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The New Zealand College of Clinical Psychologists
PO Box 24088 Wellington New Zealand
Phone 64-4-801 6088
Email: office@nzccp.co.nz, www.nzccp.co.nz

The Specialist Organisation for Clinical Psychologists

"New Beginnings and looking forward"
He ao kei tua o te awe māpara
A new world awaits us on the horizon
"*Experiences and Learnings from the COVID-19 Pandemic".*
I te ao, i te pō, he akoranga, he akoranga.
Day in, day out, there's always learning to be gained.

Editorial

Dear Colleagues

It seems that 2020 has been the year of change worldwide. COVID-19 has brought changes to how we view safety in our world, how we practice as clinicians and what we now consider normal. Some of these changes are ushering in a new acceptance of and comfort with technology, which has been required for many of us to continue to work as psychologists during our nationwide shutdown. This theme is reflected in this issue, which includes articles on the development of podcasts to support the well-being of clinicians during the lockdown, a new way of delivering a pain management programme, several reflections on the implications of using technology for the therapeutic relationship and a call for a robust digital technology implementation strategy for Aotearoa New Zealand.

These are interesting times for all of us, and no doubt while welcomed by some, some of us are grieving for how things have always been. We hope that the articles included in this issue may aid reflection and consideration of the issues that we are likely to continue to face in our ever-evolving practice.

Another change that we want to acknowledge is that handing over of the editorial mantel from Kumari to the current editors. Kumari (along with Caroline) has been the backbone of the journal and it is a real loss to see her go. We have valued Kumari's wisdom guidance in the handover, and welcome any future feedback from our readers to continue to shape the journal into an interesting, informative and reflective read.

We hope you enjoy this issue and look forward to hearing from you.

Liesje & Wade

Ka mua, ka muri; Walking Backwards Into the Future

Paul Skirrow

The theme of this issue of the Journal is 'New Beginnings and Looking Forward,' but in the context of the COVID-19 pandemic, the future seems somewhat difficult for any of us to predict. There is a strong feeling that the world will not be the same for quite some time to come—if, dare I say it, ever. Some of our relatives, some of our friends, and countless thousands we will never meet are no longer with us. Many New Zealanders will be facing a future of significant hardship, including loss of jobs, businesses and perhaps even their homes. So how can clinical psychologists contribute to the recovery—both emotional and economic—of New Zealand?

Clinical Psychology: Walking Backwards Into the Future

The traditional whakataukī '*Ka mua, ka muri'* is typically translated as '*walking backwards into the future',* with the implication that we should look to the past to inform our future (Rangiwai, 2018)[1]. An earlier edition of the Weschler Adult Intelligence Scale included the question 'Why is it important to study history?' The implication being that intelligent people understand the importance of learning from their history, and the goals, patterns and mistakes of those who came before us. For this reason, I am always surprised how few clinical psychologists I have met (and taught) know the history of clinical psychology and where terms like 'scientist-practitioner' originally came from. I often wonder how we can truly understand where we are going, if we do not understand where we have come from.

Genesis of Clinical Psychology

Most authors attribute the 'birth' of clinical psychology as a profession to Lightner Witmer, who opened the first psychological clinic in Pennsylvania in 1896[2], with the intention of treating children with intellectual disabilities. Witmer (whose life and works are summarized in McReynolds, 1997) founded *The Psychological Clinic* journal in 1907 in which he published an article entitled *Clinical Psychology*. Witmer defined clinical psychology as 'the study of individuals, by observation or experimentation, with the intention of promoting change'. His description of the profession from 1907 has a remarkably modern ring to it:

> While the field of clinical psychology is to some extent occupied by the physician, especially by the psychiatrist, and while I expect to rely in a great measure upon the educator and social worker for the more important contributions to this branch of psychology, it is nevertheless true that none of these has quite the training necessary for this kind of work. (Witmer, 1907; pp7)

Psychological clinics slowly grew in number across North America in the early 1900s, with a particular focus on supporting children with intellectual disabilities. Witmer gained increasing influence with the professional associations of the time (MacReynolds, 1997).

Paul Skirrow recently joined the Department of Psychological Medicine at the University of Otago in Wellington as a senior lecturer, after spending 5 years as Professional Leader for Psychology in the Wellington 3DHBs. Paul trained as a clinical psychologist in the UK in 2004 and completed further training in clinical neuropsychology in 2010, before moving to New Zealand in 2012. Currently, Paul's research, teaching and clinical work are mainly in fields of clinical neuropsychology, neurorehabilitation and psychological aspects of physical health conditions. You can contact Paul via email at paul.skirrow@otago.ac.nz

[1] I wish to acknowledge that this wisdom has, in itself, come to us from the tangata whenua of Aotearoa and thank my Māori colleagues for sharing this with me.

[2] The far more famous Sigmund Freud is also thought to have fathered the term 'psychoanalysis' around 1896.

War, Soldiers and Veterans

When war broke out in Europe in 1914, clinical psychologists were drafted to be part of the US war effort, developing and conducting psychometric testing for the American military (developing the 'Army Alpha' and 'Army Beta' tests). The US military remained a significant employer of clinical psychologists for many years. As a result, psychometric testing remained a significant focus of clinical psychology for at least the next 25 years (arguably, to this day).

Later, particularly following the end of the Second World War (1939–45), there was an increasing military focus upon the treatment of returning troops diagnosed with 'shell shock' (i.e. post traumatic stress disorder) and growing hunger for the development of psychological *treatments*. In the post-war years, the focus on the long-term health of returning war veterans led in part to the development of socialised healthcare in Britain (i.e., the National Health Service [NHS], although New Zealand led the world in socialised healthcare with the Social Security Act in 1938) and a significant investment in training programmes for clinical psychologists in the US. In these new contexts, psychological treatments began to thrive. While psychoanalysis remained a dominant force, particularly in psychiatry, Witmer deliberately chose the term 'clinical' to imply a strong basis in scientific methods, which was often at odds with traditional psychoanalytic schools of thought, which were more strongly allied with schools of philosophy (MacReynolds, 1997).

Such was the rise in clinical psychology training programmes in the US that the profession felt a strong need to standardise the approach to training. At the 1949 conference on Graduate Education in Clinical Psychology (the 'Boulder' conference), the (now ubiquitous) 'scientist/practitioner' model previously championed by David Shakow was adopted by all US training programmes. This laid the foundation for modern training programmes in clinical psychology (see Baker & Benjamin, 2000).

In the post-war years, there was a proliferation of new forms of psychological therapy on which clinical psychologists could draw. While schools of psychoanalytic thought diversified, these were followed by humanistic (e.g. Carl Rogers, 1951) and radical behaviourist approaches, based on Skinner's (1953) paradigm. Although exciting in many ways, the ensuing 20–30 years led to increasing acrimony and division between schools of psychological thought (much of which continues to this day).

> Freud insisted his treatments were proper; those of Adler, Jung, and his other one-time disciples were flawed. The behaviorists held the Freudians in low regard and considered them fabricators of unscientific mentalistic constructs. The humanists thought that Freudians and behaviorists took pessimistic or mechanistic views of human development and found hope in the self-actualizing nature of humans. (Wampold & Imel, 2015; pp33)

The Move to Evidence-Based Medicine and Empirically Supported Therapies

By the 1980s, there was an increasing focus in medicine (and therefore healthcare in general) on the use of randomised controlled trials to evaluate the efficacy of treatments, which was initially mandated by the US Food and Drug Administration in 1980 (Wampold & Imel, 2015). As a result, the standardisation (or manualisation) of therapies was increasingly common. With insurers (particularly in the US) increasingly funding only 'empirically supported therapies' for specified 'disorders' (such as those described in the Diagnostic and Statistical Manual of Mental Disorders), clinical psychology arguably became increasingly 'reductionist' in its focus in order to maintain its currency (Wampold & Imel, 2015). Certainly, psychological therapies lent themselves well to standardisation and evaluation. In particular, cognitive behavioural therapy experienced a

boom in research and clinical interest that prevails to this day, with others (such as dynamic psychotherapy and humanistic therapies) becoming increasingly marginalised.

Healthcare Reform in the UK

By the turn of the millennium, the UK government implemented a major pay restructure in the NHS ('Agenda for Change'), which placed significantly increased emphasis on the role of psychologists as managers and service leaders within the new pay banding. In order to progress within public services, psychologists were expected to expand their role beyond their own clinical practice towards a wider influence in, and leadership of, services. Power, traditionally centred with medical practitioners, was seen to be significantly shifting towards service managers. The UK profession adapted accordingly, with an increased focus on 'new ways of working' for psychologists and their role across the whole of the NHS sector (Onyet, 2007). Certainly over the past 20 years, there has been a notable trend of clinical psychologists taking senior leadership and management roles within the NHS and the private-sector. Although this pattern appears to have been less pronounced in New Zealand, a similar desire for psychologists to take on 'powerful' leadership roles in the health sector remains a regular theme of discussions within the College to this day.

Development of Primary Therapies and the 'Fallout' of Empirically Supported Therapies

With the influence of empirically supported therapies still a strong force, the UK government launched an ambitious programme in 2008 focused on 'Improving Access to Psychological Therapies' (IAPT) for working-age adults, based primarily on delivering cognitive behavioural therapy in primary care settings (see Layard & Clark, 2014). Notably, a similar pilot project for adults aged 18–25 years, named '**Piki**', has been running in the Wellington region since early 2019.

Given that there were not enough clinical psychologists to deliver the ambitious IAPT programme of therapy delivery across the UK, the government instead turned to training a new workforce of 'psychological well-being practitioners' (PWPs) and 'high-intensity' therapists across the UK (see Layard & Clark, 2014). Trained primarily in the manualised approaches developed by psychologists, their inception was far from universally welcomed by clinical psychologists, many of whom felt that they were being replaced with less well-trained workers (see Carter, 2016). However, the feared reduction in demand for clinical psychologists ultimately failed to materialise, with psychologists remaining in demand for leadership, governance and supervision of workers in IAPT programmes, but also increasingly taking on roles outside of primary care including, but not limited to, a significant growth in clinical *health* psychology in the UK.

Ka Mua, Ka Muri; Walking Backwards Into the Future

So, what does our history tell us about the likely future of clinical psychology in the post-lockdown world? The changes to the practice and focus of the profession over the last 120 years have been enormous; new therapies and approaches continue to proliferate and the areas in which clinical psychologists find themselves working continue to expand exponentially. Clearly though, the changes in the form and focus of clinical psychology were far from random. The changes we have seen in the focus of the profession appear to be entirely adaptive in ensuring the survival (indeed, flourishing) of the profession as a whole.

> It [the history of the profession] can be summed up as the quest of clinical psychology to align itself with what it saw, and sees, as the ruling discourse of the times, whether 'scientific', professional (therapeutic) or managerial… It is no doubt understandable – even necessary – that clinical psychology should always have kept a vigilant eye on the source of its bread and butter, which in practice has meant serving, or at the very least appearing to serve, the powers it identified as essential to its survival. (Diamond et al, 2011; pp32)

Clinical psychology, in the form envisioned by Witmer in the early 1900s, appears to be enormously adaptable to the current circumstances of the day. Witmer himself was at pains to emphasise that the term 'clinical', which he borrowed from medicine, did not imply a medical or hospital-based psychology, noting that 'the term "clinical" implies a method, and not a locality' (1907; pp8). While the locations, methods and mediums for our practice can change significantly, we remain 'clinical' psychologists, which is perhaps where our ultimate strengths lie.

Whatever the challenges faced by New Zealanders post-COVID-19, it seems likely that clinical psychology will adapt, and flourish and contribute significantly to our emotional and economic recovery, as long as we continue to stick to the foundations and values of our predecessors. To follow the traditional whakataukī used at the start of the article, it is perhaps worth quoting another which has been shared with me by my Māori colleagues. *Toku toa, he toa rangatira*: My bravery is inherited, from the chiefs who were my forebears.

References

Baker, D. B. & Benjamin, L. T. (2000). The affirmation of the scientist-practitioner: A look back at Boulder. *American Psychologist, 55*(2), 241–247.

Carter, K. (2016). Is IAPT damaging clinical psychology? Letter to the Editor. *The Psychologist*, *29*, 82–91.

Diamond, B., Cromby, J., Kelly, P., Moloney, P., Priest, P., Smail, D., & Soffe-Caswell, J. (2011). Response of the Midlands Psychology Group to Hassall and Clements. *Clinical Psychology Forum (Special issue: Clinical psychology getting lost)*, *217,* 32–34.

Layard, R. & Clark, D. M. (2014). *Thrive: The power of evidence-based psychological therapies.* Allen Lane.

McReyolds, P. (1997). *Lightner Witmer: His life and times.* American Psychological Association.

Onyet, S. (2007). *New ways of working for applied psychologists in health and social care working psychologically in teams.* British Psychological Society.

Rangiwai, B. (2018) Ka mua, ka muri: A new transformative leadership theory based on a prophecy by Te Kooti Arikirangi Te Turuki. Te Kaharoa, vol. 11, 2018.

Rogers, C. (1951). *Client-centred therapy: Its current practice, implications and theory.* Houghton-Mifflin.

Skinner, B. F. (1953). *Science and human behavior (1st ed.).* MacMillan.

Wampold, B. E. & Imel, Z. E. (2015). *The great psychotherapy debate. The evidence for what makes psychotherapy work.* Routledge.

Witmer, L. (1907). Clinical psychology. *The Psychological Clinic, 1*, 1–9.

Online Therapy: A New Dimension to Transference and Countertransference

Jillian Butterworth

I found an article by Nancy McWilliams dated 5 April 2020 entitled *Psychotherapy in a Pandemic* on a LinkedIn page with the comment 'the best thing I have read about therapy and Covid-19'. And it was the best thing, not only because Nancy McWilliams is an intellectual goddess, but also because there is a dearth of writing on the topic. Clients and potential clients are encouraged by online adverts stating how easy virtual psychotherapy is and listing all the benefits. Colleagues whisper how they hope that online therapy will remain. Not me.

McWilliams talks about how demanding online therapy is, and this is a response shared by many therapists. She mentions the positives and having a glimpse into clients' real lives. She hints at a crossing of boundaries and reports that 'the coronavirus has made my work feel more conversational, more intimate, more revealing of the realistic interdependencies between me and my patients'. Unfortunately, I am not as articulate as McWilliams, but that beautiful sentence resonates deeply with me as I see a blurring of my own professional boundaries. The frame is missing and the picture does not know where to end.

I have concerns about telepsychology and online psychology. Many are my own issues and I hold that I am old fashioned, over-reliant on my other senses and my presence, and can almost 'feel' depression, psychosis or borderline. This sixth sense is suppressed online. But some of my concerns are outside of me.

I have coined a term in my internal psychological encyclopaedia, which as therapists, we are forever expanding and will, in all probability, die with. It is called 'technology-induced transference and countertransference'. I have not really thought about definitions as yet. Those will follow as I develop the construct. Or will remain primitive internal fragments. It does not matter. What does matter is whether we will turn to our psychodynamic forefathers in order to understand the impact of technology on our therapeutic relationships. I hope so, but worry about a bastardisation of terms and a moulding of terms to suit us as therapists.

In psychotherapy, we must distinguish between client-induced countertransference and therapist-induced countertransference. This is important so that we are not conveniently projecting on to our clients and then easily masking our projections as 'countertransference' purely induced by the client. Or obliviously identifying with their projections. But I am not saying anything new. We know this. I think what we do not know about is technology-induced transference and countertransference. For one, we know that this new countertransference involves exhaustion as reported by many online therapists. This is not due to the client or the therapist (hopefully), but to the technology. Therefore, if we are to use this way of doing therapy, we have to have an awareness of this or we could fall into the trap of 'blaming the client'. We also need to educate clients around these normal responses, like we do with erotic transference.

And what about agoraphobia, social phobias and attachment disorders? Is online technology

Jillian Butterworth is a clinical psychologist who has been living in Aotearoa for just over 2 years. This has involved a level of professional re-identification. She trained and practiced in South Africa for 10 years, mostly in private practice but also contracting to NGOs, and government agencies, particularly in the fields of sexual health and sexual trauma. In South Africa, she was the Chairperson of the Southern African Sexual Health Association Western Cape (2013–2017) until leaving for Aotearoa. She was also a research affiliate of the Gender Health and Justice Research Unit at the University of Cape Town, as well as an Editorial Board Member for the African Journal of Primary Health Care & Family Medicine (2015–present). Since coming to this beautiful country in January 2018, she has worked for Corrections and recently gone into part time private work.

encouraging some forms of psychopathology? What about clients with sexual offending or hypersexuality? As I revel in the freedom of no make-up via phone and pyjama pants and my Boston terriers as slippers via Skype, I realise that my clients also have this freedom. And I have no idea what my client is doing during sessions. They choose the angle of the camera, and if there is a camera at all. Teenagers rolling eyes, other people in the room, distractions, clients messaging partners about dinner, hyper- or deviantly-sexed clients softly rubbing their genitals while we do therapy. Is this technology induced transference?

Remaining in the sexual arena, let us use the analogy of erectile dysfunction in men who use pornography, or porn-induced erectile dysfunction (PIED). I have seen 22-year olds with PIED. In essence, what happens is that these men use pornography to a degree that results in difficulties in obtaining an erection with a real-life partner, as their sexual appetite has changed (dare I say been conditioned?). They speak of repulsion from smells and bodily fluids. They also have an idealised idea of what sexual partners should look like, and how they should behave. I worry the same thing will happen to our clients. They will want one dimensional, clean attachment without the smell and feel of real relationships. The connection to others will become flaccid as we attempt to re-parent through screens.

When we self-disclose in therapy, we question the purpose of it. 'Is this for the client?' students and supervisees are constantly asked, and then reminded of the possible perils to self-disclosure. It should be the same with online therapy. 'Is this in the best interest of my client' or is it purely for my benefit? And what are the possible hazards?

Carl Jung used to ask his patients whether they would rather be good or whole. I think we need to hold this question moving forward into an online space. Are we encouraging clients to be whole through this type of connection? Am I being a good therapist or a whole therapist? Or neither?

Relativity in Therapy: AI-Based Therapy without Space and Time Constraints

Che-Wei Hsu

The 2011 Christchurch earthquake, the Christchurch mosque shooting and the COVID-19 pandemic all have something in common—the significant impact of these tragic events on those who have directly suffered from them, and the widespread aftershock on society as a whole. A 'new normal'—known as a dramatic social change—is often established following these traumatic events (Sablonniére, Bourgeols, & Najih, 2013).

From the COVID-19 pandemic, new social etiquette emerged such as social distancing, elbow bumps and foot shakes. These were all foreign behaviours before this pandemic. With respect to social communication, phrases such as 'let's Zoom' or 'Facetime me' are now part of our standard vocabulary. Digital technology has 'softened the blow' of COVID-19 on our social lives; imagine going through a lockdown at a time when messenger pigeons ruled the communication lines! This is not the first time, however, that technology has assisted in human endeavours. Digital technology has been responsible, at least in part, for transforming our lives—we can achieve more with less effort. As we progress deeper into the 21st century, our reliance on technology in the contemporary world has raised some questions: how and what

Che-Wei Hsu is a student at the University of Otago, in the final year in PGDipCIPs and a PhD candidate in psychology (Research: Use of avatars in mental health and eyewitness memory). Che-Wei is from Taiwan and worked as a primary school teacher before moving to Dunedin in 2016 to study clinical psychology.

aspects of human thinking, feelings and behaviours are affected by this advanced technological progression? Empirical evidence has demonstrated that technology may impact people in one or more domains: physical, cognitive, and socioemotional. These domains, either in isolation or in concert, govern the way people think and behave.

Impact of Technology

Physical Domain

The use of technology impacts some physical aspects of our body and mind. The physical domain subsumes the structure and functions of our brain and the physiology of our body. Depending on the cognitive task, exposure to technology may increase activity and modify the structure in one area of the brain but reduce activity and modify the structure in other regions of the brain. For example, Kühn et al. (2011) found that compared with infrequent video game players, brain imaging of frequent gamers showed larger grey matter volume in the left ventral striatum, which is associated with reward processing (for a meta-analysis on reward systems see Palaus et al., 2017). Conversely, James and Engelhardt (2012) found that compared with hand-writing and tracing of letters and shapes, functional magnetic resonance imaging showed lower activity in the inferior frontal gyrus when children typed the letters and shapes on a computer keyboard. Based on their results, James and Engelhardt suggested that typing letters and shapes may hinder children's ability to recognise and categorise symbols due to the rigid and structured nature of these methods in producing shapes.

Technology not only influences brain structure and functionality, but may also affect our body's physiology. Vegad and colleagues (2015) investigated the effects of the presence of cellular phones on participants' heart rate variability. They showed that compared with when their cellular phone was switched off, participants showed an increase in sympathetic activity and a decrease in parasympathetic activity while completing a task when their cell phone was switched on. The neurological and physiological changes that are linked to the use of digital technology may have long-term implications; that is, prolonged exposure to technology may modify the structure of our brain and body. Whether these changes are an enhancement or a detriment to the physical domain is debatable, but it appears that we are evolving to adapt to the modern technological environment.

Cognitive Domain

Alterations to our brain and body may have ramifications on our cognition. Cognition—the way we process and perform mental tasks—includes knowledge and language acquisition, memory, attention and the use of strategies to solve problems. Researchers have shown that technology influences the way we acquire and utilise many of our cognitive abilities, for better and for worse. For example, Mueller and Oppenheimer (2014) investigated the effects of note-taking on laptops and students' learning. They showed that compared with participants who took hand-written notes during a lecture, those who typed their notes on a laptop recalled less from the lecture, even when they were allowed to review their notes after the lectures. More participants who typed their notes on a laptop had notes copied verbatim than did participants who wrote their notes. Based on these results, those researchers concluded that students who used laptops regurgitated lecture information rather than processing and reframing the material.

In contrast, Giacomo, Ranieri and Lacasa (2017) examined the cognitive performance of children who were frequent video gamers. They demonstrated that children who were frequent video gamers performed better than infrequent gamers on tasks that required visuospatial and verbal abilities. However, it was impossible to infer a causal relationship between the time spent on gaming and children's cognitive development from these correlational data alone. For

example, it is possible that gaming has an impact on children's cognitive development. Still, it is equally possible that individual differences in cognitive abilities motivate children to play games (i.e., children with better visuospatial abilities may also enjoy navigating in a three-dimensional virtual world).

Taken together, exposure to technology is related to the way children and adults process information. This impact on our cognitive functioning can be both positive and negative. On the one hand, technology may engage people in their learning and provide more opportunities for acquiring more specific cognitive skills (e.g. visuospatial ability); on the other hand, technology may result in more significant distraction and long-term reduction of our attention span. Balanced use of technology may help increase the positive effects that technology has on our cognition.

Socioemotional Domain

Changes in thinking and information processing may influence the way we perceive socioemotional cues, and subsequently, the way we behave and interact with other people. The socioemotional domain comprises thoughts and behaviours that involve interpersonal relationships and communication between individuals. For example, people's responses in social settings, understanding of social cues, development of empathy, ability to regulate and express emotions and the development of self-identity concerning others are all encompassed in the socioemotional domain. Similar to the relationship between technology and cognition, a debatable issue is whether technology can be beneficial to people's socioemotional functioning in one way but detrimental in another (for a review see Lomanowska & Guitton, 2016). For example, Schneider (2000) explored the impact of excessive cybersex on offline romantic relationships. Of the 94 participants, 17.6% of their partner's online sexual activities had progressed to offline sexual affairs. Furthermore, participants with partners who had engaged in cybersex indicated that they felt hurt, betrayed, loss of trust, fear, lacked intimacy with their partner and lower self-esteem; many participants perceived online and offline affairs as a form of adultery. In addition, 68.1% of participants indicated problems in their sexual relationships with their partner, and 22.3% were subsequently separated or divorced. The common problem of inferring causality exists with these findings. That is, it is impossible to determine whether engaging in cybersex caused relationship problems or whether people who had relationship problems sought alternative intimacy online.

In contrast, Chopik (2016) studied the use of communication technology for reducing the feeling of loneliness and improving general well-being in older adults. Compared with participants who were less exposed to technology, those who were more exposed to technology rated themselves as less lonely and depressed, showed fewer chronic medical conditions and had better general health. Overall, technology provides opportunities for people to socialise and interact with others. More importantly, technology helps connect those who have fewer opportunities for social interaction, including people who have social difficulties, physical disabilities, and health problems. Conversely, the use of technology for communication may isolate individuals, leading them to develop more superficial relationships, impact their existing personal and intimate relationships and negatively affect their abilities to regulate emotions and conform to social norms.

In summary, researchers have shown that the reliance on technology in the contemporary world impacts multiple aspects of human development: physiology, brain structure and functioning, thought processing, feelings and interaction with other human beings. Whether technology is 'an angel' or 'the devil' in our lives continues to be unclear, and like everything else, too much or too little technology may distort the perfect equilibrium. There is one thing that we can be certain of, amid the uncertainty and stress of COVID-19; technology has and will continue to not only

connect people but also provide the much-needed support during these extraordinary times—specifically in the form of telehealth.

Rise of Telehealth

A new normal for conducting psychological assessments and treatment has emerged amid this global pandemic. We have seen a global resurgence in telehealth (or e-therapy) in the past 2 months (Nov et al., 2020). The New Zealand government recently established new funding to support telehealth consultations (Clark, 2020). Several advantages and ethical issues of telehealth have been raised.

Benefits of Telehealth

Traditionally, telehealth consultations were primarily delivered through videoconferencing (i.e. with a human health consultant). The value of e-therapy, however, can be enhanced through artificial intelligence (AI); that is, machines that deliver psychological assessments and interventions without the need for human input. Popular AI therapy platforms in New Zealand include *Sparx* and *Clearhead*. AI therapy is offered through either text-based chatbots or avatars (AI with a graphical interface). For example, a clinical psychologist could observe individuals' interactions with AI avatars in a virtual scenario to assess social anxiety (see Park et al., 2009). The AI system measures individuals' response latency and behavioural patterns (e.g. physical proximity, eye contact or head orientation) during social exchanges with avatars. Similarly, AI systems could be part of psychological treatments. Individuals experiencing auditory hallucinations create an avatar that they perceive as a visual representation of their hallucinations. In other words, they could 'put a face' to their auditory hallucinations (Craig et al., 2018). A concealed psychologist could also deliver standard psychological treatments through the virtual face.

The effectiveness of AI therapy has been empirically studied in several areas of mental health, including post-traumatic stress disorder (Myers et al., 2016), social anxiety disorder (Bouchard et al., 2017; Park et al., 2009), delusions and hallucination (Craig et al., 2018; Freeman et al., 2006, 2014), alcohol dependency and other cravings (Garcia et al., 2019; Lee, Liao, Ryu, 2007; Pericot-Valverda, Germeroth, & Tiffany, 2016; Saladin et al., 2006), and specific phobias (EmmelKamp et al., 2002; Rothbaum et al., 2002). By and large, AI-based psychological assessments have several benefits over face-to-face and videoconferencing sessions. These include:

i. AI assessments provide a more objective measure compared with subjective self-report ratings.
ii. The accuracy of assessments is improved through behavioural observation and analysis rather than relying on clients' retrospective experience of an event.
iii. AI assessments provide more flexibility in assessing behaviours in more ecologically-valid scenarios.

AI-based psychological treatments also have several advantages over traditional face-to-face interventions, including:

i. AI treatments are logistically easier to implement (e.g. treating flying phobias or fear of snakes in New Zealand).
ii. Patients tend to respond more positively and often show better adherence to treatment.
iii. AI treatments as effective as traditional methods in treating mental health issues, and positive results are maintained.
iv. Individuals receiving AI treatment show no differences in their overall therapeutic alliance with virtual therapists.
v. AI treatments could be tailored to meet individual needs.
vi. AI treatments provide anonymity for high-risk individuals who may be reluctant to seek help.

Another potential use of AI in telehealth is cognitive or neuropsychological testing (for a review see Vrana & Vrana, 2017). A significant portion of psychological assessment is often spent administering a standardised intelligence test, and years of training and experience are required to become a proficient examiner (e.g. Mrazik et al., 2012). For example, examiners must follow set procedures, standardised instructions, and timing restrictions in standardised intelligence tests to ensure the validity and reliability of the test. Despite these standard procedures, examiners often make administration and scoring errors. Researchers have shown that scores obtained from the Weschler's Adult Intelligent Scale 4th edition are sometimes different when a different examiner administers or scores the test (for a meta-analysis see Styck & Walsh, 2016). A fully-automated AI intelligence test could reduce or even eliminate these administration and scoring errors, and at the same time decrease the overall administration time. AI tests could address some of the current challenges in New Zealand mental health sectors, including the shortage of trained professionals, time required to complete an assessment, and broad geographical coverage of District Health Boards.

Ethical Implications of Telehealth

Despite several benefits of AI-based therapy, several ethical implications need to be considered to protect, respect and care for our patients, before integrating AI therapy (and telehealth via videoconferencing) into widespread clinical use. First, the accuracy of risk assessments and the procedure for reporting potential risks in AI therapy is not yet known. Psychologists have ethical responsibilities to report any serious or imminent risks from their assessment of their patients. AI therapists that are unable to identify potential risks accurately may jeopardise their patients' safety or the safety of others. Furthermore, merely designing an AI therapist to identify potential risks accurately without supportive responses to those risks may open up a 'can of worms', leaving the patient in a vulnerable state. Moreover, even with a supportive response to risk, AI-based therapy may not have the resources to connect these individuals with appropriate psychological or medical support, particularly in outreach areas.

Second, as with any digital system, information privacy and confidentiality are potential issues. Online therapy sessions are at risk for eavesdropping or hijack because the flow of information through digital networks is largely unencrypted. Securing a communication line is the first step to delivering online therapy. Even with this in place, however, system administrators have access to data that flows in and out of a network. Legislations and ethical guidelines should be established to secure the flow of confidential data. Issues with confidentiality are a challenge for future policymakers.

Finally, telehealth is a new area that often lacks the necessary professional guidance, supervision, training and practice guidelines. Future guidelines of telehealth practice should build on current guidelines published by the New Zealand Psychologists Board (New Zealand Psychologists Board, 2012). These guidelines should address practical and ethical issues to ensure that no harm is done for the people we support. For example, what is the best method for psychologists or other health professionals to build a therapeutic alliance online? What is the efficacy and efficiency of conducting some (or all) sessions online and subsequent sessions in person or vice versa? What are the procedures around handling technical issues during a session? Could children receive psychological treatment online without parental consent?

Conclusion

In summary, there are a handful of studies that empirically support telehealth via videoconferencing and AI-based psychological assessment and treatment for a variety of psychopathologies and cognitive issues (for a review see Freeman et al., 2017). As technology continues to advance at a rapid pace, the application for telehealth, in general, is going to

continue to grow; we can expect that more clinicians and patients will jump on the 'e-therapy bandwagon'. Current research shows AI as an alternative rather than a replacement to humans. When we think of AI as our replacements, our opinions of AI tend to be negative; when we think of AI as supplementary tools, our views of these intelligent systems are more favourable. Maybe as psychologists and health professionals, we should think about taking a holistic approach in helping our clients and patients rather than choosing a one-size-fits-all approach.

References

Bouchard, S., Dumoulin, S., Robillard, G., Guitard, T., Klinger, E., Forget, H., Loranger, C., & Roucaut, F. X. (2017). Virtual reality compared with *in vivo* exposure in the treatment of social anxiety disorder: A three-arm randomised controlled trial. *The British Journal of Psychiatry, 210*(4)*,* 276–283. https://doi.org/10.1192/bjp.bp.116.184234

Chopik, W. J. (2016). The benefits of social technology use among older adults are mediated by reduced loneliness. *Cyberpsychology, Behavior, and Social Networking, 19*(9), 551–556. https://doi.org/10.1089/cyber.2016.0151

Clark, D. C. (2020). *Backing our health services to combat COVID-19*. Beehive.govt.nz. https://www.beehive.govt.nz/release/backing-out-health-services-combat-covid-19

Craig, T. K. J., Rus-Calafell, M., Ward, T., Leff, J. P., Huckvale, M., Howarth, E., Emsley, R., & Garety, P. (2018). AVATAR therapy for auditory verbal hallucinations in people with psychosis: A single-blind, randomised controlled trial. *Lancet Psychiatry, 5*(1)*,* 31–40. https://doi.org/10.1016/S2215-0366(17)30427-3

Emmelkamp, P. M. G., Krijn, M., Hulsbosch, A. M., de Vries, S., Schuemie, M. J., & van der Mast, C. A. P. G. (2002). Virtual reality treatment versus exposure *in vivo*: A comparative evaluation in acrophobia. *Behaviour Research and Therapy, 40*(5)*,* 509–516. https://doi.org/10.1016/s0005-7967(01)00023-7

Freeman, D., Reeve, S., Robinson, A., Ehlers, A., Clark, D., Spanlang, B., & Slater, M. (2017). Virtual reality in the assessment, understanding, and treatment of mental health disorders. *Psychological Medicine, 47*(14), 2393–2400. https://doi.org/10.1017/S003329171700040X

Freeman, D., Slater, M., Bebbington, P. E., Garety, P. A., Kuipers, E., Fowler, D., Met, A., Read, C. M., Jordan, J., & Vinayagamoorthy, V. (2006). Can virtual reality be used to investigate persecutory ideation? *The Journal of Nervous and Mental Disease, 191*(8), 509–514. https://doi.org/10.1097/01.nmd.0000082212.83842.fe

Garcia, B. P., Garcia, M. R., Olszewska, A., Yilmaz, L., Ibañez, C. G., Blanes, M. G., Gültekin, G., Troncoso, E. S., & Maldonado, J. G. (2019). Is this my own body? Changing the perceptual and affective body image experience among college students using a new virtual reality embodiment-based technique. *Journal of Clinical Medicine, 8*(7)*,* Article 925. https://doi.org/10.3390/jcm8070925

Giacomo, D. D., Ranieri, J., & Lacasa, P. (2017). Digital learning as enhanced learning processing? Cognitive evidence for new insight of smart learning. *Frontiers in Psychology, 8,* Article 1329. https://doi.org/10.3389/fpsyg.2017.01329

James, K. H., & Engelhardt, L. (2012). The effects of handwriting experience on functional brain development in pre-literate children. *Trends in Neuroscience and Education, 1*(1)*,* 32–42. https://doi.org/10.1016/j.tine.2012.08.001

Kühn, S., Romanowski, A., Schilling, C., Lorenz, R., Mörsen, C., Seiferth, N., Banaschewski, T., Barbot, A., Barker, G. J., Büchel, C., Conrod, P. J., Dalley, J. W., Flor, H., Garavan, H., Ittermann, B., Mann, K., Martinot, J. L., Paus, T., Rietschel, M., Gallinat, J. (2011). The neural basis of video gaming. *Translational Psychiatry, 1,* Article e53. https://doi.org/10.1038/tp.2011.53

Lee, K. M., Liao, K., & Ryu, S. (2007). Children's responses to computer-synthesised speech in educational media: Gender consistency and gender similarity effects. *Human Communication Research, 33*(3)*,* 310–329. https://doi.org/10.1111/j.1468-2958.2007.00301.x

Lomanowska, A. M., & Guitton, M. J. (2016). Online intimacy and well-being in the digital age. *Internet Interventions, 4*(P2)*,* 138–144. https://doi.org/10.1016/j.invent.2016.06.005

Mrazik, M., Janzen, T. M., Dombrowski, S. C., Barford, S. W., & Krawchuk, L. L. (2012). Administration and scoring errors of graduate students learning the WISC-IV: Issues and controversies. *Canadian Journal of School Psychology, 27*(4), 279. https://doi.org/10.1177/0829573512454106.

Mueller, P. A., & Oppenheimer, D. M. (2014). The pen is mightier than the keyboard: Advantages of longhand over laptop note taking. *Psychological Science, 25*(6), 1159–1168. https://doi.org/10.1177/0956797614524581

Myers, C. E., Radell, M. L., Shind, C., Ebanks-Williams, Y., Beck, K. E., & Gilbertson, M. W. (2016). Beyond symptom self-report: Use of a computer "avatar" to assess post-traumatic stress disorder (PTSD) symptoms. *Stress, 19*(6), 593–598. https://doi.org/10.1080/10253890.2016.1232385

New Zealand Psychologists Board (2012). The practice of telepsychology. http://www.psychologistsboard.org.nz/cms_show_download.php?id=244

Nov, O., Testa, P. A., Chunara, R., Chen, J., & Mann, D. M. (2020). COVID-19 transforms health care through telemedicine: Evidence from the field. *Journal of the American Medical Informatics Association, 0*(0), 1–4. https://doi.org/10.1093/jamia/ocaa072

Palaus, M., Marron, E. M., Viejo-Sobera, R., & Redolar-Ripoll, D. (2017). Neural basis of video gaming: A systematic review. *Frontiers in Human Neuroscience, 11,* Article 248. https://doi.org/10.3389/fnhum.2017.00248

Park, K. M., Ku, J., Park, I. H., Park, J. Y., Kim, S. I., & Kim, J. J. (2009). Improvement in social competence in patients with schizophrenia: A pilot study using a performance-based measure using virtual reality. *Human Psychopharmacology, 24*(8), 619–627. https://doi.org/10.1002/hup.1071

Pericot-Valverde, I., Germeroth, L., J., & Tiffany, S. T. (2016). The use of virtual reality in the production of cue-specific craving for cigarettes: A meta-analysis. *Nicotine & Tobacco Research, 18*(5), 538–546. https://doi.org/10.1093/ntr/ntv216

Rothbaum, B. O., Hodges, L., Anderson, P. L., Price, L., & Smith, S. (2002). Twelve-month follow-up of virtual reality and standard exposure therapies for the fear of flying. *Journal of Consulting and Clinical Psychology, 70*(2), 428–432. https://doi.org/10.1037/0022-006X.70.2.428

Sablonniére, R. D. L., Bourgeois, L. F., & Najih, M. (2013). Dramatic social change: A social psychological perspective. *Journal of Social and Political Psychology, 1*(1), 253–272. https://doi.org/10.5964/jspp.v1i1.14

Saladin, M. E., Brady, K. T., Graap, K., & Rothbaum, B. O. (2006). A preliminary report on the use of virtual reality technology to elicit craving and cue reactivity in cocaine dependent individuals. *Addictive Behaviors, 31*(10), 1881–1894. https://doi.org/10.1016/j.addbeh.2006.01.004

Schneider, J. P. (2000). Effects of cybersex addition on the family: Results of a survey. *Sexual Addition & Compulsivity: The Journal of Treatment and Prevention, 7*(1-2), 31–58. https://doi.org/10.1080/10720160008400206

Styck, K. M., & Walsh, S. M. (2016). Evaluating the prevalence and impact of examiner errors of the Wechsler Scales of Intelligence: A meta-analysis. *Psychological Assessment, 29*(1), 3–17. https://doi.org/10.1037/pas0000157

Vegad, A. M., Kacha, Y. K., Varu, M. S., Mehta, H. B., & Shah, C. J. (2015). Effects of mobile phone radiation on heart rate variability of healthy young subjects. *International Journal of Clinical and Experimental Physiology, 2*(1), 23–28. https://doi.org/10.4103/2348-8093.155508

Vrana, S. R., & Vrana, D. T. (2017). Can a computer administer a Wechsler Intelligence Test? *Professional Psychology: Research and Practice, 48*(3), 191–198. http://doi.org/10.1037/pro0000128

Stepping Outside the Therapist's Office: A Call for a Digital Mental Health Strategy in New Zealand

Yenushka Goonesekera & Liesje Donkin

Very few aspects of modern life remain untouched by digital technology. In Aotearoa New Zealand, Internet and mobile phone penetration is approximately 93% and 135% respectively (Kemp, 2020). Advances in the field have fundamentally changed the way people live, work and socialise. Digital natives, the generations born after 1980, have grown up in a world immersed in digital technology (Prensky, 2001). They are more technologically fluent than those born prior to 1980 (digital immigrants) and as a result, are more easily able to adopt newly developed technology. As this generation increases in number, mental health professionals are likely to encounter service users who are experiencing distress as a direct or indirect result of digital technology. For example, reassurance seeking behaviours associated with illness anxiety disorder are no longer restricted to doctors' offices and encyclopaedias. Instead, easy and constant access to a plethora of online medical information, diagnoses and forums has seen the identification of a group coined the "cyberchondriacs" (Doherty-Torstrick et al., 2016). This access can exacerbate illness anxiety to a level which is impairing and requires psychological intervention.

While there is evidence suggesting links between technology and poor psychological outcomes, it is important to recognise the seemingly unrestricted potential of digital technology in supporting

Yenushka Goonesekera is a Master of Health Psychology candidate at the University of Auckland and a Postgraduate Diploma student in Health Psychology. Yenushka has a particular interest in the use of digital interventions within the areas of anxiety, post-traumatic stress disorder, cardiology, and chronic pain. She is currently undertaking a pilot study assessing the feasibility and effects of Otis, a cognitive behavioural therapy based chatbot, among health anxious individuals.

Liesje Donkin is a senior lecturer at the Department of Psychological medicine at the University of Auckland. Outside of this role, she works in private practice and does work in the field of workplace wellness and suicide prevention.

mental health and addiction services in New Zealand. The growing interest in using technologies, including the Internet, smartphones and wearable trackers, in mental healthcare is indicative of the likely and necessary transformation of the field; one that could better support clinicians as well as service users. New Zealand and Australia have been leaders in this transformation by contributing to 22% of the total worldwide e-mental health research since 2010 (Wozney et al., 2017). Despite this, New Zealand lacks a strategic plan for the integration of digital technologies at a national level. This review presents evidence for the integration of digital interventions into mental health services in New Zealand before outlining some key opportunities and challenges of integration. Finally, the paper makes recommendations for the future integration of digital mental health technology in New Zealand.

The demand for mental health and addiction services is growing (New Zealand Government, 2017), evidenced by the fact that one in five New Zealanders experience mental illness or significant mental distress in their lifetime (Government Inquiry into Mental Health and Addiction, 2018). As New Zealand has transitioned from institutional care to a recovery approach, most people who experience common mental health issues receive treatment positioned within the community (Te Pou o te Whakaaro Nui, 2018). Innovations in digital technology present an opportunity to meet the increasing demand on mental health systems and effectively further disseminate support into communities. Accessibility and reach of digital health technology can overcome individual factors such as inequity in rural healthcare delivery, transportation and mobility issues that inhibit help-seeking behaviour. However, it should be noted that the integration of technology will not address all unmet community needs. Integration should be considered a step in developing more equitable mental health services, but racial, social and economic disparities should not be overlooked as they are associated with lower e-health literacy, access and use (Jensen et al., 2010; Choi & DiNitto, 2013). Complacency has no place in the implementation of digital technology in mental health and addiction services in New Zealand, as Māori in particular may be disadvantaged while also continuing to be underserved in our health systems. Instead, the implementation should be complementary to current treatment (face-to-face therapy), but in a considered manner that will increase access, not further add to the current disparities.

There is evidence to suggest that blended treatment (digital and face-to-face therapy) is more effective than stand-alone digital interventions and promotes greater adherence to treatment (Aerts & Dam, 2018; Urech et al., 2018). Importantly, it is viewed positively by therapists and service users (van der Vaart et al., 2014; Topoco et al., 2017), whose attitudes often greatly affect the implementation of digital technology in mental health settings. Despite evidence suggesting the efficacy of numerous digital interventions and approaches, clinicians are reluctant to use them in practice (Donovan et al., 2015; Perle et al., 2011). A lack of training and understanding is a likely barrier to adopting digital technology, as approximately 92% of general practitioners from the UK reported a lack of training in digital mental health (Breedvelt et al., 2019). Digital mental health training is not currently an integral part of clinical training in New Zealand, which highlights the need for greater investment in the area. Clinicians and researchers who do not possess the necessary digital literacy to navigate new technology in care settings are unlikely to successfully implement digital mental health interventions.

The literature suggests that it may not just be clinicians who require some digital skills training. Service users with a more positive attitude towards digital health seem to have greater rates of adherence and therapeutic alliance (Aerts & Dam, 2018). While prior research has demonstrated positive attitudes and appraisals of digital mental health interventions among diverse patient populations (Topoco et al., 2017, Strauss et al., 2019; Rooksby et al., 2019, Clarke et al., 2018), most of the samples consisted of children, youth and young adults. A more positive attitude

among young people is unsurprising given that they are the greatest consumers of digital technology (Pacheco & Melhuish, 2018), and are the most comfortable as native users. Young people are also less likely to seek face-to-face help due to fears of stigmatisation, so interventions such as mental health chatbots may offer them a sense of anonymity and comfort (Lucas et al., 2014). With most mental health issues initially arising during adolescent years (Merikangas et al., 2009; Kessler et al., 2009), the implementation of digital interventions to address these issues should not be overlooked. However, there is concern that older adults who are less likely to use and accept technology in mental health due to reduced digital literacy, fear and distrust in technology (Hill et al., 2015) may be left behind. This is somewhat concerning given that this group is at risk for the loneliness endemic, and there is emerging evidence that robots and other technology can help with this among other health challenges (Bemelmans et al., 2012). While this digital divide is a valid concern, it should be stressed that the integration of digital systems is not synonymous with a complete upheaval of traditional face-to-face therapies. Training to improve digital literacy can help older adults maintain a level of inclusion in the digital age and reduce fear and distrust in technology (Cattan et al., 2005; Lagana, 2008). As we move to an increasingly digital and paperless society, investment in skills training for older adults is crucial as it facilitates the maintenance of social networking in the future and in turn improves well-being (Choi & DiNitto, 2013; Winstead et al., 2013).

Development and adaptation of digital technology for mental health only appear to be restricted by the imagination and attitudes held by stakeholders such as government bodies, clinicians and service users. When science-fiction novelist Stanley G. Weinbaum first conceptualised virtual reality, he could not have imagined that in less than a century the medium would be used to address cognitive decline (Coyle et al., 2015), depression (Falconer et al., 2018), post-traumatic stress disorder (Gonçalves et al., 2012), and anxiety and specific phobias (Parsons & Rizzo, 2008). The diverse use of virtual reality in mental health demonstrates why it is important for digital health technology innovation to go beyond simply changing the delivery method of traditional therapies and how it can be better used to help people. However, further research should focus on building the evidence base for these new paradigms and existing digital interventions (e.g. apps) that are seldom clinically tested (Donker et al., 2013).

The need for innovative research was highlighted during the COVID-19 pandemic. As the world went digital, health systems struggled to cope with demand for physical and mental health support via this new medium. It was reported that Healthline (the national hotline for free health advice) and its related hotlines saw a 2271% increase in calls (Williams, 2000). In the early stages of the pandemic, the hotline was only capable of fielding 7000 of the 24,000 calls received (New Zealand Herald, 2020) and needed to expand and adjust to meet this new demand in a short time. Existing digital mental support or a plan for the implementation of technology may have been key in reducing the burden on mental health services and facilitated a strategic plan for the transition of those services into cyberspace. However, it is noted that even with such a place in place, the development of a pandemic would have created stress and increased demand.

The COVID-19 pandemic was a catalyst for utilising e-health tools and online therapies in routine practice (Wind et al., 2020) and likely expedited this process that the therapy world had slowly been embracing. While the Ministry of Health acknowledged the profusion of digital technologies available in its Health Strategy document (New Zealand Government, 2016), there is little direction on the process of developing a 'smart system' in healthcare. The Ministry's Digital Health Strategic Framework (Ministry of Health, 2020) appears to be the closest guide for digital health integration. However, the preamble to the document states that the framework is not meant to be a detailed plan and will be revised 'as the digital future emerges'. Revision of digital technology guidelines is crucial to keep up with the latest developments but as there is an

absence of an initial strategy, the framework is not overly helpful and does not effectively direct digital health innovation or training, or offer a way to keep both clinicians and service users safe. A plan similar to the United Kingdom's Five Year Forward View for Mental Health (Mental Health Taskforce, 2016)., a report outlining system and policy level strategies for digital technology integration in mental health, may be of great benefit to the future of mental health services in New Zealand.

Despite the lack of comprehensive guidelines and strategies, the development of digital health technologies, particularly in mental health, continues to thrive in New Zealand. Researchers who devise and test these technologies should be supported by wider health systems with health professionals who are proficient in the use of digital health technologies. Therefore, to establish a system that is accepting and able to effectively use digital technology in mental health settings, skills training to improve digital literacy among clinicians and service users of all backgrounds should be an integral part of the strategy. Additionally, the innovation of newer technologies such as robots and artificial intelligence systems in mental health should receive greater investment as they continue to show great promise. A detailed strategy is now imperative to achieving the changes outlined in The Vision for Health Technology (Ministry of Health, 2018) in New Zealand by 2026; without it, the gains forced by COVID-19 will likely stall.

References

Aerts, J. E., & van Dam, A. (2018). Blended e-health in cognitive behavioural therapy: usage intensity, attitude and therapeutic alliance in clinical practice. *Psychology*, *9*(10), 2422. https://doi.org/10.4236/psych.2018.910139

Bemelmans, R., Gelderblom, G. J., Jonker, P., & De Witte, L. (2012). Socially assistive robots in elderly care: A systematic review into effects and effectiveness. *Journal of the American Medical Directors Association*, *13*(2), 114–120.

Breedvelt, J. J., Zamperoni, V., Kessler, D., Riper, H., Kleiboer, A. M., Elliott, I., Abel, K. M., Gilbody, S., & Bockting, C. L. (2019). GPs' attitudes towards digital technologies for depression: an online survey in primary care. *British Journal of General Practice*, *69*(680), e164–e170. https://doi.org/10.3399/bjgp18X700721

Cattan, M., White, M., Bond, J., Learmouth A. (2002) Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions. *Ageing & Society*, 25, pp. 41-67, https:/ / doi.org/10.1017/S0144686X04002594

Choi, N. G., & DiNitto, D. M. (2013). The digital divide among low-income homebound older adults: Internet use patterns, eHealth literacy, and attitudes toward computer/Internet use. *Journal of Medical Internet Research*, *15*(5), e93. https://doi.org/10.2196/jmir.2645

Clarke, J., Proudfoot, J., Vatiliotis, V., Verge, C., Holmes-Walker, D. J., Campbell, L., Wilhelm, K., Moravac, C., Indu, P. S., & Bridgett, M. (2018). Attitudes towards mental health, mental health research and digital interventions by young adults with type 1 diabetes: A qualitative analysis. *Health Expectations*, *21*(3), 668–677. https://doi.org/10.1111/hex.12662

Coyle, H., Traynor, V., & Solowij, N. (2015). Computerised and virtual reality cognitive training for individuals at high risk of cognitive decline: systematic review of the literature. *The American Journal of Geriatric Psychiatry*, *23*(4), 335–359.

Doherty-Torstrick, E. R., Walton, K. E., & Fallon, B. A. (2016). Cyberchondria: parsing health anxiety from online behavior. *Psychosomatics*, *57*(4), 390–400. https://doi.org/10.1016/j.psym.2016.02.002

Donker, T., Petrie, K., Proudfoot, J., Clarke, J., Birch, M. R., & Christensen, H. (2013). Smartphones for smarter delivery of mental health programs: a systematic review. *Journal of Medical Internet Research*, *15*(11), e247. https://doi.org/10.2196/jmir.2791

Donovan, C. L., Poole, C., Boyes, N., Redgate, J., & March, S. (2015). Australian mental health worker attitudes towards CBT: What is the role of knowledge? Are there differences? Can we change them?. *Internet Interventions*, *2*(4), 372-381 https://doi.org/10.1016/j.invent.2015.09.001

Falconer, C. J., Rovira, A., King, J. A., Gilbert, P., Antley, A., Fearon, P., Ralph, N., Slater, M., & Brewin, C. R. (2016). Embodying self-compassion within virtual reality and its effects on patients with depression. *BJPsych Open*, *2*(1), 74–80.

Gonçalves, R., Pedrozo, A. L., Coutinho, E. S. F., Figueira, I., & Ventura, P. (2012). Efficacy of virtual reality exposure therapy in the treatment of PTSD: a systematic review. *PloS One*, *7*(12), e48469.

Government Inquiry into Mental Health and Addiction (2018). He Ara Oranga. https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

Hill, R., Betts, L. R., & Gardner, S. E. (2015). Older adults' experiences and perceptions of digital technology: (Dis)empowerment, wellbeing, and inclusion. *Computers in Human Behavior*, *48*, 415–423. https://doi.org/10.1016/j.chb.2015.01.062

Jensen, J. D., King, A. J., Davis, L. A., & Guntzviller, L. M. (2010). Utilisation of internet technology by low-income adults: the role of health literacy, health numeracy, and computer assistance. *Journal of Aging and Health*, *22*(6), 804–826. https://doi.org/10.1177/0898264310366161

Kemp, S. (2020) Digital 2020: New Zealand. ttps://datareportal.com/reports/digital-2020-new-zealand

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. B. (2007). Age of onset of mental disorders: a review of recent literature. *Current Opinion in Psychiatry*, *20*(4), 359. https://doi.org/10.1097/YCO.0b013e32816ebc8c

Lagana, L. (2008). Enhancing the attitudes and self-efficacy of older adults toward computers and the internet: Results of a pilot study. *Educational Gerontology*, 34, pp. 831-843, https://doi.org/10.1080/03601270802243713

Lucas, G. M., Gratch, J., King, A., & Morency, L. P. (2014). It's only a computer: Virtual humans increase willingness to disclose. *Computers in Human Behavior*, *37*, 94–100. https://doi.org/10.1016/j.chb.2014.04.043

Mental Health Taskforce. (2016). *The five year forward view for mental health*. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Ministry of Health. (2018). *The vision for health technology*. https://www.health.govt.nz/system/files/documents/pages/vision_for_health_technology.pdf

Ministry of Health. (2020). *Digital health strategic framework*. https://www.health.govt.nz/our-work/digital-health/digital-health-strategic-framework

New Zealand Government. (2016). *New Zealand health strategy: Future direction*. https://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf

New Zealand Government. (2017). *Taking a social investment approach to mental health*. https://www.beehive.govt.nz/sites/all/files/Q&A_2.pdf

Pacheco, E., & Melhuish, N. (2018). *New Zealand teens' digital profile: A factsheet*. https://www.netsafe.org.nz/wp-content/uploads/2018/02/NZ-teens-digital-profile_factsheet_Feb-2018-1.pdf

Parsons, T. D., & Rizzo, A. A. (2008). Affective outcomes of virtual reality exposure therapy for anxiety and specific phobias: A meta-analysis. *Journal of Behavior Therapy and Experimental Psychiatry*, *39*(3), 250–261.

Perle, J. G., Langsam, L. C., & Nierenberg, B. (2011). Controversy clarified: An updated review of clinical psychology and tele-health. *Clinical Psychology Review*, *31*(8), 1247-1258. https://doi.org/10.1016/j.cpr.2011.08.003

Prensky, M. (2001). Digital natives, digital immigrants. *On the Horizon*, *9*(5).

Riper, H., & Berger, T. (2018). A patient post hoc perspective on advantages and disadvantages of blended cognitive behaviour therapy for depression: A qualitative content analysis. *Psychotherapy Research,* 1–13. https://doi.org/10.1080/10503307.2018.1430910

Rooksby, J., Morrison, A., & Murray-Rust, D. (2019). Student perspectives on digital phenotyping: The acceptability of using smartphone data to assess mental health. In *Proceedings of the 2019 CHI Conference on Human Factors in Computing Systems* (pp. 1–14). https://doi.org/10.1145/3290605.3300655

Strauss, P., Morgan, H., Toussaint, D. W., Lin, A., Winter, S., & Perry, Y. (2019). Trans and gender diverse young people's attitudes towards game-based digital mental health interventions: A qualitative investigation. *Internet Interventions*, *18*, 100280. https://doi.org/10.1016/j.invent.2019.100280

Te Pou o te Whakaaro Nui (2018). *Effectiveness of e-mental health approaches*. https://www.tepou.co.nz/uploads/files/resource-assets/E-therapy%20report%20FINAL%20July%202018.pdf

Topooco, N., Riper, H., Araya, R., Berking, M., Brunn, M., Chevreul, K., Cieslak, R., Ebert, D. D., Etchmendy, E., Herrero, R., Kleiboer, A., Krieger, T., García-Palacios, A., Cerga-Pashoja, A., Smoktunowicz, E., Urech, A., Vis, C., Andersson, G. (2017). Attitudes towards digital treatment for depression: a European stakeholder survey. *Internet Interventions*, *8*, 1–9. https://doi.org/10.1016/j.invent.2017.01.001

Urech, A., Krieger, T., Möseneder, L., Biaggi, A., Vincent, A., Poppe, C., Meyer, B., Riper, H., & Berger, T. (2018). A patient post hoc perspective on advantages and disadvantages of blended cognitive behaviour therapy for depression: A qualitative content analysis. *Psychotherapy Research,* 1–13. https://doi.org/10.1080/10503307.2018.1430910

van der Vaart, R., Witting, M., Riper, H., Kooistra, L., Bohlmeijer, E. T., & van Gemert-Pijnen, L. J. (2014). Blending online therapy into regular face-to-face therapy for depression: content, ratio and preconditions according to patients and therapists using a Delphi study. *BMC Psychiatry*, *14*(1), 355. https://doi.org/10.1186/s12888-014-0355-z

Williams, K. (2020, April 20) Coronavirus: Only one call away – at the end of New Zealand's Covid-19 hotline. *Stuff.* https://www.stuff.co.nz/national/health/coronavirus/121015679/coronavirus-only-one-call-away--at-the-other-end-of-new-zealands-covid19-hotline

Wind, T. R., Rijkeboer, M., Andersson, G., & Riper, H. (2020). The COVID-19 pandemic: The 'black swan' for mental health care and a turning point for e-health. *Internet Interventions*, *20*.
Winstead, V., Anderson, W. A., Yost, E. A., Cotten, S. R., Warr, A., & Berkowsky, R. W. (2013). You can teach an old dog new tricks: A qualitative analysis of how residents of senior living communities may use the web to overcome spatial and social barriers. *Journal of Applied Gerontology*, *32*(5), 540–560. https://doi.org/10.1177/0733464811431824
Wozney, L., McGrath, P., Newton, A., Hartling, L., Curran, J., Huguet, A., & Rao, S. (2017). *RE-AIMing eMental Health: A Rapid Review of Current Research*. Mental Health Commission of Canada.

The Self-Care Sessions: A Psychoeducation Podcast for Frontline Healthcare Workers

Connor Silvester

Introduction

In December 2019, worldwide attention became fixated on Wuhan (Hubei, China) after the outbreak of a novel coronavirus pneumonia (COVID-19). The virus spread rapidly, and by 1 June 2020, global cases of this virus surpassed 6 million, resulting in a global pandemic with over 370,000 deaths (World Health Organization, 2020). The rapid rate of transmission globally imposed enormous pressure on governments, medical systems, and healthcare providers to rapidly and drastically respond to this novel threat. The uncertainty and low predictability of COVID-19 represented a significant threat to the psychological well-being of many individuals in addition to the physical health impacts. This impact is perhaps most visible in frontline healthcare workers who risk exposure to the virus that could result in significant illness, injury, loss and even death for themselves or their whānau. This article discusses the development of a podcast that provided psychological support for frontline medical staff at the Auckland District Health Board during COVID-19.

Various psychological and health models suggest it is natural for individuals to experience significant psychological distress during periods of disaster and threat. For example, the behavioural immune system theory argues that negative emotions (e.g. anxiety, fear) and cognitive assessments are promoted in situations in which infection is possible, as these cause behavioural adaptations that minimise risk for infection (Schaller, 2015). Similarly, the perceived risk theory asserts that public health emergencies trigger stressful responses in the body that are adaptive in the short term as they motivate protective behaviours that reduce rates of infection (Rimal & Real, 2003). However, in situations where the risk is long-term, such as COVID-19, this response can maladaptively affect physical and mental well-being. Studies have shown that individuals with prolonged exposure to public health emergencies (e.g. severe acute respiratory syndrome; SARS) developed stress disorders, independent of whether they were personally infected or not (Fan et al., 2015; Cheng et al., 2006). Consequently, theoretical models argue that health emergencies have significant psychological consequences that are adaptive short-term, but that become maladaptive with sustained exposure.

Evidence is beginning to emerge that suggests healthcare workers are at an increased risk for negative psychological responses during health emergencies such as COVID-19. For example, one study demonstrated that to date, approximately 70% of healthcare workers in China

Connor Silvester is currently completing an internship with the Auckland Regional Pain Service at the Auckland District Health Board, in pursuit of a PgDip in Clinical Health Psychology at the University of Auckland. He has recently completed a study investigating the presence of, and psychological contributors to, the nocebo effect in recipients of an influenza vaccination. He is particularly interested in the intersection between modern society and health, which encompasses concepts such as systemic contributions to health inequities, remote delivery of health interventions, and modern health worries.

experienced clinically significant levels of psychological distress during the COVID-19 pandemic, including anxiety, depression and insomnia (Lai et al., 2020). This increased psychological distress is likely to be associated with multiple factors, including increased risk for infection, increased risk for familial infection, increased workload, decreased staffing and unstable routines (Thakur & Jain, 2020). When considering that psychological distress can reduce productivity and quality of care while increasing burnout, the psychological well-being of our clinicians is of utmost importance (Bansal et al., 2020). This is doubly important in a global pandemic, wherein the very health of society is held together by these clinicians. Consequently, greater emphasis needs to be placed on offering any support possible to facilitate positive psychological adaptations.

On a positive note, preliminary findings suggest that psychological assistance can alleviate COVID-19 associated distress. For example, Spanish clinicians who accessed psychological support during the COVID-19 pandemic had significantly lower scores on the Psychological Stress and Adaptation at Work Score than individuals who did not access support (Romero et al., 2020) This pattern appears consistent with historic data from previous public health emergencies, such as the 2009 Influenza A breakout and SARS epidemic, where psychological support became an important mechanism for controlling consequences (Fang et al., 2012). Together, the information discussed here outlines that although the COVID-19 pandemic had a significant psychological impact on healthcare workers psychological support was successful in reducing distress, which is vital for promoting the efficiency and resilience needed to combat such a substantial health threat.

Unfortunately, there are various barriers that prevent clinicians accessing appropriate psychological care, both within and outside of the context of COVID-19. A recent investigation of the uptake of psychological assistance in China showed that frontline healthcare workers were unlikely to access support because: they did not want their families to worry about them; there were practical barriers such as time and space; and many clinicians did not believe they had any psychological concerns despite clinical symptoms, likely indicative of a stigma against seeking psychological help (Chen et al., 2020). Even at the best of times, clinicians do not regularly seek assistance when experiencing stress, burnout, depression and suicidality because of concerns about confidentiality, cost, time, licensing and stigma (Pospos et al., 2018). Furthermore, these concerns are exacerbated by context-specific barriers restricting access. Closer to home in Aotearoa/New Zealand, governmental policy restricted all face-to-face, non-urgent medical consultations to limit the spread of the virus. Consequently, any interventions offering psychological assistance needed to overcome barriers associated with the COVID-19 pandemic.

One approach to psychological intervention that may overcome these barriers was remote/virtual delivery of interventions. Research has demonstrated that remote delivery of psychological treatment and interventions has similar efficacy and treatment effects to face-to-face delivery (Day & Schneider, 2002). Clinicians may be more likely to use remote and virtual methods of forms of psychological assistance given the barriers to accessing treatment discussed above (Pospos et al., 2018). In particular, audio recorded resources have been effectively used in relaxation and mindfulness training (Tsai, 2004), cognitive behavioural therapy (Schmidt et al., 2008) and acceptance and commitment therapy (ACT) (Simister et al., 2018). An online, audio delivery of information in the form of 'podcasts' has recently increased in popularity, with Apple Podcasts passing 50 billion episode streams in 2018 (Locker, 2018). However, empirical evidence specifically supporting the therapeutic effectiveness of podcasts is limited, although preliminary qualitative evidence suggests that podcasts may be a helpful alternative to traditional delivery approaches (Salloum & Smyth, 2013). Therefore, despite the various limitations imposed by a global pandemic, psychological assistance is possible and can be effectively delivered. The

remainder of this article discusses the development, implementation and effects of a podcast providing psychological support for frontline healthcare workers.

Current Context: The Self Care Sessions

Purpose

Aotearoa/New Zealand was in a fortunate, albeit unique, position to respond to COVID-19, in that COVID-19 reached the country approximately 2 months later than the rest of the world. This meant that the healthcare system could build on the shortcomings and successes of the responses that overseas systems had made. In another sense, this was unfortunate for healthcare workers as they had seen the impact that the virus was having on their colleagues overseas and this (anecdotally) was undoubtedly a source of distress.

With this in mind, the Auckland Regional Pain Service (TARPS) agreed that it would be appropriate to develop a psychoeducation podcast in response to concerns that were raised from anaesthetists in the Auckland District Health Board about their ability to cope with the demands of the virus. The purpose of this podcast was to offer practical psychological techniques and skills to reduce the effect the virus had on healthcare workers' well-being and empower healthcare workers with active coping mechanisms to facilitate benefit finding.

Design

Based on the suggestions from both the literature and healthcare professionals at ADHB, the programme for psychological assistance was designed as a virtually delivered podcast. Benefits of this approach included: assistance in a virtual manner that reduced the risk of virus transmission for psychologists and frontline workers alike; assistance in a manner that allowed participants to access content when convenient for them; and offering assistance in an easy to access and discrete manner.

The podcast was released weekly for 3 weeks leading up to and during the COVID-19 pandemic in Aoteatoa/New Zealand. While originally planned to be released for 12 weeks, the project was postponed on request of frontline healthcare workers after 3 weeks, as the COVID-19 situation looked unlikely to follow the trajectory seen overseas and therefore had less implications for healthcare staff.

Distribution

The podcast was originally distributed to anaesthetists at the Auckland District Health Board via their personal emails. However, by request, the podcast was eventually expanded and emailed to staff at Mental Health Services, such as the Pohutakawa Auckland Sexual Assault Service. The podcast was included as an audio file attached to these emails and could be downloaded and distributed freely. In this sense, more individuals might have received the file than originally anticipated. While uncontrolled distribution might have influenced the ability to assess the effects of the podcast, a free and readily available resource is valuable during a period of significant uncertainty.

Content

The content for each session targeted brief, practical techniques and skills for alleviating psychological distress and arousal. In this section, the content of each episode is briefly summarised, as well as the evidence base supporting the implementation of these techniques in distressful situations.

Episode one

Episode one of the podcast validated the difficult nature of the current situation and the effects that it was likely having on healthcare workers in particular. Following this, the podcast introduced two practical and specific techniques: a deep breathing technique called the 5/7/8 breath, and a self-care grounding technique called the doorknob confession. The 5/7/8 breath involves breathing in for five seconds, holding for seven seconds, and breathing out for eight seconds. The doorknob confession involves taking a brief moment to remember the reason why the clinician started practicing in the first place as a means to reaffirm personal values. The use of both deep breathing and value reaffirmation, while usually incorporated in wider interventions, were included in this podcast because they have shown effects in decreasing psychological distress (Wilson & Sandoz, 2008; Gallagher et al., 2016). Episode one, and each episode thereafter, concluded with the Māori proverb: 'Kia kaha, Kia māia, Kia manawanui; Be strong, be brave, be steadfast'.

Episode two

Episode two of the podcast introduced 'dropping the anchor', an ACT-specific technique for decreasing cognitive fusion and promoting emotion regulation. Russ Harris, a predominant contributor to the ACT approach, had tailored this approach to a COVID-19 circumstance using the acronym FACE, as outlined in Table 1. Under the ACT framework, dropping the anchor is an effective technique for decreasing the effects of emotions on function and promoting adaptive behaviour in the presence of such. This approach is an example of a cognitive defusion technique that has shown significant effectiveness in reducing psychological distress and promoting adaptive behaviour across a range of patient samples (Hinton & Gaynor, 2010; Pilecki & McKay, 2012). Therefore, it was assumed to be an appropriate technique to use when individuals face overwhelming thoughts or emotions, which is likely in the COVID-19 scenario.

Table 1.

Summary of the FACE-COVID technique, developed by Russ Harris, which was implemented in episode two of the podcast

Technique	Example from script
F- Focus on what you can control	*'You can't control what happens in the future. You can't control Corona virus itself or the world economy or how your government manages this whole sordid mess. And you can't magically control your feelings, eliminating all that perfectly natural fear and anxiety. But you can control what you do - here and now. And that matters'.*
A- Acknowledge your thoughts and feelings	*'Silently and kindly acknowledge whatever is "showing up" inside you: thoughts, feelings,* *emotions, memories, sensation, urges. Take the stance of a curious scientist, observing what's going on in your inner world. As you do this, often it's helpful to put this into words'.*
C- Come back into your body	*'Come back into and connect with your physical body. Find your own way of doing this. You could try some or all of the following, or find your own methods: slowly pushing your feet hard into the floor; slowly straightening up your back and spine; if sitting, sitting upright and forward in your chair; slowly pressing your fingertips together'.*
E- Engage in what you're doing	*'Get a sense of where you are and refocus your attention on the activity you are doing. Find your own way of doing this. You could try some or all of the following suggestions or find your own methods: Look around the room and notice 5 things you can see. Notice three or four things you can hear'.*

Episode three

Episode three of the podcast outlined the rationale for relaxation, presented a relaxation script and reviewed what effect this had on the listeners' well-being. The relaxation script presented in this episode was a power break, which is a brief hypno-relaxation technique that guides individuals on a break away from what they are currently doing towards a focus on breathing and relaxation. Clinically, practising two 10-minute power breaks each day has been shown to result in reduced work-related fatigue while improving work satisfaction, productivity and overall well-being (Kennedy & Ball, 2007). Similarly, relaxation in general has been clinically demonstrated to have a significant effect on psychological distress. Given the fatigue and distress associated with the COVID-19 pandemic, this was determined as an appropriate technique to employ.

Assessing the Impact of the Podcast

Feedback for the intervention programme was assessed using an online survey, the link for which was included in the email distributing the podcast file. This survey was hosted on Qualtrics, and asked participants seven questions about their experience with each episode. Item one asked participants to rate their experience with the podcast on a 5-point Likert-scale (1=Very positive, I felt much better during and after the session; 5= Very negative, I felt worse during and after the session). Item two asked participants how likely they would be to listen to further episodes on a 5-point Likert-scale, ranging from 1=Extremely Likely and 5=Extremely unlikely. The remaining questions were qualitative items that assessed: what changed for the individual after listening to the episode; the components that were most helpful; the components that seemed less helpful; if there was anything they would like to see in future episodes; and finally, if they had any other comments. The items for this questionnaire were adapted from the assessment forms for the 'Hypnosis for Chronic Pain Management' programme, developed by Mark Jenson (2009). It is important to note that there was no ethics approval for this project, so feedback could not be collected using formal psychometrics and was instead used to inform development of the programme.

Responses on this survey were limited, with only two participants completing the Qualtrics survey. These responses are summarised in Table 2 below. Given the poor response rate to the survey, participants who were actively using the podcast were contacted for qualitative feedback. Again, the response for this was limited, and only two individuals were willing to provide a statement regarding their experience with the podcast.

One participant noted that:

'Just listened to the TARPS recording...I really liked it! Bite sized, easy to listen to, only takes 7 minutes! And it was tangible, practical things we can do. Also allows people who may be shy to speak up and reach out the ability to listen to stuff from the comfort of their own home...'

The other participant noted:

'The person delivering the podcast has a trustworthy voice and made me feel calm'.

Table 2.
Summary of feedback for the Self-Care Session podcast gathered from the Qualtrics online survey

Item	Response to Episode 2	Response to Episode 1
Overall, my response to the podcast was:	Very positive, I felt much better during and after the session	Somewhat Positive, I felt somewhat better during and after the session
How likely are you to listen to further episodes?	Likely	Likely
What changed for you (if anything) during or after the session?	Different mindset about the COVID situation	I noticed that I felt less tense physically, and that my breathing was a little calmer.
The components of the session that seemed most helpful were:	Dropping the anchor	I particularly liked the breathing technique, as it was simple and something that could easily be remembered when I needed it. I also really liked the background noises during the breathing exercise.
The components of the session that seemed less helpful were:	None	n/a
Is there anything that you would like to see included in future episodes?	More ways to relax and decrease stress	I would like to see more examples of breathing exercises, as I think these would also be good to use these with clients who are highly distressed.
Do you have any further comments?	The author has a nice calm demeanour, that is relaxing and reassuring.	Just look forward to the next one!

Discussion

This article describes the rationale, development, implementation and outcomes of a psychoeducation podcast developed in response to the challenges faced by frontline healthcare workers at ADHB. The podcast featured three episodes covering evidence-based techniques such as deep breathing, relaxation, self-care, dropping the anchor and cognitive emotional regulation. While temporarily halted because of the low risk for COVID-19 in Aotearoa/New Zealand, the podcast has the possibility to be reinstated should it be needed.

Accurately assessing the effects of the podcast was limited by the relatively low levels of feedback provided by participants. However, the feedback that was received appeared overwhelmingly positive. For example, the two participants that completed the questionnaire responded to the podcast as either very positive or somewhat positive. Both indicated that they would likely listen to the next episode, and had few negative comments regarding their experience. This theme appeared consistent when we followed-up and actively tried to gather more qualitative data. While the lack of feedback was disappointing, it was not entirely surprising, especially as the target audience is one that is likely overworked (now more so than

ever). In this context, completing a survey online may not be a priority and be unpractical in a fast-paced hospital environment.

While not a formal measurement of success, I believe that the podcast made a positive contribution to the provision of psychological support for healthcare workers within ADHB. This podcast was developed rapidly in response to concerns from colleagues within ADHB and represents one of the earliest provisions of support to ADHB staff. As the podcast grew, it attracted attention from the Professional Leader of Psychology at ADHB, who then advocated for a formal psychological first-aid programme for ADHB staff. Consequently, the podcast appeared to not only have been beneficial to providing direct support to clinicians, but also raised awareness surrounding the need for psychological support for all.

References

Bansal, P., Bingemann, T. A., Greenhawt, M., Mosnaim, G., Nanda, A., Oppenheimer, J., ... & Shaker, M. (2020). Clinician wellness during the COVID-19 pandemic: extraordinary times and unusual challenges for the allergist/immunologist. *The Journal of Allergy and Clinical Immunology: In Practice*.

Chen, Q., Liang, M., Li, Y., Guo, J., Fei, D., Wang, L., He, L., Sheng, C., Cai, Y., Li, X., Wang, J., & Zhang, Z. (2020). Mental health care for medical staff in China during the COVID-19 outbreak. *The Lancet Psychiatry*, *7*(4), e15–e16.

Cheng, C., Wong, W. M., & Tsang, K. W. (2006). Perception of benefits and costs during SARS outbreak: An 18-month prospective study. *Journal of Consulting and Clinical Psychology*, *74*(5), 870.

Day, S. X., & Schneider, P. L. (2002). Psychotherapy using distance technology: A comparison of face-to-face, video, and audio treatment. *Journal of Counseling Psychology*, *49*(4), 499.

Fan, F., Long, K., Zhou, Y., Zheng, Y., & Liu, X. (2015). Longitudinal trajectories of post-traumatic stress disorder symptoms among adolescents after the Wenchuan earthquake in China. *Psychological Medicine*, *45*(13), 2885–2896.

Gallagher, R., Neubeck, L., Du, H., Astley, C., Berry, N. M., Hill, M. N., & Clark, R. (2016). Facilitating or getting in the way? The effect of clinicians' knowledge, values and beliefs on referral and participation. *European Journal of Preventive Cardiology*, *23*(11), 1141–1150.

Hinton, M. J., & Gaynor, S. T. (2010). Cognitive defusion for psychological distress, dysphoria, and low self-esteem: A randomized technique evaluation trial of vocalizing strategies. *International Journal of Behavioral Consultation and Therapy*, *6*(3), 164.

Jensen, M. P. (2009). Hypnosis for chronic pain management: a new hope. *Pain*, *146*(3), 235–237.

Kennedy, G. A., & Ball, H. (2007). Power break: A brief hypnorelaxation program to reduce work-related fatigue and improve work satisfaction, productivity, and well-being. *Australian Journal of Clinical and Experimental Hypnosis*, *35*(2), 169–193.

Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., Wu, J., Du, H., Chen, T., Li, R., Tan, H., Kang, L., Yao, L., Huang, M., Wang, H., Wang, G., Liu, Z., & Hu, S. (2020). Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA Network Open*, *3*(3), e203976–e203976.

Fang, J. L., Chai, C., & Yu, Z. (2012). Risk factors for severe cases of 2009 influenza A (H1N1): a case control study in Zhejiang Province, China. *PloS One*, *7*(3).

Locker, M. (2018). Apple's podcasts just topped 50 billion all-time downloads and streams. *Fast Company*. https://www.fastcompany.com/40563318/apples-podcasts-just-topped-50-billion-all-time-downloads-and-streams

Pilecki, B. C., & McKay, D. (2012). An experimental investigation of cognitive defusion. *The Psychological Record*, *62*(1), 19–40.

Pospos, S., Young, I. T., Downs, N., Iglewicz, A., Depp, C., Chen, J. Y., Newton, I., Lee, K., Light, G. A., & Zisook, S. (2018). Web-based tools and mobile applications to mitigate burnout, depression, and suicidality among healthcare students and professionals: a systematic review. *Academic Psychiatry*, *42*(1), 109–120.

Rimal, R. N., & Real, K. (2003). Perceived risk and efficacy beliefs as motivators of change: Use of the risk perception attitude (RPA) framework to understand health behaviors. *Human Communication Research*, *29*(3), 370–399.

Romero, C. S., Catalá, J., Delgado, C., Ferrer, C., Errando, C., Iftimi, A., Benito, A., De Andres, J., & Otero, M. (2020). COVID-19 psychological impact in 3109 healthcare workers in Spain: The PSIMCOV Group. *Psychological Medicine*, 1–14.

Salloum, A., & Smyth, K. (2013). Clinicians' experiences of a podcast series on implementing a manualized treatment. *Journal of technology in human services*, *31*(1), 71-83.

Simister, H. D., Tkachuk, G. A., Shay, B. L., Vincent, N., Pear, J. J., & Skrabek, R. Q. (2018). Randomized controlled trial of online acceptance and commitment therapy for fibromyalgia. *The Journal of Pain*, *19*(7), 741-753.

Schaller, M. (2015). The behavioral immune system. *The handbook of evolutionary psychology*, 1-19.

Schmidt, U., Andiappan, M., Grover, M., Robinson, S., Perkins, S., Dugmore, O., & Williams, C. (2008). Randomised controlled trial of CD–ROM-based cognitive–behavioural self-care for bulimia nervosa. *The British Journal of Psychiatry*, *193*(6), 493–500.

Thakur, V., & Jain, A. (2020). COVID 2019-suicides: A global psychological pandemic. *Brain, Behavior, and Immunity, 88*, 952–953.

Tsai, S. L. (2004). Audio-visual relaxation training for anxiety, sleep, and relaxation among Chinese adults with cardiac disease. *Research in Nursing & Health*, *27*(6), 458–468.

Wilson, K. G., & Sandoz, E. K. (2008). Mindfulness, values, and the therapeutic relationship in acceptance and commitment therapy. *Mindfulness and the Therapeutic Relationship*, 89–106.

World Health Organisation (2020) *WHO Coronavirus Disease (COVID-19) Dashboard.* Retrieved 14 July, 2020, from https://covid19.who.int.

What We've Discovered Using Zoom/Telepsychology With Acceptance and Commitment Therapy With Clients During Lockdown

Ōtautahi ACT Interest Group

(It is more than JUST exhausting)

The Ōtautahi ACT (acceptance and commitment therapy) Interest Group is a small interest group that usually meets monthly. We decided to meet via zoom over the lockdown. Our meeting was at the end of the day, and we were tired out. Many of us had been seeing clients through the day using Zoom. It was still Level Four; some of us were working from home, others working as essential workers in the DHB, mostly seeing clients by Zoom or talking by phone. Our meeting could easily have descended into an exhausted, co-ruminating moan about the vagaries and challenges of doing psychology and ACT by distance. In the spirit of radical acceptance, curiosity, appreciative enquiry and opposite to emotion action, spurred on by the reconnection we began feeling in seeing one another, we decided to make some observations about what we had noticed.

Welcome along! You can now do some observing alongside us as well. Take a moment or two to pause now, as best you can, allowing your tiredness from your long day to just sit beside you, while you bring your beginner's mind to noticing what you discovered doing therapy via telephone or video calling during the lockdown.

The process was different. Many of our observations related to the ways we modified what we did with clients to create a connection. We agreed most of us were explicitly asking more about client experiences. We noticed it was effective to keep remembering to physically lean in towards the camera to convey closeness and attention, or to lean out from the camera to give space and demonstrate patience. We were working harder at modifying the tone and pitch of our voices to express connection and empathy, in the way a subtle head nod or sub-verbal 'mmm' might normally function in real life. Some of us found we were more tuned into the client as many extraneous stimuli are removed. This meant possibly being more aware of more subtle signs and expressions by our clients.

The Ōtautahi ACT Interest Group (O ACT I) is a group of Christchurch clinicians who meet monthly with the aim of fostering ACT skills, knowledge and capacities in the Otautahi/Christchurch. We have been going for nearly fifteen years with evolving membership. We use an experiential, skills building and discussion format to address questions and concepts related to contextual behaviour science. Join us by emailing otautahiactinterest@gmail.com.

Someone astutely commented that, 'When you're only using only the phone, it is a bit like being a room plunged into darkness. Because the key cues are gone, I have to bring extra attention to subtleties in voice changes and breathing'. In turn, perhaps the chance to start again or do things differently in a new modality offers us a chance to increase compassion for ourselves, as well as our clients. We are reminded all the more to remember to allow pauses to happen.

Doing things differently to usual freed us up to approach therapy a little differently. We noticed a reduced pressure for therapy to need to be or look a particular way. Sometimes this was uncomfortable for us. The phenomenon of seeing a client while they were in bed was certainly an experience that evoked strong emotions. We noticed ourselves getting pretty 'judgy' about that one...and we also observed the reality; it was the way many of our clients could keep warm while seeing us. They were relaxed about having a psychology session from bed. If not, we were talking about it as a process issue with the clients. It gave us the chance to practice openness to experience, again bringing compassion to ourselves as well as our clients about this same lockdown waka we are all onboard, creating new and different versions of the same old struggles.

We discovered values work was different in lockdown working via distance. Holding strong to the value of connection, and knowing that there are many ways that you can live a value, we observed that we were able to connect, albeit in different ways. Seeing the client in their own space, including the things they are connected to, can help us connect in new and broader ways. For example, clients' values may be easier to discern; the things they have around them can speak to their values and serve as prompts. Clients can also show us things that matter to them or that have only been obliquely discussed before. Without lockdown, how would we have seen that car our client has worked on, still in the garage and immobile, yet evoking so much more passion than we non-mechanically minded ACT therapists could have imagined? Being in the client's space allows us to connect into their valuing of these things more directly.

We can confirm now, via direct witnessing, that our clients are taking committed action in their lives. Clients who have struggled to eat breakfast; we have sat through breakfast with them. We have watched people taking their medication as a valued action in real time. The attendance of our rural clients has definitely increased, and they can suddenly access psychology when they could not easily do so previously. We wonder with surprise how this has not happened before, and then we recall what a big jump moving to telepsychology seemed at the outset of lockdown.

For some clients, continuing with Zoom has been a holding ground; we are having to just keep contact while less therapy-like work can happen. We paused to consider the clients we cannot see this way, or for whom the stress of video calling was too big to make psychology sessions worthwhile. In those pre-lockdown days, the thought of seeing suicidal clients by video calling evoked terror. With no real other option, we noticed that sometimes containment was easier or boundaries were more easily placed due to environmental variables having shifted. For clients who might desire a crisis admission know that that option is not even on the table, so have begun to engage in a quite different way. For now, we are sitting with the uncertainty about how this will change.

Being in Ōtautahi/Christchurch, we are no strangers to shared trauma (earthquakes, terroristic shootings, now COVID-19 fear). We observed that the whole prospect of post-traumatic growth is here again. We are hoping this is a chance to be reminded of kindness as a key value for our society. We notice our clients and ourselves wanting to do things of benefit to the community. Our interconnectedness is re-emphasised.

What did you discover?

COVID-19 Reflections

Karen Jones

I am one of a team of clinical psychologists who, for the last 10 years, has worked extensively with organisations to help support their people's well-being. This has been through a range of group workshops on topics such as building resilience and raising mental health awareness, to working with individual clients.

During COVID-19 the organisations that I have had the privilege to work with quickly embraced and elevated the well-being of their people to priority Level 4 (top priority if we go by COVID standards). Day to day, the message resounded loud and clear, 'Put you, your family and colleagues first'. This message, and more importantly the actions that supported this message, appeared to give people permission to look after themselves and those close to them. Ongoing online group sessions, increased levels of individual support and planning for new and improved well-being initiatives post COVID-19 were just some of the ways I saw many organisations living and breathing their commitment to support people in the workplace.

For the people attending, the sessions provided an avenue for them to express their reactions openly and safely, be listened to, feel validated and know they were not alone. The sessions also allowed people to express their needs in a way that was heard and actioned. People reported that even though situations were difficult for many during this time, having their workplace come to the party went a long way to alleviating their stress and support their well-being. As a result, people's commitment, loyalty and trust towards their colleagues, leaders and workplace strengthened. In addition, as many leaders acknowledged, performance and productivity surpassed anything we could have imagined through such a difficult time.

Over the last 10 years, I have seen the impact of workplace stress increase, leading to lower levels of well-being and mental health and elevating people's risk for experiencing a mental illness. In May 2019, the World Health Organization acknowledged this when they included 'burnout' as an occupational phenomenon in the International Classification of Diseases, 11th Revision. Burnout was defined as a syndrome conceptualised as resulting from **chronic workplace stress** that has not been successfully managed (https://www.who.int/mental_health/evidence/burn-out/en/).

We know from decades of research that the message of 'people first' in the workplace results in better well-being and consequently higher performance, but to see it in real time has been, for me, re-energising. I am optimistic that the question 'What do we need to do to support our people?' may now be asked at every board table. 'Our people' includes the Board, chief executive officer, senior leadership team, leaders, general staff, stakeholders, internal and external customers, and also our families and communities. It is a cliché, but it is true that 'organisations are not separate from the people—they are the people' and the COVID-19 experience has certainly shown this as never before. Also, for me it reaffirmed that organisations have a significant role to play in protecting and supporting people's well-being and many take this role seriously. As a psychologist working in this space, this experience has provided me with a renewed sense of purpose and belief that this work is important, has an impact and is one more way that our profession can and is making a difference.

Karen Jones has been working as a clinical psychologist since 2010. Before retraining as a psychologist in her 40s she worked in the corporate sector for a major bank in NZ and raised a family of three children. While much of her clinical work has been focused around supporting people's mental health in the workplace, she also has experience working with people and their families struggling with anxiety, adjustment disorders and cancer diagnosis and treatment. She now has a private practice in Parnell.

Technology and Psychology: 'Zoom' – the 'Tweet' of our Decade

Karen Jones

The author Thomas Friedman (2016) wrote in his book *Thank you For Being Late* that it was only in 2007 that the word 'tweet' still meant 'the sound of a bird'. Today for many of us, what first comes to mind is social media or maybe even Donald Trump. How quickly some things change.

Similarly, for many of us, until March 2020, the word 'Zoom' still meant 'to move very quickly'. Now, like tweet, Zoom has taken on another meaning completely. To me and I am sure many others, it has meant frustration as we navigate new technology and weak Wi-Fi signals, exhaustion from trying to be present and attentive for an hour or more, and anxiety as to whether working this way with clients is the right thing to do. But, despite these struggles it has also led to many positives.

Zoom now also means greater connection; connection to my loved ones, my colleagues and my community. As a clinical psychologist, it has also given me another way to be available, to reach out and support people. Personally, it has also meant a more flexible work/lifestyle, less daily travel, a chance to try something new.

I am certainly not a tech guru and never will be, but my experience through COVID-19 at having to quickly embrace a new way of working has shown me that it is possible, it is useful, it has a place and I can do it. There are of course considerations and concerns that we need to be mindful of. Issues around security and privacy, how we as psychologists interact with our clients over this medium and how to determine whether online offers an appropriate and safe option for our clients and us, all need to be discussed and addressed. But that should not stop us from embracing this medium as a profession.

Maybe now is a perfect time to add to our skill set, ask why we do what we do in the way we do it, explore and try new ways of working, to take the learnings and the momentum from our collective COVID-19 experiences and be brave.

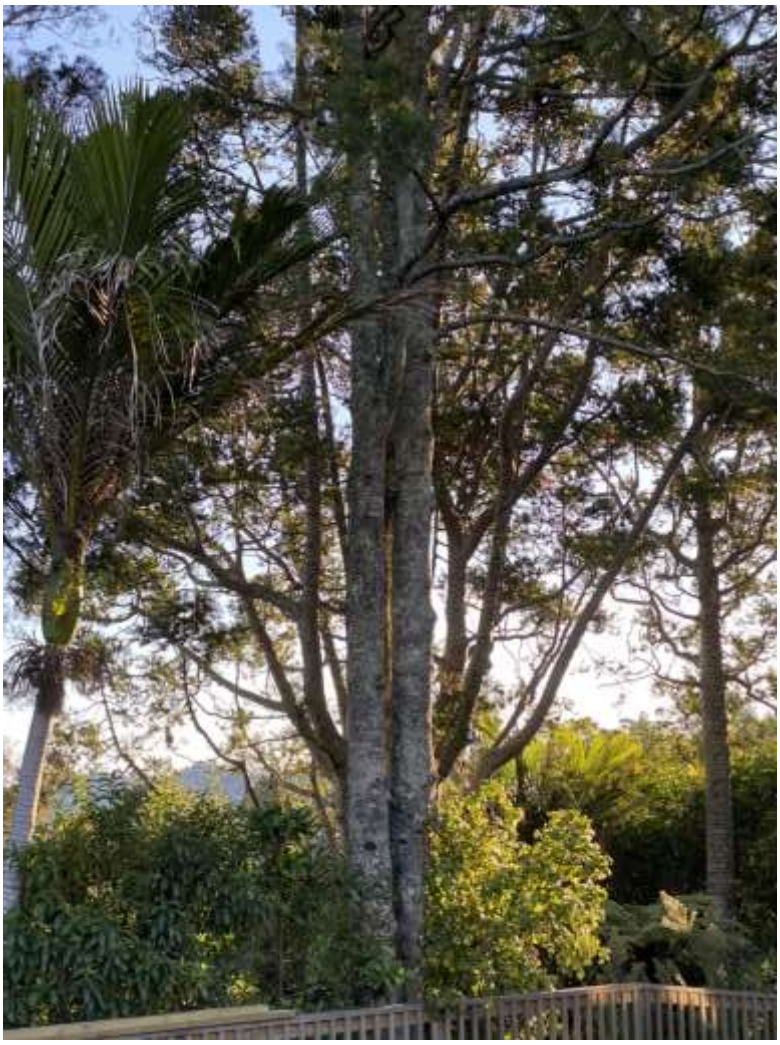
Just to finish on a slight tangent, I feel that the very word 'telepsychology' feels dated. When I asked my 24-year-old son what he thought it was he laughed and said 'a 1980s late night radio chat show'. Hmmm, not what I was hoping. Even Telecom realised the power of a name and updated to Spark! I do not have any immediate suggestions for renaming/branding but I would be keen for us as a profession to have this discussion.

Reference

Friedman, T. (2016). *Thank you for being late.* Farrar, Straus and Giroux.

Poem: NEW BEGINNINGS AND LOOKING FORWARD: *A story About Leaving our Profession. For a Little While*

Anonymous clinical psychologist working in private practice in Auckland



From my kitchen window
I turn to face you
Kauri
Your branches reaching wide
like a dozen sets of arms ready
to embrace an army of troubled
souls
(I smile as I think of all the
similes my children have
delicately crafted during our 40
days and 40 nights of 'home
learning', and now here I am,
flirting with my own)
In front of you, Kauri, stand the
two Kahikatea side by side
Tall and still
Quietly reflecting
Looking forward

Now I quietly reflect on you
Psychology
A meeting of minds 25 years ago
In a communist-style block of
concrete on Symonds Street
Through you I have learnt to
care in the deepest of ways
C-B-T-D-B-T-A-C-T...
A warm life-giving alphabet soup on a cold day
Add one pinch of grit
Two dashes of pain
And a generous dollop of my heart
Stir well until mixed and serve with freshly-baked self-raising doubt

And somewhere along this journey I was given my most precious gift
Two Treasured Tamariki
(Oh, we've crafted plenty of alliteration, too!)
And for years I wore my two hats with ease
Mother – Therapist

Until one day, not too long ago
I simply couldn't
When my own young daughter felt the flutter of a fear-filled mind
Light and gentle at first
Then rough and invasive
O-C-D-O-C-D-O-C-D…
This soup is dense and bitter and cold
I add four pinches of grit
Nine dashes of pain
And all of my heart
Yes, my girl needs All. Of. My. Heart.

When our country became still and quiet
The tui danced and sang in the Kauri
By then I understood
You are me, Kauri
And I am you
You are the Kahikatea, treasured tamariki
And they are you

Tall and still
Quietly reflecting
Looking forward

These are new beginnings for us all
Know that I am right behind you
With a dozen sets of arms now ready just for you

Transcript from a Video from Leaders in Healthcare

Rachel Prebble

Kia ora koutou, Ko Rachel Prebble toku ingoa. I hope that this video finds you well and coping with the challenges that COVID-19 brings.

I am leading the staff welfare and well-being response to COVID-19 for Capital and Coast and Hutt Valley DHBs through this time. Gosh what an intense time it has been.

When I think about leadership, the first principle for me is around intention and purpose. These drive the way we do our work, the work that we do and the way we talk about the work that we are doing.

For us the key concepts have been calm, confidence and hope. They are touchstones for me in my own personal wellbeing and self-care, they infuse all the work that we do and they help us to prioritise which activities to engage in.

Rachel Prebble is the organisation development manager at Capital & Coast District Health Board (DHB) and a clinical psychologist. She is leading the staff welfare and wellbeing response to COVID-19 for Capital and Coast and Hutt Valley DHBs. Rachel was asked to make a video for the Leadership section of the Health Quality Safety Commission COVID-19 Resource Hub

The second really important principle, for me, is about knowledge. It starts with research and literature, but very quickly takes us into context, and what that means is talking to our people. Understanding where are the natural resources already in place in our systems, what are the mechanisms and channels and communication points that we can use and who are the people who have the knowledge, skills, experience and wisdom to guide us in this work.

A big challenge at the moment, for me and for many leaders, has been the huge influx of information. Keeping up with that and then being able to make rapid, informed decisions. The reality for us is that there is no script, we do not know what is coming. There is a level of uncertainty and ambiguity. So it is important that we learn as we go, we modify, we adapt, we adjust and we develop. It is also important that we check back to that intention and that purpose to make sure that have not lost sight of our original goals in doing this work.

This also brings back the really important point about talking to our people and the importance of our network. My team, which is very small (we are three people usually) is now the nucleus for a network of maybe 50–60 people who are inputting ideas, coming up with ideas and making things happen. It is awesome to be a part of that.

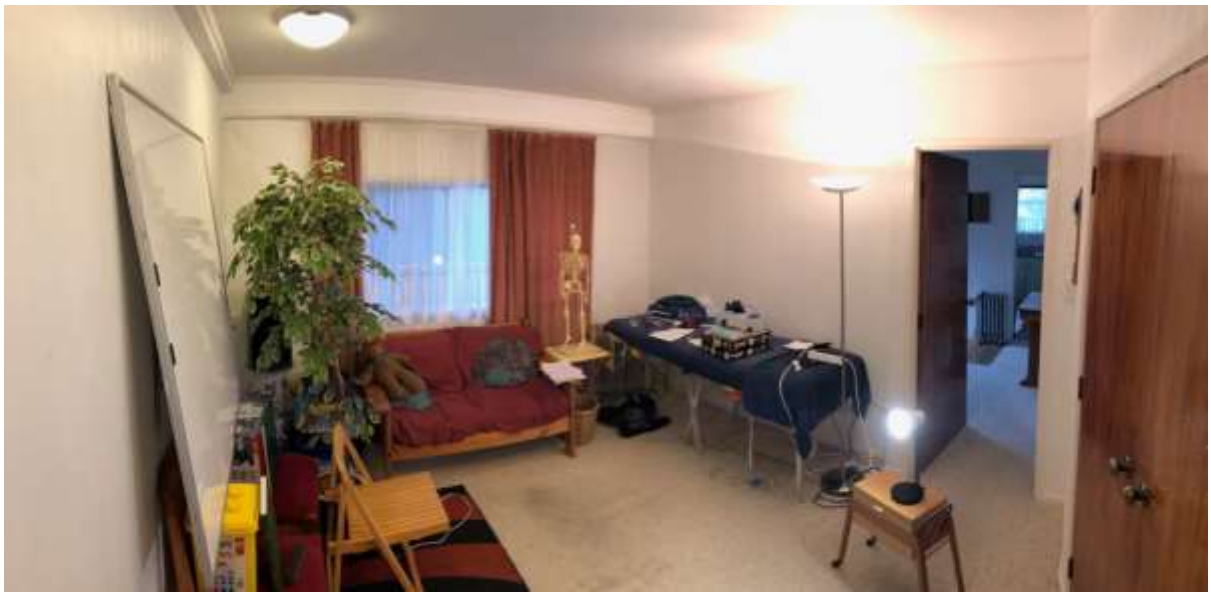
Even with that network, we still do not have a clear line of sight over our 10,000+ people who are working in all sorts of settings and all sorts of realities. So supporting our leaders and managers is a really important focus for us. They hold the tricky balance of responsibility for both operational delivery and caring for the well-being of their teams. Walking beside and strengthening their sense of calm, confidence and hope has been core for us. It is very exciting to watch that happen and see how powerful that is in helping to hold the wellbeing of the organisation.

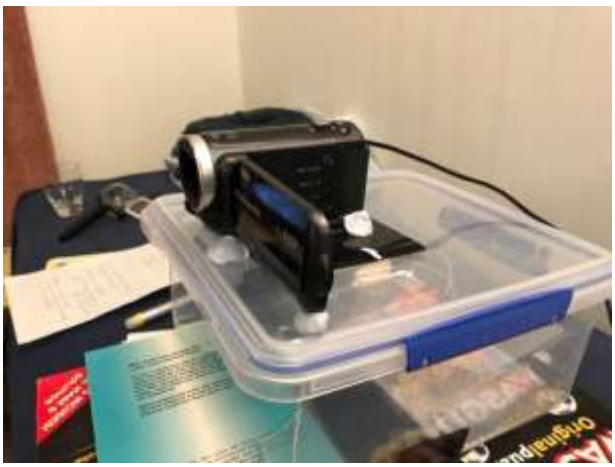
To me, connectedness and belonging for our people is really important and it is really tricky in this context. Making sure our people have information, a connectedness to the purpose of our work and that their welfare is taken care of is crucial.

All across NZ, I see fantastic activities and initiatives that do exactly that and it makes me very proud. We will get through this; we will get through this together.

The ad-hoc WDHB virtual Flexible Pain Response course: 30 March to 13 May 2020

Reviewed by Dieter Dvořák





'Firstly, I want to thank the WDHB for having the compassion and foresight to keep the North Shore Pain Clinic running during these difficult times. Living with chronic pain is a daily challenge and to also juggle C-19, lockdown and many other stressors would have been too much on my own. When most outpatient services are temporarily closed, it is a great relief to get this much needed support'.

Patient feedback at the end of the virtual Flexible Pain Response course

Overview

The Flexible Pain Response course has been the WDHB Pain Service's primary psychological intervention since late 2011 and has been attended by more than 1300 patients since then. It is a course for approximately 10–20 chronic pain patients/participants that comprises eight distinct 2-hour sessions. The course aims to promote an understanding of the necessary cognitive practices required to increase psychological flexibility. Pain willingness and activity engagement are the target key behavioural outcomes, as suggested by McCracken, Vowles and Eccleston

Dieter Dvořák is a clinical health psychologist, and has been working for the Waitemata DHB Chronic Pain Service since 2011

(2004, 2005). The sessions are highly structured and build on each other in a sequential fashion. Overall, there is a strong didactic flavour that is complemented by experiential experiments and the stepwise development of practices of non-reactive awareness of stimuli, first of a neutral and then of an increasingly aversive nature. Promoting the identification of personal values to guide meaningful goal setting is also a part of this course, as is the direct challenging of guilt-/shame- and embarrassment-related cognitions and beliefs. Participants receive a package with resources such as written instructions, metaphorical illustrations of key concepts and Microsoft PowerPoint slides after each session via email.

Overall, this course represents a conceptually congruent amalgamation of dialectical behaviour therapy, acceptance and commitment therapy (ACT), mindfulness-based stress reduction, mindfulness-integrated cognitive behaviour therapy and computed tomography 'methods' and techniques. ACT's six interlinked processes of 'psychological flexibility' provide the overarching and guiding principle of every aspect of this intervention. The course was created and is conducted by one clinical psychologist.

Because of the ongoing COVID-19 pandemic and associated strict lock down conditions between the 23 March and 13 May in New Zealand, it was not possible to proceed with the workshop as an in-person event. Therefore, a virtual substitute for the existing workshop was created in an ad hoc fashion by producing (daily) video clips in a makeshift film studio (varying in length between 5 and 25 minutes) and daily communication (primarily via email) with patients. Hundreds of previous participants were also contacted and invited to participate in this virtual course as a refresher. In the end, a total of 222 current and previous patients took part in this course.

Virtual Course Process

From 31 March onward, participants normally received one email per day, including on weekends and public holidays, for 45 consecutive days. These emails contained instructions and information materials as well as answers to patients' queries and comments. This system was tolerated quite well, although a small number of patients initially reported feeling uneasy about the sheer amount of information and materials they received. Patients were strongly encouraged to build their personal library of instructional resources by saving the emails and attached resources onto their computers/devices without feeling the need to attend to them immediately. The concept of a 'virtual library' seemed to be largely understood as indicated in feedback such as these comments:

> '*I have saved all the emails you have sent and will now start from the beginning again'.*
> *'I have taken the chance to read again all the info that you've sent'.*
> *'Being able to watch the videos and read the material in my own time was also great. Being able to go back and revise was also valuable. I will go right back to the beginning of our emails from you, as l am 70 years old and have learnt such a lot'.*
> *'Thank you so much for all your hard work putting the videos together, I am now able to refresh whenever I need to'.*

Instructional Resources Produced

The patient information materials such as Microsoft word documents, PowerPoint slides and especially the video clips, continued to be produced (in a makeshift home studio with an old camcorder and edited on a PC and laptop) throughout the duration of the course, with the total number of video clips produced exceeding 60. Of these, 41 were actually utilised for this particular intervention.

Patient Feedback Summary

Throughout the course, patients continued to provide spontaneous and unsolicited feedback that was overwhelmingly positive. For example:

> '*Please keep doing what you are doing. It works. It changes lives. I owe you a debt of gratitude that I can never begin to repay, so thank you, from the bottom of my heart'.*
> *'I have had CRPS for 8 years and nothing has helped as much as watching those videos'.*

Initially, the themes of such feedback revolved mostly around a profound sense of surprise and gratitude that such a virtual course would even be provided through the lockdown by a 'non-essential' service.

> *'When most outpatient services are temporarily closed, it is a great relief to get this much needed support'.*
> *'Thank you for your contact and direction…you are the only health professional that has done this so far'.*

The second theme that came through for the entire duration of the course was the ease of access of the virtual course. In particular, having the opportunity to watch and pause and re-watch the videos in one's own time and space was commented on, pointing to the enduring usefulness of such multimedia-based interventions beyond ad hoc pandemic responses in the future. For example:

> *'Thank you for offering this virtually. Since participating, I have thought many times it would be amazing if it [was] online, as it is less of a barrier to attend'.*
> *'Even though I have done your course before I am glad that you are delivering your material in many ways'.*
> *'Your videos are great, and they are easy to follow. I often watch them more than once, even days later'.*
> *'I do like these short videos'.*

A third common theme was that the videos in particular were seen as informative but also 'engaging' and as providing a sense of 'being connected in a personal way' to the course and the course facilitator despite the physical distance.

> *'Thank you so much as I am still going over and over the sites you have sent, and when I need help, I just come up to my computer and I just feel as if I am in the room with you'.*
> *'Now, I see quite clearly from your video what is happening. I really do find these short videos informative and helpful'.*
> *'I want to thank you so much for all of your videos, emails and for the connection that you maintained with us all during this time'.*

Reflections

The ad hoc virtual Flexible Pain Response workshop appeared to have been a success. A large number of patients (existing, newly referred and previously engaged; 222 in total) could instantly be provided with a therapeutic educational intervention that appeared to be informative and potentially efficacious for participants. It was an intervention that was easily accessible, especially under Level 3 and 4 lockdown conditions. Patients' feedback strongly indicated that they felt supported through a very difficult and generally stressful period of time, which also naturally reinforced the trans-diagnostic nature of this intervention beyond chronic pain to directly address COVID-19/lockdown related concerns and distress as well. The video clips were produced under extreme time pressure and with extremely rudimentary equipment in a makeshift home based 'film studio' and the obviously modest production quality (lighting, sound, editing etc.) reflected that. However, it also became clear that the actual 'content' and the personal presentation of this content was more important than perfect lighting or sound. For example:

'I applaud the way you took up the challenge of working to put together material that you usually present in person. Even when the video quality wasn't too good, it didn't matter as the open and inclusive way you related to us overrode those teething issues'.

This ad hoc 'beta version' of a virtual intervention that was quite literally put together overnight demonstrated great promise for being a viable and beneficial model of service delivery beyond the global COVID pandemic that seems to require an ongoing readiness by service providers to switch to telehealth methodologies if and when needed again in the future anyway. However, there have always been a substantial number of patients who found it very difficult—or impossible—to attend an eight-session course in the first place. This was difficult or impossible because they: lived a long distance from the nearest hospital (e.g. Wellsford to North Shore Hospital = 70 kms); cannot afford to take time off work; cannot attend due to child/dependent care duties; and/or had difficulty accessing course premises because of physical limitations.
For these reasons, the virtual FPR course continues to be delivered alongside the traditional in-person courses. In fact, the aim is now to provide two in-person courses at two different hospitals together with the online course in a synchronised fashion so that patients have the opportunity to switch seamlessly between them week-by-week, thus maximising accessibility for all patients of the WDHB Chronic Pain Service. The use of video clips has now also been extended into the general orientation process for new Chronic Pain Service patients who no longer need to come to the hospital in person in order to get a first impression of the Flexible Pain Response course and the clinical psychologist running it.

Concluding reflection
It has been a thoroughly exhausting but also immensely satisfying experience and a privilege to provide support and guidance for so many patients under such difficult circumstances and also to be able to use this 'experiment' as a springboard for long-term innovations in public health service delivery.

References:
McCracken, L. M., Vowles, K. E., & Eccleston, C. (2004). Acceptance of chronic pain: component analysis and a revised assessment method. *Pain, 107*, 159–166.
McCracken, L. M., Vowles, K. E., & Eccleston, C. (2005). Acceptance-based treatment for persons with complex, long standing chronic pain: a preliminary analysis of treatment outcome in comparison to a waiting phase. *Behavior Research and Therapy, 43*, 1335–1346.

Core Performance Standards for Responsible Authorities

Reviewed by Peter Stanley

The revision of the Health Practitioners Competence Assurance (HPCA) Act in 2019 introduced regular performance reviews for responsible authorities, which include the Psychologists Board. Recently, the Ministry of Health (MOH) sought feedback on the draft Terms of Reference and core standards for performance reviews. Dr Peter Stanley's response to the MOH represents a personal view on the regulation of health practitioners and their boards.

I am grateful to make this individual submission in response to the *Core Performance Standards for Responsible Authorities: Consultation Document.*

It makes obvious good sense to increase the consistency and the transparency of the work of responsible authorities across the health sector where this is relevant, and especially if there is

Peter Stanley worked as a psychologist with a secondary school and, successively, for the Department of Education, the Special Education Service, Specialist Education Services, and the Ministry of Education.

good evidence of unnecessary variations across authorities. It is proposed that there be regular, independent and separate reviews to ensure that boards are efficiently and effectively performing their functions. An alternative approach in the regulation of responsible authorities would be to establish a permanent Professional Standards Authority.

The *Consultation Document* points to concerns about 'professional' versus 'public-led processes', the possibility of 'regulatory capture', 'professional self-interest' and the need for all health practitioners to recognise that the purpose of HPCA is 'essentially outward—on protecting the safety of the public, rather than inward—on prioritising the welfare of the profession'. These repeated references appear to be the nub of the matter, and it is recommended that specific Core Performance Standards are necessary for wayward responsible authorities, and that these should prioritise public well-being.

Regular reviews and Core Performance Standards are an additional level of insistence that the simple injunction of the HPCA about the safety of the public be adhered to. Effectively, regulatory authorities are themselves to be held to account and to be regulated. This move to increase consistency, compliance, and conformity will likely prove beneficial if the essential purpose and the expressed performance standards are appropriate and adequate responses to a perceived need. Conversely, if the original objective is simplistic as well as simple and if the new Core Performance Standards are simply stipulations arising from the original objective, then the new compliance mechanisms will regularise an incomplete response to an issue and will likely exacerbate any deleterious consequences.

The HPCA's single criterion of 'risk to the public' is an incontestable purpose. What rational and caring citizen would not wish to protect members of the public from avoidable risk and harm? However, the existing objective is clearly restricted and oversimplified, and it is best understood as a sentiment, or as an aspiration. A more meaningful intention would specify how the public would be protected, and this would most likely be in an explicit statement about maintaining and enhancing the competencies of health professionals *and* by promoting the individual health professions. As it stands, the HPCA approach is inherently about practitioner fault finding. Inevitably, it also pits the public good against professionals and against health professions, as is evident in the present *Consultation Document*.

Potentially, there are a number of negative consequences that may have already arisen from the HPCA model of professional regulation. It could be that: practitioners are continually apprehensive about complaints; they choose low-risk treatments over more risky, but more efficacious, client interventions; and they are reluctant to work alongside other health professionals and paraprofessionals who may endanger their careers. It is also probable that all of the health professions as collective entities have suffered from regulation. In times past, professional associations heard complaints and vetted university training programmes as well as promoting the interests of a professional group. With legislation, hearing of complaints and course accreditations transferred to regulatory authorities but the active promotion of the health professions may have largely stayed behind. The problem is that complaint processes and accreditations are the levers of authority that gave credibility and meaning to the other functions of professional associations, and the loss of them may have meant that the health professions have been diminished accordingly.

There are also a number of ironies and paradoxes that pertain to the current (and to the intended) regulatory environment. On a personal level it is curious under user-pays that health practitioners pay to be policed, and that they will soon pay for their regulatory authorities to be policed as well. Moreover, it is contradictory that the government on its own initiative can create

new health professions (e.g. Health Improvement Practitioners) to take over the responsibilities of established health professions, and that these new occupational groups can actually represent serious threats to the purpose and requirements of the HPCA. As the recent dispute between teachers and the Teaching Council in our country highlighted, the relationship between regulators and the regulated is actually an implicit contract, and this agreement has to acknowledge the needs and preferences of the practitioners and the profession who are affected by it.

Territory disputes between health professionals can be a confusing distraction to members of the public, and they can also represent real risks to them. Many examples of such disputes exist, and included here are clashes between midwives and obstetricians and among psychologists, psychotherapists, psychiatrists and paediatricians. The present proposal, which is solely concerned with individual reviews of regulatory authorities, will be much less effective in managing territory disputes than a Professional Standards Authority could be. There will be other limitations of what is proposed regarding workforce planning, health reforms and new legislation. In conclusion, it would obviously be helpful if the oversight of regulatory authorities was centrally administered. And in the light of what is intended, it would also be useful if the new Core Performance Standards more openly acknowledged that regulatory authorities should actively contribute to the vitality and well-being of health professions, as this is also in the interest of protecting the safety of the public.

Book Review

Title:	**A Conversation With my Country. Where We've Come From. Where can we go**
Author:	Duff, A.
Publisher:	Random House, 2019.
Reviewer:	Peter Stanley

A Conversation With My Country is an appeal for all New Zealanders to talk about the situation for Maori and the future of our country. Duff is entirely clear about what he would contribute to such a conversation, and says that there is a discreet percentage of Maori who are responsible for a disproportionate amount of social damage. However, the majority of Maori are law-abiding and contributing; in many fields of endeavour, they are excelling. In reality, progress has been quick, and Maori are now 'light years ahead' (page 49) of other indigenous peoples in the world. However, according to Duff, the problem that we now have with social statistics for Maori is that they are persistently misinterpreted as the consequences of colonisation. In contemporary New Zealand, there are contingents of Maori unemployment and benefit dependency and of drunkenness and violence, which lead on to high Maori incarceration rates. These are at least as much the product of failures of personal responsibility as they are the results of historical events. It is all a question of contrasting perceptions (which the author refers to as the Yanny and Laurel effect), and the prevailing colonisation narrative is supported by many people who are deriving substantial benefit from it. Duff's justification for having a view is that 'My eyes have seen their share, my mind and lost emotions have wandered the extremities…' (page 238), and because he himself has arisen from highly challenging personal circumstances to take other life options and become an award-winning novelist and literacy benefactor.

The author's own journey is central to his polemic. While this is probably a common occurrence, here it could be distinguished by being so clearly and cogently catalogued. Interestingly, from an academic perspective, Duff's personal story is also verified by developmental studies of antisocial

behaviour and of resilience. We know that poor parenting is often characterised by harsh and inconsistent discipline; along with this, the author's mother was a bad drunk who deliberately grew her fingernails long for mass brawls on the front lawn. The author explains that she had such an 'inflated sense of self, hurt-self, justified-self' (page 65) that she 'did serious damage to her children's minds and emotions' (page 228). By contrast, the author's father was a reading and thinking man who provided his son with an attachment relationship with a capable and prosocial adult. And such connections, along with reasonable individual intelligence, are central components in adaptive functioning (Masten, 2014). Nevertheless, developmental trajectories arising from such places are rarely smooth and of the six Duff children, one was killed in a drunken car crash and four did jail time. The author himself was a state ward who was incarcerated on three separate occasions. Duff has certainly known dark times, but he continues to hope that 'I shall never be so far removed from my periods of despair, self-hatred and low self-esteem that I can't feel empathy with others in the same situation' (page 58).

A Conversation With My Country contends that colonisation beliefs absolve Maori from responsibility for their actions and do nothing to address their social casualty statistics. Europeans did act unfairly and prejudicially towards Maori in the past. But poor parenting by sectors of Maori, not rapid modernisation, underlies contemporary problem behaviours. Effectively, the author is invoking the human development concept of multifinality where similar early experiences lead to a diversity of adjustment issues. Duff says that Maori should be given more credit than is contained in the colonisation account. Furthermore, he has absolutely no intention of having whanau, hapu and iwi being foisted upon him by middle-class white people as the solution to ethnic disadvantage. 'This half-Maori would rather die than do things this way' (page 97). If the tribe and traditional practices are really relevant to present day issues, why are not Pakeha parents teaching them to their children? And why are not Maori leaders railing against 'our damning statistical black hole' (page 98)? In addition to colonisation, the author identifies the prevailing preoccupation with poverty as getting in the way of progress. Poverty means payouts, and '[g]ive a human anywhere a living for simply existing, and more often than not I'll give you back a corpulent, spiritless blob from whom the human essence has leaked away' (page 96). In Duff's view, entitlement actually touches all social strata in our country, and it is exemplified in the salaries of chief executive officers and the superannuation scheme for judges, while it also maintains hard-core, welfare sub-worlds for some Maori.

Why is it so difficult for us to have meaningful conversations about the 'statistical black hole' for Maori? Duff has overlapping answers to this question, and largely it is because there is an established group of people (many of whom are white, educated and seemingly rational) who *know* that the solution for Maori is welfarism, and they are supported by a cultural belief system that exists irrespective of other facts, experience, history or opinions. It is the Yanny and Laurel effect all over, with the exception that these insulated spokespeople, along with the inhabitants of the 'House of Big Social Decisions' (page 164), will never be held accountable for their failed projects which are quickly forgotten. Duff asserts, it is 'all the wrong analysis, treated with the wrong methods because no one is *permitted* to give an alternative view' (page 164). Most concerning is the cumulative direction of travel for our society, with the inevitable destination being further division, victim-excuse-mongering, doom and gloom and consolidated disadvantage. Leaders who really cared would have as their ambitions the reduction of beneficiary dependence and the elimination of its resultant state house hellholes. Such aims could be achieved through proven programmes for employment, training, education, mentoring and parenting. But first, we need to have some conversations and connection that are devoid of ideology and vested interests.

Reference

Masten, A. S. (2014). *Ordinary magic: Resilience in development.* Guilford.

Book Review

Title:	**The Five Invitations: Discovering What Death can Teach us About Living Fully**
Author:	Frank Ostaseski
Publisher:	Flatiron Books, 2017
Reviewer:	Louise Morgan

'Life and death are a package deal. You cannot pull them apart', are the opening words of Frank Ostaseski's book, *The Five Invitations*. In this book, Ostaseski, co-founder of the Zen Hospice Project, shares wisdom gained from sitting with countless people who have faced the end of life due to cancer, HIV and other health difficulties. He speaks of death as always with us, the 'secret teacher', helping us to discover what matters most. The five invitations are practices based in Buddhist philosophy that enable us to navigate transition and crisis, appreciate the preciousness of life and to live consciously. The invitations include: Don't Wait; Welcome Everything, Push Away Nothing; Bring Your Whole Self to the Experience; Find a Place of Rest in the Middle of Things; and Cultivate Don't Know Mind. Ostaseski describes these invitations as 'bottomless practices that can be continually explored and deepened', and which 'have to be lived into and realized through action'.

Throughout the book, these practices are evidenced with the stories of people facing their own death, each in their own way, with their own story. What influenced me the most in reading this book was the way in which Ostaseski was able to be present with those who were dying, and in so doing, allowed them to find their own way to the end of life. This, it seems, is similar to the work of therapy; to be fully present and to help our clients make sense of their world and to 'find their way' to healing and wholeness. There are some beautiful stories of Ostaseski truly resonating with those he sits with, stories of the transformative power of suffering and grief. These provide examples for us to emulate as clinicians working with those who are currently struggling in the journey of life. In his book, Ostaseski notes that he had studied Carl Rogers working with patients, and observed that he rarely spoke, but that his listening drew out the truth from his patients and allowed healing. He quotes Rogers words, 'before every session, I take a moment to remember my humanity…Whatever his story, he no longer needs to be alone with it. This is what will allow his healing to begin'.

I have a 'top shelf' on my bookshelf. This is where I place the best books I have read, those that have moved, challenged or transformed me in some way. I took this book out of the library just prior to lockdown, but will be buying a copy for my shelf. This book resonates with my own values, how I would like to live my life, but also how I want to practice as a psychologist. I will be recommending this book to students entering the field of clinical psychology, alongside my other favourite *The Miraculous Journey of Edward Tulane* by Kate Di Camillo. Both stories capture the need to embrace both joy and suffering in order to live life fully.

I would like to end this review with Ostaseski's invitation, 'An invitation is a request to participate in or attend a particular event. The event is your life, and this book is an invitation for you to be fully present for every aspect of it'.

Louise Morgan has worked as a Clinical Psychologist for the past 15 years in both Community Mental health and private practice. Louise is currently employed as the Clinic Director at the Centre for Psychology at Massey University in Albany. Louise works with children, adolescents and adults and with a wide range of presenting issues. Louise is an avid reader, and considers the art of story-telling and life journey integral to her therapeutic practice.

Book Review

Title:	**Stuff That's Loud: A Teens Guide to Unspiralling When OCD Gets Noisy**
Author:	Sedley, B. & Coyne, L.
Publisher:	Robinson, 2020
Reviewer:	Tania Stanton

> Notice that the loud stuff, sneaky as it is, tells you one story…What if…there's a whole other story here for you to discover?

Wellington-based clinical psychologist Ben Sedley and US-based clinical psychologist Lisa Coyne have written a guidebook for teens with obsessive compulsive disorder (OCD) symptoms to start them on their way to 'unspiralling and finding freedom from OCD'. Both work with young people and both work with acceptance and commitment therapy.

Stuff that's Loud opens with 18-year-old Ethan describing his journey accessing tools to help him challenge OCD symptoms:

> But I was wrong to think that anyone could 'fix' me. Whether it's a therapist, medicine, or even a book like this one, there is no magic that is going to 'fix' you. If your struggle is a battle, then those are your weapons. All anyone or anything can do is give you weapons and strategies to fight your battle with. But in the end, you are the only one who can make a difference.

This voice of self-empowerment remains throughout the book, and the book's illustrations are often from this same person-centred view, giving the sense of being inside the struggle. The authors' include direct quotes from young people and the narration has a validating and empathic tone that speaks with such deftness of psychoeducation that you never feel the graunch of a teaching moment.

> Think of the sneakiest thing you can think of. **Double it.** The stuff that's loud is sneakier. Much sneakier. It can pull you down a hole and then tell you that you're crazy for following it down the hole. It can tell you that bad things will happen if you don't follow it. Really bad things.

The authors and young people's voices weave together offering a seamless message of understanding and hope. From Ethan:

> Horrible things happen to many kinds of people every day. I don't want to undermine anyone else's struggle when I say that OCD is a different breed of hardship. It is not an outside force that is making your life difficult. It is your own brain that is doing this to you. Every time you complete a compulsion it may provide temporary relief, but at the same time it reinforces the cage you have trapped yourself in.

The presentation of the book sets the tone for what lies inside. *Stuff That's Loud* is a small square-shaped paperback with just over 100 pages. It has an arresting cover and powerfully emotive illustrations. Its light and accessible feel gives it the best chance of not daunting its teenage readership. The short chapters are fully illustrated and offer emotional containment; they signal

Tania is a Wellington based Clinical Psychologist working for the CCDHB Maternal Mental Health Team. Prior to this role, Tania worked with young people in a Child and Adolescent Mental Health setting.

this book is not overwhelmed in the presence of OCD. The writing is economical and often beautiful, and you will find yourself re-reading paragraphs for pure delight. The authors have grounded the book in exposure and response prevention (ERP), which continues to have the strongest evidence base for treating OCD.

The book is divided into two parts, the first part is called 'Spiralling' and provides three chapters that acknowledge the universality of the spiralling mind, the different ways that people can be affected by OCD, the sneaky ways that it takes hold and its tricks for maintaining its hold. Narrated with empathy, validation and a satisfying sass toward OCD.

> George Bernard Shaw said, 'Never wrestle with a pig. You both get dirty, and the pig likes it'. Your mind isn't a pig, but the stuff that's loud does enjoy a good wrestle.

Part two offers the tools for challenging OCD with accompanying experiential learning tasks, headed as: Curiosity, Willingness, Giving A $#!% and Flexibility. The Curiosity chapter focuses on guiding the reader through different techniques to observe OCD thoughts and feelings and the reader's responses, 'Notice that the stuff that's loud is talking to you. Notice its sneakiness. Observe the ways it tries to be the only sound you can hear…What happens when you don't do what the stuff that's loud tells you to do'. The next chapter is on Willingness to challenge OCD and offers an authentic portrayal of how tough it is to face fear.

> Here's the thing about unspiralling: you'll never feel ready. It will never be the right time. You will never feel like, I can 100 percent do this? It doesn't get easier/righter/better tomorrow, if you don't do it today. Right this moment.

The relentless honesty about the discomfort this brings offers a wonderfully inspiring chapter with a coming of age feel.

> Notice that the loud stuff, sneaky as it is, tells you one story. What if… there's a whole other story here for you discover?

Giving A $#!% focuses on helping the reader connect with what matters to them and includes a little of Greta Thunberg's story. The book is heavily weighted toward motivation for change. The Flexibility chapter guides through the 'how to's' of ERP and offers lots of things to try, including mindfulness, and equips the reader with a radar for OCD sneaky play. The later part of the book covers getting support and staying well. It gently encourages starting a conversation with parents, explaining that OCD thrives on secrecy. Other chapters include a focus on connecting with others, sleep, exercise, eating and drinking, medication, device use and therapy, alongside some extra resource information. Like the rest of the book, these later chapters honour the autonomy of the reader by never preaching, but instead offering information to set them up for success.

I can highly recommend *Stuff That's Loud* for people who struggle with OCD or who struggle with persistent loud thoughts that are getting in the way of them leading the life they want. It is written specifically for teens and I would recommend it for age 15 years and upwards. It is also useful for parents, partners and friends who will gain understanding of both OCD and the journey to well-being. While small and accessible, it offers a diversity of content, brimming with rich descriptors, metaphors and techniques to turn down the volume on the stuff that's loud. Therapists seeking new ways to express OCD concepts or use ACT in the treatment of OCD will find it a valuable resource.

Before *Stuff That's Loud*, Lisa co-authored *Acceptance and Commitment Therapy: The Clinician's Guide for Supporting Parents*. Ben authored *Stuff that Sucks* in 2015, which is a teen guide for accepting thoughts and emotions instead of struggling against them.

Book Review

Title: **My Coping Skills Journal**
Author: Sarah Bell-Booth
Publisher: Self-published, 2020
Reviewer: Annetta Bouius

My Coping Skills Journal has a simple and attractive lay out. Focused on using CBT tools, its uncluttered pages contain one bite-sized coping tool per page under a number of different section headings, including emotions, thoughts, physiological sensations, behaviours, lifestyle choices, social support and positive psychology. Each page relies primarily on diagrams and tables to present information with minimal writing, which makes it accessible to a wide range of people.

Bell-Booth's induction to the book suggests that it can used as a self-help guide or part of the therapeutic process. While the bite-sized strategies are simple and effective, there is little in the way of support to plan how to translate the contents of the pages into actions in everyday life. I assume based on this that the primary audience are people with relatively straight forward difficulties who would benefit from an introduction to coping skills.

I would certainly recommend it as an adjunct to support knowledge and understanding of various coping skills. It would also make a fantastic basis for a coping skills group or as part of time-limited therapy.

Annetta has 25 years' experience of providing clinical psychology services. She enjoys working with people who have Autism and other neurodevelopmental disorders and undertakes assessment of Autism, Intellectual Disability and Executive functioning. She also provides support to various organisations, agencies and the court wanting to understand how a client's disability affects their support needs and behaviour. Additionally Annetta undertakes private practice assessment and therapy, alongside ISCC assessment and therapeutic work.

Book Review

Title: **Free to be Children – Preventing Child Sexual Abuse in Aotearoa New Zealand**
Author: Robyn Salisbury
Publisher: Massey University Press, 2020
Reviewer: Bernadette Berry

My first thought when I saw the subtitle of this book was 'that is a big ambition', and I wondered how any book would manage to make any inroad to that aim. It is rare in a text book that I bother reading the preface, but I did so with this text to see if it gave me any insight into the actual aims of the book. I was not disappointed. Robyn Salisbury clearly outlines the purposes of all the chapters and writers included in this text and towards the end of her preface

Bernadette was one of the early graduates of the Dunedin Clinical Programme. She has worked in community psych teams, a specialist child and adolescent service, and for the last 20yrs has started and worked in a small-group private practice. She has spent many years on her local NZCCP committee as well as serving on the Council when it was in Dunedin.

explains why this is a first step in reducing the prevalence of sexual abuse in this country.

All of the contributors to this book are experts in some form or another. Two chapters are from the personal perspectives of a victim and someone who lived near a perpetrator. The rest are all experts in their fields, with essays from the obvious contributors such as a paediatrician, a social worker from Oranga Tamariki and also a senior sergeant from the Child Protection Team, the Chief Censor in relation to technology and a psychologist working in a sex offender treatment programme along with others. Each essay is concise and well researched, but also written so that information is easy to understand and recall.

I cannot recommend this book highly enough. Judge Becroft wrote the forward for this book and I cannot improve upon his final words:

> Free to be Children makes an excellent and contemporary contribution to the discussion of child sexual abuse. It will provoke thought on this crisis. It will broaden readers' understanding of the key issues at play. It will contribute to a better response and encourage more professional and effective practice across all disciplines. It should be required reading for anyone working in the field, and it will richly repay careful reading.

You cannot work as a therapist in NZ without encountering clients who have been traumatised by sexual abuse. This book is an excellent summary of much of the latest thinking in this area and is likely to be useful to beginner and experienced therapists alike.

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	NEW DATES: 25-28 March 2020	NZCCP 31st National Conference "Tui, tui, tui, tuia"

Other Events

LOCATION	MONTH	PRESENTER/ CONTENT
Webinars	Various	DBTNZ webinar training series
Wellington	Sep, Nov	ACT workshops
Webinar	11-12 September	Emotionally Focused Therapy with Individuals – EFIT Level 2
Napier	24-25 September	Trauma and Personality Disorder: Integrative Psychotherapy of Trauma Induced Personality Disorders
Auckland	17-23 October	MTI NZ Intensive
Auckland	October	Trauma Education presented by Dr Leah Giarratano
Napier	15-16 October	Modern Therapy Approaches for Narcissistic Personality Disorder
Wellington	29 October	National Trauma Symposium
Auckland	7-10 November	ANZ ACBS conference 2020
Napier	12-13 November	Complex Cases: Treatment of Chronic and Recurrent Mental Health Problems by Personality Functioning Informed Therapy
Napier	30 November-2 December	RANZCP 2020 New Zealand Conference
Wellington	10-11 December	ASfAR 2020 Autism Conference
Bay of Islands	18-20 March 2021	Annual Scientific Meeting of the New Zealand Pain Society