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"He tina ki runga, he tāmore ki raro" The growth above is strong when the roots below are secure

Those with a strong grounding in their own culture will find satisfaction in life

Editorial

Dear Colleagues

It is that time of year when we hear those familiar carols again with lyrics like "…dashing through the snow…" and "I'm dreaming of a white Christmas." I have grown up with Christmas in the southern hemisphere, and every Christmas I feel amused at this cultural mismatch. Not all instances of cultural mismatches are amusing though. My parents are ethnically Sinhalese Sri Lankan and throughout my life, growing up primarily in South Africa and New Zealand, the majority of people I interacted with looked different from me. My own experiences of cultural conversations have been influenced by the tone of voice and manner of the speaker that imply assumptions about who I am. Just the other day, my sons and I were getting photos with Santa (an operation, incidentally, not for the faint-hearted) and a man who appeared NZ European said something to my youngest son then brightly announced: "He can understand Hindi!" My instant thought was, "Well, that's curious as he's never heard Hindi before" and "He assumes that because I'm darker skinned, I'm Hindi" but there was also more to this brief exchange. I was recounting this brief conversation to a dear friend who is passionate about travel and very interested in meeting people with different backgrounds. I was trying to explain to my friend that it was not just what this man said, but also his attitude. It was so difficult to put into words. I explained to my friend that when she asked me a question and we talked about our different (cultural) experiences, I found her to be curious and deeply interested. "I suspect you do not even know how to be racist," I said, "because you do not see cultural differences. You see diversity and people know that you are very interested, curious, and want to learn more."

One of the readings (which I cannot locate again) that stands out the most to me from my training was a discussion about the use of behavioural analysis as a guide to culturally safe and appropriate assessments. The authors argued that a behavioural analysis was, by definition, a culturally respectful analysis because it forced the assessor to make no assumptions and simply look at behaviour and ask questions about behaviour. I would add to this that an attitude of curiosity and openness to gathering and understanding information is helpful. I hope you will be able to sit down, pour a glass (or mug) of something delicious, and enjoy the variety of offerings in this journal, and that they inform you, delight you, aid in reflection, and inspire you in your practice. Many of you will be aware of discussion within our College about leadership and supporting leadership in clinical psychology. Articles in this issue speak to the roles we have as leaders, educators, and promoters of change.

Once again, this issue would not be possible without the rich contributions of our talented authors, the hard work of our reviewers, Audrey who diligently ensures we confirm to APA guidelines, and Caroline who calmly organises and makes things "come together." Thank you so much to everyone who has contributed to this journal, and to you, our wonderful readers. This is our first online version of the Journal and we hope you join us in celebrating this eco-friendly move.

I hope that you, and those you love, are able to have a relaxing and rejuvenating break over the festive season. I wish you all the very best for a fabulous 2017.
Merry Christmas!
With great warmth, Kumari

Belonging

Wendy Radford

Wha you doin?
Screamed the pink grain of sand
as it tumbled from her hair
on to the cold Ohope Beach

Wha you doin?
I doan belong here

And she stared in amazement
and onderstandin
and initially did not know what to say

To reassure
the pink grain
that with time
Oh with endless time
it would sort of belong

Though would always be tied
to the pink and white sands of a Barbadian beach
would always remember the sound of those waves crashing
gently on its body
would always be part of those warm salty waters

where it was born and grew

The pink grain
(she knew)
just wanted to jump back up into her hair
and live quietly there
among the roots of her childhood
To whisper folk stories in her ear
sing calypsos to her
calm her with images of her Caribbean sea.

She had not even known it had travelled back with her

Wha you doin?
the pink grain whispered up to her
as the Pacific ocean picked it up
in his strong fingers

And her tear
of gratitudeandsorrow
dripped into the ocean
to wind its way around the pink grain
as it travelled back to its source.

Wendy Radford, MNZCCP, is a Barbadian New Zealander—born on the island of Barbados in the West Indies and enriched by living in NZ. Her fusion poetry is the expression of holding both cultures in her heart.

Challenges of Culture and its Cages

Mark Ottley and Jo Jarvis

We are clinical psychologists working in a service where we often see trauma cases. In this article, we present a case study involving work with refugees. Consistent with ethical recommendations for case studies that we believed appropriate in this instance (Pies & Kantrowitz, 2011), names and details have been changed, and features of several cases amalgamated, to create a composite case study to protect privacy.

Aktar and Vani are a man and woman who had experienced the recent traumatic loss of relatives in a drowning. They were referred to psychological services for support for grief and adjustment issues arising from this trauma. Mark saw Aktar and Jo saw Vani, and we worked collaboratively on this case with the mutual consent of the pair. This helped bridge anxieties and misunderstandings between the two, while giving each the chance to process their own experiences in a supported way.

Aktar and Vani were South Asian refugees who arrived in New Zealand several years ago thanks to UN advocacy. They established well integrated and successful lives here, with many connections to the local community through schools and workplaces. They were also involved with the community groups of their ethnic nationality, and retained many aspects of cultural affiliation in belief and practice, including various Hindu traditions. Traumatic experiences and consequent adjustment presented numerous challenges, with cultural beliefs and practices being an intimate factor. This case study focuses on some of these cultural issues and how we worked with them; in particular, "the vexed issue of what is right" (to use the phrase of a reviewer), when it comes to value conflicts.

Theoretical Orientation: The Universalism of Human Needs

Despite the differences that may separate us due to culture, a starting point for working with any person is recognition of the core needs and values that unite us all. At a minimum, we assume this involves normative human phylogenetic needs of social connectedness, competence, and autonomy (Deci & Ryan, 2000). The term autonomy in this instance refers to the theoretical construct of self-determination rather than "independence," as people can, and often do, choose interdependence as an act of self-determination. There are also good methods for studying patterns of psychological universals (Norenzayan & Heine, 2005). Considerable evidence suggests that humankind has attended to the development of a small number of fundamental valued character strengths over the history of our species, and they apply across world ethical codes, philosophies, and religions (Dahlsgaard, Peterson, & Seligman, 2005). While such assumptions should be carefully examined with clients, these features of human nature can form a powerful basis for therapeutic efforts, as they did in this case. Such an orientation integrates empirically grounded models of a universal human nature with cultural considerations. This helps avoid excesses of potentially iatrogenic cultural relativism in client formulation and treatment objectives (Leising, Rogers, & Ostner, 2009), while still giving important weight to cultural factors (e.g., Sue, Zane, Hall, & Berger 2009).

Mark's Experience of Working With Aktar

In working with Aktar, it was clear that he was feeling an overwhelming sense of grief, with

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anger directed towards himself for his role in failing to prevent harm to family members. Time was spent providing space to process this experience, as might be expected in any such case. There was also fear of how the experience would be viewed by New Zealand society and authorities, given his past victimisation by overseas authorities. Therefore, an important initial part of psychoeducation was to reassure him that sympathy and compassion would be the most typical response, not torture or other violent victimisation.

There were stringent cultural practices associated with such losses for Aktar, involving fasting and other rituals for quite a period of time. An initial session concentrated on exploring Aktar's beliefs about death and loss, and ways of coping. Although Aktar was attending to his precise rituals and customary practices, it was notable that both he and Vani expressed much doubt about the veracity of the doctrines associated with them. Despite the considerable demands, they were doing these practices because they were socially expected and because in such circumstances, the automaticity of engaging in the practices was the lesser demand. However, Aktar had worked with people from many different cultural backgrounds, and in this context, his own cultural beliefs had become less rigid. He queried the possibility of alternatives, while still placing trust in some aspects of existing practices. He struggled to accept that the traumatic event had been part of a divine plan as doctrine would suggest. Instead, he said he was focusing his efforts on building a good life for himself and his family here and now, with less dogmatic belief about the way this should be.

Another pressing issue that was quite stressful for Aktar and Vani was pressure from visitation by members of his extended family and ethnic community. Visitors would arrive unannounced with the expectation that everything would be dropped and plans cancelled in order to attend to them in a hospitable fashion. A key element of discussion with Aktar was strategising how to deal with burdensome visitations, the load of which often fell on Vani. Initially, Aktar had left town or visited friends to try and achieve some respite from visitors.

After careful exploration of these matters, as a point of analogy I discussed how older members of my family in times past would often walk for an hour or so to visit people, because there was not a method of communication to check if people were home or faster transport. Given these visitors had travelled some distance it would be very rude to refuse them. I suggested that his own culture of hospitality may have evolved in similar circumstances and made sense in those circumstances. But, as we discussed, he and his relations had cell phones now, and perhaps it would be helpful to adjust cultural traditions to take into account the realities of his life and needs today. Following discussion of principles of assertiveness, he believed that such practices would not result in social ostracism (or if they did from some people he would be prepared to live with it). After implementing such strategies he reported that they had been helpful.

In addition, the issue of gender role expectations and self-determination for Vani was something I carefully raised. My colleague had recognised that Vani wished to socialise and be more independent in general, but Vani worried about the shame and stigma this might bring on Aktar and how this would affect him. Aktar's strongly expressed view to me from the start though, was that he wanted Vani to do what she could to build a good life for herself in New Zealand, including building new social connections, and traditional cultural and community concerns were very much secondary to this. He was less trapped by community cultural concerns than she was by the fear of these. Vani's fear of even hoping/asking was the major barrier in this instance.

Jo's Experience of Working With Vani
Vani presented initially wanting to talk about her and her family's history. Her views about life and death and basic planning for life differed from many New Zealanders, because of her and

her family's past trauma as refugees. It was clear that she was very concerned about issues relating to the justice and legal systems, so ongoing education about this was implemented. She saw the recent traumatic event as very unfair, and related it to the many other traumas of her life. She spoke a lot about the cultural expectations of her family and her ethnic community. Initially, this was more historical, but as the sessions progressed, the content revolved about her immediate concerns. She struggled to integrate her desire to assimilate herself into the New Zealand culture and the expectations she felt from her family, extended family, and ethnic community. Her concern was particularly around the impact that her behaviour might have on her immediate family if she did not act in a way that was expected by her community, and Vani wanted to protect them from this. Achieving these expectations was at great expense to herself.

Her role in her family and ethnic community completely changed following the recent trauma, and revolved around other people; serving visitors, caring for her family, and doing everyday and other chores. Her own independence completely changed. In taking on these roles she was no longer able to do age appropriate activities (for example, seeing friends). This was problematic for Vani, as in all this she was also trying to cope with her own grief and loss. It was very hard for her to prioritise herself. Her health suffered. We discussed that her parents and her community were proud of her doing things for herself and being a good role model for her community (even though it was different from the cultural tradition). Vani also identified that her family had a different perspective to other families of her culture. Therefore, it was hard for her to balance the cultural expectations she felt with what she had become accustomed to and wanted to continue. Vani noted that others in her family used to protect her from extended family/ethnic community expectations, but post-trauma this had not happened. Becoming clear about her immediate family's expectations was very hard for Vani, because this kind of communication between genders was not culturally acceptable.

Vani was clear that she did not believe in many of the cultural or spiritual practices, although it was also obvious that they were very ingrained for her. She engaged in them with resulting hardship to herself. She did this to protect others. For Vani, providing assistance in culturally appropriate ways involved the challenge of clearly understanding not only her traditional cultural norms, her beliefs about them, and her cultural assimilation, but also finding a way of assisting her in applying those within her framework of concern for others, while still having some priority for herself.

In treatment, I got consent to talk to my colleague working with Aktar, both generally and about any specifics. At times, Vani wanted Aktar's psychologist to talk to him about issues to gauge his thoughts and feelings. But I was unsure how much she believed the feedback she got back. Over time, it did allow her to have the confidence to slowly broach subjects she otherwise would not, with positive results. As time passed, Vani started returning somewhat to more everyday New Zealand activities (work/study), which met many of her individual needs.

During therapy we dealt with other more straightforward topics, such as panic attacks and anxiety, using somewhat more traditional methods (although content was culturally appropriate, as it is for every client). This more traditional psychology work came much later in the work with this client, with the cultural content needing to be addressed first.

Conclusions

An interesting feature of this work was the similarities between these clients wanting to talk about family and history, where they and their ancestors had come from, and what we as clinicians knew about Māori culture and their whakapapa. This process of establishing identity and connection created a base of understanding on which to build. Of much importance too,

was discussion of belief about beliefs and the impact that beliefs, and beliefs about beliefs, had on their lives. We were reminded of the potential problems of what the philosopher Daniel Dennett termed "Belief in Belief" (Dennett, 2006); the notion that beliefs are positive and to be fostered, even if one does not believe in those practices/beliefs. In aiming for respect of different cultures, one can risk a patronising relativist view of foreign cultures and iatrogenic harm in the process. Assumptions should be carefully examined and reification of culture avoided, recognising instead that people shape culture in addition to being shaped by it (Markus & Kitayama, 2010). This is especially the case in today's world, where all cultures are in a state of rapid reformulation, evolution, and deconstruction that leaves many individuals with a fractured, multiple, or rapidly changing sense of identity and self (Hermans & Dimaggio, 2007). The inequality of gender roles in many traditional cultures has also been evident. One useful resource for clinicians and patients is Shakti New Zealand (http://shakti-international.org/shakti-nz/), an organisation "…set up by ethnic women…to break the bonds of cultural oppression imposed on them for generations…(and) promote greater gender equity and social change."

It is a challenging task to navigate the complexities of cultural value conflicts. One must proceed cautiously to avoid the potential pitfalls of cultural relativism (e.g., tacit endorsement of oppressive cultural practices), while appreciating limitations of our present scientific models (Leising et al., 2009). We gained a new practical appreciation of this process through our work with Aktar and Vani, and others like them.

While many challenges lie ahead, Aktar and Vani are moving forward. We also very much enjoyed working together as psychologists with these clients, and think it greatly enhanced what we could have done working with these clients alone.

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Narratives and Nonverbal Presentations[1]

Noel Tiano

This brief article presents three cases of trainees in clinical pastoral education who used nonverbal presentations in their case reports. The trainer interviewed the trainees several months after their programme ended, particularly regarding their reflections on the nonverbal presentations. All trainees were in their 50's and were either working as clergy or with a religious order. One was an Irish-Māori who performed a silent haka and narrated about how he came to terms with his bi-racial roots. Another was a Filipino who presented a "silent verbatim" case study using only actions, facial expressions, and visual aids. The third trainee was a Tongan who presented her silent narrative about her life experiences using contrasting motifs of light and dark, dead flowers, and living rose plants. A narrative analysis of the interviews highlighted the function of clauses in relation to the overall structure of their stories. The use of nonverbal presentations can expand case reports and enhance cultural expressions of trainees.

Introduction

Studies in nonverbal communication have become more prominent, particularly in healthcare settings and workplace interactions. Little, White, Kelly, Everitt, and Mercer (2015) demonstrated how brief training of general practitioners in predominantly nonverbal communication can significantly improve patients' perception of satisfaction, distress-relief, partnership approach, and health promotion. Some have estimated its meaning in communication to constitute by as much as 66–93% (Burgoon, Guererro, & Floyd, 2016). These may include facial reactions, posture, body language, gesture, appearance, touch, proximity and distance, timing, decorum, and formality. Hence, actual words that people say may only comprise 7–34% of their meaning. Carney, Cuddy, and Yap (2010), experts on nonverbal behaviour reported that "power posing" can influence others and even one's brain. They concluded that changing physical posture can prepare one's mental and physiological systems, which can "improve confidence and performance in situations such as interviewing for jobs, speaking in public, disagreeing with a boss, or taking potentially profitable risks" (p. 5). Meditation, silent retreats, mindful walking, and practices such as the Japanese tea ceremony emphasise the importance of noticing certain rituals such as bowing, opening and closing doors, seating arrangements, clothing, and others.

To be sure, nonverbal forms of communication existed before humans developed the capacity for language. Nowadays, different cultures around the world have accepted various forms of greetings such as the hand wave, handshake, kiss on the cheek, or hongi. The thumbs up means "ok," the "V" sign usually means "victory" or "peace," and the "shaka" signifies "hang loose." In the animal world, pets such as adult cats generally do not "meow" to other cats (Houpt, 2011). Kittens say "mew" to their mums when they are hungry, or "hiss" at another cat or dog. But basically, for adult cats "meowing" is a new language specifically used in relating with their humans (ASPCA, n.d.). Cats communicate nonverbally through their ears, tails, posture, grooming, purring, kneading, rubbing, and scents.

This paper presents three case studies of former clinical pastoral education (CPE)[2] trainees in Wellington and reflections on their nonverbal presentations. The latter consisted of exhibiting the highlights of their training using visual instruments, art work, drawings, props, mime,

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[1]The full article that featured six cases was published in Elsdorfer, U., & Ito, T. D. (Eds.) (2016). *Compassion for one another in the global village.* Zurich: Lit Verlag GmbH & Co. KG Wien.

charade, dance, visual instruments, family albums, "selfies," collage, PowerPoint slides, written instructions, banners, symbols, sign language, cooking/baking, included food items, candles, incense, aromatherapy, and others, but excluding the spoken word. Most found these presentations highly beneficial as they discovered novel ways of expressing their cultural upbringing, experiences, and learning. The nonverbal presentation model we used came from Allison Whitby, Australian CPE Supervisor (A. Whitby, personal communication, 2015). During a conference, she featured a silent verbatim in which a supervisor acted out nonverbally her struggles in losing her eyesight. Participants shared that the presentation was deeply moving and helpful in noticing facial expressions, emotions, body language, the creative use of silence, and passage of time.

Method

The former CPE trainees were interviewed by telephone and an online survey. Demographic questions such as gender, age, and ethnicity were ascertained. Open-ended questions consisted of reflections about their nonverbal presentations, cultural narratives, and feedback they received from other trainees. Due to space limitations, photos, graphics, and other visual media could not be included in this article. This qualitative study was largely based on social constructionism which emphasises postmodernist approaches and use of critical reflection on language and meanings (Healy, 2005). It highlights its contextual nature, as well as the interactive, dialogic, and multiple perspectives (Fook, 2002; Parton & O'Byrne, 2000). In conducting the narrative analysis, I adapted the methods described by Riessman (2008) and Wells (2011). Both authors drew on Labov's (1982) early conception of the function of clauses in narrative. Identifying the clauses sheds light on the overall structure and thus illuminates key elements of the interview. This way of unpacking the data makes it easier to trace the relationships between functions of clauses and overall themes. The cases were classified in tabular form as outlined in Table 1 below.

Table 1

*Function of Clauses*Function	Clauses from Interviews
ABSTRACT	Summary of story
COMPLICATING ACTION	Presents a turning point(s)
EVALUATION	Narrator's commentary
RESOLUTION	Resolve the plot

Findings

"Poe" (Māori-Irish, male, 50's)

Presentation summary

Poe began with a silent haka to welcome his co-trainees, and they were awed by the special reception. He displayed his books, photos of his colleagues taped on the wall, sports equipment, and his paintings and other art work. He then led the group to the garage and showed his classic light blue car still in pristine shape and invited the group for a ride around the hospital campus.

2CPE is a standard training in pastoral care around the world. One unit consists of 400 hours under individual and group supervision in a healthcare or community setting (NZACPE, n.d.)

Table 2
Poe's Silent Haka

Function	Clauses from Interviews
ABSTRACT	"With the silent haka I was welcoming the CPE group..."
COMPLICATING ACTION	"...you can trust me with your life...bring your waka (boat or vessel)
EVALUATION	... bring it into this space, a peaceful space... you can bring who you are and share this space"
COMPLICATING ACTION	(*As the group entered the flat there were several hats, paintings, symbols regarding church activities, social outreach*) "...This is me, complex, full on..."
EVALUATION	"I need to delegate more...I need to balance aspects of Māoridom with paddles on both sides."
COMPLICATING ACTION	"...I took the CPE participants on a road trip in my 'Mach 3 car' which I called the Blue Thunder" (smiles)
RESOLUTION	"Trust me as we take a ride around the hospital grounds"

In his profession, Poe learnt to put aside his Māori heritage and be more European. During his training, he re-examined his roots and travelled with his mother to visit their Māori relatives and graves. He also took photos and taped stories of his mother's family, which made a profound impact on him. In his nonverbal presentation he embraced both his Māoridom and European descent and eloquently demonstrated without words, "this is who I am!"

"Solo" (Filipino, male, 50's)

Presentation summary

Solo presented a silent verbatim where he played the role of a patient suffering from multiple sclerosis (MS). He dressed up as a patient and arranged the furniture to recreate a typical rehabilitation hospital room. On top of the TV were family photos and memorabilia. On the wall was the November calendar with a highlighted date. The window blinds were open so that he could peer outside, anticipating the arrival of his family. He sat on a chair next to a table anticipating a meal time.

Narrative analysis of the interview

Table 3
Solo's Silent Verbatim

Function	Clauses from Interviews
ABSTRACT	"My silent verbatim...is about the life of a patient with MS"
COMPLICATING ACTION	"I was not able to eat properly...my hand was shaking...I went into a quiet space...I looked at the parts of the room, looked outside the window waiting for visitors to arrive. I looked at the calendar, encircled the date...looked at a card that read 'Happy Birthday'"
EVALUATION	"It was very emotional for me...It made it possible for me to portray what people with disabilities struggle with...." - "It would be very different had I just written a verbatim or case presentation about it...I'm not a good writer anyway...I think it was easier for me to act it out, because for me I'm not good in writing...acting it out is probably more universal"
RESOLUTION	"...It added a dimension in expressing the story...in the end, the presentation was better than any other medium"

In his silent verbatim, Solo demonstrated his propensity to the helping professions, which is predominant in his culture. He portrayed in detail what the world of his patient was like without the spoken word. With English as his second language, he admitted his limitations in writing verbatims. Nevertheless, he found his "voice" and ability to communicate through a silent sketch.

"Leia" (Tongan, female, 50's)

Presentation summary

Leia arranged different pots with dying rose plants on top of a table as well as dead leaves and flowers around the floor. There were dried red rose petals near the kitchen sink where all the windows and doors were shut which made the room very dark and little bit eerie. Inside the tub in the bathroom was another dead plant with its dried up twigs, dirt, and flower pot. However, at the end of her presentation, she led the group into a bright room where the curtains were open, the fluorescent light was on and the mood was definitely celebratory. There was another pot on the table but this time, noticeably, the rose plant was alive, healthy, and blooming with a bright dark red rose flower. The pot had some colourful wrappings, the plant looked very healthy and the garden soil was well watered. Now she embraced her experiences of drought and loneliness with a renewed sense of identity and expanded circle of friends.

Narrative analysis of the interview

Table 4
Leia's Suggestion

Function	Clauses from Interviews
ABSTRACT	"I really liked it (*nonverbal presentation*)"
TURNING POINT	I had the courage to approach conflicts instead of bottling up...I am grateful to have_____(the training); ....
COMPLICATING ACTION	"...my suggestion…is to share a bit more about culture...(*Islanders usually*)...put their heads down, don't look into face; bow head…"
EVALUATION	"Some interpret this as a lack of confidence and struggle with self esteem, but actually it is not."

Leia talked about how generally westerners prefer to look at someone "in the eye" and face-to-face to signify interest and trust in social transactions. It is a common conception that those who do otherwise may be shifty or untrustworthy. However, this gesture might have a slightly different meaning for many Pacific Islanders and Asians. In fact, Thomas (n.d.), and King, Knott, and McCane (2003) argued that direct eye to eye contact for Māori, Samoans, and other Polynesians may be considered impolite and even aggressive. Others prefer to look at the floor or sideways, raise their eyebrows when affirming, use implicit communication, body language, silence, and less verbal feedback.

At our hospital, we have numerous clients who originally come from the Pacific Islands. Instead of the usual "face-to-face" and "eye-to-eye" body language conversations, many prefer talking "side-by-side." Staff find this posture more effective because it is not confrontative, clients can share their story at their own pace, have a sense of control, and it allows the carer to see things from their perspective.

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Implications

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Nonverbal presentations can expand case reports and enhance cultural expressions of trainees. Furthermore, the discipline of silence encourages participants to hone in their skills in noticing, observing, sensing, and listening.

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Practising in Singapore

Cissy Li

I relocated to Singapore 16 months ago, after having just graduated from the clinical programme at Victoria University. I am ethnically Chinese and identify as "bicultural," although I suppose I tend more toward the Kiwi side in terms of my personality and mannerisms. Back in NZ, I had work experience in public mental health services working with adults and adolescents with moderate to severe mental health issues. In Singapore, I have now worked for 15 months in a large, multidisciplinary private practice where I see a diverse range of local and international clients; primarily children, adolescents, and their parents. Living and working in Singapore has been challenging, although sometimes it is hard to separate what constitutes the normal growing pains of learning the trade of a clinical psychologist, and what is additional environmental stress. I found the first 4 months to be the most difficult, which was compounded by starting work in a new setting, working under different employment laws, suddenly realising I was separated by time and distance from my friends and family, and that I missed NZ terribly. With hindsight, I believe I am now able to paint a clearer picture of some cultural differences, novel concerns that clients bring, and the challenges I have faced and overcome in Singapore.

Cultural Differences in Beliefs and Emotional Expression

Looking back, my first 4 months were spent pacing in the dark trying to understand a legion of novel cultural issues. I was now embedded in a cultural system where the majority of the general population held strong stigmas toward mental health, as well as superstitious beliefs about its causes. Free and easily accessible public information about mental health is still in the development stages, and mental health experiences have only recently become publicised and discussed as they are in NZ. Perhaps because of common stereotypes or a lack of widely disseminated information, many Singaporean parents hold misconceptions about assessment and therapy for children. In addition to parents who are eager to learn and help, I have also seen parents who have used therapy as a threat to their children and others who believed that speaking to a "doctor" would "fix" their children.

In meeting and working with clients, I have found perspectives to be functional, black and white, and seemingly less emotionally imbued. Some parents are reluctant to disclose previous assessments or familial information that may mean they lose "face" (*mian zi*). Emotions are expressed differently, with new words to learn ("*lor*," "*lah*," and "*leh*," which are sound snippets that connote feeling; "*kiasu*," a fear of failure or missing out; and "*paiseh*," to feel embarrassed or ashamed). Further, there is a much stronger tendency to demonstrate love and care through spending money and implicit behaviours as opposed to words or explicit behaviours. I get treated as a professional with all the answers, and some clients become afraid to speak out in case they have the "wrong" answer. These differences in expression mean that many of the clients I see find it more difficult to speak directly about their feelings or thoughts. Generic "downward arrowing" summaries and my direct form of emotion labelling and empathy do not have the same effect of drawing out a client's innermost experiences. As a result, interactions between two people with different cultural backgrounds can feel stilted because of the language used, the meaning implied, and even the use of silence. Because interacting with a client is a dance, it is hard to provide nuanced empathy when you do not know the steps!

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Novel Clinical Concerns

Personal differences aside, novel concerns are borne of the different education system, family organisation, and the huge international population.

From an educational standpoint, the education system is much more vigorous and demanding of both local and international students. Exam- or homework-related stress is palpable, culturally appropriate, and cannot be resolved by suggesting better work-life balance or changes in expectations. For example, an exam taken in Year 6 (when children are 12) is a significant determinant for the rest of a Singaporean child's course of education. Children as young as 10 will be able to tell you the score that they want to obtain or the secondary school they wish to attend. The different education system also means that psycho-educational assessments constitute a significant proportion of a psychologist's work in Singapore. Local Singaporean children are expected to learn two languages at school (English and their mother tongue). Due to low exposure, speech delay, flailing grades, or other difficulties, many parents wish to exempt their children from learning their mother tongue, as otherwise the result would impact heavily on their average score for the Year 6 exams. Exemption can be recommended by way of a psycho-educational and comprehensive diagnostic assessment for the Ministry of Education. As such, many parents seek DSM-5 diagnoses for their children, even when they are functioning typically.

In addition, it is common in Singapore for families to employ a foreign domestic worker (FDW; live-in maid). A FDW typically takes care of the daily household chores, cooking and childcare, which is convenient as most parents work in time-demanding jobs. The time that parents spend with their children can be further limited by the practical tasks of homework, dinner, and bedtime. There is a small population of international children who are sent to Singapore to study while living in guardianship homes (akin to a homestay, but for children as young as 6 years). In these circumstances, there are variations in how well a parent knows their child, how much the "family system" is contributing to the problem, and their expectations of a therapist! Differences in hierarchical structure and family practices mean that parenting strategies I advocated for in NZ must be adapted and changed. Mostly, the challenges are around how much the family are able to be part of the therapeutic process. In other cases, parents may be reluctant to include the FDW as part of parent management training, despite the FDW being the primary caregiver to an oppositional child.

Internationally relocated families face different psychological issues, mainly with cultural identity and belonging. Adults face the stress of redefining their lives, with some trailing spouses learning how to become a person of leisure, while others begin the search for a job as they recognise how much employment forms part of their identity. For children and adolescents, there is a term "third culture kid," which many schools give presentations on to help parents understand the unique acculturation challenges that these children face. Their schools and their friends come and go in transitory cycles. They experience the stress of "where is home?" and "who am I?" at a stage in their lives where these notions matter most.

Professional and Ethical Differences

I was overwhelmed in my first 6–9 months with calibrating to societal differences, a new raft of clinical issues that I had little experience with, and culturally-imbued client presentations. It felt as if I was putting out fires and that I had little time to venture out and find answers to my questions about risk, support, and professional ethics. For example, one of the first questions I had when I arrived was "what constitutes abuse and when/who/how do I report it?" Although similar laws exist about physical abuse of children, there are differences in the interpretation of what is "reasonable" and what constitutes grounds for reporting, as physical discipline is still a

relatively common practice in Singapore. Also, although psychologists make up a large part of mental health professionals, they have not yet been recognised as a formal allied health profession and there is no mandatory regulatory body to whom consumer complaints can be directed and who uphold the standards of the profession. These overarching issues created difficulties in clinical and ethical decision-making that required a higher level of self-governance than I had experienced in NZ.

Becoming Proactive and Personal Growth

This is but a whirlwind tour of the differences that I wish I learned in a week-long orientation *before* I moved. I still wish someone could tell me what to expect and give me a toolkit of cookie cutter protocol for my cases. Instead, my perfect storm involved culture shock, homesickness, and fumbling in the dark from a professional standpoint. It affected my outlook on Singapore greatly. I realised it was much easier to take a victim stance and feel pessimistic about the state of affairs and apathetic about finding out more. My post-university impostor syndrome became stronger when there were no peers around me to normalise and validate how lost I felt. I became fearful of inadequacy in basic professional competency because I felt like I was backpedalling while there were few avenues for learning and growth. I was yet to set up support networks. Those to whom I spoke had already passed this period and my venting was met with condolences.

However, these ambiguities helped me to grow professionally and personally in ways of which I am only becoming cognisant. Because I felt there were no set protocols, I have become far more proactive in managing my own professional development. I set up regular NZ supervision. I set up peer supervision. I attended a stranger's group supervision from an event I found on Facebook (where I am now a regular attendee). I established supervisory staff meeting agendas similar to what exists in the public system in NZ. I bought a new therapy book each time I had a worry about a client (and now I have a small library of them). I over-corrected and obtained double-checks on everything I did. I tried to be proactive in finding out what I did not know. I set up meetings with child protection services to learn about abuse thresholds and schools to learn about education systems. I volunteer my time to more experienced clinicians to keep up old skills and learn new ones.

I have tried to forgo the helpless stance to learn to be more confident in myself. My stepping stones to success? I use exposure-response prevention and try not to bring every question I have to my colleagues and supervisor. I look over my thank you cards. I ask myself what my own ethical and moral responsibilities are and how I could persevere to live within my own expectations. I ask myself what my expectations would be of a therapist, how I want to behave even if I fail, and who I want to be for my clients. When I feel stressed, confused, or just out of sorts, I make planning days. I drag a bean bag into my office and I read textbooks and keep a pen and notepad handy. I search keywords such as "culture _____ (insert cultural group here)."

A New Way to Work With Clients

With my clients, I have given up having all the answers. Not knowing continues to bring up a lot of anxiety for me. Sometimes I backpedal and take back a position or standpoint. I feel guilty when I do this; I mind read that my client will think I am incompetent. My coping thoughts for situations like these are to remember that the fun of therapy comes from joint exploration and that I would want my client to be able to do the same thing with me.

When families come to me as a "professional" and ask me about the benefits of auditory integration training or homeopathy for autism spectrum disorders, I now speak out from the

psychology that I know and from the evidence base. I open the floor for further discussion while encouraging them to find their own answers. I stopped saying "so what do you think are your next steps/you will do next?" as many of my clients: a) get worried as I have not told them what to do, or b) think this is a trick question because they should do as I say (and I have not given any explicit instruction). Instead, I now tell my clients very specifically what I believe to be the best course of action and give plenty of multi-choice caveats for them not to feel obligated to follow through.

Empathy now comes easier to me, and I can understand why clinical programmes look for people with "life experience." I had not realised the homogeny in worldviews and how natural it felt to anticipate the feeling and behaviour of my NZ clients, due to growing up in NZ and simply identifying as Kiwi. I felt like a fish out of water as I noticed the judgmental thoughts entering my mind about my foreign clients and their behaviours. I noticed that these were due to encountering clients who had come from very different cultural systems. From my perspective, they had cultivated incredibly novel, ineffective, and unhelpful perspectives or solutions to their problems. These judgments always disappeared with time, and I realised strongly that empathy comes easiest when there is a shared worldview, which is strongly influenced by culture. Now, I recognise judgments as a flag for when I have to more consciously practice and shift to an absolute positive regard.

On a continuum of adjustment, I would say it took me about 12 months to become comfortable before I found myself slyly admitting some positive aspects of working in Singapore. Now I can see that the challenges I have faced are part and parcel of working in a culture where mental health and psychology are in their nascent stages. I am definitely not the only one who has struggled, which is evidenced simply by the number of sojourners with cultural-adjustment concerns coming to the clinic where I work. The best thing is I can say to them quite confidently, "you are not alone."

Understanding Schizophrenia: A Cross-Cultural Perspective
Michelle Gregory and P.S.D.V. Prasadarao

Culture influences prevalence, presentation, clinical manifestation, and treatment outcomes in schizophrenia. The present review attempts to understand schizophrenia from a cultural perspective, highlighting the need to explore the role of culture. It is important to be sensitive to the explanatory models of patients and their families. Variations in causal attributions, prevalence, stigma, treatment, and prognosis of schizophrenia are discussed from a cultural viewpoint. Attempts are also made to explore the Māori cultural perspective. It is imperative that health care providers adopt a holistic approach to understanding schizophrenia within patients' cultural frameworks to recognise and resolve potential obstructions to providing culturally appropriate interventions. It is recommended that by adopting emic and etic approaches, clinicians can offer culturally sensitive mental health care to clients and their families.

Culture can be both born into and gathered over the course of time. It can unite individuals in a group and set people apart, thus forming individual and group identities. Normality and abnormality, and the expression of emotional distress are all defined by culture. Thus, our creation, definition, and understanding of reality are all interpreted through our cultural

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experiences (Kalra, Bhugra, & Shah, 2012). Culture has a pathoplastic effect on mental illness by shaping its clinical manifestation and presentation (Bhattacharya, Unadkat & Connan, 2010). The fact that culture influences individual perceptions of reality means that the manifestation of psychopathology may differ across cultures (Marsella & Yamada, 2010), and cultural norms influence symptom expression in psychopathology (Hassim & Wagner, 2013). Further, culture shapes stressors, mediators of stressors, personality patterns, conceptions of mental illness, and patient preferences for, and compliance with, treatment approaches (Marsella & Yamada, 2010; Prasadarao, 2014). Culture also influences aspects such as onset, triggers, severity, prevalence, duration, and prognosis (Marsella & Yamada, 2010). Understanding illness perceptions provides an opportunity to design the most suitable clinical interventions (Sanders, Kydd, Morunga, & Broadbent, 2011). While attempting to understand human behaviour (both normal and abnormal), the "emic-etic" approach (Darling, 2016) plays an important role from a cultural point of view. The emic aspect focuses on the "unique" characteristics of a culture (i.e., internal), whereas the etic emphasises the "universal" nature of behaviour across cultures (i.e., external). Such a distinction provides insights into how generalisations could be drawn across cultures, but at the same time, focusing on the role of internal aspects and unique characteristics of a specific culture. To have a comprehensive understanding of health and illness and their explanatory models, it is vital that we focus on both emic and etic aspects (Darling, 2016; Prasadarao, 2009, 2014).

Schizophrenia is a major and common psychiatric disorder that alters an individual's perception, thought, affect, and behaviour. Schizophrenia has a significant impact on an individual's personal, social, and occupational functioning. A wide range of biopsychosocial factors are attributed to the aetiology of schizophrenia, and culture has an overbearing moderating influence on its overall manifestation (British Psychological Society & the Royal College of Psychiatrists, 2010). The present review focuses on understanding schizophrenia from a cultural perspective. Efforts are made to explore the role of explanatory models and belief systems, and the role of culture in the clinical manifestation, diagnosis, and treatment of schizophrenia.

Role of Explanatory Models in Psychopathology

Explanatory models incorporate the multi-faceted influence of culture on the conceptualisation, manifestation, treatment, and outcomes of psychopathology (McCabe & Priebe, 2004). Therefore, conflict between the explanatory models of the patient and the clinician can affect the likelihood of treatment seeking (MacCarthy, 1988), compliance (Foulks, Persons, & Merkel, 1986), and satisfaction (McCabe & Priebe, 2004). As explanatory models shape the response of an individual to their illness (Prasadarao, 2014), clinicians conducting culturally sensitive practice must seek to amalgamate their explanatory model with that of the patient's conceptualisation of their illness (McCabe & Priebe, 2004; Prasadarao, 2014). Differences in beliefs about mental illness between health professionals and patients can lead to nonadherence to treatment and frustration (Bhui, Rudell, & Priebe, 2006).

Schizophrenia is associated with occupational and social dysfunction (American Psychiatric Association; APA, 2013). While schizophrenia occurs across cultures, its manifestation may differ (Kalra et al., 2012). Therefore, understanding and treating schizophrenia within the context of culture is vital. For example, African-Caribbean, Bangladeshi, and West African individuals with schizophrenia are more likely to attribute supernatural and social rather than biological causes for their illness. In contrast, Caucasians born in the UK attribute biological causes. Beliefs about the causes of schizophrenia are likely to influence the desired treatment, with those who support supernatural causes seeking religious treatment or no treatment, whereas those with explanatory models that validate biological or social causes are more likely to prefer medication or psychological therapy. As many clinicians believe in biological/biomedical explanatory

models, it is not surprising that patients who support biological causes are more satisfied with the treatment they receive, thus highlighting the importance of incorporating explanatory models into case conceptualisation (McCabe & Priebe, 2004).

Causal Attributions of Schizophrenia Across Cultures

Risk factors such as unemployment, social isolation, and mismatch between aspiration and achievements are moderated by social contacts in both white British and Afro-Caribbean groups. Separation or death of a parent before age 16 years increased the likelihood of psychosis in both white British and black Caribbean groups, but not in black African groups (Bhui & Tsangarides, 2008). In Germany, psychosocial stress is the most frequently reported cause of schizophrenia; in West Germany, family is held responsible for the development of schizophrenia, whereas in East Germany, social conditions are considered more influential (Holzinger, Kilian, Lindenbach, Petscheleit, & Angermeyer, 2003). In China, external stressors and non-family relationship conflicts are often considered important (Phillips, Yonghun, Stroup, & Xin, 2000). Placing blame with external factors decreases the belief that the patient is able to control their behaviour (Yang, Phillips, Licht, & Hooley, 2004). This is similar in both developed and developing countries (Peluso, Peres, & Blay, 2008); however, people in China make significantly fewer personal and controllable attributions. This may be due to the nature of Chinese family structure, where most couples have one child, and therefore the family line could be jeopardised by illness (Yang & Pearson, 2002). Further, Western cultures tend to underestimate situational and overestimate personal attributes to behaviour, whereas the Chinese attribute illness to external influences (Yang et al., 2004). In Brazil and Ethiopia, religious causes are considered more influential (Peluso et al., 2008). Similarly, Sri Lankans are more likely than the British to view people with schizophrenia as being unpredictable, dangerous, and of some significant threat to their personal wellbeing. Further, while the British believe in biological explanations of schizophrenia, Sri Lankans attribute schizophrenia to social, parental, developmental, and superstitious causes (Furnham, & Pereira, 2006).

Prevalence of Schizophrenia Across Cultures

Schizophrenia has a lifetime prevalence of approximately 1% (Kalra et al., 2012); however, this varies across cultures, countries, and genders. Higher prevalence rates are reported in developing countries (Brown, 2011). Broader syndrome definitions (i.e., inclusion of briefer presentations and more mood symptoms) can lead to increased prevalence rates (APA, 2013; Kalra et al., 2012). To illustrate, Afro-Caribbean and black African individuals in the UK, and African Americans and Hispanics in the USA, were more likely to be diagnosed with schizophrenia compared with Caucasians (Tortelli et al., 2015). Similarly, migrants in the USA (Malzberg, 1940), the Netherlands, and Germany were more frequently diagnosed with schizophrenia (Selten et al., 2005). Paranoid schizophrenia was often over-diagnosed in African American patients, as opposed to being under-diagnosed in white patients (Anglin & Malaspina, 2008).

Psychopathology Across Cultures

Internationally, although the DSM-5 (APA, 2013) requires the presence of delusions, hallucinations, or disorganised speech as essential criteria for a diagnosis of schizophrenia, the manifestation of symptoms differs across cultures (Kalra et al., 2012). For example, the content of delusions differs; while a delusion for an American may manifest as a belief that the President of the USA is a close friend, an Indian may believe he or she is a well-known "Bollywood" icon. Similarly, in the UK, the content of delusions changed over time from being commonly related to mustard gas, to science fiction-related content, and more recently, to content related to the internet and terrorism (Kalra et al., 2012). The most commonly reported delusions in Austrian and Pakistani samples were persecutory; Austrians also reported higher rates of delusions of

guilt, grandeur, and religion than the Pakistani sample (Stompe et al., 1999). Persecutory delusions were higher and affective symptoms lower in Dutch people living in Holland compared with Moroccans and Turks living in Holland (Veling, Selten, Mackenbach, & Hoek, 2007). Religious delusions were seen at a higher rate in Western cultures (ranging from 21–36%) than in Japanese or Pakistani cultures (ranging from 4–7%) (Stompe et al., 1999). The Xhosa people of South Africa reported predominantly religious content (70%) (Connell et al., 2015).

Lack of a cross-culturally accepted definition of hallucinations is a limitation (Pfeiffer, 1994). Although hallucinations are common in both traditional and modern societies, in non-Western cultures they are often attributed to spirit possession or an attempt to contact spirits (Bauer et al., 2011). In Australian Aboriginal and Torres Strait Islander cultures, communicating with spirits or animal totems is part of their spiritual experience, and needs to be differentiated from mental illness (Kanowski, Kitchener, & Jorm, 2008). There seems to be a strong association between culture and the type of hallucinations (Kalra et al., 2012); although there is a difference in the content, auditory hallucinations are most common across Western, African, and Asian cultures (Bauer et al., 2011). In contrast, UK samples and people in Nigeria reported lower levels of abusive, angry, frightening, fighting, or third person content (Okulate & Jones, 2003). Similarly, compared with Americans, people from India and Ghana reported lower levels of violent commands and strong relationships with the voices (Luhrmann, Padmavati, Tharoor, & Osei, 2015). People from Africa and the Near East reported visual and tactile hallucinations (Ndetei & Vadher, 1984). Bauer and colleagues (2011) reported that patients from Nigeria and Ghana experienced visual hallucinations more frequently compared with those from Pakistan and Europe. Overall, culture seems to have a decisive impact on the nature of reported hallucinations, although factors such as age, age of onset, and duration of illness influence the prevalence of hallucinations (Bauer et al., 2011).

The higher incidence of visual hallucinations in East Asian cultures has been proposed to be due to differences in processing; these cultures incorporate context in relation to objects, whereas Western subjects were more likely to ignore contextual information (Han & Northoff, 2008). Moreover, East Asian cultures are more oriented to concrete rather than abstract aspects of an environment (Al-Issa, 1977). There may also be cultural differences in brain region activation in relation to perceptual processing (Masuda & Nisbett, 2006). It is interesting to note that more immediate environment or exposure to a newer culture could override culture of origin in influencing hallucination type and content. To illustrate, patients living in Pakistan exhibited higher levels of visual hallucinations and lower levels of auditory hallucinations compared with Pakistani migrants living in the UK and white patients of UK origin (Suhail & Cochrane, 2002).

Further, migrants may experience auditory hallucinations in their first or second languages, or both (Wang, Morales, & Hsu, 1998), indicating that schizophrenia is minimally affected by the comprehension of English language. Culture-specific deficiencies in language are evident in Mandarin speakers, due to the variety of tones they use to convey word meanings; each syllable may have one of four tones assigned to them, which alters word meaning. Similar to what is seen in Western patients, Mandarin-speaking patients display impairment in recognising tonally different but syllabically similar words. This may partly explain the reasons for more significant social disability in Mandarin-speaking patients (Yang et al., 2012).

Culture seems to influence the experience of negative symptoms in schizophrenia. For example, Moroccans living in Holland displayed higher levels of negative symptoms compared with Dutch people living in Holland (Veling et al., 2007), as did Indians compared with Australians and Malaysians (McLean et al., 2014). However, features such as flattened affect and anhedonia (associated with poor prognosis and generally stable across time regardless of medication status)

are seen in approximately two-thirds of cases (Kring & Germans, 2003). Indian patients reported less positive affect in response to both positive and negative stimuli compared with Germans and Americans, although control group subjects reported higher levels of positive affect in response to all stimuli. It is hypothesised that the collectivistic cultures promote positive emotions and discourage negative emotions; therefore, the control group subjects might have been responding to this cultural value, whereas the schizophrenia group lacked such ability (Habel et al., 2000).

Patients with schizophrenia also lack the ability to respond to others' emotions (Moller, 2007). This may be due to an impaired ability to recognise emotions (especially negative) from facial expressions (Edwards, Jackson, & Pattison, 2002), which is independent of basic disturbances in perception (Okada et al., 2015). Such a deficit is seen across cultures, including French, Japanese (Okada et al., 2015), American, Indian, and German (Habel et al., 2000). While such impairment is evident in both Eastern and Western cultures, Japanese and Indian patients experienced lower rates of negative emotional facial recognition compared with Western patients (Habel et al., 2000; Okada et al., 2015). It is hypothesised that this may be due to collectivist cultures being less able to recognise negative emotions in stimuli from other regions (Elfenbein & Ambady, 2002; Okada et al., 2015), and hence focusing more on positive emotions while seeking to reduce negative emotional experiences (Habel et al., 2000).

Expressed emotions (EE; emotional and behavioural interaction within the family) and emotional over-involvement (EOI) play important roles in the onset and manifestation of schizophrenia. For example, Mexican and Indian families were less critical of their relatives with schizophrenia and had lower EE than British or American families (Karno et al., 1987). However, findings are mixed across cultures, with British Pakistanis displaying significantly higher levels of EOI and EE compared with white British and British Sikhs (Hashemi, & Cochrane, 1999). The response of family members is influenced by how their culture defines appropriate behavioural interpersonal interactions (Suhail, Ikram, Jafri, Sadiq, & Singh, 2012). EOI involves highly involved, protective, self-sacrificing behaviours, which are valued and encouraged in many Eastern cultures, but seen as undesirable in Western cultures (Hashemi, & Cochrane, 1999). Criticism in Eastern cultures is more likely to be given for behaviours that disrupt the family, whereas Western cultures are more likely to direct criticism at personal traits or psychotic behaviour (Suhail et al., 2012).

In West Africa, a diagnosis of *ukuthwasa* or *amafufunyana* is offered instead of schizophrenia (however, not all patients with a diagnosis of *ukuthwasa* or *amafufunyana* meet criteria for the diagnosis of schizophrenia). A preference for such terms may be because of lesser stigma associated with them (Niehas et al., 2004). *Ukuthwasa* includes symptoms such as auditory hallucinations, social isolation, irritability, and restlessness. *Amafufunyana* is believed to be caused by possession by multiple spirits due to sorcery, and can manifest as unpredictable behaviour, an unusual or muffled voice, and "hysteria." In Mexican-American culture, schizophrenia is substituted with the term *nervios*, which encompasses a broad range of psychopathology; compared with the diagnosis of schizophrenia, this term attracts less individual blame (Lopez et al., 2004). Similarly, in Brazil, the concept of "evil forces causing schizophrenia" is associated with less stigma, and helps in removing blame from the patient (Redko, 2003).

Stigma and Prognosis Across Cultures

Stigma occurs universally, yet its impact, manifestation, and source can vary across cultures (Shrivastava et al., 2011). As a result of stigma, many patients with schizophrenia experience discrimination (Loganathan & Murthy, 2008), and it impacts on prognosis across cultures (Littlewood, 1998). In India, patients living in rural settings experienced higher levels of

discrimination compared with those living in urban areas (Loganathan & Murthy, 2008). Discrimination may influence the incidence of schizophrenia (Veling et al., 2007), and delay first and subsequent treatment attempts (Sartorius, 2002). Young black Caribbean and black African men with schizophrenia were more likely to commit suicide than young white men, with up to a third of these suicides being preventable (Bhui & McKenzie, 2008; Bhui & Tsangarides, 2008).

The language of a culture can also encourage stigma. In Greek, schizophrenia means splitting of mental faculties. In ideographic cultures (e.g., China and Japan), the ideographs translate directly into the meaning of the word, whereas in English, the meaning is not as easily accessible. This makes schizophrenia a stigmatising label, and psychiatrists may be less likely to divulge a diagnosis or may offer terms such as "autonomic nervous dysfunction" rather than an actual diagnosis. As a consequence, only a small proportion of patients (16.6%) and family members (33.9%) in Japan were aware of their diagnosis of schizophrenia (Banerjee, 2012).

Developing countries such as Mauritius, Sri Lanka, India, Colombia, and Nigeria, report a better prognosis for schizophrenia compared with developed regions such as Europe and America (Bhugra, 2005; Cohen, Patel, Thara, & Gureje., 2008; Kulhara & Chakrabarti, 2001). It is speculated that differences in family structure and bonds, and community responses to mental illness could explain the link between culture and mental health outcomes (Sartorius et al., 1987). Cohen Patel, Thara, and Gureje (2008) argued that the reliability of reported prevalence rates is influenced by the fact that many patients may not seek treatment in developing countries, and hence, not be included in studies.

Treatment approaches are often influenced by culture. For example, in the USA, African Americans were more likely to be given depot antipsychotics, and less likely to be prescribed new generation drugs than Caucasians presenting with similar symptoms (Kreyenbuhl et al., 2003). In India, individuals with schizophrenia who refused to take medication were often administered medication by their family, under supervision of a psychiatrist, without the knowledge of the patient. Family playing a significant role in providing care to patients in a collectivist culture may make this acceptable, whereas in a Western individualistic culture, such involuntary dispensation could be considered unethical and unacceptable (Banerjee, 2012). In Brazilian culture, various religious resources are considered imperative in conjunction with psychiatric treatment (Redko, 2003).

Schizophrenia: A Māori Cultural Perspective

Overall, compared with NZ Europeans, Māori are disproportionately affected by mental illness and experience significantly poorer mental health. The prevalence of schizophrenia in Māori is approximately three times higher than in the non-Māori population (Kake, Arnold, & Ellis, 2008). Differences between Māori and NZ Europeans are attributed to traditional Māori beliefs about mental illness (Sanders et al., 2011). Some Māori patients attribute schizophrenia to *chance* or *spiritual* causes for mental illness. Traditionally, Māori attribute mental illness to the infringement of *tapu* and believe that making penance for the offence and treatment by a *tohunga* can cure the illness. However, Māori with schizophrenia experience fewer symptoms, less disability, and have better overall functioning than NZ Europeans. Māori patients believe that schizophrenia will last for a shorter time compared with NZ Europeans.

Sir Mason Durie made significant contributions to the development of a holistic approach to Māori mental health with the inclusion of Māori cultural perspectives. This approach, termed *Te Whare Tapa Wha* (four cornerstones of health), conceptualises health as comprising four important dimensions; namely, *Taha hinengaro* (cognitive and emotional wellbeing), *Taha tinana* (physical wellbeing), *Taha whānau* (social wellbeing) and *Taha wairua* (spiritual wellbeing).

Traditional Māori attribute illness to the violation of *tapu* (supernatural influence or restriction) or to the presence of *makutu* (curses) (Durie, 2011). While working with *tangata whenua* (people of the land) it is important that mental health clinicians are sensitive to these explanatory models, and a holistic approach should be adhered to while offering health services (see Prasadarao, 2009).

Conclusion

Schizophrenia is a complex psychiatric disorder. Aetiology, explanatory models, clinical manifestation, treatment seeking, adherence, and outcomes are all influenced by a multitude of factors moderated by culture. Endeavouring to integrate a clinician's explanatory model of illness with the patient's explanatory model is essential in providing culturally sensitive and effective practice (McCabe & Priebe, 2004; Prasadarao, 2014). In this article, we described how schizophrenia may be understood from a cultural perspective, and outlined some key differences in clinical manifestation, diagnosis, and treatment/outcomes across cultures. We also illustrated the need for a focus on cultural context while working with clients with schizophrenia and their families. To conclude, it is imperative that health care providers focus on emic and etic approaches to understand people, their cultural practices, their causal explanations and belief systems, and unique clinical manifestations of illnesses, so that the barriers to providing culturally appropriate interventions can be identified and addressed (Prasadarao, 2014).

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I'm Screwed: A Client's Perspective on the Influence of Schema in Response to and Recovery From Serious Injury

G. Barclay and S. G. Middlemas

Preface

This work is based on my (Gary Barclay) personal reflections regarding response to and recovery from serious injury. Reflections on my injury, post injury events, and relevant events from my childhood that helped shape my most recent injury experience are provided within the frame of an auto-ethnographic approach to help the reader appreciate my perspective. The influence of schema and schema therapy as part of my psychological experience are discussed throughout, with the aim of helping mental health practitioners appreciate how schema therapy may be useful in helping clients recover from serious injury. It may be that schema therapy or similar interventions can provide an avenue for some clients to identify and overcome psychological processes that impact their response to and recovery from injury. Additional personally-relevant recovery strategies are briefly highlighted in the "Thoughts for Practice" section near the end of this paper.

It Goes Dark

Saturday 18 May, 2013: Local football field. It's a drizzly, cold and cloudy Saturday. I've spent the morning transforming my daughter's old pink bike into my son's "new" blue bike, for his third birthday on Thursday. He's already able to ride without training wheels so I'm really excited about the idea of going out for family bike rides. I've decided to play club football this season for the first time since 2006…now that my children are a bit older (5 years and almost 3 years) I thought it might be good for them to see "the old man" out running around on the field having a good time…however, my family isn't coming to watch me play today because of the miserable weather.

It is midway through the second half in the game…I'm breathing heavily but feeling strong. I'm running towards the ball which is a few metres away. I'm feeling quite happy and confident as I know I can get to the ball. "It's mine!" I think to myself. As I'm approaching the ball, I hear heavy footsteps coming from behind me. I suspect that it's one of the opposing players who also wants the ball, but I'm in front of them. I know I will get there first. I start to turn my head slightly to the right to see if I can see what's happening behind me before I get to the ball, as I do so I hear an effortful grunt and I'm hit, hard, somewhere on the side of my neck or head. Then I feel like I'm being forced to the ground somehow, maybe pulled back and thrown down, I'm not sure. It's rough. I feel like my head is flopping around, like I'm on a rollercoaster. I don't know which way is up. I actually see stars. It goes dark.

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I wake up on the ground. I don't know if I'm in pain. I'm lying flat on my back. I feel tingling in my arms and legs. I've done first aid courses; I know instantly that this is a sign of spinal damage. I tell the people around me "Don't move me!" I try to lift my head but, I can't even do that…I'm screwed, big time! I'm lying here thinking about a life of paralysis. I'll never be able to go for walks or bike rides with my family. My kids are going to miss out on me. I'm going to miss out on them. Images of my family riding their bikes next to our local stream come to mind, but where am I? I'm really scared…I can't take this anymore, I just want to sleep.

I was taken to the local hospital's emergency department by ambulance and spent the next 4 days in hospital. I had sustained a "significant" fracture of the second cervical vertebra. Treatment for this injury consisted of 12 weeks in a halo brace and vest, which included the insertion of four screws into my skull. That is right; I was literally screwed in the head. Following removal of the halo and vest I wore a cervical soft collar neck brace and gradually reduced use of this over a 2-month period as neck strength was regained. Over a period of time following initial physical recovery from my neck injury, it became apparent that I was not coping well with various aspects of my life. I recognised that I was behaving in an excessively anxious and fearful way. I felt like I had a "screw loose." Thankfully, I was able to access mental health support, a process which identified that I had been suffering from post-traumatic stress disorder (PTSD). The psychologist I worked with during my rehabilitation used a variety of models in my treatment including schema therapy. Schema therapy was selected because of some of my earlier life experiences having an impact on my ability to cope with the injury; several of these will be discussed throughout. In particular, sessions with the psychologist identified the influence of an existing (yet personally unrecognised) "vulnerability to harm" schema that appears to have had a significant impact on my recent injury experience. Had my underlying beliefs remained unrecognised, my therapy may have only treated the symptoms of anxiety and not some of the underlying factors; therefore, my PTSD may have only been partially treated. Schema and schema therapy is used to contextualise my experience of this injury and my subsequent recovery, both physical and psychological.

Schema and Schema Therapy

Schema, also known as early maladaptive schema, can be described as self-defeating emotional and cognitive patterns that begin at a young age and repeat throughout life (Young, Klosko, & Weishaar, 2003).

More specifically, Young Klosko, and Weishaar (2003) suggest that there are six defining characteristics of schema, which include "a broad, pervasive theme or pattern; comprised of memories, emotions, cognitions, and bodily sensations; regarding oneself and one's relationships with others; developed during childhood or adolescence; elaborated throughout one's lifetime and; dysfunctional to a significant degree" (2003, p. 7). It is important to also consider that schemas are descriptors of learned responses, and that a person's behaviour is not part of a schema per se, but rather behaviours develop as responses to a particular schema. Young and colleagues (2003) went on to identify 18 different schema, including abandonment/instability, mistrust/abuse, emotional deprivation, defectiveness/shame, social isolation/alienation, dependence/incompetence, vulnerability to harm or illness, enmeshment/undeveloped self, failure, entitlement/grandiosity, insufficient self-control/self-discipline, subjugation, self-sacrifice, approval seeking/recognition seeking, negativity/pessimism, emotional inhibition, unrelenting standards/hypercriticalness, and punitiveness. Schema therapy seeks to understand and adjust maladaptive client schema, and has been described as an "innovative, integrative therapy…that significantly expands on traditional cognitive-behavioural treatments and concepts" (Young et al., 2003, p. 1).

Vulnerability to harm schema is characterised by an "exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it" (Young et al., 2003, p. 15). According to Young et al. (2003), fears focus on one or more of the following: (A) medical catastrophes (e.g., heart attacks, AIDS); (B) emotional catastrophes (e.g., going crazy); and, (C) external catastrophes (e.g., elevators collapsing, victimisation by criminals, airplane crashes, earthquakes). For me, it was vulnerability to medical catastrophes that appeared to have a significant influence in my development of PTSD. So, what led to developing this schema? To answer this question I will draw on critical reflections and stimulated recall (self and others) in an attempt to explore the relationship between my previous life experiences (and subsequent schema) and my psychological response to and recovery from injury. The aim of this work is to facilitate mental health practitioners' consideration of the use of schema therapy as part of a client's treatment regimen as and where appropriate.

Methodological Considerations

An auto-ethnographic approach to exploring experiences involving personal trauma in sport is not an original research concept. For example, Dashper (2013) discussed her responses to the injury experience in relation to gender and sporting identities; Brown, Gilbourne, and Claydon (2009) explored the trauma and challenges of a career-ending sports injury; and Clifton (2014) looked at the grief associated with a spinal cord injury. However, its application to the client experience of schema therapy in relation to such trauma does appear unique. Given the sensitive nature of this topic, an auto-ethnographic approach was considered the most appropriate way to achieve the aims of this research, and as such, a first person approach is used throughout much of this text. I undertook a critical reflection process to explore my recent personal experiences and consider the influence of schema in response to and recovery from this serious injury. The text that is created is a journey through which we will tell my story. Ellis and Bochner (2000) suggested that to be an auto-ethnographer, you must be introspective about your feelings, observant about the world, self-questioning, and vulnerable. With this in mind, the text created in an auto-ethnography is "a world in a state of flux and movement—between story and context, writer and reader, crisis and dénouement. It creates charged moments of clarity, connection, and change" (Jones, 2005, p. 764). It has been argued that there can be "no clear window into the inner life of an individual," as any gaze is always filtered through the lenses of language, gender, social class, race, and ethnicity (Denzin & Lincoln, 2011). Therefore, it is important to bear in mind that this research is filtered through my "lenses," which include husband, father, sport and exercise enthusiast, psychology lecturer, researcher, and client of mental health support services. In using personal experience, it is imperative to consider that close, intimate others may also be implicated in the narrative. This research has been approved by the Otago Polytechnic Ethics Committee, and in an effort to protect the identity of others, names have not been used.

Research Methods

The auto-ethnographic journey began with generation of a dense description of the personal context of my injury and my experiences during rehabilitation. These reflections were prompted using extracts from my personal diary that I kept following the injury, and stimulated recall of critical incidents and significant others (e.g., my wife). The second author (Dr Simon Middlemas) read my description and made notes of the thematic materials that helped interpret my experience. We discussed these early reflections and I revisited my notes to thicken the description in parts of the narrative until I felt that saturation was reached regarding my story. Inductive coding was then used to bracket segments relevant to understanding these experiences of rehabilitation, and in my everyday life. A series of collaborative research meetings were held between myself, Dr Middlemas, and an experienced independent researcher in my academic department, who acted as "critical friends" (Smith & Sparkes, 2006). These critical friends shared their interpretation of the findings, stating rationale as to why one interpretation or narrative

might fit well over other possible interpretations or narratives. Having lived this experience, I was best positioned to make final determinations about which themes, quotes, and journal entries best represented and supported my experience. This ensured that my narrative was enhanced and my voice remained strong throughout this work. Medical notes and family members were also used to help ensure historical accuracy. Although this is "my story" I believe that my experience has relevance beyond myself including professional and lay readers.

My Story

What's Wrong with Me?

Friday 29 June, 1986, at Primary School: It's a Friday afternoon, I'm 11 years old and at primary school. I'm walking towards the path that goes between the sports shed and room seven but need to cross a blind t-intersection to carry on up that path. I can't see if anyone is coming from the left of the intersection. I'm just about to start crossing the intersection when a boy runs past at full speed. Luckily, I'm able to step back and avoid a collision. That was close! I can see him running away to the right. I step out again to carry on my way but another boy, who is chasing the first, collides with me. His forehead hits my left temple area. The impact of the initial hit has me in shock and I have a very sore head. The other boy is relatively fine. I sit down on a low fence nearby as a crowd gathers around to find out what has happened. After a while, I'm escorted by a teacher to my classroom where I lie down on some cushions in the reading area. The pain doesn't subside. I have to go home; a 10 minute walk away. I lie down in my parents' bed staying there for the rest of the day. At around 10 p.m. I start vomiting and continue to do so throughout the night until 7 a.m. the next morning. During the Saturday at home, my right foot and leg gradually stop working properly and by Sunday morning I also have right side facial weakness and cannot use my right arm. I'm unable to eat breakfast and Mum is getting really worried about me. My parents lay me down in the backseat of our car and drive me to hospital with my pyjamas and dressing gown on. [Later that day I had surgery to remove what was turning into a life threatening extradural haematoma. According to the medical notes, I made a good recovery.]

Mine was a sporting family, and from around 8 years old I was encouraged by my parents to try a variety of winter and summer sports to find what I liked. First it was rugby; it had to be rugby because like many other New Zealand boys, I wanted to be an All Black. Then it was on to football (soccer). I tried several other sports as well including cricket, softball, and athletics. However, after my head injury, my parents were not enthusiastic about me playing rugby anymore and encouraged me to continue with football, believing I would be less likely to have another head injury. The only proviso was that they did not want me heading the ball; they thought that as a result of my injury, it might cause some kind of further "damage," and often reminded me "Don't head the ball." I often wondered if they were right and there were times when I did try hard not to head the ball, but if I felt that it was important for my team, on occasion I would still do it because I did not want to let the team down. As it turns out, my parents may have been right. Recent research, for example, Lipton et al. (2013) found that heading the ball in football was associated with microstructural and cognitive abnormalities.

Because of my head injury, rugby, my first sporting love, was no longer an option. I also had to be careful not to head the ball while playing football. Further, for me to continue playing my next favourite sport, cricket, I had to wear a helmet while batting which was rare for children to be doing in the 1980s. The combined effects of feedback like "be careful," "don't head the ball," not being allowed to play rugby and having to wear the helmet for cricket made me feel like I had become "special," vulnerable, like I was not a normal child anymore. In short, it made me feel different. I had to be protected from harms that other children did not. But it was not just my own experiences that were reinforcing a developing vulnerability to harm schema. In addition to my own health, two other health-related incidents had an impact on me when I was around 11 years old (1986). The first was my father having a heart attack in September; he was 56 years old at the time. The second, and perhaps most disturbing for me, was my mother's first angina attack

at age 55 years. I had no understanding of what an angina attack was at the time or what it meant for Mum's health.

Date unknown, 1986, at home: I'm in the kitchen at home. Mum and I have just walked home carrying groceries from the local shop. Something's not right with Mum, she looks worried. She has a sore arm. She makes some phone calls and people come to see her. Family and her friends are worried about her. Our family doctor visits her at home. What's going on? The next day I'm at cooking class at school. I can't focus on what I'm meant to be doing. I'm distracted by thoughts about Mum. She had that thing. The doctor came. People are worried about her. Is she going to die? Mum's going to die! My anxiety builds to the point that I start to cry. The teacher escorts me out of the class... [Later that day] *I'm lying in bed crying. Mum hears the noise of my sobbing from the hallway and comes to comfort me. She asks "What's wrong?" and I explain that I don't want her to die. She tries to console and reassure me that she isn't going to die, that she will be okay.*

My Poor Children

I realise now that my early experience of head injury and the associated changes (no rugby, having to wear a cricket helmet) and feedback ("be careful," "don't head the ball"), combined with my anxieties regarding my parents' health helped establish my vulnerability to harm schema. But how was this schema brought to the fore and expressed with my neck injury? I believe that three main experiences triggered my schema. The first, most significant, and underlying experience was the terrifying belief that I would be paralysed and what that would mean for me and my family. The second occurred in the hours following the injury, and the third a few days later.

Saturday 18 May, 2013, at the hospital: A member of the medical team has just informed me that they are going to take my football jersey off. Instantly I think that this is not okay. "How are you going to do that?" I ask. They explain that they will take it off over my head like you would normally take a top off. Instantly I think "Fuck Off!" I'm still waiting to have scans and X-rays for Christ sake! I have a neck injury, I had tingling in my limbs and they want to take my top off over my head! I'm thinking they could damage my spinal cord if they move my head. I'm not in serious pain at this moment but I lie and tell them that I am. I tell her to just cut the jersey off because I hurt too much. They say that some people want to look after their jerseys. Given my situation I think this sounds pretty bloody stupid. The staff member cuts the jersey off me and covers me with a robe, then goes away. I talk to my wife about how much damage could have been done if she had done that with no knowledge of the extent of my injuries…I'm feeling really vulnerable. Someone's stupidity put me in this situation and now others' mistakes could paralyse me. If I hadn't been capable twice now (the first time when I told people not to move me) I could have serious spinal damage and miss out on my kids, my wife, and my life. Who can I trust? I feel really tense and uptight. Really vulnerable and on the lookout for potential things or people that could harm me further.

Tuesday 21 May, 2013, at the hospital: The specialist to whom I have been assigned comes to see me with a group of people, presumably other doctors and medical students. They ask me how I'm feeling with the halo and vest on. I tell them that I feel pretty good considering what I've been through and just relieved that I dodged the rest of my life in a wheelchair. At that moment they succinctly respond that it was more likely I would have been in a "pine box" rather than a wheelchair. Excuse me!? They explain that my C2 vertebra sustained a significant fracture, the nerves of which are involved in breathing [I didn't remember that from Functional Anatomy class!]. *I'm absolutely shocked! I could have died, while playing "oldies" football! What the fuck! I'm experiencing a mixture of feelings right now including surprise, relief I'm not dead…but also anger that my wife and kids could be without a husband and father due to one person's ridiculous actions…I know now that I need to be really careful until this thing has fully healed, or I could die. Where would that leave my family, my wife, and my poor children?*

I am now sure that my vulnerability to harm schema intensified my thoughts of paralysis while lying there on the field. However, this was at least partially qualified by having done first aid courses in which I learned that tingling or "pins and needles" sensations in the limbs can be a sign of spinal injury (New Zealand Red Cross, 2012). It may also be that my reaction to the staff member's willingness to remove my jersey was due to my perceived vulnerability and fear of spinal injury. The addition of the specialist telling me that I could have actually died as a result of my injury heightened my anxiety, and my focus is firmly on the lookout for potential harm: I am vulnerable. I could die!

I Need to Get Out of Here

My underlying vulnerability to harm schema and my anxiety surrounding the events that immediately followed my injury might also have had an influence on my behaviour and reactions throughout the recovery process. There are several key moments that illustrate this point.

Sunday 19 May, 2013, at the hospital: In the afternoon the nurses come. They want to wash me and put moisturiser on my back. To do this they have to roll me onto my side. The prospect of this, given my previous experiences, is really scary!…One of the nurses is very quiet. She seems to me to be too quiet. This makes me feel like she isn't competent to help with something that is so important. Does she actually know what she's doing? Or is the quiet nurse anxious too? The other nurses seem relaxed and calm. This has to go well! I know now that I have to look after myself so I tell one of the other nurses about my concerns. She does her best to assure me that the "quiet nurse" is very good at her job. They have to roll me as a team onto my side and keep me there while one of the nurses cleans my back and rubs in the moisturiser. It all goes well, it feels nice to be clean but it's such a relief when it's over.

Monday 20 May, 2013, at the hospital: At last, it's Monday afternoon. It feels like it has taken so long for this day to come. Three or four doctors come to attach the vest to the halo. The vest is lined with wool and I have a mild wool allergy so I've opted to wear a t-shirt under the vest to keep the wool off of my skin. I'm really anxious. I'm trying to be positive about getting the brace attached, what it will mean for me as far as being able to be "active" again. But at the same time, I'm really scared of what it would mean for me if something went wrong…The doctors take off my hospital gown and replace it with a clean t-shirt. For the briefest of moments it feels cool and clean against my skin. But gradually, as the doctors are manipulating me, the halo, and the vest, the fear and anxiety has me perspiring so much that my new t-shirt is soon soaked with my sweat; sweat that will now be with me for the next 12 weeks…The whole process takes less than an hour and goes without a hitch, but I'm "buggered" physically and emotionally. I'm absolutely drained.

Wednesday 22 May, 2013, leaving hospital: It's great to be going home…I'm anxious about the car ride but the excitement of being home for my son's third birthday is winning at this stage…I'm about to have my first ride in our car with the halo on. It's a cold, dark, and wet night…I struggle to get into our car due to the shape of the halo and my inability to move very well with it on. I bump the halo lightly on the door frame a couple of times but I'm okay. My wife has to help me put my seatbelt on. It's very uncomfortable sitting in the car. I have to sit forward slightly to keep the brace off of the back rest; it just doesn't feel comfortable…I'm starting to feel very anxious about the trip ahead. I'm holding onto the door handle very tightly, and bracing myself for any movement. The fear of being driven around, knowing full well that I have a broken neck, is almost overwhelming. I could die if we have an accident. Shit! If we have even a minor "fender bender" will the halo be of any benefit? I'm very fearful. As we start to drive away from the hospital it seems like I can feel every bump on the road. It feels as if the bumps go right up me to the screws in my head. When other cars are close to us I remind my wife to stay well away from them, I don't want to take any risks. It's very uncomfortable. I hate this! I don't feel at all safe; I just want to get home…we made it. My wife helps me out of the car and we go inside. The door shuts, I'm safe. Physically and emotionally, I'm very tired. I try to sit down for a rest but I can't get comfortable…Although I adapt over time to car travel, every car ride is pretty much the same for the next 3 months: physically and emotionally draining. I don't go anywhere in the car unless I have to for fear of being in an accident.

Monday 27 May, 2013, at home: I'm going for my first walk outside since I've been home; my wife is with me for support. It's a nice day and I usually enjoy a walk, but today it's different. I shuffle out of the garage with small, very careful steps like an old man who doesn't want to have a fall. As I walk I have to check the ground three or four metres ahead to make sure that the path is clear, that there's nothing I could trip over. Our driveway is fairly smooth and felt okay to walk on, but as we get onto the footpath I'm immediately conscious that it is more uneven. Crossing the hollow of our neighbour's driveway is unnerving. I can feel my muscles starting to tense even more. We walk on towards the next house. I'm starting to panic. I'm not breathing properly; my breaths are short and shallow. My mind is racing, thinking that I need to get out of here. I don't want to continue. I'm freaking out, scared of injury, scared of tripping and falling, scared of doing more damage, scared of dying. I've travelled approximately 20 metres from home when I tell my wife "I can't do this anymore," and we head back home. I have to get to the safety of home. Once we are back in the garage I slip my shoes off and we go inside. I walk into the hallway and start sobbing. Only last week I was running up that path without a care in the world. It's going to be a long time, if ever, that I will be able to run that way again. I'm afraid of what the future holds, how much better will I get? I just don't know. I hate the not knowing, the fear, the frustration.

Thursday 13 June, 2013, at home: As I've settled into my new lifestyle at home over the last 3 weeks I've tended to be brought to tears very easily, and I have been very emotional. I've been feeling anxious about walking and being in the car. Recently I have begun to fear that the person who did this to me will come and hurt me or my family and I will not be able to protect them. I called the orthopaedic ward at the hospital and spoke to the charge nurse who was familiar with my case about how I had been feeling. She assured me that they would not have let me go home if they did not think that I was safe. She also said that so long as I'm moving about and getting the blood flowing then I don't need to do a lot else. She suggested that if I was not comfortable travelling in the car, then I could only do it when necessary. She tried to assure me that my neck should be healing and getting stronger every day. Although I already knew most of what she said, it did help me feel a little better, but still not entirely convinced. There was always an element of doubt about my safety.

Despite the nurse's best efforts I do not think anything she said would have made me feel significantly less anxious. The psycho-therapeutic process has helped me realise that it was likely my schema that was holding me back and keeping my anxiety levels higher than necessary. I believe that my responses to these various experiences indicate the underlying influence of my feelings of vulnerability. My vulnerability to harm schema led me to exaggerate the level of perceived danger I was in post-injury. This led to certain feelings (anxiety) and certain behaviours (e.g., avoidance). Therapeutic exploration of my early life helped me to make the links between my schema and my reaction to injury. Insight and therapy enabled me to "sit back" from my immediate reactions and be thoughtful about those reactions. Furthermore, I believe that, without understanding my schema little could have been said to convince me of my relative safety while wearing the halo. This *may* highlight an advantage to having a greater understanding of deeper psychological processes, such as those identified through schema therapy, for me to achieve optimal recovery. My schema was vulnerability to harm, but others may have different schema that influence their post-injury behaviour. For example, how might someone with mistrust/abuse schema behave following such an injury? Would they be caught up in anger? Would they find it even harder to trust others?

I continue to live with the ongoing influence of my schema; however, thanks to my increased understanding of self, I am able to keep this in check, most of the time. Some of my vulnerabilities relate to me personally, including fear of being attacked, and fear of being paralysed by another neck injury; while others relate to my loved ones; for example, the fear of family members being hurt, injured, killed, or attacked, or my children feeling anxious about their parents' health like I did. However, I have been able to develop more adaptive coping strategies with the help of my psychologist as well as using self-help techniques from Young and Klosko

(1993), which appear to support the findings of Priemer, Talbot, and French (2015) that self-help schema therapy has the potential to help a large number of people who may not have the ability to access mental health services. Additional strategies have included brief mindfulness meditation, the use of flashcards and a schema diary (Young et al., 2003), imagery, and graduated exposure.

If this depth of understanding of personal psychological processes had a positive influence on my ability to recover from PTSD, perhaps others would benefit from a similar level of personal understanding. Cockram, Drummond, and Lee (2010) found schema therapy to be of benefit to war veterans suffering from PTSD. Edworthy, Chasey, and Williams (2008) found associations between pre-existing schema and PTSD following childbirth.

More generally, a systematic review of the evidence for schema therapy by Masley, Gillanders, Simpson, and Taylor (2012) found this form of therapy to have relatively large effect sizes and positive impacts for a variety of mental health issues, including borderline personality disorder and personality disorder. Further, Hawke and Provencher (2011) suggested that schema therapy may be successfully extended to mood and anxiety disorders. Carter and colleagues (2013) concluded that such therapy may be an effective alternative therapy for depression. In addition, Pugh (2015) suggested schema therapy is a promising intervention option for those with complex eating disorders.

My Football Plan Did Not Work

Having not played football for many years I decided to play in 2013 to help my children see how much fun I, and they, could have running around on the sports field, keeping fit, and being part of a team. In part, this was motivated by my enjoyment of being at my older brothers sports events, but it was mainly motivated by a desire to role model being physically active. My football plan did not work! But, I continue to try and lead by example through other health-related activities and am ever mindful, now that I know about my schema, to keep it in check and prevent the inadvertent "passing on" of a schema that has created a great deal of anxiety. Thankfully, my children do not appear to have suffered long term mental ill health as a result of parental injury, which Rivara, McCarty, Shandro, Wang, and Zatzick (2014) suggested can seriously impact a child's mental wellbeing, including the development PTSD.

As previously discussed, schema therapy has been found to be beneficial for those suffering from a variety of mental health conditions including PTSD (Cockram, Drummond, & Lee, 2010; Edworthy, Chasey, & Williams, 2008). I believe that my experience provides additional support for this intervention regarding the treatment of PTSD. However, I also believe that my experience, including response to and recovery from injury, and the influence of my underlying psychological processes, highlights a further challenge to those working with injured clients. I teach in the area of health and exercise psychology, and as such, may have a greater appreciation than others of biopsychosocial influences on health and wellbeing (Abraham, Connor, Jones, & O'Connor, 2008). Yet I lacked awareness of the potential underlying influences of my schema. Despite this, I was able to recognise my poor psychological wellbeing and had the capability to seek help; but what of those without such recognition or capability? I acknowledge that my experiences and interpretations are unique to me so, what is the journey like for others?

Support for the physical component of my injury was available soon after the injury occurred. However, I had to be aware of my need for psychological assistance and figure out how to access the support I needed. My experience brings to mind a number of questions, including "How many people are suffering from the ongoing psychological effects of their injury experiences?"

New Zealand's Accident Compensation Corporation (ACC) annual report 2014/2015 indicated there were 1.8 million new claims in that period (ACC, 2016). With every physical injury carrying the potential for associated psychological harm, the numbers of those potentially suffering mental ill health as a result are staggering. It is also important to consider that many of those claimants may have children who could be psychologically impacted by their parents' injury. How much is all this costing in terms of personal, familial, and societal wellbeing? ACC spent $3.2 billion on claims in the 2014/2015 period (ACC, 2016), but what about the financial cost of the ongoing mental effects of injury? How many injured people are suffering psychologically with little or no idea why, or what they can do about it? How can an understanding of my experience help?

Thoughts for Practice

Reflecting on my experience may be useful to health practitioners in several ways. Schema therapy and the associated personal reflections appeared to be a useful adjunct to my recovery and may well be useful for other clients struggling with their mental recovery from injury whether they experience PTSD or other mental health difficulties. However, for various reasons, many clients may not have the time, access or financial support necessary to be involved in the relatively lengthy therapy that I experienced. Regardless of the model of therapy being used, where appropriate, it may be beneficial for the therapist and client to gain an increased awareness and understanding of the potential impacts of previous experiences on the client's recovery from injury. Openness to exploring such experiences may be useful from the earliest stages of therapy. Further, helping clients appreciate that mental processes beyond conscious awareness may be impacting their response to and recovery from injury may be beneficial and assist in the "discovery" of impacting experiences early in the therapeutic process.

Reflecting on my injury and recovery experience also helped me appreciate the value of several other strategies I found useful, and which clinicians may want to consider emphasising in practice when working with injury-related clients. Having been involved in exercise and sport from a young age I feel that being as active as safely possible within the restrictions of my injury helped me to cope both physically and mentally with the injury and recovery. Over time I became more comfortable going for walks with my family and I was able to do some very light resistance exercise. I feel that exercising enabled me to feel productive and develop greater confidence in my abilities. The value of social support networks was pivotal in helping me, my wife, and young family get through this challenging situation. The support of family, friends, teammates, colleagues, and professionals was uplifting and helped ease the burden of my injury, particularly for my wife.

The aim of this work was to facilitate mental health practitioners' consideration of the use of schema therapy as part of a client's treatment regimen as and where appropriate. By reflecting on my experiences and some of the questions and thoughts above, perhaps the health sector, including mental health practitioners and policy makers, will be better able to assist those in need.

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Adolescent Wellbeing in Aotearoa New Zealand: The Importance of School Environment

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The school environment plays a significant role in the wellbeing of young people. One aspect of school environment that appears important is school connectedness; the degree to which students feel they belong or fit in to their school, and accepted and cared for by their school. In this article, we present New Zealand cross-sectional data on school connectedness and wellbeing factors to demonstrate the importance of school connectedness for New Zealand youth. Our results indicate that for our sample of New Zealand secondary school students, school connectedness was associated with greater wellbeing (e.g., lower rates of depressive and anxious symptoms). Participants with poorer parental attachment appeared to benefit from school connectedness the most, at least in regards to lower depressive symptoms. We propose that school connectedness is an important factor to consider when developing treatment plans for youth, particularly those who are disconnected from their family or whānau.

Introduction

Youth wellbeing is strongly linked to the social context in which an adolescent lives, learns, and matures. Adolescents spend a large proportion of their time in school; engaged in academic and social learning, forming relationships, and fostering their identities as they progress into adulthood (Eccles & Roeser, 2011). Hence, it is particularly important to understand the role of school environment on adolescent wellbeing; what factors buffer risk for negative outcomes (e.g., depression, self-injury) and what factors support healthy development? This article aims to identify the importance of school connectedness in regards to wellbeing factors in a sample of New Zealand youth. We present cross-sectional data from our research project, the Youth Wellbeing Study, on facets of the school environment and how these relate to wellbeing.

There are several terms frequently used when considering school environment and wellbeing. The term "school climate" has been used to refer to the "quality and character of school life, including both social and physical aspects of the school, that can positively promote behaviour, school achievement, and the social and emotional development of students" (Lester & Cross, 2015, p. 1). School climate is often used interchangeably with "school culture" (Lester & Cross, 2015). School climate is inclusive of student safety, social relationships, and school connectedness. The term "school connectedness" refers to the degree to which students feel they belong or fit in to their school, and accepted and cared for by their school (McNeely, Nonnemaker, & Blum, 2002). Hence, school connectedness is a subset of the factors that make up school climate.

Why School Connectedness is Important

School connectedness has been linked to a host of wellbeing factors, including an inverse relationship to mental health concerns (e.g., depression: Anderman, 2002; Jacobson & Rowe, 1999; Schochet, Dadds, Ham, & Montague, 2006) and social risk factors (e.g., bullying: Gower,

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McMorris, & Eisenberg, 2015). Longitudinal data indicate that poorer school connectedness is predictive of increased depressive symptoms over time (Schochet et al., 2006). Research has shown that feeling connected to school and safe at school are longitudinally predictive of mental and emotional wellbeing in early adolescents (aged 11–14 years) (Lester & Cross, 2015). Connectedness to teachers appears particularly important for fostering wellbeing among students (Jamal et al., 2013; Lester & Cross, 2015). In a review of 16 qualitative studies investigating the school environment and adolescent wellbeing, Jamal et al. (2013) reported that positive relationships with teachers were strongly associated with positive student wellbeing as well as reduced risky behaviours. In their review, these researchers concluded "health behaviours such as lack of safety, poor student-staff relationships and lack of student voice are amenable to interventions and should be the subject of future investigation" (Jamal et al., 2013, p. 798).

Given the above, school connectedness and having good relationships with adults at school appear to be important variables to consider in early intervention and/or prevention (both individual and school-wide), as well as mental health treatment plans. School policies that promote connection and safety seem particularly important for fostering student wellbeing, especially in the first few years of secondary school and the transition from primary to secondary schooling (e.g., Lester & Cross, 2015).

The Youth Wellbeing Study: Methodology and Sample Details

The research we now discuss is part of a larger research project funded by the Health Research Council, entitled the Youth Wellbeing Study. The data presented here were drawn from a survey of more than 600 young people from a single, large, mixed-sex secondary school in the South Island (N=668; 292 identified as male, 373 as female, and three as transgender; 89.7% identified their primary ethnicity as Pākehā, 2.5% as Māori, 0.6% as Chinese, 5.2% as other, and 1.9% could not choose one primary ethnicity). This represents approximately half of the eligible students in the cohort. Several weeks before data collection, we met with staff and students and provided information packs to all students, including parental consent forms for students aged under 16 years. Over a 4-day period, we surveyed all students aged over 16 years and younger students with parental consent during scheduled English periods. The survey included measures of depression, anxiety, and stress (Lovibond & Lovibond, 1995), self-injury (Gratz, 2001), suicidal ideation and behaviour (Suicidal Behaviours Questionnaire; Osman, et al., 2001), self-esteem (Rosenberg Self-Esteem Scale; Rosenberg, 1965), parental and peer attachment (Inventory of Parent and Peer Attachment; Armsden & Greenberg, 1987), as well as a variety of other constructs not reported here (e.g., emotion regulation, peer attachment).

We asked young people how connected they felt to their school. Responses to school connectedness survey items were on a 5-point Likert scale, with participants indicating the degree to which they agreed or disagreed with the statements "My school is important to me," "I like school a lot," "I feel like I'm a part of the school I go to," and "I feel safe at school" (averaged to make a reliable scale, α=.77). These items reflect the definition of school connectedness described above. We asked participants whether they would feel comfortable talking to a teacher or counsellor in the event they were experiencing difficulties, to reflect feeling supported and cared for at school (part of the definition of school connectedness). Participants were also asked how frequently they had experienced bullying in the past year, and "How often do teachers (or other school staff) take action when they know a student is being bullied?" to reflect sense of safety at school (a facet of school connectedness).

Students identified as potentially at risk of suicide were referred to the school counsellors. All participants were informed that if the research team were concerned about their wellbeing based on their responses, then this referral would occur. Participants' responses were not given to the

pastoral care team; the referral included whether the participant was deemed high, medium, or low risk, with examples of the types of cognitions and behaviours warranting this ranking. Risk was assessed based on participants' responses to the Suicidal Behaviours Questionnaire, and responses were evaluated by the team's clinical psychologists. Approximately 10% of students were referred to the school counsellor for follow-up.

Results

In regards to seeking support, most participants (77%) indicated they could talk to parents if something was bothering them, while fewer indicated similar comfort talking to a counsellor (33%) or teacher (14%). In total, 72% scored above the theoretical school connectedness scale midpoint of 3 (mean 3.72, standard deviation .76), indicating that most participants felt they fitted into their school and felt safe at school. We found that 66% reported that they had not experienced any bullying in the past year, and 26% reported one or two incidents. Very few (2%) reported being bullied on most days, but 23% of participants said that teachers did not step in to address bullying. This indicates that a significant number of participants (at least one in 4) are likely to experience interactions at school that impact negatively on their sense of feeling safe and supported (i.e., a facet of school connectedness). We found that 19% of young people reported having deliberately hurt themselves (without suicidal intent) and a further 9% had thought about doing so (but had not done it).

Table 1 presents the correlations between school connectedness scale scores, comfort speaking to teachers and counsellors, responses to bullying questions, and scores on wellbeing measures. Predictably, school connectedness was associated with more positive adjustment. Although less strong, young people who indicated they could talk to a teacher reported more positive wellbeing.

Table 1
Correlations Between School Connectedness and Social and Wellbeing Variables

	School Connectedness	Talk to a teacher?	Talk to a counsellor?	Frequency of bullying?	Teacher seen to address bullying
Self-Injury	−.22***	−.09*	.07 ns	.29***	−.21***
Suicidal Ideation	−.30***	−.11**	.09*	.33***	−.25***
Self-Esteem	.48***	.21***	.02 ns	−.30***	.31***
Depression	−.40***	−.15***	.01 ns	.26***	−.21***
Anxiety	−.27***	-.09*	.02 ns	.28***	−.20***
Stress	−.55***	−.15***	.01 ns	.28***	−.27***

Note: *p<.05, **p<.005, ***p<.001, ns = not significant

It may be argued that how one views one's school and the relationships within this environment (i.e., feeling nurtured and supported; facets of school connectedness) will be influenced by one's understanding and experience of other key relationships; specifically, parental attachment. Attachment to primary caregivers provides a basis for understanding relationships more generally, and information regarding how one can be expected to be cared for and responded to (e.g., in a nurturing or dismissive style). We sought to understand the role of parental attachment in the relationship between school connectedness and psychological wellbeing. Is it that having strong parental attachments provides helpful working models of relationships, thereby providing youth with the scaffold to use school connectedness to good effect regarding improved wellbeing? Or do students with poorer parental attachment benefit more from school connectedness because they do not have the same subjective level of support outside of school? Therefore, we investigated whether parental attachment (which can be considered a proxy

measure of secure and well-functioning working models of relationships) interacted with school connectedness to predict depression (a significant outcome measure in regards to youth mental health). We conducted a moderation analysis following the procedure outlined by Jose (2013), with interesting results (see Figure 1).
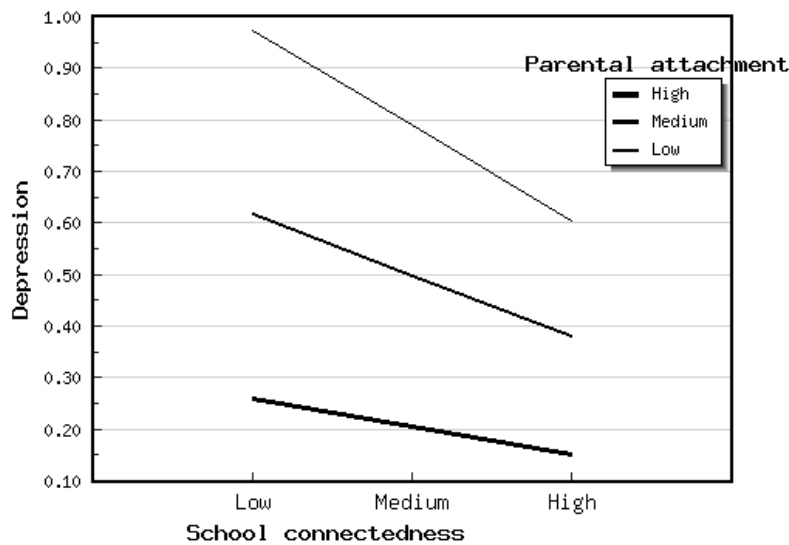

Figure 1. Parental Attachment Moderates the Relationship Between Depression and School Connectedness.

An initial regression showed that school connectedness and parental attachment significantly predicted depression scores (F(2, 648)=161.70, p<.001, $R^2_{adjusted}$=.33), and that the inclusion of a parental attachment by school connectedness interaction term significantly explained an additional 1% of variance in depression symptoms; (F(3, 647)=113.22, p<.001, $\Delta R^2_{adjusted}$=.01). It should be noted that moderation analysis is a conservative statistical procedure, and thus, while 1% of variance appears relatively small, that it is detected at all suggests it is important (McClelland & Judd, 1993).

As shown in Figure 1 (using ModGraph; Jose, 2013), we found that depression scores declined with increasing school connectedness, but this was particularly true for students who had low scores on parental attachment (i.e., the gradient for the "low parental attachment" group was the steepest, indicating a stronger relationship). Meanwhile, the group with high parental attachment had a much weaker relationship between decreasing depression scores and increasing school connectedness. It may be that school connectedness is particularly important in regards to mental health for adolescents who do not have strong relationships and connections at home, and therefore will benefit most from receiving this sense of connection elsewhere. School culture in regards to connection, strong and supportive student-staff relationships, and efforts towards inclusion and respect may be especially useful for students who do not have strong relationships with their parents. Our findings are limited by the cross-sectional design; we cannot infer causality. Additionally, the sample was largely Pākehā, and therefore cross-cultural application of these findings remains unclear. In the near future, we intend to carry out analyses using our longitudinal dataset from participants in the wider Wellington region, and will be investigating causal risk and protective factors in the school environment for adolescent wellbeing.

Summary and Conclusions

Clinically, the literature briefly reviewed above, along with our research data indicates that it is important to consider school connectedness when conducting an assessment and when developing wellness or relapse prevention plans. Adolescents who have poor familial relationships may especially benefit from school initiatives that foster connection. Through our work in New Zealand secondary schools, we are continuously impressed by various schools' initiatives to foster respectful, inclusive, and connected school environments that encourage young people to learn more about themselves and celebrate diversity. In New Zealand schools, groups that foster acceptance of gender and sexual diversity (e.g., gay straight alliance groups), political freedom of speech (e.g., feminism awareness), and cultural expression are likely to assist with sense of belonging, respect, and feeling safe in schools. In working with clients, it may be useful to consider what avenues already exist in clients' schools to foster a sense of connection, and whether our clients would benefit from engaging in these (or getting together with like-minded peers to create a group of their own). For teachers and other secondary school staff, it may be particularly important to identify students who have less family connection or are potentially estranged from their family in some way, and whether these students' connectedness to school can be bolstered to potentially improve mental health outcomes.

For further information about the Youth Wellbeing Study, please visit:
http://www.victoria.ac.nz/psyc/research/youth-and-wellbeing-study.

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Educating for Equity: Stepping up to the Challenge

Eileen Britt

Mā te mōhio, ka mārama
Through knowledge, there is understanding

In 2014, at the joint Australian Clinical Psychology Association and the New Zealand (NZ) College of Clinical Psychologists Conference in Christchurch, Dr Suzanne Pitama (Ngāti Kahungunu), Associate Dean Māori and Associate Professor at the University of Otago, Christchurch, challenged clinical psychology training programmes in NZ with regard to the extent of bicultural training in their programmes in her keynote address Educating for Equity? *In particular, she noted that it was important that bicultural training did not maintain power, the status quo, and outcomes, or blamed the community, as this served only to maintain disparity. Instead, she challenged programmes to develop bicultural training that: is not "piece-meal"; is evidenced-based; includes application to practice; is integrated within other training and aligned with the general curriculum; and includes assessment and evaluation. This paper describes bicultural initiatives in the University of Canterbury Clinical Psychology Programme, which go some way towards meeting Pitama's (2014) challenge, and the evidence-base to support these changes.*

Introduction

The process of introducing bicultural initiatives into the University of Canterbury Clinical Psychology Training Programme started in 2000, and has been an ongoing process of reflection and development. The process can be seen in the context of Cross, Baron, Dennis, and Isaacs' (1989) cultural inclusion continuum, which can be applied to organisations (in this instance the clinical programme itself) and individuals (staff and students). The challenge, according to Cross et al. (1989), involves moving as far as possible as quickly as possible along the following continuum.

Cultural destructiveness: those who believe or engage in behaviours that reinforce the superiority of one culture over another, with the resultant oppression of the group viewed as inferior; attitudes, policies and practices that are destructive to a culture and individuals within the culture. In clinical psychology, this could include the misuse of psychometric tests with populations for whom the test was not standardised.

Cultural incapacity: those who have less actively destructive beliefs or behaviours, but are paternalistic and lack the capacity or skills to be effective with individuals from diverse groups.

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Cultural blindness: individuals and organisations that provide services with the intent of being unbiased, and function with the belief that culture makes no difference; that is, all people are the same and should be treated the same. Explicitly or implicitly encourage assimilation.

Cultural pre-competence: individuals and organisations that recognise and acknowledge cultural differences and accept the need for culturally competent policies and procedures, but do not proceed beyond searching for ways to respond or only make only small (token) changes, such as making the physical environment more welcoming for individuals from another culture with pictures that reflect their culture.

Cultural competence: individuals and organisations that accept and respect cultural differences and implement policies and practices that support these beliefs and commitment to improve. Examples include developing a library of cultural resources and involving representatives of a cultural group to assist with teaching.

Cultural proficiency*:* those who seek to refine their approach by learning more about diverse groups through research, dissemination, and fully inclusive practices. It includes a process of continuing self-assessment of cultural awareness, knowledge, and responsiveness.

There were a number of drivers to the initiation of this process. Firstly, there were the obligations under the Tiriti o Waitangi/Treaty of Waitangi and the 1989 Education Act, which states that "it is the duty of the council of an [tertiary education] institution, in the performance of its functions and the exercise of its powers…to acknowledge the principles of the Treaty of Waitangi" (Education Act, 1989, Part 15, Section 181). There had also been earlier challenges for clinical psychology training programmes to be more biculturally responsive. For example, Abbot and Durie (1987) identified a dearth of Māori students and staff, and little or no course content devoted to clinical psychology practice with Māori.

The lack of Māori in the clinical psychology profession was identified as significant problem, which not only affects service delivery for Māori clients who may wish to see a Māori psychologist, but also means that there are few Māori staff in universities who can assist with bicultural training (Abbot & Durie, 1987; Levy, 2002). Several barriers to Māori students entering and completing clinical psychology training have been identified. These include: Māori clinical psychology students being "forced to consider human dysfunction in terms which do not reflect Māori beliefs or value systems (Brady, 1992, p. 59); a lack of cultural support for Māori students (Ihimaera & Tassell, 2004); and Māori students being relied on to do "all the Māori things in terms of protocol and so forth" (Barnett, 2004, p. 194). Waitoki (2012) further commented that "although the practice is unethical, Pākehā academics often use Māori students and staff as educators so that the illusion of good bicultural standing is maintained" (p. 54). This latter point also highlights the importance of educating non-Māori academics and teaching staff so that they feel more biculturally confident and competent, and therefore can facilitate and support bicultural training, as well as being more responsive to the needs of Māori students.

Levy's (2002) report for the NZ Psychologists Board regarding barriers and incentives to Māori participation in the profession of psychology identified the lack of Māori-focused psychologies as important for attracting Māori to psychology. Levy (2002) also identified that a "major incentive for Māori participation in psychology is the creation of environments in which Māori wish to participate" (p. 60), which involves provision of effective support for Māori students, and "meaningful participation for Māori," which provides "actual and real opportunities to influence outcomes, directions and priorities" (p. 6). Further, Lawson-Te Aho's (2002) study of Māori psychology staff to identify whether cultural safety principles were embedded in teaching

psychology in NZ raised several issues for psychology training programmes to consider. These included consideration of how culturally-safe are our practices and teaching, and that consumers of psychological training and services should be the ultimate judge of cultural safety.

Other drivers for change included the *Code of Ethics for Psychologists Working in Aotearoa/NZ* (2002), which states in its preamble that "there shall be due regard for New Zealand's cultural diversity and in particular for the provisions of, and the spirit and intent of the Treaty of Waitangi" (p. 3) and one of its four guiding principles is "respect for the dignity of people and peoples" (p. 4). Further, the NZ Psychologists Board developed cultural competencies required for psychologists registered under the Health Practitioners Competence Assurance Act (2003) and those seeking to become registered. The most recent (2011) version makes the distinction between cultural safety, which includes a process of reflection on one's "own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice" (p. 3), and cultural competence which is defined as "having the awareness, knowledge, and skill necessary to perform a myriad of professional tasks that recognised the diverse world views and practices of oneself and of clients form different ethnic/cultural backgrounds" (p. 4).

The Change Process

The first step in the process was to consult with Māori psychologists. Again, this is an ongoing process, as the bicultural initiatives change and develop overtime.

The following basic principles were developed as an overarching guide to the bicultural initiatives.

- It would be a **journey**. This meant that the programme and its bicultural responsiveness would change and evolve overtime. Similarly, students' learning to be biculturally responsive practitioners is a process that extends beyond their time in the programme.
- A **graded approach** would be adopted. That is, the changes in the programme to become more biculturally responsive would be developed over time, starting with simple to implement strategies (e.g., a Treaty of Waitangi workshop) through to incorporating Māori processes and teaching that require a greater staff skill level to implement. Similarly, a graded approach would be taken to bicultural teaching to facilitate student learning, so that the training moved from a focus on cultural safety and cultural awareness to cultural competency. This graded approach could also be likened to a poutama, which comprises a series of steps that build on each other, and is similar to the cultural competency poutama described by McFarlane (2011). In describing the cultural competency poutama, Macfarlane described how individuals move: from Mōhiotanga (having a desire to explore new learning and knowledge) via exposure; to Mātauranga (exploring and enhancing new learning and knowledge) through exploration; to Māramatanga (integrating and applying new learning and knowledge) through experience.
- To be truly biculturally responsive, changes and bicultural teaching need to be **integrated** throughout the programme and across all years; bicultural knowledge and skills would need to be formally assessed; and cultural competence would be seen as overlapping with clinical competence.
- A **collaborative** (partnership) approach would be adopted so that Māori psychologists and service providers contribute to both the development of the bicultural responsiveness of the programme and to the provision of bicultural training.
- **Bicultural** training would be **prioritised** over training on multicultural and diversity issues.

These guiding principles are consistent with Pitama's (2014) recommendations, and with Thomas' (1993) suggestion that an add-on approach to training "has little or no relevance to the

delivery of psychological or mental health services" (p. 2), and that "learning can only take place over an extended period of time" (p. 2). Similarly, others have commented that a single-course or workshop (as in the add-on approach), while having some benefits, is not an effective approach to developing cultural competency (D'Andrea, Daniels, & Heck, 1991; Glover & Robertson, 1997; Ponterotto, 1997). Further, Waitoki (2012) observed that when bicultural competence is an "add-on" separate component to training, it creates a problematic clinical-cultural distinction.

If bicultural teaching is to be seen as truly integrated into a programme of teaching, there also needs to be some form of assessment of student learning, just as there is for other coursework, yet "diversity training programmes, however, suffer from a lack of systematic evaluation" (Waitoki, 2012, p. 204). Further, Waitoki (2012) suggests that evaluation should extend beyond reaction measures (whether they liked the training, satisfaction with the training) to include measures of knowledge and skill acquisition.

It has also been argued that cross-cultural training should be placed in parity with the development of other clinical skills, because development of cross-cultural competence overlaps with clinical competence (Evans, 2008; LaFromboise, Coleman, & Hernandez, 1991). This also avoids the risks described by Durie (2007) of undervaluing and/or dismissing bicultural practice as the lesser practice. Additionally, "the cultural-clinical distinction privileges the dominant group by enabling them to determine what is cultural and what is not" (Waitoki, 2012, p. 42). Further, non-western views of cultural competence see it as a process rather than an endpoint (Kingi-'Ulu'ave, Faleafa, & Brown, 2007; Smith, 2003).

Macfarlane, Macfarlane, and Gillon (2015) argued that "all too often Western knowledge and indigenous knowledge are represented as two totally incongruent and oppositional knowledge systems" (p. 55). They proposed that the challenge is to ensure that "one world view is not prioritised at the expense of the other" (p. 11).

There have been two frameworks proposed by which Western and Māori knowledge and clinical and cultural practices can be blended so that "neither needs to concede or to sacrifice" (Macfarlane, Macfarlane, & Gillon, 2015). Tō Tātou Waka (Macfarlane, Blampied, & Macfarlane, 2011) provides a framework for blending clinical and cultural knowledge and practices within the process of psychological assessment, which they suggest can be generalised to other situations and other cultures. Tō Tātou Waka means our canoe, and as such, represents a shared approach in which the process of moving forward (paddling) needs to be carried out in a collaborative partnership, and "promotes the notion that the convergence of the clinical and cultural practice components in our present-day bicultural society are more powerful than either one on its own" (Macfarlane et al., 2011, p. 60). He Awa Whiria, or the braided rivers framework (Ministry of Social Development, 2011) is a framework for programme development and evaluation based on the analogy of two streams—Western science and the indigenous Māori streams—that interconnect and eventually converge. In this framework, both steams are seen as distinct, and knowledge from each stream is able to inform the other. Similarly, evaluation methodology from one stream can be applied to the other, and programme efficacy relies on evidence from both streams.

The prioritisation of bicultural training over multicultural or other diversity training was also seen as important to be consistent with obligations of the Tiriti o Waitangi/Treaty of Waitangi. Further, Love and Waitoki (2007) caution that "bicultural imperatives and relationships should not be obscured by multiculturalism" (p. 271), and there is a risk that multiculturalism maybe "a way for Pākehā to avoid their responsibilities" (Waitoki, 2012).

In addition to the guiding principles outlined above, the intention was to make changes which were also consistent with tikanga Māori and Māori values. In particular, values of whanaungatanga (building relationships, connections), manaakitanga (showing respect, reciprocal caring), and kotahitanga (bonding, and sense of inclusiveness and unity) were incorporated in the changes, as these values have been identified as important for bicultural responsive education (Macfarlane, 2004). Additionally, by incorporating Māori values within the programme itself, it was hoped that this would facilitate student learning, consistent with Dickson, Jepson, and Barbee's (2008) research that found that the degree of "cultural ambience" (p. 114) (which relates to the day-to-day practices, attitudes, and behaviour that contribute to the environment of the training programme) was a good predictor of positive cultural attitudes in students and the development of cultural competency.

Changes Introduced

Before Admission

Individuals considering applying to the Clinical Psychology Training Programme at the University of Canterbury are recommended to take a Te Reo Māori course before they apply. The hope is that in doing so, students entering the programme will at least have basic skills in te reo Māori (e.g., will be able to pronounce Māori names correctly) and will have been exposed to Māori tikanga (Māori processes and protocols; e.g., pōwhiri) as part of this learning. Additionally, the programme application form asks applicants to describe any cultural experiences they have had which may be relevant to training as a clinical psychologist.

Māori clinical psychologists from the community are part of the selection committee, along with programme staff, and representatives from the main local employers of programme graduates. The Māori clinical psychologists on the selection committee enquire as to the applicants' knowledge of the Tiriti o Waitangi/Treaty of Waitangi, and bicultural experiences, and attempt to assess applicants' openness to consider how their own culture may shape their personal values, assumptions, judgments, and biases. Additionally, during the selection interviews, candidates are asked to reflect on a case vignette, and questions regarding Māori culture and bicultural practice are asked as part of this process. An inability to demonstrate openness to consider the effect of culture, and/or limited or no knowledge of the Tiriti o Waitangi/Treaty of Waitangi or exposure to Te Ao Māori is likely to lead to an applicant being declined.

Selection day commences with a meeting at which all short-listed applicants are present, along with the selection committee, programme staff, and current students (representatives from each year of the programme). This meeting follows the Hui process outlined by Lacey, Huria, Beckert, Gilles, and Pitama (2011), which comprises mihi (initial greeting and engagement), whakawhanaungatanga (making connections), kaupapa (attending to the main purpose of the encounter), and poroporoaki (concluding the encounter). During this process, applicants are welcomed in te reo Māori and English (mihi), which is followed by introductions (mihihi), during which all present have an opportunity to introduce themselves, where they are from, and their research and/or clinical interests (whakawhanaungatanga). Then, there is a brief description of the Clinical Training Programme at the University of Canterbury and the selection process is described (kaupapa). The process of the selection interviews and what will happen after the interviews is outlined (poroporoaki). This is then followed by morning tea (manaakitanga) before the formal selection interviews commence. Although the selection interviews are individual interviews with selection committee members, there is opportunity for applicants to bring a support person if they wish, which is consistent with the collectivist world view of Māori (Durie, 1995; Harrington & Liu, 2002). The Hui process also shapes the interviews, at which there is a support person present, with brief mihi and whakawhanaungatanga, followed by the kaupapa/interview with the applicant, after which the support person is given the opportunity to

say something in support of the applicant should they wish to do so, then poroporoaki at which the support person's contribution is acknowledged.

After completion of the interviews, there is a selection committee meeting at which the external members of the committee have the opportunity to share their observations and thoughts with regard to who should be selected into the programme. Therefore, the Māori clinical psychologists and other external selection committee members have opportunity to influence selection into the programme. Further, the programme has adopted affirmative action whereby there is an agreement if a choice is being made between selecting two applicants of similar ability, and one is Māori, then the Māori applicant will be accepted over the other applicant.

Post Admission

Processes. The first day of the academic year commences with an orientation day for the new clinical students, which is again guided by the Hui process. At the beginning of the day, the new students, all programme staff, and all students from the year ahead gather together. There is a welcome (mihi) in te reo Māori and English for the new students, followed by a waiata by programme staff and second year students. This is followed by introductions, during which all present are able to share about themselves in more detail than during the selection day, followed by morning tea. The rest of the day involves orientation to the programme for the new students (kaupapa), and includes staff and students eating lunch together. Later in the day, everyone (second and first year students and staff) comes back together for afternoon tea and petanque (with a trophy awarded to the winning staff or student team). This provides relaxed social time, which facilitates bonding at the beginning of the year (kohitanga), and the building of relationships (whakawhanaungatanga) between staff and students (within and across the two years), consistent with the values in McFarlane's (2004) "educultural wheel" (p. 30).

This is held at the University of Canterbury Staff Club, which is also the venue for a function at the end of the students' training when they have passed their final examination. This later celebration is jointly hosted by the Clinical Training Programme and the Canterbury Branch of the NZ College of Clinical Psychologists. It is attended by the successful students, programme staff, community placement supervisors, and other members of the clinical psychology community. This event is opened in te reo Māori and English, and serves as both a farewell from the programme and a welcome the clinical psychology profession.

Content. All programme staff are expected to consider and raise issues related to bicultural practice and working with Māori, including NZ research, during their teaching and supervision of students. In addition, specific bicultural teaching occurs across the 3 years of the programme.

This commences in Year 1 with a 2-hour cultural safety seminar to facilitate students' exploration of their own values and increase their cultural awareness and understanding of cultural safety. The seminar comprises two practical activities to facilitate this: a cultural awareness exercise (Roysircar, 2004) and a values card sort exercise (Miller, C'de Bacca, & Wilbourne, 2001). Then, later in Year 1, students attend a 2-day Te Tiriti o Waitangi/Treaty of Waitangi workshop.

In Year 2, there is a marae-based wānanga (2 days and 1 night). During this time, students are exposed to Ngāi Tahu protocols and history and many aspects of taha Māori, and experience first-hand tikanga such as manaakitanga. They experience a pōwhiri both as manuhiri and then later when welcoming guest speakers, as tangata whenua. The wānanga is facilitated and guided by two kaumātua, one who leads a preparatory session before the wānanga, and who are both present for the entire wānanga. A variety of speakers from Māori mental health service providers and Māori present to the students. Students learn about the pōwhiri process as a means of

engagement with Māori clients and Māori models of health/well-being. These models include Te Whare Tapa Whā (Durie, 1985), Te Pounaumu Model (Manna, 2002), and the Meihana Model (Pitama et al., 2007; Pitama, Huria, & Lacey, 2014). In addition, this provides an opportunity for students to develop awareness of Māori mental health services, and connections with Māori practitioners and services in the community. Rather than learning about cultural issues in a formal classroom situation, this immersion experience is considered important as it provides experiential learning in which students experience emotions and new ways of behaving and thinking that may deepen their sensitivity to the cultural context in new or different ways (Gerstein, Heppner, Ægisdóttir, Leung, & Norsworthy, 2009). Such an experience can provide "opportunity for impactful growth" in cultural competency (Wathen & Kleist, 2015, p. 61).

In the final year of the programme, there is a 2-day bicultural workshop provided by a Māori clinical psychologist. This workshop focuses on increasing students skills in working (assessment and intervention) with Māori clients/whānau and on the application of bicultural knowledge to clinical practice consistent with Pitama's (2014) recommendations. It was only after bicultural training was embedded in the programme that broader culture and diversity training was added; this training is deliberately scheduled to occur after the bicultural workshop. The broader culture and diversity training comprises four lectures of 2 hours duration by guest speakers on: working with Pasifika, Asian, and refugee and migrant clients; and sexuality (gay, lesbian, bisexual, transgender, intersex, and Takataapui).

Further to this bicultural training, students undertake practica in the programme's in-house clinic (The Psychology Centre/Te Taumata Kaupapa Hauora Hinekaro). During the practica, students are able to attend, along with programme staff, cultural supervision by a Māori practitioner. Additionally, community placements in Year 2 and internships in the final year of the programme provide students with further opportunities to work with Māori clients. Students are also exposed to, and work with, the Pūkenga Atawhai from Te Korowai Atawhai (CDHB Māori Mental Health Service), and Māori consultants in the Department of Corrections. These experiences are written explicitly in the practica objectives.

Assessment. As a consequence of the weaving of bicultural teaching and learning experiences throughout the programme, assessment of students' bicultural knowledge and skills occurs at various points. Students' performance is evaluated at mid- and end-placement using the Clinical Psychology Practicum Rating Scale, which involves the placement supervisor rating the students' performance on core skills expected of a clinical psychologist using a scale comprising four stages (from Stage 1 which is beginner through to Stage 4 which is Competent). The scale includes some items that specifically assess the students' skills related to bicultural practice. These are:
Clinical Assessment Competencies: Undertakes clinical assessments in an interpersonally engaging and socioculturally sensitive manner.
Case conceptualisation Competencies: Integrates cultural knowledge into case conceptualisation.
Professionalism: Demonstrates concern for the welfare of others including the profession, organisation, and community, and shows respect for cultural values and diversity.
Reflective Practice: Reflection on own emotions, beliefs, values, and behaviour, and their effect on others. Appropriately self corrects. Actively reflects on ways in which others' cross cultural values and perspectives influence one's own responses and vice versa.

This means that students are regularly assessed and receive feedback with regards to their bicultural skills within the practica context. In addition, there are formal assessments of students' bicultural knowledge and skills during other courses within the programme. These comprise:

Year 1
PSYC642: Clinical Practicum I—within the clinic practicum and clinical interview examination.
PSYC643: Psychometric Assessment—within the psychometric examination (written and oral).
Year 2
PSYC654: Comprehensive Examination—students may be asked anything with regards to any course material covered, and a bicultural question is included.
Year 3
PSYC661: Oral Examination—paper case focused specifically on a Māori client.
PSYC670: Diploma Examination.

In addition to the practices outlined above that are embedded in the programme, in 2009–2010 the Clinical Training Programme successfully bid (in conjunction with the University of Otago Clinical Psychology Training Programme) for priority programme funding from the Tertiary Education Commission for a project entitled *Building Cultural Competencies and Minority Participation in Clinical Psychology Training*. This aimed to promote community engagement with the programme and increase the numbers of Māori and ethnic minority graduates in clinical psychology training. Through this project, funding was provided for a bicultural audit and programme development, and two targeted scholarships per year in 2009 and 2010 for two Year 1 clinical students of Māori descent (or if insufficient applicants of Māori descent, scholarships could be awarded to ethnic minority students). This resulted in one scholarship in each year (2009 and 2010) awarded to a Māori student and one each year to a Chinese student.

All programme staff assume responsibility for increasing their own confidence and capabilities in bicultural teaching and bicultural competence. In so doing, they model to the students that bicultural competence and knowing how to work with Māori is part of one's personal and ethical (as a clinical psychologist in NZ) responsibility. Additionally, new programme staff that have not attended a Treaty of Waitangi workshop are encouraged to attend the workshop with the Year 1 students and the wānanga with the Year 2 students.

The Clinical Training Programme also developed a mentoring programme, which involves students having the opportunity to be mentored by a clinical psychologist (not involved in evaluation or assessment of that student) in the community for the duration of their training. As part of this, staff facilitate Māori students, who wish to do so, linking with a Māori clinical psychologist as their mentor.

Outcome

There have been many positive consequences of the changes outlined above. Short-listed applicants (both Māori and Pākehā), based on their experience of the selection process, describe the programme as warm and welcoming, and that they get a sense of real connection between programme staff, students, and the community. This has been a factor in students' decision to come to the University of Canterbury Clinical Psychology Training Programme.

There has also been an increase in Māori students applying and being accepted into the programme. Some Māori and Pākehā applicants specifically said that they applied to the University of Canterbury programme because of its commitment to biculturalism. Students who have been accepted into the programme also expressed appreciation for the process on the first day. Again, students reported experiencing a sense of warmth and welcoming, but also a sense that it recognised and showed valuing of the significance of their first day in the programme (as they have strived for many years to prepare themselves for selection into a Clinical Psychology Training Programme). This first day also facilitated the building connections (whakawhanaungatanga) within the first year group, and between the first and second year

students and staff. Students reported a similar experience from the function at the end of their training, feeling both recognition of their achievement and welcomed into the clinical psychology profession.

The programme also developed closer links with local Māori, Māori practitioners, and Māori services. These links have extended beyond bicultural training, to research and publishing collaborations. Further, feedback from students on the bicultural training they received has almost uniformly been positive. The following are examples of student feedback.

Cultural safety seminar:
"The card sorting (values) task was really useful—made me more aware of my own values."
"I found I learned a lot about myself."

Treaty of Waitangi workshop:
"Extremely interesting! A lot of information about NZ history that I either was not aware of or knew little about."
"…Understanding the history that is not taught in schools and digging deeper than what we hear in the media."

Marae-based wānanga:
"The wānanga was a rich and extremely useful experience in so many ways…It was personally and professionally enriching. It has given me the opportunity to reflect on these levels and to strive to integrate the values, learning and kaupapa that were evident over the two days."
"Really enjoyable and culturally enriching experience that enhanced my learning."

Bicultural workshop:
"A useful, open forum for discussing how to apply biculturalism in a practical setting."
"Great to finally integrate all the teaching on culture so far in a way that I can put directly into practice."

Additionally, the Clinical Training Programme met the cultural competency standards for accreditation by the NZ Psychologists Board when it was accredited in 2014. Further, the accreditation report noted that one of the strengths was that the programme had a "good working relationship with the local Māori community," which is largely a function of the collaborative relationships formed to develop and maintain the delivery of the bicultural training.

Summary

The Tiriti o Waitangi/Treaty of Waitangi provides the foundation in Aotearoa NZ for a bicultural nation. This paper provides a description of the University of Canterbury Clinical Training Programme's journey towards being more biculturally responsive. These changes go some way toward addressing Suzanne Pitama's challenges and recommendations in her 2014 keynote address. The programme adopted an approach to bicultural training that is graded, consistent with Cross et al.'s (1989) cultural competency continuum and MacFarlane's (2011) cultural competency poutama. Bicultural training and tikanga Māori are integrated within the curriculum and programme more generally, consistent with the braided rivers (Ministry of Social Development, 2011) and Tō Tātou Waka (Macfarlane et al., 2011) approaches. Further, this was undertaken in partnership with Māori, and with a commitment to biculturism before multiculturism. Lastly, the process is on ongoing journey, with continuing reflection and development.
Hāpaitia te ara tika pūmau ai te rangatiratanga mō ngā uri whakatipu.
Foster the pathway of knowledge to strength, independence and growth for future generations.

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Climbing the Political Mountain: A Reply to Karen Kyne

Paul Skirrow

"Silence encourages the tormentor, never the tormented. Sometimes, we must interfere. When human lives are endangered, when human dignity is in jeopardy…sensitivities become irrelevant." Eliezer Wiesel- Author, Holocaust Survivor and Winner of the Nobel Peace Prize.

Karen Kyne's article "A Day in the Life: Psychologist Meets Politics" in the June edition of JNZCCP called upon clinical psychologists to use their knowledge for the betterment of society "even when this means stepping out of one's comfort zone." In her article, Karen spoke of her long-time reluctance to engage in "politics" and her aim to always be seen as "a quiet and unassuming team player." I am certain that these latter words will have struck a chord with a significant number of clinical psychologists in New Zealand—including, for one, me.

Sophie Holmes, consultant clinical psychologist and author, who recently starred in a documentary series *Obsessive Compulsive Hoarder* for the UK's Channel 4, recently wrote that "A lot of psychologists wouldn't think of themselves as experts. We take the position that the client knows best—it's the centre of our psychological training." Indeed, we are a profession that thrives and focuses upon fostering good relationships with others and avoiding conflict— ultimately, to be "liked." Experts in etiquette will tell you that there are two topics to avoid in

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polite conversation: politics and religion, and perhaps it makes sense that psychologists rarely involve themselves in either.

Coincidentally, and just before reading Karen's article, I also read Professor Peter Kinderman's (clinical psychologist and President of the British Psychological Society) presidential column in *The Psychologist*. Peter himself has strongly advocated for psychology as a profession to address the issues of social injustice at the root of psychological distress, and in his turn, has received some significant criticism:

> Assiduous readers of The Psychologist will also have seen that I have attracted some constructive criticism for what is perceived by some to be a political stance. I am strongly motivated by the philosophy that, when faced with policies that impact upon our profession, and on the clients that we serve as professionals, it is at least as much of a political statement to say or do nothing, as it is to speak out. I don't believe that the BPS should tacitly support injustice through inaction… (July, 2016)

It is, perhaps, safer and easier for us clinical psychologists *not* to speak out. Indeed, since coming to New Zealand, many people have told me that it is the "tall poppy" that's first to be cut down; a philosophy, they tell me, that pervades New Zealand society. But then, I always think…Isn't New Zealand also the home of the All Blacks? Of Sir Edmund Hillary? Of Ernest Rutherford? Of Lydia Ko? Of Kate Sheppard? And of Wiremu Tamihana? A greater list of pioneers and visionaries you will struggle to find, even in the largest of nations. Aotearoa is also the country that first gave voting rights to all of its women, that fought nuclear power and won, that has pioneered same-sex marriage laws, that fought apartheid in the 1980s, and that has, in the Treaty of Waitangi, some of the most extraordinary constitutional laws relating to the rights of its tangata whenua. So, although some NZ tall poppies might be cut down along the way, it seems that with a little bravery, they can also be the first to stand atop the highest mountains.

Perhaps then, the time is right for New Zealand clinical psychologists to stand tall, face our fears, and take the next step up the mountain.

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Toward Becoming More Critical Clinical Consumers of Statistics and the Conclusions Drawn From Data

Llewelyn A Richards-Ward

Remaining empirically and scientifically driven is critical to effective application of clinical psychology. This short practice reminder invites the reader to become more aware of the important data-driven and statistical debates engaging our field of interest. It outlines and reminds of some relatively simple tools to better allow us to examine data and research findings. It highlights that clinicians cannot abdicate conducting, disseminating, and interpreting research to researchers or even academics, for the simple fact that they and their findings may be, plainly and simply, incorrect. To avoid a lack of focus, the main thesis of the present article is to remind clinicians that our practice relies on how well we engage in critical review of research before adapting our practice; starting with the position that current practices of frequentist research ought to be accurate and available for review, re-analysis, and critique. Hopefully, there is inspiration for the reader to delve much more deeply into an emerging and rich area of debate about research methods.

After the review of the present article, it seems appropriate to include a disclosure of professional interests and bias. The intention of this article is not to present a "balanced view" and let the reader decide for themselves; the intention is to present the view that psychological research has been lacking because of a number of statistically incorrect practices, starting with inaccurate reporting of statistics. To present a balanced view would suggest that the author thinks it acceptable to "p-hack" and engage in other sloppy analyses of data, which is not an accurate reflection of my position.

First, here is a brief outline of the background and key findings that precipitated some rethinking about data and research methods. In a time where the momentum of the Internet exposes vast troves of data that are available for examination and processing, consumption of the analyses and conclusions from those data requires statistical literacy. As part of this wider expansion of data, there is a strong open-source movement (referring to the concept that data is not owned by the collectors of it) requiring that researchers allow peers and others access to the data on which published conclusions are based. This has been met, in some instances, with significant resistance from both authors and publishers. However, the premise that data needs to be open for review is at the core of replicable findings and analyses. Indeed, the argument for pre-registration of hypotheses,[1] for example, is at the point where there are Internet sites for this to occur (Open Science Collaboration), along with some surprising advocates for the process (e.g., World Bank, 2015). There remains some resistance to the idea (e.g., Gonzales & Corbin, 2015; Mathot, 2013), but, as will be seen below, it is hard to imagine that this is any more tenable than was "climate change" skepticism.

As a result of wider examination of research methods and findings, there is a more focused debate occurring around use and abuse of statistics and the "replication crisis" or problem, particularly in the field of psychology (e.g., Bohannon, 2015; Gelman, 2016; Nosek, Spies, &

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[1] Pre-registration is the process of specifying your formal research hypotheses BEFORE you collect or analyse data. The rationale is to preserve the purity of the assumptions behind hypothesis testing. It also avoids the heinous practice of trawling data, from which the original hypotheses were not supported, for p-values so that there is something the aspiring researcher can publish in the way of a "significant" result ("p-hacking"). But more importantly, it helps researchers be clear about how they intend to manage data so that implicit assumptions about data do not impact on conclusions.

Motyl, 2013). This debate, through formal representation to authors and editors, plus in blog-space, has exposed "unhelpful use" and abuse of statistical testing. Psychology, in particular social psychology, has attracted the most negative attention. This has been due, in part, to the "replication crisis studies," in which 100 seminal psychological experiments were taken and only 36% were replicated in terms of statistical significance (Nosek, 2015). Other features of these replications included:

1. A diminished (half of the original) average effect size of the originals.
2. Counter-intuitive findings were less likely replicated.
3. Social psychology findings were less than half as likely to replicate as findings in cognitive psychology.
4. Main effects were more replicable than interaction effects.

In addition, there have been overt examples of data being "invented," and of frankly silly studies that have been published in academic journals, only to be exposed. An entertaining example is the "Himmicane" study by Jung, Shavitt, Viswanathan, and Hilbe (2014). They examined deaths from hurricanes and used a grouping factor of the gender of the hurricane name (before you read on, maybe it would be useful to the reader to consider why is this not a useful approach). Their surprising (and incorrect) conclusion was that people take less care with hurricanes with a female name because they see them as more benign, and thus die more often. Taking the time to read the critiques of this paper (e.g., Gelman, 2014) plus the subsequent debates, will assuredly entertain, educate, and surprise anyone taking the time to do this. The key issue is the statistical error arising from the garden of forking paths approach to analyses. As with the critique of the Himmicane study, it appears that exposure of erroneous statistical reasoning in itself was not the main issue; what has surprised a vast number of us was the entrenchment of the authors (and editors) in the face of being patently wrong, while clinging to a defence of their findings.

So why are these statistical debates important for clinical psychology? This process of scientific review is significant for clinicians, as we purport to base empirical best practice on the findings of published research. For research findings to be clinically useful and ethically applied, it absolutely relies on them being accurate and valid, including in their statistical methodology. It is not enough to feign ignorance of statistical methods in the application of the tools of clinical psychology.

When we read empirical papers, researchers use statistics and come to conclusions. However, errors may be present. I do not wish to get into how frequently important errors occur, but rather want to suggest that making an uncritical assumption about research quality based on whether it is peer-reviewed, in a prestigious journal, and so on, is not always accurate.

So, how do we check on the statistics that are reported? The following, non-exhaustive guidelines may help clinicians become more scientific and critical consumers of research:

1. Actually read and understand the method and results sections of a paper; this is where the data are presented on which the conclusions depend. If these data and analyses are not correct or clear, neither are the conclusions. Do not skip over these sections assuming they are correct. As you will see below, this is an inaccurate assumption more often that might be expected.
2. Check the data and analyses for accuracy and whether they "make sense" in the context of the study; this is the focus of the remainder of the paper. Do not assume that not being an expert in statistics means your examination is not worthwhile. Of course, it also is not that difficult to gain greater statistical expertise either.[2]

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[2] There are some highly useful online communities that help those not comfortable with statistics. The MOOC communities (e.g., EdX.com, Coursera.com) regularly offer introductory statistics courses for review/extension. If

3. If the data and analyses seem really complicated, be suspicious. Be very wary of large tables of statistics with associated p-values. What do these mean and how did the authors decide on those particular multiple analyses? Do not self-handicap through self-talk about not being "good" at statistics. If you are a clinician, you probably are capable enough to get a general intuition for the results. If you are not "getting it," maybe the failing is in the research paper. The goal for a results section is to begin to make sense of the data rather than simply restate it. Otherwise, why not just attach a file of all the data? Are there figures that present the data so as to anchor the numeric and statistical text? Do they make sense and match the results? For example, a common error is where axes on plots are not clearly anchored to a zero point and so appear to magnify effects that are minor. Another is failure to indicate the degree of "noise" or error of fitted data against raw data, for example.
4. Are there main effects? If only interaction effects are reported where main effects are absent, be suspicious. The reason why is a whole other article. This seems to be one of the most common areas where "findings" become debatable.
5. Be more believing where the authors replicated an initial finding at least once.

As noted above, one (key) element of checking research is to recalculate statistics. The obvious flaw in this is that nobody has the time to do this regularly. However, if all of us do this once in a while, we can influence the accuracy and validity of research. The collective action of clinicians all checking an occasional article for accuracy would greatly increase the feedback to journals and authors overall.

The concept for this paper arose from a software illustration of this process. Let us take a study by Rees, Tombaugh, and Boulay (2001) as an example. This area of research was selected because of the writer's concerns about some of the conclusions and uses of effort testing in the ACC/neuropsychology forum locally. After reading and testing the data in five studies that referenced the Test of Memory Malingering (TOMM), this (fifth) study was selected because it was found to contain an important statistical error. In this study, the authors looked at whether affective state, particularly depression, affected scores on memory functioning on the TOMM. The study compared groups with "depressed" scores on a measure of affect with a control group. Their hypothesis arose from the evidence that the TOMM is not affected greatly by neurological factors, but that little data had been gathered to examine the impact of mood on score. To examine their data they performed tests of main effects and of interaction terms. The test statistic that was used was based on the F-distribution.

To check some basic statistics, a very useful option is a package "statcheck" (Eskamp & Nuijten, 2016; Nuijten et al., in press) in R that can semi-automatically check some basic significance testing; in this instance the accuracy of the F-value and the associated p-value (an easier option is to use the online tool (beta) at http://statcheck.io/index.php). First, download the statcheck package from CRAN and install the dependencies by ticking the "load dependencies" box. Load the library using the library(statcheck) command. Next, either download the file (or even a directory of files) in HTML, pdf, or other format, or simply paste a section of an article into R, as below. If you get stuck, read the documentation [type help(statcheck)]; it is not that complex at all, or search the StackExchange site. Here is what you get:[3]

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you have a particular statistical question, there are the StackExchange communities (http://stackoverflow.com/) where you can post questions and have those answered and discussed. Or read a blog by someone who shares an interest in applying effective statistical thinking to problems. However, the key in all of this is developing current critical thinking; it is in reality much less about learning to "crunch numbers."

[3] Cut and past the text below and try it yourselves.

> library(statcheck)
> Text <- "A one-way repeated measures analysis of variance (ANOVA) confirmed these observations. It yielded a non-significant main effect for group (F(2,73)=5.97, p>0.05) and a non-significant interaction of group by trials (F(4,146)=0.14, p>0.05). A significant main effect of trial was observed (F(2,146)=49.4, p<0.01), indicating that scores were significantly lower on the first trial compared to Trial 2 or the retention trial. A further repeated measures ANOVA was performed to determine if the different levels of depression had any effect on the TOMM. No effect of level of depression was observed: Depression (F(2,23)=0.04, p>0.05), Trials (F(2,46)=37.1, p<0.01), and Depression×Trials (F(4,46)=0.07, p>0.05)."
> summary(statcheck(Text))
Source pValues Errors DecisionErrors
1   1   6   1   1
2 Total   6   1   1
>

Watch the magic. Running statcheck on the text example above shows that one p-value had been reported incorrectly and we get the message that there is a decision error. In this instance, the researchers report no significant main effect of group membership, whereas the statistic indicates otherwise. If you inspect the error using the command "statcheck("Text")," there is a more complete printout detailing the reported and correct calculations. This printout details the input data and recalculates the test statistic (in this case F-value) plus the correct statistical probability of this F-value occurring. In the example used for this illustration, from Rees et al. (2001), the F-statistic (F(2,73)=5.97, p>0.05), reported as not significant, in fact is "significant" from a frequentist perspective (the correct value for the probability density function is 3.969054e-03, which is much less than 0.05). So, the conclusion (main effect) that group (depressed and otherwise) performance on the TOMM was not different appears not to be supported by the reported F-statistic, even though the means suggest the conclusion is accurate. If this is a true error and thus incorrect conclusion, then maybe mood status does impact on detection of malingering. Clinically, this would indicate use of the TOMM where patients are depressed might affect the results, rather than, in the view of Rees et al. (2001), that it had no impact. Well, that just might have some clinical relevance to our use of this tool. It also is a concern that when papers are included in meta-analyses and so forth, these errors are perpetuated and therefore obscure other, more accurate, findings. The whole meta-analysis process absolutely relies on accurate research results being reported. In some processes, the test statistics are used in developing the wide literature synthesis. Thus, inaccuracies in the results sections only add further unwanted noise to an already imprecise research domain.

This overview is aimed at inspiring clinicians to become more critical of research methods and analyses, drawing only on the point that errors along with more systemic research design factors (Gelman, 2016) have very real consequences for clinical work. Recall that only five papers were checked before finding an error. Is that a representative sample? Who knows? The point is rather that now, with more sophisticated computing that allows text data to be read and re-analysed, we clinicians have both tools and some incumbency to become more critical consumers of research. From the author's perspective as a clinician, it is accepted that much of the psychological research will continue to be presented using a frequentist approach. Thus, the intent of the present article is to help clinicians engage meaningfully in critical appraisal of research, starting even as simply as ensuring statistics and design are appropriate. From the author's perspective as a computational scientist, one can hope that, as Bayesian techniques become better understood and more available to clinicians (e.g., Richards-Ward, 2015), they will help quantify our uncertainty in whether research findings are appropriate to the practice of clinical psychology.

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Recipe for a Workshop: *Mana Wahine,* a Bicultural ACT Group for Mothers and Babies
Donna Roberts (Tainui Waikato) and Kathryn Whitehead (Ngai Tauiwi), South Island

Based on a workshop initially presented at the Australia/NZ Association of Contextual Behavioural Science Conference, Wellington 2015.

Nāu te rourou, nāku te rourou, ka ora ai te iwi

(With your food basket and my food basket, we will feed the people: with cooperation and everyone's contribution, we will all benefit)

Tēnā koutou katoa! Welcome to your virtual workshop. We hope it will be a reka (tasty) treat. To teach you about how we worked together, we are going to model our process as well as help you reflect as you learn. Begin by collecting your ingredients together, follow the method and read the comments/rationales in italics for each step.

Donna Roberts (Tainui Waikato) is a pukenga atawhai at the Mothers and Babies Regional Inpatient Service, Canterbury DHB. Donna is also whaea of eight tamariki, and 11 mokopuna. She has a back ground of spending a lot of years in the Te Kohanga Reo and Te Kura Kaupapa Maori movement, and a passion for sports and kapa haka. Whanaungatanga.
Waikato taniwharau, he piko he taniwha, he piko he taniwha.
Kathryn is a clinical psychologist who works half time at the Mothers and Babies Inpatient Service at the Canterbury DHB. The rest of her time she mothers an eight year old and creates art.

Recipe

Serves 1–40 people. Modify as required according to local tikanga (custom).

Ingredients

- A friend or two (alone is okay too)
- Your curiosity and willingness to try out exercises
- An Internet-connected device
- A balloon
- Two old pages of a book/magazine/print out
- A pen (ideally a vivid or felt tip)
- A dice (optional)
- This article

Whakataka te hau ki te uru
Whakataka te hau ki te tonga
Kia mākinakina ki uta
Kia mātaratara ki tai
E hī ake ana te atakura
He tio, he huka, he hau hū
Tīhei mauri ora!

Cease the winds from the west
Cease the winds from the south
Let the breeze blow over the land
Let the breeze blow over the ocean
Let the red-tipped dawn come with a sharpened air.
A touch of frost, a promise of a glorious day.

Karakia acknowledges nga atua (creators) and is a way of grounding ourselves and creating safety. This particular karakia was chosen for the group we ran in winter time. We also chose it for the metaphorical meaning it conveys with the promise of a beginning after cold, hard times.

Method

Step tahi (one): Karakia. Read this out loud, as best you can.

Why do we use Karakia?
This is a formal and absolutely necessary tool for opening and closing the pathway (the experiential workshop we will do together today). It helps to create a tapu space to learn in. We arrive as noa, the karakia makes us tapu, and we end with a karakia to make us noa again to head back out into the real world.

Step rua (two): Do some mindfulness of listening to a piece of music in Maori. Read the instructions below before you start. We suggest:
https://www.youtube.com/watch?v=feiP2WxHGKY

a. Listen to the sounds of the words. Notice what you hear. Observe what it is like to listen to words you may not understand, you may know some of, or which may be very familiar with you. Play around with this: try noticing the sound of the words without hearing the meaning. Then try noticing the meaning (or what you think might be the meaning) without hearing the sounds. As best you can, try to listen without judging, as if this were all utterly brand new.

b. Tune into the melody. Can you hear the melody without the words?

c. Feel the beat of the music. Where do you feel the beat most strongly? Do you have an urge to move your body? What is that like?

d. Notice your emotional response: enjoyment, discomfort, boredom, a sense of connection, or maybe something else entirely. Observe this response, and see if you can track its intensity over a bit of time. How does it change?

e. So in summary: Listen to the sounds. Hear the words. Focus on the melody. Focus on the beat. Notice your emotional reaction.
f. Now listen away.
g. You can jot down anything you especially noticed doing this exercise here:



Step toru (three): **Start with a mihimihi.** *This is to help whakawhanaungatanga (making connections) within the group.* Illustrated is a picture of our tree from the group.

a. What words do you connect with on the tree?
b. We stuck photos of our babies on the tree. Whose picture(s) would you put on the tree? If you do not have a baby in your life, what or who is your metaphorical baby?
c. Roll your dice (or choose a number between 1 and 6). Use the table on the final page to see which question to answer.
   In the group we used a large soft dice with colours rather than numbers. The babies really enjoyed it being rolled, and sometimes helped out.

> Your picture here

d. What is it like to share this information about yourself? Did you discover anything interesting?
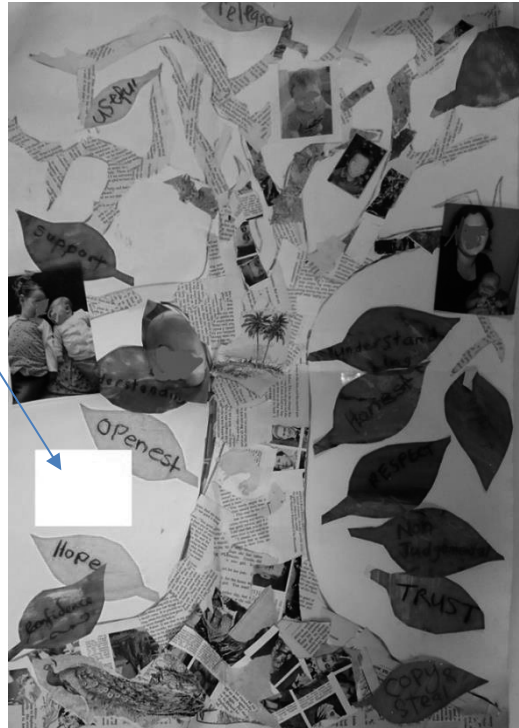
Step whaa (four): **Aakona.** Read some information about how we run the Mana Wahine Group:

Pragmatics. *The Mana Wahine group is an eight session group programme run at the Regional Mothers and Babies Inpatient service in Christchurch. Participants are 4–6 pairs of mothers and their babies who are in the treatment phase of their stay on the ward or recently discharged from the ward. Mothers were assessed by the ward psychologist before joining the group to ascertain suitability. Criteria for inclusion were having some psychological goals to work on and willingness and availability to attend the group.*

Session process. *The process of this virtual workshop mirrors the session format for our group. Each session included a core ACT process with mindfulness skills woven through. As leaders, we had a mantra "go slow and aim low for what you'll achieve." This slowing down allowed time for mindful noticing of the babies, allowed space for the needs of the babies to be met and also allowed us space to model psychological flexibility by being flexible in response to the needs of the group.*

An altered book cover 1

Altered books were used as an important process tool throughout the group programme. Our altered books were old and unwanted hardcover books. Participants and leaders chose a book, and in the first session drew/painted or collaged on the front of the book. Over the course of the group, we then "altered" the pages of the book in various ways by tearing out pages, creating pockets, collaging and drawing on pages, and painting others. The rationale behind using altered books was multi-faceted. Firstly, it gave group members something physical to take away to record their learning. Secondly, the books were a meta-metaphor for the whole group and linked sessions together. There is a strong developmental fit with creating books in the perinatal period: the perinatal period is often a time of making photo albums and scrapbooking for many of our clients. Altered books allowed us to bring creativity into the group, and extend on the success of an infant mental health scrapbooking group that takes place on the ward. The books themselves were symbols of idiosyncrasy, context, and choice. Changing and modifying a concrete object mirrored the internal change happening over therapy. There was a powerful sense of doing something naughty or "against the rules" in ripping pages out of a book, which helped to challenge group members to take a totally new perspective on how the world works. In this way, we were able to gently validate fear of change and begin to challenge this. Finally, the books were also a metaphor for self as context: they could contain the good, the bad, and the boring parts, and still just be, even after drastic change.

Session Content

Tahi (one)	Rua (two)	Toru (three)	Whaa (four)	Rima (five)	Ono (six)	Whitu (seven)
Karakia	Karakia	Karakia	Karakia	Karakia	Karakia	Karakia
Mihimihi	Reviewed homeplay: Noticing	Reviewed homeplay: Defusion	Reviewed homeplay: Vitality moves	Reviewed homeplay: What did you defuse from?	Reviewed homeplay: Valued action	Reviewed homeplay: Committed action
Choose book	Introducing fusion and defusion	Pain vs. suffering intro	Values intro	Values compass	Acting out Ngaangaara on the bus	Self as context: Chessboard metaphor
Created tree of connection	Defusion spoken	Identifying suffering and vitality moves we make	Values speed dating exercise	What is willingness?	Wheels on the Bus singing	Creating chess-board shakers.
Ground rules and hopes	Defusion activity	Raranga (weaving) defusion activity	Collaging a values bookmark	Introduce Ngaangaara (Monsters) on the bus	Creating drawings or Collage of your own monsters	
Mindfulness	Jellybean mindfulness		Your baby's 21st birthday exercise to		Round: What do we appreciate in each	Tohu (certificate) ceremony

			elicit parenting values		other here?	
Homeplay: noticing	Homeplay: Practice defusion	Homeplay: Notice suffering, do vitality	Homeplay: Practice defusion in service of your values	Homeplay: Act on a value	Homeplay: Committed action toward another value	Karakia
Karakia	Karakia	Karakia	Karakia	Karakia	Karakia	Sharing kai (food)

Step rima (five): raaranga (weaving). Practice a defusion exercise we used in group.

a. Identify a thought that you are struggling with and/or works as a barrier to you doing something that really matters to you.

b. Take out your magazine pages, and using your pen, write the thought over the page. If you notice more thoughts showing up, write them down too. Scrawl your thoughts big enough that it covers a lot of the page. If you think in images, draw a picture or symbol.

c. Now start tearing your page across-ways into 1–2cm wide strips. If this is not working well, folding and then tearing can help.

d. Notice what it is like to tear the thought up. The purpose of this exercise is not to get rid of this thought: see that the words and letters are still present even on your strips of paper.

e. Place half your strips in a row with the strips running vertically. Hold these at the top or with one hand (or tape onto the second page).

An example of Raaranga Defusion 1

f. Take a strip from the left over ones. Weave this strip horizontally under and over the vertical ones.

g. Take another strip, and repeat, this time going over and then under.

h. Repeat until all your strips are used up. You should now have a woven mat of your thoughts.

i. What is it like looking at your thoughts in this mat? Are you as caught up in your thinking as you were at the start of this exercise? Or do you have a bit more space to move? Would you be able to take a small step towards that thing that matters now, seeing your thoughts in the mat compared with when they were in your head?

Raaranga was used as a way of linking a traditional craft into our more modern craft of altering books. Raaranga is used to tell stories and connects to the importance of nurturing whānau. It is symbolic of weaving the internal and external together.

Step ono (six): whakaaro mai! (brainstorm!). Below are some of the ways we used altered books to convey ACT concepts to the group. What other ideas can you come up with? How could you use an altered books with a client or group to help them learn in therapy or to illustrate important therapy concepts?

Values: Create a bookmark with symbols and words recording values. The bookmark is then moved through the book each time a client takes a step towards their values.	**Your Idea:**
Mindfulness/Acceptance/Action: (*with interoceptive exposure to emotion*) Think of a struggle or painful feeling. Imagine it has a colour. Put that colour of paint down onto a page in your book. Now imagine it has a shape, texture, and size. Convey that with the paint. Play with the paint as you pay attention to the feeling, noticing whether new colours, textures, shapes or sizes are needed as you go.	
Self as Context/Acceptance: Create pockets by gluing pages together, folding pages around each other or cutting pages to fold back onto themselves. Jot down things you care about and things you struggle with on pieces of paper, and put them into the pockets. Notice how there is space for all of these experiences in your book. Take the slips out at random next week and look at them. Practice carrying them with you as you do what matters to you.	**Your Idea:**
Raaranga (monsters) on the bus: Cut a bus shape with window holes out of a page of your book. Stick the top edge of this to another page in your book. Find pictures or make drawings to represent your "monsters." Collage these under the bus so that you can see them through the windows.	**Your Idea:**
Mindfulness with Babies: If you have crawling or toddling babies, this works best. Use the way the babies move around the room as metaphor for how our minds constantly wander. Ask the parents to mindfully watch the babies as they move, noticing how this is similar or different from their experience of their own minds.	**Your Idea:**

Step whitu (seven): make space for babies.

a. What do you think could be the advantages of including babies with their parents in this group?
   We saw this as an opportunity for enhancing hapori (a sense of community) and whānau. It links to traditional child-rearing practices: the whole group attended to all the babies together. Having babies in the room allows in-vivo learning, and is a way of enhancing ecological validity. Having babies in the room parallels and models "being with" the hard parts of life. It is not always easy to focus on learning in a traditional way with babies around, which is often part of the challenge for parents in our group. Most of all, babies introduce a playfulness that enhances the creativity and connectedness of the group.

b. What would you need to do to have babies present in your sessions? Consider safety, who is responsible for the baby, how you might manage making room for the parent to attend to their baby's needs within the session.

> **Mā te tuakana te teina e tōtika, Mā te teina te tuakana e tōtika**
>
> **(The older will lead the younger and the younger will lead the older)**

Step waru (eight): create your own exercise with a balloon.

a. Take out your balloon and just have a play with it for a little while. You might blow it up, let it go, make sounds with it, feel the air.

b. Choose a core process from ACT or a key point from therapy you would like to illustrate.

c. How can you use the balloon to illustrate this process or point? Get really creative. Try it out for yourself.

Step iwa (nine): work biculturally.

a. Consider what you have worked on in this bicultural workshop so far. What aspects of bicultural practice can you identify?
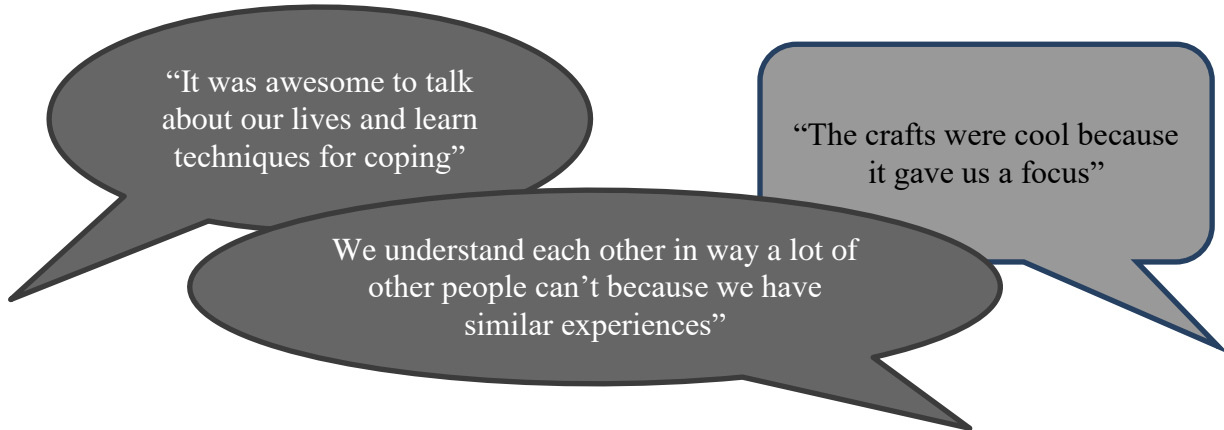
A lot of our bicultural approach was in the format and process of the group as we have shown you today. We modelled partnership by having two presenters from Māori and Tauiwi cultures. We incorporated Māori practices and treasured cultural concepts (e.g. Karakia and raranga). Te reo (Māori language) has been used throughout, coming first as a sign of respect. Creating an atmosphere of whanaungatanga (community/commonality) was intentional and key. We celebrated the mana of the people in our group by giving certificates and talking about our appreciation of what each person brought to group.

b. What ways might you create compatibility between the psychological model(s) you work from and Hauora Māori? Write down three points.

We view ACT/contextual behavioural science as highly compatible with Hauora Māori. The recognition of context allows the therapy to sit side by side with Māori models. There was room for us to respect the mana of the persona and culture. We were especially able to make links to important indigenous spiritual concepts via mindfulness and self as context work. However, it was not an entirely perfect fit. Here are some of the similarities and differences we observed.

Similarities between ACT/CBS and Hauora Māori	*Differences (from a Tikanga Māori perspective)*
• *Stories as metaphors* • *Contextual approach* • *Experiential learning more important than verbal instruction* • *Respect, compassion, learning/growth* • *Self is more than just who you are now and what your mind tells you*	• *Importance of stories: do not takahi (trample) the mana of the korero story. ACT often interrupts stories we have about ourselves* • *Language is sacred* • *Identity is incredibly important—not just me here now vs. you there then. It is me and them, here and there, now and throughout time* • *ACT opens up things Māori would not normally talk about*

Step tekau (ten): listen to the voices of the tangata whaiora (clients).

"It was awesome to talk about our lives and learn techniques for coping"

"The crafts were cool because it gave us a focus"

We understand each other in way a lot of other people can't because we have similar experiences"

Step tekau ma tahi (eleven): what will you do?

a. Identify something from this workshop you would like to incorporate into your own practice.

b. Turn this into a concrete goal. Are you at least 70% confident you will follow through on this goal?

c. If you are not 70% confident, make your goal smaller and more achievable. Keep going until you are at least 70% confident you will take action on this goal.

d. Connect your goal to a value you have about your work or life in general. For example, you might be working on a goal of using more reo in your work, in service of a value of respect and connection with others.

e. Tell someone else what you are doing! It is easier to keep a commitment if other people know.

f. Email me when you have done your action. You can tell me what it was or not, as you prefer: kathryn.whitehead@cdhb.health.nz. Send me any other ideas or questions you have as well.

Step tekau ma rua (twelve): finish with karakia. Choose your own or use this one here:

Kia tau kia tātou katoa
Te Atawhai o tātou Ariki
A Ihu Karaiti
Me te aroha o te Atua
Me te whiwhingatahitanga
Ki te Wairua tapu
Ake Ake
Amine

Recipe best served raw. Over-cooking may ruin outcome.

Questions for step three

Number on Dice	Question to answer	
1	What Olympic sport would you most like to enter?	
2	What was your first pet?	
3	What's something others wouldn't believe you do?	
4	What do you want to be when you grow up?	
5	Who is your favourite superhero?	
6	Who was your favourite pop star when you were a teenager?	

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Opinion: 'Culture' and Couples

Marianne Quinn

One of the "mysteries of attraction" is the mixture of sameness and difference that draws two people together. At the start of a relationship, we usually find this delightful, bonding around "sameness" and seeing difference only as novel and exciting. However, over time, we can come to feel "ordinary" if all we see/experience is "sameness," when at first, this made us feel safe and "at home."

In my work with couples, I have seen a number of couples whose different backgrounds and cultures mean they do not share a first language. For example, English might be a second language for them both, the one they use together; the one they have both had to learn to get by. However, it is not the language of their early life; the one that often contains their emotional life.

Rather than being a negative, in my experience, these couples are much less likely to assume that they "know" their partner's full experience and what their words mean; they are more able to hold that their partner is a separate being with their own unique experiences. These couples often have fun with different words, "mashing up" words from more than one language to create their word that vividly conveys meaning.

Every family is a culture of its own. Being born first means you have a different experience of "family" than if you are the second or third born. Experience changes people: The parents of the third child will be different people from those who experienced their first pregnancy. Holding on to difference to challenge our tendency to assume sameness is an ongoing challenge for every couple. Keeping this awareness alive can bring greater depth of understanding and connection to the culture of each couple.

Marianne Quinn is a registered clinical psychologist, Psychotherapist and Imago Couples' therapist in private practice in Dunedin.

A Culture Submission

Leona Manna

When I agreed to submit something for this journal it was not going to be this. I was thinking about how we define ourselves culturally and what defines culture in general, and had planned to review the literature around this. However, this was derailed when I came home from a full-day NZCCP-hosted workshop on Friday September 9 to find that I had been burgled.

The following is to provoke thought and increase awareness the emotions you, as readers, may or may not experience throughout this process. Reflecting on this experience may also provoke memories of similar events that you might have been through. The aim is also to reflect back as to what we do, and why? How are we able to continue to provide the work we do, day in/day out? (some may only work 1 day/week, but will understand the idea I am portraying). Resilience and insight, and the ability to work through and process our own experiences are necessary and important to work safely as practitioners. I am discussing different aspects of culture: the culture of safety, the culture of us as colleagues and clinicians, the culture of self-reflection, and of resilience.

It has been just over 3 weeks from realising that this event had in fact impacted on my life, despite working hard to look at the positives—my house was not "trashed," there was no unnecessary damage, or deliberate destruction, things were easily tidied, and the window will be fixed. I have reflected that I was also glad I was not home, and on the difference between what matters and what does not matter in life. Of course, there is now a security system in place, and life is hobbling along. There are those I know of, and some closer in my life, who are going through much worse experiences, such as losing loved ones. This event, while unpleasant in my reality, was not anything that had an irreversible impact on me. It was only material items that were taken (and yes, some were sentimental and irreplaceable), and as I did not get around to updating my insurance, many things will never be replaced.

I am now a statistical number. It appears that while I could have perhaps deterred it from occurring, any such action may have been for nought. The policeman who came and took fingerprints mentioned something along the lines of "It's a matter of who is targeted on any one day, and by whom." If someone (read as one or more) wants to gain entry, they will. Dogs, burglar alarms, bars, window locks and so forth are deterrents that can prevent entry, but this is dependent on how much time and/risk those who break in are willing to take.

Those who know me are aware that I have just started working for myself as a contractor. Some people have expressed suspicion that the burglar might have be one of those I am working with. I have not once thought of this as a possibility. I see the event has "just having occurred." It is inevitable that if it was not me, it most likely would have been a neighbour. This is the reality of life in this world. This is the culture we are all part of. Some of us deliberately offend, and others try hard to be law abiding people.

The police have indicated there has been a rise in burglaries, even in the last 1–2 weeks. They have taken an approach that indicates awareness that culturally, it is not just possibly career criminals now, but people who are at risk, and have needs—perhaps it is to find something to sell off quickly to provide food or to pay bills. Yes, it does not take away from the fact that for every action, there are consequences, but it does raise an idea that is all too familiar for those in

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Canterbury; we live in a culture of uncertainty.

In reading this piece through, I can honestly state that I am not sure where to go with it. It is a cathartic process to write about it, and while some small emotions arose while doing so, they have mostly been worked through. The concept of culture is huge. We can define it using large or small domains. For me, right now, the culture I align with is that of a clinician who has been through a negative experience and has come out the other side, and is still going strong.

A Categorisation of Present Giving

Peter Stanley

I have had a lot of fun at different times designing diagnostic categories. One of my first forays into this genre was academic deficiency disorder (another ADD), which was applicable to the university students that I was teaching at the time. ADD is suffered by students who feel tired when they are confronted with major academic tasks, who become flustered as assignment deadlines approach, who find other (any) activities more attractive than academic work, who think that the other people in tutorial groups have more intelligent things to say, and who feel anxious that they will be "found out" as not really capable of university study (Stanley, 2006).

Over time, I found that the students themselves enjoyed inventing mental illnesses as well, and a favourite activity was listing the symptoms of dieting deficiency disorder (DDD). They would go at this task with serious enthusiasm and before you could say chocolate sandwich, the white board was covered with ploys such as taking off rings and bangles before getting on the scales, promising to exercise in the future while gorging, pledging to diet after one final breakout, cutting slices into halves and then eating both bits, and having clothes that include a range of sizes to anticipate all eventualities.

As Christmas approaches it might be thought necessary to have a typology of present givers. After all, how can we respond to other people if we cannot categorise them? In fact, there are six types of present giver, and each one reveals the personality, dispositions, and intentions of the individual concerned. And there you were thinking that present giving was as simple as buying something from a shop, wrapping it up, and placing it under the tree.

Firstly, there are "true givers," which are people who are sensitive and empathetic, and who think sufficiently about the other person's situation that they give them something that is special, surprising, and truly valued. The numbers with this personality type will fluctuate because people who are in love, for instance, will behave differently from people who are just fond of each other. Whatever the prevalence of this type, being a part of it will be simply unattainable for many people because of their personality configuration. Included here are the parents who give their young son a large stuffed toy when he was hoping for a real live puppy.

In the second category we find "self givers," who buy gifts for others that they would really like for themselves. You may be disgruntled by this human type; I certainly have been when, for example, I have been given books about royalty (for goodness sake!) which have clearly already been read (and which will certainly not be read again). However, there is a subclass of this group, which is admirable, and these are the people who will only give things to others that they hold in

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value themselves. For instance, they give the most recent cell phone to a friend or relative when they would desperately like it for themselves.

Thirdly, we have "thoughtless givers." People who evidence this class of behaviour are the opposite of true givers; the cliché that "it's the thought that counts" certainly does not apply to them because there is very little thinking involved at all. Included here might be the lethargic partner or parent who always gives money to his or her family members. In fact, the market caters for thoughtless givers with a whole swath of easily accessible gifts that can include alcohol, gift vouchers, shop-made hampers, chocolates, and even flowers. Nevertheless, we need to be careful with this category because these items can also be selected by true givers who are actually giving someone precisely what they want.

In reality, it is difficult to know whether the "emergency gift" fits within this category. This is the box of chocolates that is wrapped and placed under the Christmas tree just in case someone turns up who warrants a present but for whom no specific provision has been made. The gift itself is fairly thoughtless, but the intention is sort of thoughtful. This just goes to show why specialist skills and advanced training are needed to make these categorisations.

Next, there are "strategic givers." The businesses that buy from catalogues of gifts with the intention of perpetuating client custom are in this group, but so too are seducers of all sorts. As we know, people who take our gifts are beholden to us. That is, unless we overdo it and they become used to getting the things that we give them, and then they may become resentful when we fail to indulge them.

The fifth group is "altruistic givers." These people have always been around as philanthropists but they can also appear in family contexts. On one occasion my wife and I were altruistic givers, but we never will be again. On Christmas day we gave each of our children pledge cards for goods that we had donated to kids and families in Third World countries, like school uniforms, a bee hive, a bicycle, and a goat. You may have also experienced that particular feeling when you know for certain that your present is a flop.

The sixth and last typology is "mixed givers." These givers will have elements and shades of two or more of the other five categories. As this class often includes many of us, and since it shows the overriding influence of circumstance on what we do, it tends to make nonsense of the rest of what has been said.

Happy (and spontaneous) present buying and present giving.

Reference
Stanley, P. (2006). A case against the categorisation of children and youth. Part 1: Theoretical perspectives. *Kairaranga, 7*(1), 36–41.

Psychologists as Leaders: Insights

Consistent with the NZCCP Strategic Plan and supporting our membership, one of the areas of focus is to **build the <u>leadership capability</u> of our members**.

As part of this, insights from NZCCP members who have moved into leadership roles will be regularly published in NZCCP publications as a way of sharing information about pathways into leadership. The following are from Michael Williams and Julie Zarifeh.

Michael Williams

Current Role

I am the Director of Operations in a large NGO that delivers research-based interventions to children and young people with emotional and behavioural problems, with a particular focus on young people with conduct disorder. I have a team of regional managers that report to me.

Path to Leadership

I had a 10-year career as a clinical psychologist in adult mental health as a practitioner. I held a team leadership role near the end of that period. In 2008, I was appointed to a clinical director role for the NGO where I still work. As clinical director, I was responsible for the clinical standards of the organisation, research activities, and quality improvement initiatives related to the treatments we offered. In this role I reported to the CE and no longer delivered interventions to clients myself. My focus became strategic and leadership-oriented. I enjoyed this shift in focus. I was still able to work in the field for which I was trained, and use my skills and knowledge to support our therapists and psychologists to deliver high quality services. I stayed in that role for 5 years. Over that time, our organisation grew substantially and I took on increasing operational responsibilities such as setting up new services, project managing the implementation teams, and then holding line management responsibility for the new services for a period until they could be transferred to management. I discovered that I enjoyed the line management tasks and the challenges of building new services. When an operations role became available in my organisation I was grateful for the opportunity to switch across. I was fortunate to move from a senior clinical role to a senior management role without the many preceding years of middle management experience that are typically required.

Training

In terms of my current role, I attended a week-long strategic leadership course, but mainly I had learned by observation through being in the senior team over several years, and through project-based opportunities to apply operational management functions.

Dealing With Failures

My first year as an operations manager was survival. We were growing new services and I had a steep learning curve in what was already a busy period for our agency. I had plenty of failings in that year, which I could summarise in three patterns. Firstly, I was totally unprepared for the multitude of competing demands of the role. My previous roles had been more singular in their focus, but in operations I had dozens of conflicting pressures. Initially, I did not prioritise my time well. I did not focus on the things that were most important. When under pressure I had a tendency to focus on the latest issue in my email inbox rather than the most pressing issue. It taught me an important lesson about being purposeful in my planning. Secondly, in my first year

I did not delegate sufficiently—this wore me out and starved my managers from taking on responsibilities they would have thrived on. In my previous roles as a psychologist or clinical director, my technical expertise and therapeutic skills were valued, but in this new role I needed to stop leading by doing and instead help others to do the doing. Thirdly, in my anxiety to do a good job I became task focused and did not balance this with a relationship focus. This meant that my relationships with staff did not get the attention they deserved, and to them, I seemed remote and not available to listen and/or connect. The emotional-based leadership was not there. I had assumed that because I had spent my career listening to others that this would have come naturally to me. The competing demands on my time and my desire to be a "success" made it difficult for me to drop my task agenda. I needed to learn to consciously spend time with staff in ways that were not about driving my own agenda.

Support to Enter Leadership

I had a great clinical supervisor who helped me understand my own psychology in relation to these roles. I also had excellent mentors in the NGO who encouraged me to step up into these roles.

Advice for Others

The skills we acquire from providing therapy to clients plus the rigour of our academic training provide a good foundation for stepping into leadership roles. However, on its own, our training is not sufficient. If operations leadership is of interest to you then I would encourage you to seek opportunities to take on team leadership roles or informal leadership roles, and actively encourage staff, colleagues, and your manager to give you feedback on how you perform and ways to improve. Ideally, you will also be able to observe and receive coaching from an outstanding leader within your agency. I think observation has been the most important part of my learning. Read management and leadership books and aim to continuously become better at the art of leading through determination, planning, coaching, and review. I think the transition is easier if you take on leadership roles within the health or social service sector, but I know others that have moved into corporate work successfully. Psychologists are trained to have a particular sensitivity to interpersonal dynamics and to have a strong ethical base. This equips us well to be leaders that have integrity who can lead in a values-based manner.

At some point you may have to make a choice. Either you are going to be a specialist practitioner/clinical expert, or you are going to be a leader on the management pathway. The transition to management is not straightforward or intuitive, and necessitates acquiring a different set of skills than we learned in our degree course. It can be difficult to make this decision, given the investment we have made in our training. You trade the rewards of helping clients face-to-face with the rewards that come from helping a group of people pursue a business or undertaking.

Challenges and Advantages of Leadership Roles

By taking on such roles, you get to experience whether leadership is a good fit for your strengths and interests. I valued being a clinician and I had no particular aspiration to be a leader; however, as I took on small leadership roles and experienced the capacity to effect change beyond the clinic room, this sparked an ongoing interest. One other advantage, at least in my experience, is that leadership roles are less emotionally demanding than clinical work. There is a degree of separation from the pain of clients when leading others who are delivering the interventions. For those that are at risk of burnout from clinical work due to their personal makeup or work situation, this may be an important consideration.

Skills of Leadership

The ability to be black and white about some things. You need to be firm-minded enough to hold people accountable to expectations. The ability to stay calm (or at least appear calm) under pressure when there are multiple competing demands. The tendency to be a problem solver and to take a solutions oriented approach to problems. Being able to have an action orientation rather than a reflection orientation when the situation demands it; that is, the ability to be decisive, take action, and drive things forward even when the ambiguities of the situation have not been fully explored.

Extent my Role Requires Leadership Skills

Mine is a management role, and yes it largely has a leadership and strategic focus.

Julie Zarifeh

Current Role

I currently hold the position of Regional Lead for the Cancer Psychological and Social Support Service (CPSSS)—Upper South Island. This role is one of 6 nationwide, under a new Ministry of Health (MoH) initiative to improve psychological and social support for patients and their whānau, under high suspicion of, or newly diagnosed with a cancer, and while undergoing active treatment for that diagnosis.

Path to Leadership

As is often the case in career change and development, this was through a mixture of opportunity and timing. I ended up following this path by initially becoming increasingly involved in the delivery of appropriate psychological assessment and intervention to patients with comorbid physical and mental health diagnoses. Originally, this was through my position as a clinical psychologist within the Canterbury District Health Board (CDHB) Psychiatric Consultation-Liaison Service (8 years), followed by a brief period as the CDHB Nephrology Department team psychologist. In conjunction with these clinical roles, I had also become involved in several research projects that emerged in the wake of the Christchurch earthquakes. Therefore, when the above role was advertised, I viewed it as an opportunity to use some of the new skills that I had been lucky enough to be in positions to absorb, and thus to broaden and extend these skill-sets going forward in the new role.

Training

No extra training was undertaken to start in this role, and training has been very much as the role has evolved; with, it would be fair to say, a reasonable degree of "baptism by fire." I am fortunate to be one of 6 regional leads nationwide, and as such, we have learned a great deal from each other in terms of what is involved for new service roll-out across the different regions. Locally, I lead an excellent clinical support team of two clinical psychologists and three social workers, collectively involved in design and start-up of a brand new service from scratch. This has included: design and implementation of a new referral form and referral pathways; ascertaining where, why, when and how to document patient contact under the new service; development of a template for such documentation; and provision of upskilling and education to potential referrer groups. There has been a great deal of "learning the ropes," in fact, "inventing the ropes" as it happens.

Dealing With Failures

Because the role is a regional one and there has been a huge amount of juggling and multi-tasking, there have been times where, very unintentionally and non-deliberately, people who should have been kept abreast of developments have been overlooked. This resulted in confusion and misperception on a couple of occasions, requiring some appeasing and smoothing over of ruffled feathers; all a learning curve on both sides. With, I hasten to add, positive outcomes once worked through.

Support to Enter Leadership

The support and encouragement to apply for, and ultimately be successful in, moving to a leadership role has come from many quarters—work colleagues, management quarters, friends, and family. The MoH initiative has been extremely well supported in its concept and aims, which has felt supportive. We have also been very much welcomed as a new team at the CDHB hub, from the Director of Allied Health, the Southern Cancer Network, Southern Alliance Group, the CDHB Clinical Lead for Informatics, and many other crucial "set-up" people along the way.

Advice for Others

"Go for it!" I would suggest that any graduating clinical psychologist has already proven themselves to be a leader by virtue of their selection for, and progression through, Dip.Clin.Psyc training. The requisite clinical years of course need to be followed with a broadening of experience and depth of knowledge. But, the basic blocks and foundations are there already and I really think that it is a natural progression (i.e., movement into a leadership/management role) and one that would be good to see happening more often. The ultimate position is probably a combination of both clinical tenths and a leadership/management portfolio.

Challenges and Advantages Leadership Roles

As one progresses in their career, I think that there are definite advantages in becoming involved with different committees, be they for a conference, an area group meeting, a portfolio on a steering group, or similar. These roles all shape leadership skills in terms of learning how to have a voice, and encourage organisational skills, reliability, accountability, and so forth.

The challenge is in the subtle acknowledgement to yourself that not only are you still a peer and colleague, but you have also been voted into a position of responsibility and need to perform as a leader in that role, which occasionally may involve delegating and overseeing tasks; a step up from a collegial and equivalent work relationship.

Skills of Leadership

As alluded to above, and inherent in clinical psychology training, is the ability to listen, reflect, and formulate. Over and above that, an important skill is to be highly organised and thus be able to be effective, confident, and have the ability to motivate and inspire others wherever possible. It is also important to have the ability to acknowledge that different professionals have different skill sets and perspectives that need to be drawn on in a way that lends to positive group dynamics and processes, and thus efficiency.

Extent my Role Requires Leadership Skills

Mine is a clinical lead role, deliberately not having a management facet as it would make this role too overwhelming. Therefore, I do not manage a budget or leave requests and so forth.

How my Leadership Position Differs From a Management Role

In terms of the breakdown, the "management role" sits elsewhere in the department, with the leadership role thus focusing on being "the face of" the CPSSS both locally and regionally. As mentioned, I meet frequently with the other regional leads around the country (especially the lower South Island lead), and with the national lead for the initiative, members of the South Island Governance Group, and now also, the new, recently appointed evaluators for this project.

Book Review

Title:	**All or Nothing—Bringing Balance to the Achievement-Oriented Personality**
Author:	Mike McKinney
Publisher:	Exisle Publishing Pty Ltd., 2016
Reviewer:	Mary Miller

Short description: This book is a self-help guide for those whose drive to achieve dominates their lives so exclusively that they fail to recognise other important aspects of life and put themselves and their important relationships at risk. The author clearly describes the "All" part of the title as individuals who throw themselves into achieving a goal to a very high (and at times, unrealistic) standard, behaving as if their very worth and/or value depends upon the achievement. The "Nothing" part of the title describes the result of this single-minded pursuit, which can lead to loss of motivation, despair, anxiety, and "burnout."

Mike McKinney tells us that the drive to write this self-help book came from his extensive experience in clinical practice. He goes on to explain that we are taught as psychologists to "look for patterns, reflect upon how they might have come about and then identify whether they are helpful to the individual or not" (p. 4). While I can claim no particular knowledge or expertise in self-help literature, his excellent description of what we do as clinical psychologists is, in fact, the basis of my expertise to offer this review. I have spent about 30 years doing precisely what he has described; that is, trying to find "patterns" and exploring the cost and benefits, spending time predominantly in primary mental health care settings (e.g., private practice, university clinics, GP practices).

McKinney does an excellent job of introducing readers to his proposal of finding a better balance in life. Through his engaging writing style, he invites his targeted audience to explore the possibility that they can gain more balance in their life without losing out on the benefits of their motivation to achieve. His language is playful and accessible, for example when he discusses schemas as "your pre-Google guidance system" (p. 46). He wisely attempts to lower the fears of this group by suggesting that achieving balance will not mean losing touch with one's true self, but in fact, re-balancing one's life is likely to open up new ways to interact with the world. He also convincingly points out in the early chapters that these driven individuals may be paying hidden costs that they fail to notice. For example, he describes Tessa, a young ballet dancer, who, because of her drive to achieve, fails to heed advice from medical professionals until she loses her potential career through injury (pp. 20–21).

The book is well laid out; the author competently takes readers on a journey of self-discovery.

Mary Miller, PhD, immigrated to New Zealand in 2001 as an established clinical psychologist providing clinical psychology service in training clinics and private practice, as well as teaching in graduate psychology. Since 2001, she has continued to provide outpatient clinical psychology services in private practice as well as holding management roles in establishing psychological services to the public. She has continued teaching and supervision of clinical psychology post graduates.

McKinney seeks to help the reader gain greater awareness of the ways in which certain styles of thinking and behaving may have locked him or her in the single-minded pursuit of goals based on the promise of satisfaction to the exclusion of all else. As many who have worked with such clients know, these individuals rarely pause to drink in the pleasure of a long-sought goal, instead the achievement is little noticed, and the person is soon off on the chase for other new goals. The author helps us understand that the constant pressure to move to the next target is much like having a wolf nipping at your heels (he identifies this wolf as "The Harsh Internal Critic" (Chapter 5). He helps his readers develop psychological-mindedness to observe and contemplate the origins of the patterns to which they are so rigidly adhering. Each chapter concludes with helpful tools to aid reflection and suggestions for exercises that help elucidate the subject matter of the chapter.

An entire chapter of the book explores the origins of the All or Nothing (A/N) adaptation to life, and the author relies heavily on social learning theory to explain the basis of this personality style. Further, he does an effective job of providing vignettes to illustrate key dimensions of this style. He articulates the most obvious basis of this personality style well: parents who leave their child feeling as if only perfection will elicit their approval and love. From my point of view, a missing ingredient in this discussion was any attempt to explore other possibilities. As a case in point, McKinney makes specific mention of a man who says in response to McKinney's explanation of this particular style being based on critical parents: "not at all, Doc, my parents were both hippies; they didn't expect anything of us" (p. 39). The author goes on to describe how the man consciously set out to establish his own standards and suggests that this example of overcompensation is a "variation on a theme" (p. 39). From my perspective, this example is a lost opportunity for exploration of another very common path to this personality structure. For example, it may be that this client was driven to achieve as an expression of his frustration and anger about his parents' failures in his young eyes. In such circumstances, there can be no conscious awareness of these feelings as they would likely jeopardise the parental bond. Such split-off anger is often the very fuel of the harsh internal critic, which is so central to the book's description of a key cost of the A/N personality style.

In fact, there seems to be no mention anywhere in the book about a connection between disavowed anger and the harsh internal critic. This point seems important because integration and resolution of such feelings could mean the difference between managing critical thoughts in the way outlined in later chapters, and no longer experiencing them. Further, feelings that cannot be consciously acknowledged are often projected externally, which may be why many of these individuals claim that it is their bosses' expectations they are driven to meet. While in-depth processing of this kind may be beyond the scope of a self-help book, it would seem important to raise with clients, for there are many A/N people who did not come to this place only by the critical parent route.

With each chapter, McKinney does an excellent job of raising awareness around the costs and pitfalls that are often associated with the A/N personality. In later chapters, we are walked through the "Nothing" part of the structure as constituted by fear of failure, loss of motivation, and burnout. It is important to note that this phase is often the motivation for when such people seek help. He describes how dynamics of experiencing intrinsic versus extrinsic motivation are connected with a person's wellbeing. Again, he brings in relevant research in a way to clarify his points, showing the increased risk the target audience has for depression, anxiety and physical health problems by following the A/N trajectory.

The last chapter of the book is dedicated to, and is meant to be read by, partners of such individuals. He helps them understand the likely dynamics that they participate in and the

importance of honest communication in curtailing them. These people are often unwittingly contributing to the very behaviour they find so problematic.

Throughout the book, I was struck by the compassionate understanding which McKinney brings in describing both the suffering of the target audience as well as those individuals close to them. I suspect that this empathic stance will entice such narcissistically vulnerable people to read on in hope of finding a way out of the relentless pursuit of ever-increasing expectations. Many people who embody this personality dynamic will never present for treatment with a therapist, but they very well might seek out a book, such as the present one, because it would be perceived as a safer alternative. For those people, this book would be a good resource in helping them make sense of and alter their counterproductive approach to life.

Book Review

Title: How and Why People Change: Foundations of Psychological Therapy
Authors: Evans, I. M.
Publisher: New York: Oxford University Press, 2013
Reviewer: Peter Stanley

The theme of this text is that psychologists should apply fundamental principles of change to problems of living rather than rely on evidence-based programmes. Working from first principles is about understanding processes, it is concerned with the responsiveness and integrity of an individualised method, and it seeks a higher plane altogether than that offered by packaged therapies. Evans says that the problem with the evidence-based approach and movement is that it can subordinate process understanding to the demonstration of outcomes, and it will typically result in the matching of clients to discrete treatments rather than more consciously helping them to realise their goals. Fundamental principles of change are to be found in the corpus of psychological research that is continually amassing, and includes classical conditioning, instrumental conditioning, imitative learning, cognitive therapy, self-regulation, and autonomous decision-making. In addition, a practitioner needs to have a detailed knowledge of the patterns of a client's life: the cultures that they participate in, the routines and rituals that embrace them, and the social support that they can call on. At the least, what Evans contributes is a detailed picture of the many influences that can be applied to people's lives in the context of therapy as a deliberate and planful endeavour.

How and Why People Change is a demanding book to read, and this is despite the author's accessible and disarming writing style. The difficulties arise from the conceptual level of the text and the span of the subject matter. In the jargon of primary school teaching, this book requires a fairly advanced reading age! To assist my mastery of the material, I made lists of the individual topics discussed in the text and found that they fell into five categories. The groupings I discerned are: the therapeutic journey, psychological phenomena (e.g., stimuli, cognitions), problems of adulthood, problems of childhood, and specific change strategies (e.g., goal setting, self-talk). Each domain contains many original and illuminating observations, but I decided to limit the discussion that follows to just three aspects. These matters, which provide additional perspectives on the theme of planned and principled action, are the therapeutic relationship, working with significant others in parent training, and a critique of mental illness.

Evans suggests that the therapeutic relationship suffers from popular misconceptions, and these exist among both lay and professional audiences. People who seek therapy probably do not

expect that they are going to have to make significant changes in their lives. Equally, among professionals, the client-practitioner relationship can have a mystical quality and can be seen as the change mechanism in and of itself. Evans states that the client is far from a passive participant in therapy and that processes of self-influence have to increasingly function if he or she is to achieve self-sufficiency. The author also asserts that, while the therapeutic relationship per se may serve when clients' goals are concerned with self-exploration and insight, explicit change programmes are needed for intractable and multicausal problems of living. Moreover, psychological therapy is about persuasion and the clinician can, and should, model, cue, shape, and reinforce client behaviour. None of this detracts from the need for a warm, empathetic, and trusting relationship between psychologist and client. These components are very important to understanding the client's situation and for the successful implementation of planful change strategies.

Working with non-professionals, such as parents and support people, replicates many of the features of the therapist-client relationship. According to the author, collaborations with non-professionals can also have unparalleled potential to effect change for child and adult clients. Nevertheless, Evans questions the efficacy of parent training packages, and he does so on the basis of a single reference that he provides on Parent-Child Interaction Therapy and the Triple P-Positive Parenting Programme. As it happens, it is the achievements of the new generation of parenting training programmes that provide a check, and a counter, to the thesis advanced by the author. In particular, the Incredible Years Parent Programme (IYP) (www.incredibleyears.com), which has become such a central feature of service provision in education (www.pb4l.tki.org.nz) and among non-government organisations, directly addresses the concerns that Evans has about personal goal attainment and cultural relevance (Webster-Stratton, 2009). Meanwhile, IYP has the economy, the potentially productive interactions, and the support advantages of group work. Furthermore, it intersects well with individualised interventions (Lees & Fergusson, 2015), can promote interagency work where there is a commonality of programmes across organisations, and is a refreshing and rewarding experience for the practitioners who provide it (Hamilton, 2005; Stanley & Stanley, 2005). Evans acknowledges that all interventions are not born equal, and similarly, much the same can be said about the array of packaged programmes that are presently available to practitioners.

The author critiques the notion of mental illness both directly and indirectly. He points out that rarely do people come to therapy because they have a specific condition; instead they obtain a syndrome after entering therapy. A psychiatrically defined syndrome is no more than a description of the dominant features of a problem; it will lack explanatory power as it can have a range of causes, and can result in very different treatment regimes. When an individual is said to have an addiction, biological control is implied and personal responsibility is diminished. And if ADHD is a distinct medical disorder why does treatment not make it go away? Undoubtedly the two most pervasive arguments that the author provides against the reductionist model of the "so-called mental health services" (p. 267) are his explanations on the functionality of behaviour and the consequences of experience. Genetics, temperament, and personality serve as substrates for behaviour, but ultimately every act that an individual makes serves a specific function for him or her. For instance, some responses gain control, others give pleasure, and others help to avoid pain. Moreover,

> . . .in the final analysis it is experiences that shape and change behaviour, it is rarely the case that suitable experiences cannot be arranged or created or redesigned in order to improve people's lives according to their needs and desires and the expectations of their community. (p. 268)

How and Why People Change is an eminently psychological text, and is especially valuable for being so. Evans does not achieve the theoretical integration that he may have hoped for, and perhaps there is not such a tension between principled and individualised therapy, and those evidence-based programmes that aspire to personalisation, and that are based on proven principles of change. However, what the author has effectively done is provide a standard that can be used to evaluate the activities of psychologists and the methods of other occupations that profess a commitment to changing behaviour. As a consequence, questions abound, such as why do psychologists persist with the diagnostic system (the DSM) and administrative arrangements (the MDT) of another profession?

A sad fact that I learned from the work I have recently done on recommending a greater role for psychologists in child welfare (e.g., Stanley, 2015) is that professional psychology actually has a negligible profile in the broader human services in New Zealand. *How and Why People Change* makes it clear what psychologists have to offer. The pressing question now is how our health, education, and welfare services can be persuaded to this reality in the interests of their clients who are seeking effective ways to change their lives.

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Book Review

Title:	**Te Manu Kai it te Mātauranga: Indigenous Psychology in Aotearoa/New Zealand**
Authors:	Waikaremoana Waitoki and Michelle Levy
Publisher:	New Zealand Psychological Society (NZPsS) and Ngā Pae o te Māramatanga, 2016
Reviewer:	Eileen Britt

This book presents a Māori perspective on psychology and mental illness, with an overall message of hope. The editors have collated perspectives from 18 Māori psychologists as they describe their view of Ripeka (on whose story the book is centred and who is facing mental health challenges) and her whānau. In so doing, it traverses a range of psychological and social issues, which will be familiar to issues clinical psychologists in practice in Aotearoa/New Zealand will have encountered in their work.

The contributors include Māori practitioners, researchers, and teachers of psychology, including a number of Māori clinical psychologists, many of whom have been in practice as psychologists for over 20 years. Each chapter is written by a different Māori psychologist(s) from: their own unique perspective; the Māori knowledge or world view they bring to Ripeka's story; and how they would approach different aspects of Ripeka's care. The chapters, therefore, are written and presented in a range of ways that best conveyed the unique world view of each contributor. As a

result, each chapter can be quite distinct from the other chapters in writing style, content, and approach.

This approach contributes to the richness of the information and insights contained in the book. It also means that the book may not be easily read in one sitting. Because of the diversity and richness of content, it is also likely that the reader will benefit from revisiting the book, or individual chapters, with new or greater understanding and insights with each read, and as their own understanding of Māori knowledge and world view develop.

This book provides valuable information and insights for clinical psychologists in New Zealand, as well as psychology students and academics. It provides a range of Māori perspectives, insight into Māori psychological practice, and the unique approaches Māori psychologists bring to their work. At the same time, a collective vision for indigenous psychology in Aotearoa/New Zealand is presented.

Te Manu Kai I Te Matauranga: Indigenous Psychology in Aotearoa/New Zealand is published by the New Zealand Psychological Society (NZPsS) and Ngā Pae o te Māramatanga, and is available for purchase through NZPsS website (http://www.psychology.org.nz).

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
Queenstown	27-28 July	**NZCCP 2017 Pre-Conference workshop with Matthew Berry**
Queenstown	29-30 July	**NZCCP 2017 Conference**

Other Events

LOCATION	MONTH	PRESENTER/ CONTENT
Hamilton	13 January	Mindfulness Day Retreat for Psychologists
Auckland	25 January	Using Cognitive Analytic Therapy (CAT) to understand and work with adolescents and young adults with challenging behaviours
Hamilton	25-26 February	Women, Food, and Embodied Power
Nelson	2-4 March	NZPS17
Auckland	9 & 10-12 March	Somatic Experiencing (SE) training events
Nelson	9-15 & 17-19 March	DBT Intensive Training 2016 with Alan Fruzzetti
Nelson	16-17 March	2 DAY DBT WORKSHOP
Christchurch	31 March-1 April	Meaning-Full Disease, and the call to whole person-centred healthcare
Wellington	31 March – 2 April	Hakomi workshop
Wellington	9 May	The Nature and Treatment of Anxiety in Youth
Hamilton	19-21 June	Level 1 Schema Therapy Workshop