside down

Imagine life from another's perspective
its less easy
and somewhat awkward
to be a student, therapist and teacher
of a knowledge already in you
revealing itself too quick.

Māori research is like doing therapy with Māori. As is the case in Māori research, stating the positionality and identity of the researcher is methodologically necessary to ensure a high standard of systematic and responsive research (Greaves, 2017). This concept has not comprehensively made the uncomfortable transition into the therapy room when working with Māori. My doctoral research beckoned the creation of appropriate and useful measures of Māori identity, and I will use it as an example of the context of our new problems and old solutions. Identity cannot be captured by a seven-point Likert scale but parts of it can be explored. Māori identity is impacted by a shared sense of intergenerational trauma and whakamā (shame, embarrassment) rooted in colonisation. And so, with the help of my advisory rōpū, we opened my doctoral research with a survey item stating 'I openly identify as Māori' (1=Strongly Disagree, 7=Strongly Agree). This statement is heavy with further pātai; Why is it radical to be openly Māori? (read on.) Is this a choice if you are 'socially ascribed' as Māori? (Maybe?) What about those with dual and hybrid identities? (We all count.) Does this question come from a place of privilege? (Yes). What does this have to do with mental health? (Everything). To state some simple facts; at last count over 20% of New Zealand's population recognise they have Māori ancestry and yet only 15% identify with Māori ethnicity (Statistics New Zealand, 2013). Both the 15% of Māori who state their ethnicity and the 5% who do not, have whakapapa Māori. Openly identifying as Māori is as therapeutically relevant as it is political.

My critique of looking for new solutions for old problems;
a state of potential
is where we start

when we forget that,
we go looking for
more problems and get distracted
into needing something new
a compulsion to look beyond
stuff we already knew.

Not everyone can chameleon their way through different worlds and contexts like many Māori can and have to do. Although we have 'tuakiri', our identity beyond our skin, as well as our whakapapa, our wairuatanga—our skin—plays a huge role in our experiences as Māori. Further, the ways in which Māori identify ourselves are rooted in surviving our contexts. It is funny when terms such as 'identity politics', 'minority culture' and even 'internalised racism' get applied to us. Most recently, we have been taken under the umbrella of the North American term 'BIPOC'; termed in 2013 to denote 'black, indigenous, people of colour' (Garcia, 2020). These are the global layers to consider when working with our people. Then there is the multiplicity of who we are right now and who we have been. Our connection to knowledge(s) and contexts on microscopic, macroscopic, whānau, community, Māori society and mainstream society levels is varied. We are a people who have always been navigators faced with systems of racist bureaucracy, inequity and barriers that make us feel like we are drowning.

> *'Proud to be Māori, the best thing about me is that I am Māori. The fact that Māori are badly represented in mainstream media and statistics is what gives me the drive to try do good things. My journey and the decisions/sacrifices I make is an effort to push back and create a new "norm" of what it means to be Māori' (Raniera Rewiri, 2018).*

I am breaking up this commentary with a turn to the whakaaro of contemporary Māori voices who are often under-credited or excluded from the kōrero around therapy, academy and Māori identity. In the design of our study that I mentioned earlier, we decided that the identity items in this survey would resist reverse coding and avoid whakamā inducing statements. It is a premise that can easily translate into therapy. As asserted by Rewiri (2018), we as Māori are hungry for different representation. Anti-racist kōrero from Māori and tauiwi alike is broadening of 'traditional' Māori identity markers and acknowledging the racist stereotypes that colonise our potential. And so, how and why should Māori identity be brought into the therapeutic process?

My critique of looking for new solutions for old problems;
is the lack
of consideration
whose problem is it
whose solution is it
did you even think to ask
whose version of events
you had listened to
or formulated in your head, before we even met?

The floodgates opened a few decades ago, welcoming in models, guides and codes offering a roadmap to working with whānau Māori (e.g., Durie, 1985, 1994, 1999; Pere, 1991; Pitama et al., 2007, 2014, 2017). There is innovation that has been generations in the making. Protective factors contributing to hauora hinengaro (Māori mental well-being) have included positive identity formation, large whānau support, economic stability, increased access to cultural engagement, ability to kōrero Māori and so forth (e.g., Durie 1985, 1991, 2001; Harris et al., 2006; Harris et al., 2013). As well as this, practitioners are urged (but not mandated) to demonstrate cultural competencies (New Zealand Psychologists Board, 2011) and cultural safety (Curtis et al., 2019) to ensure best practice in maintaining Māori psychological well-being. Despite all of this progress, Māori clinical psychologists still account for less than 5% of our workforce and Māori are still at least twice as likely to experience psychological distress (Asher et al., 2018).

My critique of looking for new solutions for old problems;
is that
new solutions leave us disillusioned
because listening
and feeling
and being
might feel new
but it's the oldest solution
to an epidemic of problems, that are new.

Being Māori means we have already experienced the work we do with our people. To survive our lives, we have concurrently learned two systems, two ways of being and have become expert in the tools, methods, language and science that was once used to oppress us. Truth be told, the English language will forever have its limitations in explaining the complexities of being indigenous in Aotearoa. As earlier explained, the work of finding solutions and re-orienting Māori mental health and well-being has already been and will continue to be done for and by Māori—Tā Mason Durie's life-long contributions to this space cannot be understated. Unfortunately, beyond what the less than 5% of us can do, much of the work remains in theory rather than practice (Mathieson et al., 2012). While the demography of our workforce plays catch up, the challenge and problem of working with Māori is not Māori identity itself. It is acknowledging Māori identity and embracing the discomfort of cultural humility, when describing who we are pierces some of us at our core.

Ki taku arokatenga kei te whāia ngā mehenga hou mō ngā raruraru o mua
He mahi pai noa iho
Kaupapa hou, Kaupapa o mua
Whakarongo, Whakarongo, whakarongo.
He ngakau marae tātou
He Māori, he Tauiwi rānei
E kore e hekeheke
he kākano rangatira
Kaua e wareware.

Translation:
My critique of looking for new solutions for old problems;
it is no problem
new issues, issues of old
We must listen with our intuition, heart and soul
As we all have a generous heart
Māori and Tauiwi alike
A noble heritage
will never perish
Don't forget.

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To Therapy or Not to Therapy: Should Trainee Clinical Psychologists Engage in Personal Therapy as Part of Their Training?

Tamara Smolinski

The infamous metaphor by the 17th century poet John Donne 'no man is an island' signifies the human need for connection with others for survival. This knowledge is shared through time, cultures and peoples. In Aotearoa, we are fortunate to have the opportunity to gain knowledge from Te Ao Māori concepts regarding connectedness and relationships. One such concept 'Whakawhanaungatanga', which refers to establishing connection and relating well with others, has been incorporated into clinical training programmes across Aotearoa given the importance of connection and relationships to physical and mental health outcomes. Embedded in a Māori health model of practice to improve Māori holistic health and well-being, these concepts provide vital clues about how we can develop strong therapeutic connections with clients. This is particularly important in the therapeutic space, as research consistently demonstrates that the

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quality of the connection between therapist and client is the most important factor related to therapeutic outcomes.

Seeking psychological support requires courage and strength. One must allow oneself to be vulnerable with someone who, while a trained professional, ultimately is a stranger. As part of clinical training, we regularly reflect upon the likely experience for clients when seeking support. We are aware of barriers such as complex public systems, finances or access to culturally inclusive services. We learn of the complexity that stress, anxiety, depression or isolation adds for someone thinking about seeking help. We develop insight about concepts such as Whakawhanaungatanga and how we can incorporate such knowledge into our practice to improve relationships.

However, it was not until personally seeking therapy in my second year of clinical training that I developed a true sense of what it was like to form a connection with another from the client perspective. I reflected upon the likely similarities between my own and others' experiences when seeing a clinical psychologist for the first time. I experienced how Whakawhanaungatanga helped me relax into the therapy space. Personal therapy undoubtedly strengthened my understanding of the challenges that come with allowing oneself to be vulnerable and seek support. Hence, I was left pondering some questions. Should it be necessary to have the lived experience of being a client? Would such experience enable trainee clinical psychologists to increase their capacity for connection, thus possibly improving client outcomes?

Sigmund Freud, a name known to many given his influence in the development of talking therapy, strongly advocated for therapists engaging in personal therapy. He argued that therapists would be able to identify their own blind spots and biases, therefore improving their practice. In Aotearoa, personal therapy is not a mandatory component of clinical psychology training. There are ethical issues that arise when mandating therapy; therefore, I do not advocate for this approach. While there are some situations, such as within the criminal justice system, where therapy is mandated in the interest of personal and public safety, the best connections are made when the individual seeking support is internally motivated to do so. Yet learning how to be vulnerable in front of another for the goal of personal growth and development is a valuable experience likely to benefit our professional practice. Therefore, I propose, what do we have to lose?

To complete any clinical programme a trainee must demonstrate competence in reflective practice. A reflective practitioner engages in self-reflection to increase awareness of their strengths, weaknesses, biases, motivations and beliefs. Reflective practice aims to help practitioners become more effective in their work with clients. Yet the purpose, goals and outcome of (client-focused) supervision differs greatly from that of (self-focused) personal therapy. As a recipient of both supervision and therapy within the period of my clinical training I have experienced this distinction. The growth I made within therapy would not have eventuated from supervision and reflective practice alone.

Clinical psychologists rely on scientific research evidence to guide their practice and are therefore referred to as 'scientist-practitioners'. Research alludes to many advantages of personal therapy for training clinical psychologists. Personal growth, professional development, learning from the lived experience of being the client and the positive outcomes of therapy itself are the key reported benefits. However, research also indicates that for some trainee psychologists engaging in personal therapy negatively impacted them and their relationships, especially if personal therapy was a mandatory part of training. Furthermore, the costs of therapy were crippling for clinical students without a steady income and was emotionally taxing alongside a physically and emotionally demanding training programme. While the jury is still out as to whether engaging in personal therapy will certainly result in one becoming a better therapist, the benefits of the lived experience of therapy for a clinical psychologist's practice are clearly cited. I consider that the costs and benefits for trainees engaging in personal therapy likely mirror the costs and benefits for clients. As trainee clinical psychologists we strongly advocate for therapy, given the evidence that engaging in therapeutic intervention improves outcomes over no intervention at all. Given this, trainee clinical psychologists will most likely benefit personally and professionally by engaging in their own therapy as part of their training journey.

Furthermore, by engaging in personal therapy we help to break down the stigma associated with seeking psychological support. We have an ethical obligation to normalise help-seeking in the interest of promoting psychological health and well-being. If we are hesitant about engaging in therapy, why is this? How may this mirror our clients' experience? We owe it to our future professional selves and our future clients to develop as much awareness of our biases and blind spots that we can. We could be better equipped to understand how we can incorporate Whakawhanaungatanga and connection in the therapy room having been the client ourselves, knowing what it is like to sit on the other seat. Therefore, while not mandatory, I consider that we as trainee clinical psychologists should strongly consider what we can gain, both personally and professionally, from engaging in personal therapy throughout the course of our training.

Evolutions of Group Supervision: Reflections of Using Video Conferencing When Delivering a Cognitive Analytic Therapy (CAT) Supervision Group

Nicola Crook

I became an accredited cognitive analytic therapy (CAT) supervisor in October 2019 and have been delivering CAT group supervision via video conferencing to the same CAT trainee practitioners for almost 2 years. This experience proved helpful when transitioning to delivering teaching and therapy online during the COVID-19 pandemic. This article summarises some of my learning experiences from delivering online group supervision. While I draw upon the CAT model when discussing my experiences, I believe this article is of value to those from a range of therapeutic backgrounds. Given the recent increase in the number of clinicians that temporarily had to transition to using video conferencing more frequently and for multiple purposes, this article offers reflections that may be helpful to your own practice. I will begin with a brief introduction to CAT and its key principles to familiarise readers with the model before sharing my experiences.

CAT is a relational and collaborative model that involves working alongside clients to help identify their repetitive and problematic interpersonal patterns of relating both to themselves and others. These patterns, otherwise called target problem procedures, are understood to originate from early childhood relationships that provide a blueprint for later adult relationships. CAT is an integration of cognitive, psychodynamic and Vygotskian ideas. It provides a more compassionate and descriptive understanding of how a client's difficulties developed, supporting them to recognise their patterns through a co-created diagrammatic illustration of these on a

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map, before identifying and practicing healthier ways of relating or exits from these patterns. CAT is structured and time-limited, with courses of therapy usually lasting around 8, 16 or 24 sessions.

CAT was formalized in 1984 by Anthony Ryle and while originally developed for the purposes of individual therapy in the National Health Service (NHS) it has expanded to provide case conceptualisations for complex clients, as well as serving as a model for consultation and supervision. The supervisor supports the supervisee to make CAT theory–practice links and implement CAT-specific tasks while maintaining the usual components of psychotherapy supervision. This includes addressing client and trainee development needs and managing ruptures to both the therapy and supervisory relationship. The latter sometimes reflecting a parallel process originating from the client–therapist relationship (Ryle & Kerr, 2002). CAT's relational focus therefore lends itself well as a model for supervision with the process of learning in supervision reflecting the process of learning in therapy. CAT supervision can be a demanding activity in itself and so when faced with the additional dimension of delivering this via video conferencing, some of the key challenges have been how to retain fidelity to the CAT model. The CAT supervision group that I reflect upon in this article ran at the same time every fortnight for 90 minutes across two different countries. The group comprised two CAT trainee practitioners and we were all clinical psychologists by profession seeing clients in both the public and private service.

Supervision via video conferencing produced some challenges as well as some benefits. One of the difficulties was adhering to the collaborative nature of CAT of ideally working side by side rather than screen on screen. For example, the sharing of visual tools such as the drawing and tracking of maps, as well as being able to equally attune to both group members and support a three-way conversation has been tricky. Difficulties in communication by picking up verbal and non-verbal signs that someone was wanting to speak and checking this out led to a sense of it being disjointed at times, impacting on the relational focus of supervision. A shared appreciation of the scope for miscommunication highlighted need for transparency such as naming if choosing to be silent to think, or saying if switching to read a letter on screen that may be reflected in changes in facial expression and tone of voice that could otherwise be misinterpreted to mean something else. Attention to these details is warranted given that the importance of a collaborative, boundaried relationship offering support and mutual respect is repeatedly associated with the quality of the supervisory relationship (Beinart, 2004; Lawson, 2003). The latter impacting upon the supervisee's experience of supervision, and the quality of their practice (Ladany et al., 2013).

It has been helpful to recognise when the use of video conferencing has magnified our own roles and patterns. For example, my pattern of striving to provide valuable learning experiences in the supervision context was triggered when trying to develop a group map using an unfamiliar interactive whiteboard feature. This co-created group map illustrates each group members most common and less helpful interpersonal patterns that could be activated within a supervision or therapy session. This can be a challenging and exposing activity in itself given the need to draw upon oneself and possibly even more so via video conferencing. Perhaps unsurprisingly, I found myself working too hard at the expense of being less emotionally attuned and available to the supervisees. This left me feeling more disconnected and judging of my performance which likely activated the supervisees' less healthy patterns. Recognition of this enabled a discussion of our experiences and allowed our efforts to be validated while ultimately providing a valuable group tool that continues to be used in supervision today. This was a valuable experience for all in terms of understanding our own zone of proximal development (ZPD) when using new technology and adopting realistic expectations of our abilities. The ZPD is the gap between what one can do alone and what once can learn to do with the help of a more competent other (Vygotsky, 1980).

I observed greater difficulty determining whether a rupture or an enactment consistent with our own patterns had taken place within the group via video conferencing. For example, on one occasion noticing and naming a potential emerging pattern regarding the unequal distribution of allocated time to each supervisee and being able to explore whether this was a possible oversight from me, or an enactment of roles. Discussion of this helped support further recognition of the supervisee's role and pattern namely trying to please and avoidance of challenging others. It enabled both supervisor and supervisee to take ownership for their part and create shared responsibility within the group to help address this and provide appropriate exits. A willingness to be openly curious to address discomfort helped model appropriate group behaviour that could be addressed within the context of video conferencing, and importantly gave permission to express potentially less pleasant experiences that may feel more daunting to communicate via this medium.

I found myself leaning more towards naming slight indicators of a possible rupture even if based upon limited observation given the restricted information available through video conferencing. More often than not, even if my initial hypothesis was discounted, such questions gave rise to much energy, along with equally valuable discussions. This approach was made explicit, the rationale provided and agreed upon within the group. While important to achieve balance of focus between both content and process issues, I found myself having to more consciously attend to the latter in order to support the development of a cohesive alliance that felt safe to self-disclose, especially as we did not know one another before the group started. This is a pertinent issue that despite working with trusted supervisees, research has highlighted nondisclosure by supervisees in psychotherapy supervision (Ladany et al., 1996; Webb & Wheeler, 1998; Mehr et al., 2010).

I placed emphasis on goal orientation and seemed to work much harder at maintaining structure during video conferencing. This was reflected in part by requesting the supervisees' agendas with specific questions and CAT tools (e.g., therapeutic letters and maps) to be emailed to the group ahead of supervision, keeping to time and planning what needed to be discussed in which supervision session to allow for timely delivery of clinical tools for effective clinical practice (e.g., therapeutic letters). This attention to structure may have also affected the pacing, with it feeling more pressurised at times. On one occasion, a supervisee expressed feeling rushed at the beginning of the session as the discussion had turned immediately to clinical cases. This in part reflected my experience of video conferencing as helpfully sharpening the focus of discussions at times but this importantly needed to be managed so it was not at the expense of holding a nurturing and containing space allowing for curiosity, exploration and play. This experience emphasised the importance of regular summarising, checking people's understanding in the moment and an informal check in at the beginning of every supervision. The latter being significant given that the usual 'settling into the room' process of informal greetings and the shuffling of chairs, marking the transition from the previous activity to the focus of a safe space in supervision, was absent.

I also noticed that boundaries shifted when using video conferencing for supervisees and supervisors, especially when working from home such as occasionally drinking and eating lunch in supervision, people entering the room where supervision was taking place (albeit rarely), having wet hair and wearing casual clothing. These experiences made me question whether these were acceptable boundary crossings, and led to greater appreciation for flexibility when using video conferencing and working across international time zones. The idea that what may be right for me or a group in one situation may not necessarily be in another. The key thing was to be questioning this, and especially in different environments where workplace boundaries vary widely. In this situation, flexibility aided a more nurturing environment within busy individual schedules that reflected a more trusting and validating space.

Caution has been expressed regarding the lack of regulation in technology-assisted supervision, and it is advised for guidelines to be developed to support supervisors towards safe and ethical practice (McAdams & Wyatt, 2010; Vaccaro & Lambie, 2007). Rousmaniere (2014) encourages a set of 'best practices' for online supervision and training to be developed specifically in relation to the supervision process, legal and regulatory issues and technology. Currently, the New Zealand Psychologists Board's document *Best Practice Guideline – The Practice of Telepsychology* (2012) offers a helpful regulatory framework to ensure safe and effective practice online, although this refers to the broad range of psychological services that make use of online technology, rather than offering anything specific to supervision. I would like to acknowledge my own need to increase my knowledge base regarding informed consent procedures for client and supervisees using video conferencing and develop better understanding of the security standards specific to this and the full network of connections underlying this technology. Increased awareness of the importance of these and other legal and technology issues emphasises the need to consider the attainment of competencies in the technology medium used, as well as fundamental clinical skills in supervision.

Given the challenges described, it has been important to consider my own self-care and a significant part of this has been accessing my own supervision. This has offered holding and encouragement that in turn enabled me to provide this to the group. My beneficial experience of receiving supervision also via video conferencing enabled me to feel contained and have confidence that effective learning and support can occur through this medium, especially as similar problems were addressed in my own supervision as within the group supervision. Keeping the delivery medium of supervision consistent for both trainees and I aided learning of using video conferencing in this context, and most likely enhanced the cohesion and learning of the group. The demands of delivering supervision in this way also raises consideration for clinicians who may be required to use this medium frequently and the associated risk of fatigue given the concentrated effort required. The need for self-compassion has also helped with the only too familiar practical difficulties encountered of slow Internet speed, intermittent loss of connection, and human error. I found the use of humour was effective in alleviating frustration at these times, such as when group members found themselves waiting in different rooms due to duplicated invites.

In summary, I have been surprised at how effective video conferencing can meet the needs of providing 'good enough' supervision. While undoubtedly some aspects are compromised such as modelling the collaborative nature of CAT (e.g., co-creation of maps), there is still a lot that can be addressed effectively such as addressing process issues (e.g., recognition and revision of patterns enacted within the therapy and supervision and working with transference). In fact, ratings of the supervisory working alliance, trainee satisfaction and trainee self-efficacy were found to be similar between the videoconference and in-person group supervision conditions for a study involving nine counsellor trainees (Reese et al., 2009). I have found that those areas compromised can generally be mitigated such as sending photos following supervision of maps and copies of letters, or even slowing down and holding maps up to the camera to be seen. While I believe in-person supervision remains the ideal experience, video conferencing is certainly a good compromise when this is not possible, and particularly in places where geographical restrictions can place limitations on people accessing services.

When using video conferencing, I find myself continuously reviewing the focus of balance between structure, content and the therapeutic process in order to ensure the relational alliance key to CAT is maintained. In some ways, it is now more crucial than ever that we reflect upon our learning of new technological practices as both clinicians and clients alike will be presenting during this pandemic with increased needs, requiring a nurturing and supportive space. Learning from these new experiences is most likely to enrich supervisee's experiences within supervision allowing them to continue delivering therapy effectively and ultimately move closer towards meeting the growing mental health needs of the population.

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Zooming in and Zoning out: A Reflection on why we get Fatigued When Using Telehealth

Liesje Donkin

The rapid onset of the COVID-19 pandemic has pushed many clinicians into telehealth much quicker than was expected. This meant that many people felt unprepared and anxious about the use of these new technologies and how to successfully negotiate these to effectively deliver therapy. But the adaptation to technology-delivered therapy has not been the only challenge. Many people have reported increased levels of fatigue, an experience coined 'Zoom fatigue'.

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Zoom fatigue is the experience of high levels of fatigue following a telehealth session delivered by any video-calling platform. It is therefore not specific to the delivery of sessions by Zoom, but rather is called Zoom fatigue for brevity. Zoom fatigue is widely reported in all areas where video calling has a high frequency of use. So why does Zoom fatigue occur and can we mitigate the effects of it?

Zoom fatigue is likely to be a result of changes in how therapy is delivered and having to 'relearn' how to do therapy using a different modality. Take for example a face-to-face session, this may follow a format similar to the clinician walking from their office to collect the client from the waiting room and then walking the client to the therapy room while making rapport building small talk and engaging in some observations of how the client appears to be doing. Once the client is situated in the room, the clinician may offer a drink and then go and make the drink. Once back in the therapy room the session begins. During the session, the clinician may get up at times to get a resource, write on a whiteboard or move position to show the client something that they have drawn on their writing pad. At the end of the session, the clinician then walks the client out of the room to farewell them, and then may return to write notes. In telehealth sessions, many of these steps are removed. Specifically, there is no longer the requirement to collect the client from the waiting room, walk the client to the therapy room or make the client a drink, no moving around to draw/show the client something, and the therapist is not required to walk the client out. Therefore, the level of incidental activity and micro breaks during the session are decreased. This incidental activity can reduce fatigue, and the loss of this because of telehealth likely increases the level of fatigue felt. For those of us that have time taken up by multidisciplinary team and other meetings, there is also less walking between these meeting and less social banter with our colleagues as we do not have to move from our seats to attend the next meeting. This further impacts our levels of fatigue.

In addition to less activity, we tend to have more meetings. Each meeting is often scheduled in advance as it is harder to 'pop in' to a colleague's office over Zoom. The increased number of meetings can often feel psychologically challenging as our calendars suddenly seem overbooked and it is hard to find a space anywhere. These meetings have also decreased social contact as we tend to chat less over Zoom; nor do we have the social rituals of grabbing a coffee, which helps buffer the stressors associated with our work.

In the Zoom sessions we also behave differently. For starters, we are drawn to images of ourselves and so cannot help but notice our own appearance and behaviour. Once we attend to a perceived flaw or idiosyncratic behaviour, we cannot help being drawn back to this and engaging in re-checking behaviour. The attention placed on appearance and behaviour divides the attention placed on the meeting or consultation, which then requires further concentration to be engaged. This is an exhausting process as we continue to observe and judge our own behaviour while maintaining our professional behaviour—another new demand on our time. And this behaviour may not cease when the call has ended. Telehealth consultations for appearance medicine are reported to have increased significantly over lockdown and this was reported to be linked to spending hours viewing our appearance online (Duffy, 2020).

Our social cued behaviour is also different during telehealth calls. In order to compensate for the two-dimensional nature of the call, we tend to engage in bigger emotional expressions to convey empathy and build engagement. As our clients may not do the same, we tend to need to concentrate more in order to capture the subtle nuances that are harder to detect online, particularly as we do not have access to other non-verbal cues. Face-to-face interactions have also been shown to lead to greater activations of the reward pathways in the brain when compared with two dimensional recordings. So not only are we concentrating more, we are receiving less reward for it (Redcay et al., 2010).

In Zoom meetings, we also do not have the luxury of having side conversations like we do in face-to-face meetings. These side conversations are good for checking understanding and ideas before sharing. Yes, we can do this in the chat function, but it does not have the spontaneity nor the depth of conversation that we do face-to-face, thereby potentially limiting our creative engagement in content leading to feeling less energised.

There is robust evidence to indicate that eye contact is important and one of the key behaviours required to build connection and rapport. Good eye contact can lead to better recall of faces Mason et al., 2004) and faster and more intuitive responses (Von Grünau & Anston, 1995), and can make us seem more likeable, attractive and confident (Nurmsoo et al., 2012). To convey engagement online, we tend to use sustained eye contact to show that we are listening. This is particularly important for our clients who cannot see our behaviour and language below the range of the camera, as when we look down to write notes it may appear that we are not listening or that we are engaging in other behaviours that may lead to us appearing disinterested. For example, looking down to write notes cannot be differentiated from looking down to send a text message. For this reason, we often compensate by engaging in constant gaze behaviour, which can be exhausting but can also be perceived as threatening to our clients (particularly those from non-Western cultures).

This need for constant gaze to convey engagement and capture subtleties in behaviour becomes problematic when there is more than one person on the screen. Multiple windows continuously draw our attention to the people and stimuli in these meetings so that we are engaging in continuous scanning behaviour and continuous partial attention. This means that we may struggle to be as engaged in conversations and to recall the details of whom we have spoken to. This continuous scanning can be made worse by moving and changing backgrounds which continually capture our attention rather than the content of the interactions or the person/people that we are speaking to. Likewise, we engage in less mutual gaze and the relations that we form are less strong, meaning we have to work harder to maintain engagement and relationships.

Finally, as we develop and grow, we have learned to engage in effective social communication. This process is a dance of carefully timed behaviours such as movements, vocalisations and gestures to communicate with others. Social communication requires the rapid interpretation of and response to these in order to engage in effective conversation. As such, much of our communication is non-verbal and we communication emotional states through this behaviour in a process called synchrony (Hoehl et al., 2021). This means that when we communicate, it is really face-to-body, rather than face-to-face. When there is a delay introduced to this system and we do not have access to as many non-verbal cues, our brain works harder to overcome this to ensure effective communication, which creates fatigue (Wiederhold, 2020). Telehealth consults introduce this delay which may explain why you may have had more experiences in telehealth of people interrupting before someone what finished speaking. Additionally, small delays due to technology can impact our perceived friendliness and rapport (Schoenenberg et al., 2014), and also require our brain to work harder to overcome delays that we are rarely aware of.

Simply put, telehealth may seem to be low-reward-high cost for many of us and is not the preferred way to deliver therapy. However, many clients have reported that they found telehealth beneficial, with one study reporting that 82.7% of clients felt that the care they received over telehealth was equivalent to what they would have received face-to-face (Powell et al., 2018). In the same study, 86% of clients reported that it was easier to access care, with over half reporting time savings associated with telehealth and over 40% reporting these savings were more than 3 hours.

The benefit is not just for clients but also for clinicians. Telehealth offers flexibility of sessions that can also be to our advantage. So how do we overcome Zoom fatigue? There are a number of ways that we can help to buffer the effects including:

1) Build in break times and incidental activities during your day. Make sure there are breaks between telehealth sessions and get up and walk around or plan to go for a walk around the block during lunch breaks.
2) Pick up the phone and call a colleague rather than meet over telehealth. This reduces the delay and cognitive demand of visual delays and is much less formal than sending a link and waiting for it to be accepted before calling someone. Alternatively, have walking telephone calls with colleagues if possible. If you do not need to be on a telehealth call, why do so?
3) Set client expectations about behaviour at the start of the call. Explain that you may look away while you are thinking or look down to write notes as you would face-to-face, but this does not mean that you are not paying attention, but simply engaging in normal behaviour that is not captured as readily over telehealth.
4) Be compassionate to yourself. Telehealth is tiring, and we are relearning to do therapy. Remember when you were training that you probably felt an increased cognitive load that you do not feel as an experienced clinician. Adjustment to telehealth will take time, so take steps to support yourself around this.
5) Turn off your self-view on Zoom so that you will not be tempted to check your own behaviour on the screen (although remember that just because you cannot see yourself, does not mean that your client cannot see you!).
6) Consider strategies to maintain boundaries and keep clients engaged online. This could be how to maintain boundaries, how to set expectations, and asking clients to complete activities and share with you online via the whiteboard function or similar. Ensuring that clients are actively engaged will help with your own fatigue.

But finally, let us not forget that Zoom fatigue has really become a focus when many of us are facing extraordinary stressors above and beyond what we would normally have experienced when doing therapy. There would seldom, if ever, be another situation where we would be juggling therapy sessions and meetings while also engaging in simultaneous parenting and home schooling, tolerating the uncertainty of a pandemic, juggling workspaces with loved ones or flatmates, and trying to ensure that we engage in self-care when our traditional manner to do so may not be available. So perhaps the fatigue we feel is not only due to the modality of telehealth but also the recent changes we have had to manage. So, for this reason, I would encourage you not to give up on telehealth as it will likely become easier over time.

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Review of Sleep DownUnder 2019

Reviewed by Kimberly Falconer

In 2019 I was honoured to receive the NZCCP Research Grant. This award enabled me to attend the Sleep DownUnder Conference held in Sydney in October that year. Sleep DownUnder is the annual scientific meeting of the Australasian Sleep Association (ASA) and the Australian and New Zealand Sleep Science Association (ANZSSA). Having worked for the past 3 years as a specialist sleep clinical psychologist, the opportunity to both network and develop my skillset at such a prestigious event was invaluable. The structure of the conference included a full day of pre-conference workshops in speciality areas prior to a full 3-day itinerary of presentations and research summaries, attended by clinical psychologists working in this area and the many, varied medical doctors and specialists associated with sleep medicine. The conference was held at the International Convention Centre in Sydney and featured expert sleep clinicians and scientists from Australia and New Zealand in addition to international speakers who shared the latest advances and innovations in the world of sleep research and clinical practice.

For the pre-conference workshop I was lucky enough to attend the session entitled '*How I do it' – practice tips in sleep medicine*. This provided a thorough overview of the latest research and clinical recommendations regarding working in this field. This was of particular interest to me, given I am increasingly being asked to work with younger populations and comment on best practice treatment for paediatrics in the sleep field. The first presentation by the preeminent Associate Professor Honey Heussler was a deep-dive on behavioural insomnia. This included an intensive overview of what behavioural insomnia is, with respect to paediatric challenges in separation, emotional regulation and the role of genetics. Consideration was also given to sleep hygiene and the effects of the environment (namely, disorder or chaos as measured by the CHAOS scale) on the effectiveness of these interventions. Differential distinction was appropriately given to those children who *will not* sleep, compared to those who *cannot* sleep, with discussion around circadian shift difficulties (causing sleep onset insomnia) and sleep association or early waking difficulties (leading to sleep maintenance insomnia). We also reviewed the main comorbidities within this population, with a specific review of children presenting with feeding issues, chronic pain, obstructive sleep apnoea, respiratory failure and epilepsies. Within a case discussion section, some of the helpful strategies such as red-card strategies, cognitive behavioural therapy for insomnia (CBT-I) (age and cognition-limited), and mindfulness and relaxation were also reviewed. In conclusion, it can be said that sleep problems in this age group are common and complex. Behavioural and cognitive psychological solutions should be first-line, with a recognition that there is a clear interplay between neurocognitive outcomes and sleep. It is possible that sleep might just offer a treatment target and research has confirmed that improving

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sleep can improve neurocognitive outcomes in addition to quality of life measures (for both individuals and their carers).

In addition to behavioural insomnia, the workshop also focused on the excessively sleepy child, with a presentation by Arthur Teng from Sydney Children's Hospital. Causes of this presentation can be diverse, including abnormal sleep hygiene, delayed sleep phase, depression/anxiety, drug implications, sleep disordered breathing, brain lesions, idiopathic hypersomnia and narcolepsy-cataplexy. The latter concern was the focus of our workshop segment, with a good review of the history of paediatric narcolepsy and the recent updates to its diagnostic criteria. We also reviewed the management and treatment aims for this population and some of the key problems when working in this area, including misdiagnosis and key comorbidities (specifically depression).

Supplementary to these presentations were additional overviews on the use of actigraphy in children (by Dr Scott Burgess) and a specific focus on infant sleep, with respect to the underdevelopment of circadian rhythms. As infants do not produce enough melatonin or produce it consistently at night, circadian rhythm only emerges around 2–3 months old when babies become responsive to light and dark cues, as well as feeding and night-time routines. This discussion was supplemented with an in-depth review of electroencephalography patterns in infants both younger than and older than 2 months of age.

Interspersed with a traditional early-morning fun run(!) on the first day of the conference, the rest of the conference continued to deliver outstanding presentations and keynote addresses. Symposia sessions covered a fantastic range of sleep-related issues while simultaneously pulling together experts from all branches of the sleep field ranging from psychologists to medical doctors, sleep scientists and early career researchers. One of the first sessions looked at the treatment of sleep problems in vulnerable paediatric populations such as obesity, premature birth and genetic developmental disorders. This was followed by a symposium looking at the influence of gender on sleep disorders across the lifespan, with a specific focus on hormones, pregnancy and elderly populations. An additional session looked exclusively at perinatal women with a review of recent research on links between sleep and mental health during pregnancy and the postpartum period, and the impact this has on maternal and infant well-being.

Sessions also reviewed the latest research on sleep and cannabis (including the use of medicinal cannabis), and the role of sleep and circadian rhythms in emotion regulation and mood. This was a strong theme throughout the conference this year, as more recent literature has concluded that sleep and the circadian system are fundamental in how we regulate emotions and mood and how we learn to respond to different social situations (i.e., the impact of sleep deprivation on mood and cognitive functioning). There was also a very interesting session on the role of sleep in cognitive impairment and dementia (with recommendations for tailoring continuous positive airway pressure therapy in these groups), and this was nicely paired with a symposium looking at sleep across the generations. Connected to a focus on the role of circadian rhythms, there were some excellent sessions looking at shift work and the implications of jet lag and sleep/wake disturbance in people with mood disorders. This specific focus on the role that circadian timing plays in our sleep health culminated in the very lively and entertaining Annual Sleep Health Foundation Great Debate for the year which was '*In terms of sleep health, the body clock trumps the upper airway*'.

I was thrilled to see such a richness of discussion and research being done in this area as I am certainly seeing an increase in cases related to sleep phase shift disorder in my own practice. While my primary client population continues to be those patients struggling with clinical insomnia (many having experienced this for over 10 years), there is certainly an increase in presenting issues to do with chronobiology and people struggling with the phase shift implications that shift work, jet lag and some modern lifestyles can cause.

It was fantastic to be able to attend this prestigious event and finally connect with my Australian colleagues working in this area. The ongoing support of the insomnia peer supervision groups and ASA membership has been invaluable in supporting my clinical practice and my supervision of other clinicians looking to work in this area. As a follow on from this conference, I was accepted into the Advanced CBT-I training with Dr Michael Perlis at UPenn, in Philadelphia, USA in April 2020. However, because of COVID-19, this was understandably postponed until a later date. I am therefore even more grateful to have attended Sleep DownUnder in Sydney in 2019, as although the experience of international travel and conferences feels a rather distant memory at present, the importance of sleep medicine could not feel more paramount and essential.

Book Reviews

Title:	***The Origins of You. How Childhood Shapes Later Life***
Author:	Belsky, J., Caspi, A., Moffitt, T., & Poulton, R.
Publisher:	Harvard University Press, 2020
Reviewer:	Peter Stanley

The Origins of You is a 'big' book for at least four reasons. Firstly, it addresses the central question of human development: why are we the way we are and different from others? Secondly, it attempts to answer this question using evidence from major longitudinal studies in New Zealand, Great Britain and the United States. Thirdly, each of the four authors is an international figure in human development. The fourth reason has to do with the richness and span of the ideas in this volume. Numerous developmental topics are touched on in this 400-page book, with particular discussions of causality and research considerations, and extensive examination of genetic and biological contributions to development and ageing. Of special interest to postgraduate students and other readers may be the relevance of the reported research to different populations and times. Belsky et al. say that the findings are generally applicable to other WEIRD places (an unfortunate acronym for white, educated, industrialised, rich, and democratic societies) and they may have a wider application.

It has been said that the books that everybody admires are those that nobody reads. We know from the dust jacket of the present text that it is highly regarded by psychology luminaries like Dante Cicchetti, Laurence Steinberg, and David P. Farrington among others. In the circumstances, I am concerned that the corollary of the aphorism also applies that *The Origins of You* actually receives a restricted readership, and so some of the important lessons of the book are listed below. Note, as Belksy et al. frequently reiterate, human development involves the mind and the body, is contextual and affected by multiple factors and forces, and is probabilistic rather than deterministic.

- Temperament at 3 years of age can predict later personality, and especially for those individuals who move away from the world and for those who move against the world. Being inhibited at the outset may mean less friends later and being stroppy near the start can lead to subsequent negativity and risk taking.
- Self-control shows continuity, and it is equivalent in its predictive power to IQ and childhood social class. Serious missteps in adolescence can mediate poorer self-control in

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childhood with poorer outcomes in adulthood.

- Attention deficit hyperactivity disorder (ADHD). Most parents later forget that their child once had ADHD. Some people are diagnosed in adulthood with ADHD for the first time. There is no neurodevelopmental evidence of continuity of ADHD from child to adult.
- Intergenerational transmission of parenting. The experiences that girls have growing up are very important for the next generation; the good stuff that they get is what they pass on.
- The Dunedin Multidisciplinary Health and Development Study largely confirms Moffitt's distinction of life-course-persistent and adolescent-limited antisocial behaviour, with the difference that in adulthood, many in the second group had health and financial problems and continued to abuse drugs.
- Girls mature earlier when they grow up in father-absent and in high-conflict, families; and hastened pubertal development predicts sexual behaviour at a number of subsequent age points. A girl who develops early is likely to be at greater risk for delinquency if she attends a co-educational, rather than single-sex, secondary school.
- Day care. The 'good news' is that quality care can promote linguistic and cognitive development, and the 'bad news' is that there is a graded dose association between hours in childcare and risks for teenage psychopathology. Both effects are modest.
- Neighbourhood. Not all deprived communities are the same, but a low socioeconomic status (SES) locality can impact on parenting and is a determinant of antisocial behaviour. Interestingly, low SES neighbourhoods are less conducive to antisocial behaviour in boys than are pepper-potted suburbs.
- Bullying can elicit longer-term adverse effects, including emotional problems and self-harming behaviours, and it can contribute to being overweight. A 'dual-risk' condition exists for some children when they are bullied by peers and unsupported by parents.
- Cannabis. Early use contributes to schizophrenia-related outcomes. Heavy use increases the probability of IQ loss, downward social mobility, money troubles, problems at work and relationship issues.
- Genetics of tobacco smoking. There is a limited polygenic risk for smoking. Higher risk scores were related to becoming a daily smoker, and quickly moving to a pack a day, in adolescence.
- Genetics of life success. There are genes associated with educational attainment, and genes contribute in other ways to personal accomplishments. While there is a lot of variation left for other factors, life does seem to be unfair 'because none of us gets to choose our parents, yet genes inherited from them give some of us more of a head start in life than others' (p. 267).
- Genetics and violence. Work with a single candidate gene shows that some adult males are prone to violence if maltreated as children. A genetic and an environmental risk condition need to happen together, but genetically-liable individuals who receive positive parenting actually score lower than others on antisocial outcomes.
- Genetics and depression. A gene–environment interaction was found for stressful life events and depression for some people. But rather than thinking of the gene(s) for a particular pathology, it is probably preferable to see them as representing a susceptibility to potential environmental influences both good and bad.
- Victimisation and epigenetics. Cumulative exposure to adversity across childhood and adolescence is a clear predictor of psychopathology at age 18 years but this effect does not appear to be associated with genetic change. Further research may prove otherwise, but this study does raise skepticism about developmental adversity and DNA functioning.

- Physical health costs in adulthood can be incurred by a disadvantaged childhood. At age 26 years there was a dose-response relationship of health with social-class origin, and at 32 years a sustained low-SES beginning doubled the risk for cardiovascular disease. Counting 'adverse childhood experiences' retrospectively is not a certain assessment method because some will be missed and others imagined.
- The biological mechanisms of deteriorating physical health are likely to be increased inflammation, stress physiology and telomere erosion. By these and other biological processes, childhood adversity could move inside the body to take its toll at midlife.
- Physical ageing can occur at different rates to chronological ageing, and this is shown in biomarkers as well as in how we appear to others. Among 38-year-olds, most participants had a biological age of 35–40 years, but there were small numbers of people who were physically under 30 years or over 45 years.

These research 'headlines', each of which attempts to represent a chapter in the book, have all manner of implications for psychological (and biological) interventions and treatments. Nevertheless, in the text's final chapter, Belsky et al. express hesitancy about the social policy applications of their findings. They make the point that rarely is there a direct link from evidence to practice and policy. They also contend that while investigators may have additional expertise and insights, other people's beliefs and values are important in what is done; and so are other sources of information (such as economics, philosophy and history). However, maybe it depends on the sort of problem a society is confronting as well, and whether it is accepted that science should have a leadership role with respect to social issues. Certainly, in dealing with COVID-19 in this country, the Ministry of Health has relied on data for decision-making and medical specialists have been consulted on a daily basis. *The Origins of You* is avowedly empirical, and it delights in its scientific detachment, but perhaps there was also a place for some contextualisation of the present book to the current human development conversations in New Zealand; and not least because the reported research is mostly concerned with the Dunedin Longitudinal Study. For example, there might have been an endorsement of science in public debates to provide analysis alongside prevailing discourses and narratives. Matters of daily concern in our community do have some precedence and, as the authors say in relation to their studies, the special contribution of the scientific approach is that the evidential chips will fall where they may.

Title: ***Irreversible Damage: Teenage Girls and the Transgender Craze***
Author: Shrier, A.
Publisher: Swift, 2020
Reviewer: Peter Stanley

Irreversible Damage comes well recommended as it has been both applauded and lambasted by international commentators. Given the seriousness and topicality of the subject matter, it is appropriate that this author's viewpoint be heard. Shrier is concerned by the extraordinary rise in adolescent females in America who are identifying as transgender and who are seeking sex-change hormones and surgeries. For example, between 2016 and 2017, the number of gender surgeries for females in the US quadrupled, and females represented 70% of all such surgeries. Until recently, a very small number of boys were diagnosed with gender dysphoria (or gender identity disorder); and overall 70% of patients with early diagnoses who were not affirmed and who did not socially transition ultimately left their dysphoria behind them. It is the author's contention that teenage transgenderism is largely a popular craze that can be to the long-lasting detriment of those girls and young women that it consumes. Shrier also argues that many adults and institutions are complicit in this popular movement, which has far-reaching societal developments and consequences as well as harmful personal outcomes.

Social media is a special target for Shrier, and she asserts that the introduction of the iPhone in 2007 has proved spectacularly bad for mental health. The least of it is that social media is 'humanity's most colossal distraction' and 'an endless ledger of wasted time' (p. 203). Meanwhile, this 'hideous public diary' also mocks girls in particular by parading an endless succession of unobtainable beauty and success. For the average young women, failure is on her phone and in her pocket. But just as there are standards that can never be reached, there also exist warmly welcoming communities that offer alternative spaces for every teenager who does not feel completely comfortable with her body. Over a dozen of these online forums assist in the discovery of a trans persona, and the cleverly customised ways of the Internet mean that this beckoning lamp will burn brightly from the moment it is lit. Invariably, online immersion is a prelude for those who transition.

Shrier describes the transgender influencers who inhabit the online home sites, and who are evidently highly attractive to many teenage girls. The author also enumerates the standard mantras that these trans gurus espouse. First up, self-knowledge is central ('If you think you might be trans, you are'), and being trans is a choice and cause to celebrate. Next, you need to know that there are people (like parents) who will oppose your transition, and this is unspeakably cruel and toxic because they are putting your life at risk. And then there are the means of transition, which typically begin with breast binders, lead onto testosterone, and could involve 'top surgery' (or double mastectomy) and more. The dangers and detractions accompanying these procedures are quickly dealt to, and any deceit of parents or healthcare providers is considered justified in the attempt to change from female to male. From the outset, the natal female receives enthusiastic support from strangers ('love bombing'; e.g., 'You're so brave'). But equally, any questioning of fundamental beliefs will likely be construed as 'hateful conduct' and result in shaming and cancelling.

The incidence of teenage transgender is highest in friendship clusters, and high schools also unswervingly support diverse sexual identities. But then so too do many primary schools in the US, where even young students can be asked to publicly locate themselves on a gender spectrum, and where there is seemingly continuous feting of 'LGBTQ'. Shrier identifies other ways that affirmative processes operate in schools and somewhat ironically, they often involve instruction in gender stereotypes. Inevitably, gender teams assemble within the student body, and while these can provide support and protection, they may solidify a premature sexual identity as well. Indeed, the need for protection is given such a priority that parents can be surprised to learn that the school has been referring to their daughter as 'him' and calling the child by a male name for some time. Trans young people are vulnerable to being bullied and marginalised, but the author believes that the response of schools is so disproportionate that it has to be a pretext for indoctrination in gender ideology. Certainly, the fact that 12-year-olds in California are able to obtain testosterone without parental consent strongly suggests that some strong policy motivations can operate in this arena. Shrier concludes that with their safe spaces and other provisions, schools are 'greasing the skids' for trans kids, and the actions that they take are 'framed with moral superiority [and] insulated with civil rights' (p. 70–71).

Shrier interviewed nearly 200 people and 48 families in her research for *Irreversible Damage,* and she discerned familial trends. Girls wanting to be boys more often appeared to live in white, affluent and politically progressive families where the parents tended to present as excessively attentive and caring. There is a hypersensitivity to feelings, and these may be relatively speedily codified as symptoms. The problem in these circumstances, the author suggests, is that a teenager has nothing to push against to achieve her own personal identity. Moreover, the parents comply when the daughter has a transgender epiphany and demands to be recognised as a son. Many parents facilitate the transition because of threats of cutting or suicide, and it is a fact that self-harm is disturbingly high in the trans community. Nonetheless, Shrier's thesis that becoming transgender is inseparable from adolescent rebellion garners support from the 'edginess' that can be reported with these teens, and from the completeness of their demands ('You don't want your child to hang "himself" in the garage just because you accidentally referred to her as "Rebecca"' p. 104). In addition, trans adolescents may 'topple the board' again by pursuing other sexual identities, and nothing that they do seems to bring them happiness. It is not surprising perhaps that some parents describe the 'mind-bending' discovery of having a transgender daughter as similar to a death; while the transition process itself might appear as if a 'wrecking ball' has been taken to their family.

Transgender young people tend to occupy echo chambers provided by the Internet, peers, schools and parents, and healthcare professionals are frequently mandated to be encouraging as well. The stipulated medical standard is 'affirmative care', which seems to exclude any real challenge to the patient's (supposedly) self-selected new identity; any such challenge is likely to be interpreted as 'conversion therapy'. A particular understanding of informed consent underpins the affirmative healthcare response and in this context, informed consent means that a girl is insistent that s/he is a boy. This stance on patient self-determination may be thought to absolve the healthcare provider of responsibility for their actions but it is contrary to other understandings that have developed over time, regarding the protections that should be afforded to minors.

Actually, *Irreversible Damage* provides a catalogue of objections to what is currently being done in healthcare in the name of 'best practice'. This starts with the presumptive stance of the therapist and extends to the collusion that they enter into around a preferred explanation that may, or may not, account for the young person's distress. Then there is the question of the immutability of the chosen identity, which cannot be lightly dismissed, as puberty blockers, testosterone and surgeries all have psychosocial implications (in addition to short-term and unknown long-term physical effects), and the changes that occur with both social transition and medical transition are hard to walk away from. Shrier says that the trans community is beset with depression, drug abuse and other problems, and affirms that every patient deserves sympathy, respect and appropriate treatment (which could include medical transition). Finally, the author relays the concerns of independent medical authorities who believe that the present preoccupation with affirmative therapy 'is either a terrible dereliction of duty' or 'a political agenda disguised as help' (p. 127).

In conclusion, Shrier contends that the current contagion of girls wanting to boys is representative of the frailty of American society. The multiple shifts, rifts and reversals that now exist in the larger community deny any meaningful conversation, and those with a contrary view are invariably harassed and hounded for being hurtful and hateful. As with some other identity causes, gender activists have recast the genuine struggles of a small minority as a major rights crusade to assault and to convert established professions and other social institutions. The fate of the American family is the most pernicious and poignant outcome with dedicated parents desperately trying to participate in the new language game (transgender, transsexual or genderqueen?) while their hard-bitten daughters, and society at large, increasingly regard them as 'obstacles, bigots, and dupes' (p. xxiv). Meanwhile, the valuation of womanhood in the US is itself under severe attack as biological uniqueness is denied, and since female to male changes are clearly the preferred destiny for many young women. In this ferment, therapism and selective expertise continue to rise, notions of what constitutes 'bullying' and personal 'safety' are forever expanding, and the primacy of feelings over facts is increasingly triumphant. *Irreversible Damage* asks whether there is not a place for some hesitancy and humility here, and not least because it is impossible to predict personal futures with certainty. But perhaps there is no way back for those adults who have promised girls and young women a metamorphosis because what has actually been done to them is too awful for these adults to contemplate.

NZCCP

National Education Training Timetable

The NZ College of Clinical Psychologists aims to encourage and facilitate continuing education opportunities for members, by providing nationally coordinated events to a high standard. Our goal is to coordinate training opportunities between branches with the goal of facilitating training in all regions. Please **consult the College website** for further information and links (http://www.nzccp.co.nz/events/event-calendar/)

TRAINING TIMETABLE

NZCCP Events

LOCATION	MONTH	PRESENTER/ CONTENT
Christchurch	25 March 2021	NZCCP preconference workshop, *"He Puna Whakaata"*
Christchurch	26 March 2021	NZCCP preconference workshop, ACT Skills Intensive: An Intermediate/Advanced Workshop to enhance your clinical practice
Christchurch	27-28 March 2021	NZCCP 31st National Conference "Tui, tui, tui, tuia"
Nelson	8 April	Perspectives in Forensic Psychology risk, interface and practice

Other Events

LOCATION	MONTH	PRESENTER/ CONTENT
Webinars	Various	DBTNZ webinar training series
Webinars	Various	NZSIGN Monthly Neuropsychology Webinar Series
Online training	Various	Foundations in Suicide Prevention All New Online Training
Various	Various	EMDR Institute Trainings
Auckland	26-28 March	Hold Me Tight Couples workshop (EFT)
Wellington	6-7 May	ACT & Exposure Response Prevention for OCD
Christchurch	31 May-1 June	Introduction to Acceptance and Commitment Therapy
Webinar	17-18 June	Use of Adapted Dialectical Behaviour Therapy Coping Skills for Cognitively Impaired Clients with Challenging/Offending Behaviours
Auckland	9 August	ACT for Chronic Pain
Auckland	7-8 September	Treating PTSD, Dr Leah Giarratano
Auckland	9-10 September	Treating Complex Trauma, Dr Leah Giarratano
Wellington	1-2 November	Introduction to Acceptance and Commitment Therapy