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Pae Tū, Pae Ora

Living today, Thriving tomorrow.

Journal

of the New Zealand College of Clinical Psychologists

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"Ko te amorangi ki mua, ko te hāpai ō ki muri"
Leadership is essential across all operations. All operational areas are as significant as the other.

Editorial

Dear Colleagues

It is that time of year again. I am writing this in Christchurch airport, about to board a plane to Melbourne for a workshop before racing back to mother and therapist duties. There are two giant Christmas trees heavy with ornaments before me. People are arriving and leaving all around. It is that time of year when there is so much connection and warmth and love, and perhaps because of the work we choose to do, we also know of the disconnection, sadness, and stress that accompany this holiday season. It is certainly my hope that you are experiencing more of the former, and less of the latter.

As clinical psychologists, our interest in helping others bring about positive changes in their lives may lead many of us, however reluctantly, to positions of leadership. We thank our wonderful authors for sharing their reflections, opinions, and scholarship on leadership in this issue. We would love to hear from you. What does leadership mean to you? What does it mean to you, within your role, to show leadership? We would also love to hear your opinions about the works you have read. Our authors have devoted tremendous time to writing, and it also takes courage to put ideas out there, open for scrutiny and evaluation.

As always, we would not have a journal without the time and knowledge our authors share with us. In addition, we would not have a journal without the work of our reviewers who work anonymously in the background. Our reviewers do an important job; one that as we move more toward being a peer reviewed publication, we are training our membership to respond to, as well as learning more about ourselves. We have some ideas about how to do things better and would love to hear from you about where you would like resources or help.

I have been struggling with my health this year as I have been bombarded by bug after bug that my little boys have had, and have been less actively involved in guiding the journal as I would have liked to have been. Reflecting on leadership, as I have been quiet, I am extremely grateful for the gentle and firm leadership that Caroline shows in organising each journal. Additionally, without Audrey, this journal would certainly not read as it does. Thank you Audrey and Caroline for your care and attention to detail.

In this issue, we are extremely lucky to have two thought provoking articles that herald our upcoming theme, "Whanau." While we had the choice to hold these articles back for next year, we thought you might enjoy this sample of what our next issue will feature. Do you have an opinion or a reflection based on these articles? Let us know for the next issue.

I am signing off to go and check in. I hope that you will be able to sit back, reflect on another year, be able to give yourself a pat on the back for all that this year has been, be surrounded by love and care, and be able to enjoy this festive season with those who are important to you.

With great warmth,
Kumari

Reflections on Leadership and Change: Is Destruction a Necessary Part of the Process?

Quintin Leith Chrystal

THEY'LL BRING YOU MANAGERS
(Hipnottick Erra, 2013)

They'll bring you Managers
From the cities' business schools
They'll bring you Managers
To crucify the sheep
They'll bring you Managers
From the cities' business schools
They'll bring you Managers
They'll slaughter whilst we sleep

They'll bring you Managers
On the fancy business class
Rolex watches
And Gucci on their feet
They'll bring you Managers
On the fancy business class
Rolex watches
And they always smell too sweet

Disestablishing
Everything that's functioning
Disestablishing
Everything that works
Disestablishing
They're calling it restructuring
Disestablishing
There's no place for your quirks

So, tell me, where's the reason?
Where's the reason?
Tell me, there's no reason
This is treason

And then they've gone again
They count their dollars while they can
And then they've gone again
To plunder somewhere else
And then they've gone again
They count their dollars while they can
And then they've gone again
But they've taken your good health

Quintin Leith Chrystal is a clinical psychologist who was born and bred in Durban, South Africa. He was awarded a Master of Arts (Clinical/Counselling Psychology) with cum laude at the University of Natal, Durban in 1980. He was first registered as a clinical psychologist in South Africa in 1981, and has been living and working in New Zealand since 1996. He is a full member of the NZCCP and is currently in full-time private practice at Bethlehem Psychological Centre, Tauranga.

Part II: The Story

Reflections on Consumerism, Dissatisfaction, and Property Renovations

I remain fascinated by our collective willingness to embrace the endless consumerist treadmill. Like hamsters on wheels, we keep spinning for as long as our energy supplies permit, seldom stopping to reflect about the processes in which we are caught up.

In the evenings, we watch seemingly innocuous television programmes about property renovations, and without us even noticing it, we gradually become increasingly dissatisfied with our own living space and even our own lives. It is not long before we find ourselves noticing the hardware store flyers that have been pumped daily into our suburban mailboxes for as long as we can remember, and before we know it, we are scanning the back pages of the local newspaper in search of a builder.

The initial estimate seems reasonable and we commit enthusiastically to a process of change and improvement. We are vaguely aware that the preliminary estimate is likely to be an underrepresentation of the final costs, and we know that kitchen designers, plumbers, carpenters, electricians, plasterers, painters, and flooring experts will be involved at some point; but, any potential future pain is comfortably eclipsed by our hopes, dreams, and aspirations of "better living."

We are, of course, fully aware that the old, essentially functional kitchen will need to be smashed and ripped out with crowbars and hammers before the new units can be installed. But, in the final analysis it is just "material stuff" and New Zealand has plenty of gullies and valleys that require filling. Renovations always require some destruction and "collateral damage" is an inevitable part of progress and development.

Reflections on Organisational Restructuring

The difficulty with people is that you cannot move them easily with hammers and crowbars without attracting some negative attention from relevant law enforcement agencies. The most elegant option is, of course, to lure them along with "shiny things"; but if your access to suitably motivating material incentives is limited, it may become necessary to seek out some metaphorical crowbars and hammers. Welcome to the world of "constructive dismissal."

As a young clinical psychologist in the public sector in Africa more than 35 years ago, I was blissfully unaware of these organisational machinations, and would have been frankly sceptical if someone had attempted to explain these seemingly Machiavellian, conspiratorial ideas to me. I erroneously assumed that if a worker had the necessary qualifications, skills, and experience, coupled with a sound work ethic, he or she could comfortably continue providing effective service until retirement age and possibly beyond. Sadly, I am now very aware that this is certainly not the case.

Employment lawyers and unionists have always been acutely aware of these issues of course, but unfortunately my postgraduate training programme failed to include any such material in the curriculum. It simply was no considered "core business." Times have changed of course, and many clinical psychologists will quickly recognise at least some of the issues I have documented in this article. Anyone who has been personally subjected to these often cruel and barbaric practices will hopefully feel at least partially validated by having this territory exposed in a public arena.

Change Management Strategies

Disposing of able, competent workers is a tricky business indeed, and often requires input from expensive, external consultants who are affectionately known in some circles as "occupational hit men" or "hired guns." Do not be distracted by the gender-specific language here: this professional group clearly attracts players from at least both primary genders. In summary, the central task in the process of constructive dismissal is to attempt to make the worker feel so uncomfortable that he or she eventually decides to "voluntarily jump ship." In effect, the worker has been "pushed," but a good push should always remain "plausibly deniable."

This is very complex territory, because the employer has certain legal obligations to be a "good employer" and ensure that any occupational hazards are "identified" and "effectively managed." This requires particularly clever sleight of hand, because the employer should never be seen to be contributing to the worker's stress in any way. Even openly admitting to "intentional ejection strategies" within the "organisational inner circle" is typically avoided for obvious reasons. Ostensibly, the employer is doing everything possible to retain the "valued worker" concerned.

The gold standard for "increasing the heat" on a worker is the **performance management programme**. Some organisations prefer the terms "performance improvement programme" or "performance enhancement programme," as these more up-beat terms avoid the negative connotations frequently associated with the term "management." From the employer's perspective, this is a wonderful "human resources instrument" for legitimately implementing a highly stressful micro-management package. This strategy alone will typically reduce most erstwhile competent and confident workers to bumbling, emotional wrecks within a few days or weeks. This is a very elegant and effective way of destroying an able, but unwanted, worker under the guise of "helping," "supporting," and "guiding" them.

Curiously, I have worked with more than one client who has "voluntarily" resigned before the performance management programme has technically started. Now that is a winning ejection strategy: the mere threat of further help and support is enough to prompt the worker to bail.
Another useful trick for masking and obfuscating the real intentions of the employer is to offer the worker access to free, confidential counselling via an **Employee Assistance Programme**. This sends the explicit message that the employer genuinely cares about the wellbeing of the worker concerned. The implicit message of course, is that the worker is clearly not coping. An interesting twist here is that any worker refusing to avail themselves of counselling is quickly labelled "unwilling to fulfil their obligations as a good employee." Anyone familiar with the works of Gregory Bateson and colleagues will nod knowingly. Employee assistance consultations are typically limited to two or three sessions. All parties concerned are generally aware that this is woefully inadequate given the gravity of the situation, but it is hard to pick a fight with an employer that willingly pays for a worker to receive appropriate professional care. This clearly indicates that the employer "means well" and has the employee's best interests at heart.

There are various other strategies for dislodging sticky "hangers on," including the old "trumped up charge" with the associated **temporary suspension** while the matter is being "investigated." This is a particularly nasty one, and often involves the alleged offender being "frog marched" off the premises by security guards. For offending health professionals, the culprits are typically prevented from completing any outstanding clinical tasks and access to clinical files and records is generally blocked. In addition, computers are usually removed, email addresses cancelled, and so on.

In my clinical work as a private practitioner, I have gradually learned about a range of **other management strategies** for squeezing out unwanted staff, including: critical performance

appraisals; offering time-management training (as opposed to reducing the person's workload); packaging away the worker's personal effects; moving the worker into a less desirable workspace, often while he or she is away on "stress leave"; increasing workloads and expectations to unmanageable levels; reducing paid working hours by "mutual agreement"; ensuring time-off-in-lieu can never be taken; changing job titles to "lesser" positions; preventing access to other staff; and blocking training applications. One final point that I really need to share was a comment from a high-level manager in a large corporate organisation who indicated that the overall goal was, in his opinion, to create a "burning platform," so that all workers needed to "actively scramble" to retain their positions. The expressed intention was to prevent complacency and retain a general sense of occupational insecurity in the workplace, thereby ensuring high levels of motivation and commitment.

I personally find all these strategies deeply disturbing for various reasons, and remain incredulous that at least some of them have apparently become a regular part of the occupational landscape in contemporary Aotearoa/New Zealand. Probably the most concerning factor for me is that many of my clients have subsequently been fully exonerated of any wrongdoing via the legal system. In some cases these settlements have involved gag clauses, preventing the public from ever knowing the truth, but for others, the documents are firmly in the public arena for all to see. Despite technically winning their cases, many victims of "organisational violence" remain significantly emotionally compromised long after their employment relations crises have been technically resolved. Tragically, I have also encountered completed suicide following "restructuring" and "redundancy."

Part III: Tying it All Together

Under the "Hipnottick Erra" mantle, I continue writing songs about the many things in life that disturb me. I am aware that very few people will ever hear these muffled protests, and that the probability of effecting any significant beneficial social or psychological change through this medium is essentially zero. Nevertheless, I still remember the huge relief I felt as an adolescent when I first discovered literature and art that portrayed uncomfortable human experiences and observations approximating my own. In short, I knew I was not alone. In the words of Cesar A. Cruz, "Art should comfort the disturbed and disturb the comfortable."

At another level, perhaps my boldness in coming forward with my relatively low-brow contributions to the world of art, music, and literature will inspire others to step out the shadows and seize some creative space. As I have written elsewhere, "Creative realms are not reserved for the 'gifted and talented': they are part of the fabric of life itself." In this article, I have juxtaposed a provocative, cynical, socially critical song about business managers with some brief reflections about materialistic consumerism, before linking this to some thoughts and concerns about organisational restructuring and situations involving "staff shedding," with their associated social and emotional fallout. I have attempted to explicate some of the strategies, techniques, experiences, and outcomes I have learned about through both clinical and general life experience. Essentially, I made no effort to formally research or reference any of this material, and the ideas expressed here are offered at the level of personal observations and insights, rather than scientifically established facts.

In the interests of balance, I need to clarify that I too have worked as a service manager and professional leader in the past, and I fully grasp the complexities and difficulties involved in managing and potentially shedding staff that seem to be consistently working against the best interests of all parties concerned. I have also worked extensively with other highly competent service managers in a supervisory capacity. Managing problematic staff is of course, a common theme in this territory, and most intelligent, ethically sensitive managers have literally lost sleep

while grappling with these issues. The central question is whether destruction is a necessary part of the process when it comes to restructuring an organisation or attempting to "move someone on" from the workplace. Sadly, most old kitchen units end up in landfill. It is simply too expensive and time-consuming to carefully remove and recycle them. They generally land up broken and destroyed. Is this a necessary outcome for workers who have "passed their use-by dates"?

As a practising clinical psychologist, I have always done my very best to "first do no harm." This Hippocratic principle of "primum non nocere" has both guided and haunted me throughout my professional life. Change can certainly involve pain, and in some areas it can be very hard, if not impossible, to avoid this. However, if we proceed with empathy, sensitivity, care, and compassion, we can hopefully minimise any deleterious effects along the way. In a world where profit often seems to come before people, the application of these principles would probably appear somewhat alien and burdensome for many business leaders; but I know for sure which world I would rather live in.

Thought Leadership: How Psychologists Can and Do Influence Politicians, Policy, and Civil Society

Malcolm Stewart

I was fortunate to attend the Congress of the International Union of Psychological Sciences in Yokohama, Japan, in July 2016.[1] This was a large international conference of several thousand attendees and hundreds of papers over 6 days. During the conference, I attended papers related to several themes, one theme being how psychologists can effectively communicate about psychology to non-psychologists and increase the influence of psychology with government and society. The following notes are based on several presentations given during the Congress, most notably by Tor Leven Hofgaard (President, Norwegian Psychological Society), Amanda Clinton (former Legislative Aide, US Congress), Manuel Berdullis (Spain), and Telmo Baptista (Portugal, President of the European Union of Psychological Societies). The term "officials" is used in this paper to mean people such as national and local politicians, civil servants, leaders of business and not-for-profit organisations, and other people in positions that assist them to potentially create change in society.

Working with Government and Similar Agencies

While it is easy at times to be cynical about politicians and other influential people, Telmo Baptista reminded us that there are many competent and well-intentioned people in politics, government, and civil society groups, so being prepared to work with them is important and valuable. As in other areas of life, the building and maintaining of relationships with politicians and other influencers was seen as potentially as influential as the content of your communication. The suggestion was to build relationships with as many politicians and key decision makers as you can, in part so you can figure out who will be helpful/sympathetic and who will not. Similarly, do not forget other organisations in civil society, such as local government, relevant national organisations, and political parties. Having a relationship with political parties was seen as useful because it is often easier to get access to up-and-coming leaders than the current leadership. Take your message as far up the hierarchy as you can get. Additionally, working to be

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[1] Malcolm self-funded his attendance at the Congress after he and Deb Moore represented the NZCCP at the Asia-Pacific Psychology Leadership Forum, a meeting of psychology organisations and boards in the Asia-Pacific region.

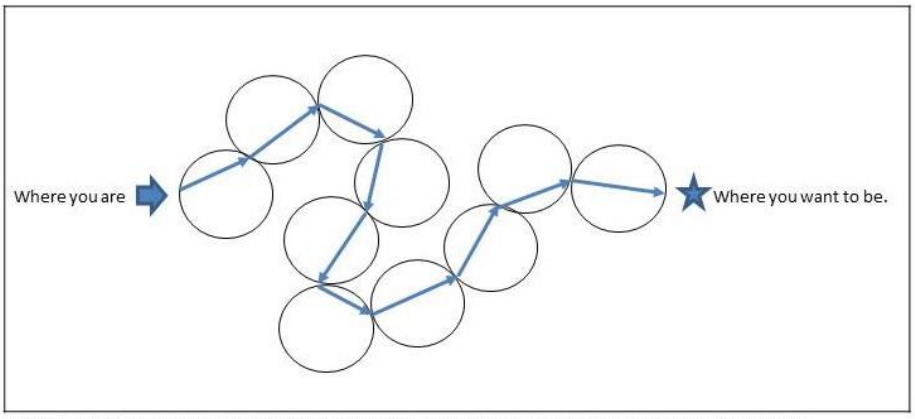
involved in, and have visibility with, national health and social service programmes for all kinds of conditions is very useful.
The point was frequently made throughout the presentations that while a scientific view is valued in the political sphere, it is only one of many viewpoints to be considered, and is not in and of itself uniquely compelling. Two statements made reflecting this were: *democracy is not a truth machine* and *politics is not the implementation of science*. A model for thinking about drivers of the political process was shown as:

$$\text{political action} = \text{substance of the issue} + \frac{(\text{upside of doing something} \times \text{downside of not doing something}^2)}{\text{amount of decision-making latitude the politician has}}$$

Messages, therefore, should include the NEED for a change and the CONSEQUENCES for not making the change (particularly financial consequences). An example of this is that some countries have found that determining and publicising the actual cost of mental illness was important for creating action towards better service delivery. This is related to the "downside of not doing something" in the equation above. This information encouraged politicians to be much more interested in psychological approaches that can help to bring the costs down.

Several presenters discussed how bringing about change often relies on use of opportunities that arise. This often involves connecting with what officials want to do, rather than telling them what we want them to do/have done. Change is often most effectively achieved by using windows of opportunity when they arise, because change is most likely to occur when it fits with some existing agenda. This may appear less deliberate and planful than what we might like, but actually requires a clear strategic direction to recognise and take opportunities that support (even tangentially) your ultimate objectives and are consistent with your professional values.

The point was also made that working to bring about change with government and civil society is not a linear process. Windows of opportunity open and close and need to be engaged with, even if they do not appear to lead directly to where you are aiming for. Sometimes they will seem to lead you backwards or round in circles. When you engage with one window, it may not take you where you want or expect, but it may move things forward to where the next window of opportunity emerges. This was shown as:



Note: The circles are the windows of opportunity, the arrows are the actions we take within them.

It was also frequently stated that you need to keep the focus on the problem for longer than you think. This is because it is important to get officials' clear understanding and acceptance of the problem you are trying to fix before proposing the solution. If you rush too quickly to proposing the solution, then the problem you are trying to solve may not be fully appreciated as a problem,

and may lead to the solution you are proposing being seen as the problem and therefore discounted. This needs to be balanced against another important principle: it is often important to bring solutions, not just problems, to officials because they are frequently already overwhelmed by problems that are difficult to deal with, and will switch off from being presented or reminded with one more. Offers of evidence-informed ideas about potential solutions are likely to be more influential, as long as the problem is well understood and "owned" by the official.

Some speakers reported they had been successful at getting the term psychology/psychologist into many different laws and government directives, and had found it useful for embedding both the psychological perspective and psychologist involvement in policy and activity.

Communication for Influence

There was discussion of the mismatch between the psychological/scientific way of addressing issues and the political way. The political way is also generally more persuasive with the general public, and is therefore important for communicating with the public. The differences are summarised in the following table.

	Psychological messaging	**Political messaging**
Content	Scientific, data based "cognitively driven"	Populist, story driven "emotion-driven"
Time scale	As long as it takes	High urgency Quick turn-around
Communication	Careful, guarded Many qualifying statements ("It depends…")	Clear concise messages Catchy phrases Sound bites

While it is important that we maintain our integrity through our messages, the usual psychological/scientific approach is not ideal for getting these messages heard in the political and public arena. A different approach, which involves accepting simpler messages that are consistent with the psychological perspective but often not completely comprehensive, is required for these messages to be influential. This will look more like the "Political" column above.

Several speakers described aspects of the languaging to use with officials and the public. They noted that it is often better if messaging about what you are trying to achieve focuses on the overall goal (e.g. improving primary mental health care) rather than focusing specifically on psychologists (e.g. psychologists in primary care). While this runs the risk of psychologists being side-lined in the process, it means the whole endeavour is more likely to move forward. If we can stay part of the conversation, there is scope for continuing influence that is not there if it is just seen as "one profession pushing its own self-interest." Similarly, speakers regarded it as better to talk about "psychology" rather than "psychologists" in influencing officials, as it reduces the risk of the messages being discounted because they are seen as simply self-serving.

In addition, to reduce the suspicion of being primarily self-serving, the speakers described it as very helpful to have people other than psychologists to convey the messages to government; for example, client groups, other professions, or other sympathetic champions. These people add a different type of credibility to the message and may also be seen as representing a bigger constituency. People such as clients may also tell their story in a way that may have a more lasting impact in this arena than "the evidence" or "second-hand stories." Tor Leven Hofgaard talked about how after some time, the key role of the psychologist was to get the advocate and

the official together, and support the advocate in conveying messages that were consistent with psychological thinking.
An overarching principle related to the approach described above that is well-supported by psychological research is that communications that evoke emotions are more memorable than those that relate primarily to cognition. Therefore, to have influence, it is important to think about what you want people to feel at the end of your message, not just what you want them to know. In other words, talk "to the heart" just as much as to the head.

Similarly, and also supported by a growing body of psychological research, the use of stories is important. Stories are remembered in more detail and link into the emotional response more than non-story communications, so are retained for longer and in more detail. One speaker said, "If you tell a politician the science—they are just normal people—they will forget it. If you tell them a story (or even better, if the person concerned tells them the story) they will remember it much longer." Tor recalled having politicians retelling stories carrying psychologically important messages when debating legislation in parliament years after he had presented them the stories, whereas any facts presented were long forgotten. As mentioned above, stories are even stronger if told by the person concerned, and are somewhat less strong if relayed second-hand. Authentic stories from "real" people are the strongest.

The importance of "single messaging" was also frequently stated. Keeping clear and consistent messages is very important. Over-complex messages will not be well understood. This includes the tendency of psychologists to be tentative in their messages and state all the qualifiers, which in the official/public context will lead to loss of message rather than strengthening. Similarly, if you change or broaden your message, politicians will often forget your previous message or think you no longer care about it, so will also lose any focus on it. Therefore, being straightforward, keeping the qualifiers for our own internal discussions, and sticking to consistent messages is very useful.

Amanda Clinton talked about another subtle way of influence in written communication: using the semicolon at the end of phrases. Her description of this was that the semicolon metaphorically conveys the message that "The story isn't over yet." This is signalling persistence in the advocacy process. The point was also made that, in most cases, our training does not prepare us well for communicating effectively with officials (or even the public). Training for psychologists at national conferences about how to influence politicians, and perhaps also some input into training programmes about this, could be valuable.

What to Communicate About

Officials benefit from psychological knowledge, but often do not know if/how we can be of use. They are often eager to have assistance that will support them to achieve their goals. This requires a willingness to engage if their goals are consistent with psychology's goals and we can assist them with achieving the goals. Psychologists can help to translate the science into policy. Providing reports that give guidance on tricky issues that the government faces is one avenue. For example, when Portugal was considering legislation about adoption by same-sex couples, politicians said that a report from the psychological organisations that addressed the issues and related them to the psychological literature was very important in getting the law change through. It was suggested that such documents address the thorny issues directly with a heading for each, and provide reasoned thinking based on the psychological literature. Keep them short, clear, concise, and avoid any unnecessary equivocation. Provide a short executive summary.

Work with economists could also be very important to support messages, particularly about how psychology can help fiscally, given the extent to which saving money is (and justifiably so, given

the increasing demands on the health services into the future) a significant driver of the system. For psychology as a whole to have credibility in society, it needs to be shown to be useful. This is true with politicians and the public. If we are to have influence we need to show that we are useful in general, and in relation to the particular interests of groups we want to influence. Just telling them how useful we are will not get us very far.

Main Messages

Following are some of the key messages that presenters emphasised.

- Be patient and tenacious.
- Politicians (and others) can have a high investment and interest in using our skills for mutual benefit if we make ourselves visible and available.
- Officials have their own agendas, and often we can be most effective by helping to advance those agendas in ways that are consistent with our/our clients' agendas.
- A longer term view is important because the pathway to change is often circuitous, slow, and multi-staged.
- Keep your messages straightforward and consistent.
- Be creative and thoughtful about the intersection between science and policy.
- Advocacy, advocacy, advocacy.

Being able to influence and change society and systems well beyond the walls of therapy rooms is obviously an important part of clinical psychology and other psychology sub-disciplines being able to contribute as much as possible to improving society and the lives of the people within it. This article aimed to convey learnings about how we can achieve this from the reflections of people who have been involved internationally over many years.

What is it Going to Take for Women to Start Leading in our High Density-Female Profession, When the Past Continues to Shape the Present?

Helen Buckland-Wright, Kirsty Agar-Jacomb, Megan Anderson

Psychology is a profession that is 80% female. However, females are paid less and do not reach the same level of seniority and influence as their male counterparts. This is a common finding across many professions. We argue that while there may no longer be a patriarchy in the traditional sense, gender discrimination has been a bedrock of social interaction between men and women for the past 3000 years; it continues to govern our interactions with one another, and consequently maintains the status quo. We present a brief overview of a pathway towards recognising these interactional styles, and suggest alternative behaviours for men and women based on the pursuit of gender equality.

The Gender Gap in Psychology

Over the past few years there has been a growing conversation among female psychologists that in a profession that is almost 80% female, women are less visible at the top echelons of the profession than men. Having recently attended the 2017 NZCCP conference, it was notable that the majority of keynote speakers and presenters were male. In addition, a quick review of the past presidents of both the NZCCP and NZPsS revealed that men predominantly held this position. Further, women are less likely to apply for merit step on the APEX MECA contract than their male counterparts. This is not a finding unique to New Zealand. A recent report by the American Psychological Association identified that as women have moved into the

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profession, the pay and prestige has decreased. In addition, female psychologists are less likely to achieve the same level of seniority and influence as their male counterparts (American Psychological Association, 2017). This phenomenon is not unique to psychology. The New Zealand Ministry for Women (2017) identified that across the board, women continue to be paid less than men, and although women are better educated and more qualified, they will not reach the same heights in their careers as their male counterparts. Research by Motu Economic and Public Policy Research New Zealand reported that there was a 16% pay gap for women aged 25–39 years, a 21% gap for those aged 40–54 years, and a 49% gap for older women (Sin, Stillman, & Fabling, 2017). This gap is due to the unconscious bias against women and ongoing sexism in the workplace (Ministry for Women, 2017), and not because we work in different professions or have different educations. It seems that as women gain seniority in their career, they face an exponential increase in gender-based barriers, which significantly impact their financial prosperity. This echoes research carried out by Williams and Dempsey (2014) that showed gender begins to significantly impact a woman's career only when they reach mid-career.

Why are Women Still Experiencing a Gender Gap

These findings are timely as we ask ourselves why are female psychologists, who are among some of the most highly educated women in New Zealand, not visibly leading and occupying air time in a profession that is considered female friendly, and in which we are the majority? The narrative that there is an active patriarchy hell bent on oppressing women in the traditional sense does not hold as much weight as it used to. Second-wave feminism in the 1970s did a great deal to deconstruct that, giving women a stronger voice, establishing a legal framework prohibiting discrimination, and getting women into the work place. In addition, we are conscious of the increasing number of men who believe they are in just as much of a crisis as women with regard to gender roles (Webb, 2017; Perry, 2017; Hemmings, 2017). Many men, including male psychologists, are aware of the level of toxicity associated with traditional models of masculinity, how utterly damaging it has been for themselves and their loved ones, and how it has made them just as miserable as women they live alongside (Perry, 2017). We also believe many men are feminists in that they believe in gender equality, but do not identify themselves as such because of the negative historical narrative associated with that word. However, despite this, when we go to work each day, men and women find themselves in situations in which discriminating on the basis of gender has been bedrock of our social interaction with one another for the last 3000 years. We now have a 40-year-old legal framework that attempts to tackle this, but it is not fit for purpose, as women continue to be paid less and are not achieving as well as men. Changes in the law may deal to some of the gross abuses of the power to discriminate against and harm women, but the law does not deal with the more subtle ways in which the status quo is maintained.

The status quo is largely maintained by the way we interact with one another. When one group has power and privilege over another, there are a set of thoughts, schemas, and behaviours that accompany being in power; just as are there for the people who do not have the power. Each and every person born into a society with a power imbalance will be socialised to behave and think in a way that maintains the status quo. Further, their day-to-day interactions will continually reinstate the status quo. This occurs to some level unconsciously as we repeat what has always been, as there has been a historical mandating of such behaviour. The socialisation of males and females into their relative positions of power starts early. For example, male children are chosen to speak in class more frequently than female children. Subsequently a male child's voice, thoughts, concerns, and ideas are heard more frequently than a female child's (Kleinfeld, 2017). In most cases this is done in an unconscious way by the teacher, as it is merely a reflection of what has always been. However, this establishes and reinforces the parameters whereby a female's voice is of less importance than a male's. This early socialisation means that as adults, we find women are less likely to speak up in meetings than men, and when they do, are more

likely to be interrupted or talked over by men. In addition, women will frequently monitor and modulate how much they have spoken to ensure they do not "speak too much" or "take-over the conversation" (Tannen, 1994). This not only robs them of the opportunity to be heard in the moment, but also reduces their chances of being heard in the long term. Thus, the interactional styles that hold women in a less powerful position are subtlety reinstated again and again and again by both men and women.

We are not assigning blame to men or women in highlighting the disempowering nature of our social interactions with one another. However, we are now in a situation in which what has been is no longer acceptable, and the responsibility to change lies with all of us. We have made the obvious changes at a legal level, but have yet to reformulate, or even properly acknowledge the complex web of social interactions that maintains the status quo and keeps women in their place. To achieve gender equality in the work place, unpicking this must be our next goal. We need to closely observe our assumptions, values, behaviour, and thoughts in real time and catch the moments when we engage in behaviours by which we reinforce gender inequity. Both men and women have a role to play in this. Simon MacKenzie, CEO of energy-based company Vector, stated that unconscious bias is the biggest challenge for their company, and it is mandatory for all managers to undertake training so they are aware of their own unconscious bias. Similar trends are seen in other companies internationally across the corporate sector. Psychology must keep up.

How do we Start to Challenge the Gender Gap?

So, how do women start to challenge the subtle ways in which status quo is maintained? The place to start is to begin to notice what is happening around you. The next time you go to a meeting, who talks the most? What roles do men and women play within the teams in which you work? Who holds the power? Not just the power bestowed by a particular job title, but who has the social power? How often do you see men talking, and women recording the minutes? Do you ever see a man volunteering to write the minutes? Growing up, what did you see at home in terms of gender roles, and how is this playing out for you in your own life? The point of this is to raise your awareness, and take stock of how gender roles are influencing behaviour. We also recommend that you find a couple of like-minded female friends with whom you can talk, deconstruct, examine, and question your day-to-day social experience and reality with regard to gender. You may find that the pressure to behave in certain ways associated with your gender is just as strong within your own mind as it is within the social forces around you. It is important to unpick the reality that has been created for you through the process of your own socialisation. You may find you are shocked by the number of double binds that continue to affect women's working lives. For example, working outside the home in paid work has higher social value than working within the home in unpaid caring work (e.g. for children or elderly relatives). However, if a woman works outside the home and gains social value, she can only work a certain amount of time outside the home before she is perceived as being neglectful of someone at home. Women working fulltime outside the home often have to deal with the perception that they cannot love their children as much as a stay-at-home mothers, and are seen as having less moral value. However, work carried out by the stay-at-home mother is not valued and does not have the social status of working outside the home (Williams & Dempsey 2014).

Another example of a double bind is that for women to succeed professionally they must engage in behaviours that are stereotypically masculine, such as being visible, assertive, highlighting their competence and intelligence, and actively pursuing career goals associated with seniority and authority. However, women who engage in these behaviours are perceived as less warm and feminine, and consequently as less likeable. This is sometimes called the "bitch-bimbo" double bind (Williams & Dempsey, 2014). If a woman gains a position of leadership or authority, she

will often find it necessary to be especially nice, assuring others that she is not cold and will not throw her weight around. She will also be more likely to use indirect communication styles (e.g. "how about we," or "do you think you could") as if having to pre-emptively manage others perceptions of her and mitigate the risk of conflict. If she does not use this communication style, she will often be called (or at least thought of as) a "bitch." The double binds created by narratives about what it is to be female can often be paralysing for women, and challenging them can cause anxiety. These double binds can be especially shocking if you were born after the 1970s, brought up on the mantra that "girls can do anything," and fully expected the work place to be sexism free.

In our recent workshops at the NZCCP and NZPsS 2017 conferences, it emerged from the women who attended that they often felt uncomfortable with being in a position of power, or the idea of being powerful. Not only was it not quite acceptable for a women to be powerful, but given the kinds of personal stories we hear all day, power has, in the minds of some female psychologists, become synonymous with abuse. Let us be clear: power associated with leadership or dominion is different from the power of domination or abuse. If as female psychologists we do not get comfortable with power, how can we possibly stand within the authority and expertise associated with our advanced education and profession? Take care to look beyond Karpmans's triangle of abuser, victim, or rescuer. Consider how you are powerful, whether being powerful makes you feel anxious, and how you may relinquish components of your own power to others because you fear your own power, or the backlash of exercising it.

Once you have developed a good understanding of how social forces around your gender are shaping the way in which you function, we encourage you to begin behaving in different ways. This is likely to require a period of learning what to do, upskilling, and behavioural experiments as you begin to take advantage of the opportunities now available. There is also a significant body of literature with which to familiarise yourself, starting with the corporate world, that identifies the ways in which you can alter your behaviour (*Lean in* by Sheryl Sandberg [2013] is a good place to start). In preparing for our recent workshops, we identified over 400 action points for women in how they could alter their behaviour to manage and mitigate the impact of gender discrimination. Only a few are presented below. In addition, it will be especially important to learn how to manage the anxiety associated with behaving in ways that challenge the status quo. This can feel lonely, and your female colleagues and friends will be essential in helping you manage this.

One of the first changes many women can make is to change where and how they sit in meetings. Sandberg (2013) encourages women to sit at the table or in a central position, and to physically take up more space, essentially claiming part of the table or more powerful central space. This raises your presence in the room and you are more visible so it will be harder to ignore you when you speak.

Consider the processes around speaking in a meeting. If you are interrupted, instead of stopping, you can say "I haven't finished talking," or carry on talking until the other person stops, or when they have stopped, say loudly "As I was saying" and continue speaking. A behaviour to try to refrain from is modulating or reducing how much you speak in public settings like meetings. Frequently, women chastise themselves if they feel they have "spoken too much," and will then down-regulate how much they speak at a later time to compensate. This is driven by a fear of being seen as "domineering." While no one likes a bore, we think there is little danger at this point in time that women are going to have spoken "too much." Take a risk, ignore the anxiety, and speak up as often as you have a thought. Just see what happens when you do this. In addition to watching what you say, watch how you say it. Women tend to use quite non-

threatening preambles before expressing an opinion. This is further reinforced by our training as psychologists, and we become very apt at using preambles such as "I am curious as to why," "I wonder," "Is it possible," "I have just had a thought," and "I'm not sure, but." This is great, for the therapy room. Preambles like this significantly soften the message being delivered, which is why it works in therapy. Women frequently use this strategy in the workplace because they risk being disliked if they do not. However, it can be problematic as it serves to undermine their message and appearance of competence. Competence is judged in part through perceived confidence (Tannen, 1994). If the message is not delivered clearly with authority, the credibility of the message is reduced. The next time you speak to another professional consider your communication style. Are you using preambles? How is this impacting your message? How do medical doctors speak? Do they use preambles? Consider saying "I think" or framing your message as though it were a simple fact.

Tannen (1994) discovered that in Western styles of communication, men tend to be competitive and avoid putting themselves in a one-down position. Women's communication style differs. They are trained to stand back, be humble, and not look too sure of themselves lest they are called bossy. Women will put themselves down to make the other person comfortable. However, in return, and to equalise the relationship, women tend to expect the other person to say something nice to mitigate the put down, or for the other person to put themselves down as well. The ritual depends on mutuality. Neither style is problematic until you combine them between adult men and women in the workplace. In this situation, a woman will try hard to keep everyone equal, works hard to save face for the other person, and self-deprecate. However, a male who has been trained from an early age to take advantage of the one-up position that has conveniently presented itself, will be extremely unlikely to redress the balance. Therefore the male is likely to come off as more powerful and with an advantage. So pay attention to whether and when you self-deprecate in conversation and whether this inadvertently undermines your power.

Suggestions for Our Male Colleagues

For our male colleagues, please, consider whether you are doing all you can to engage in gender equality, it is not just women who are negatively affected by the patriarchy; you are too. Are traditional models of masculinity working for you? The biggest killer of our young men is sadness; you are dying by your own hand, in greater numbers than women. Your emotional needs frequently go unmet, and perhaps the burden of having to provide for your family could be shared. If men do decide to engage, we know that with each step they take, their own lives, and the lives of their partners, sisters, brothers, mothers, fathers, friends, and daughters and sons will be infinitely better. We cannot speak for men as to how to manage deconstructing their own gender roles, but we do have some suggestions as to how you could help the women around you. It will not take much to make a difference; just make space for your female colleges physically. Give women space to speak in meetings, and if they are not talking, then ask for their opinion. If you see a woman being interrupted, make sure she gets the opportunity to make her point. Consider whether you are giving women overly long explanations of things they already know about. If you see a woman doing well, encourage and support her. Please consider checking the behaviour of your male colleagues if you hear them make gender-based comments that objectify women or put them down. Finally, and probably most importantly, if a woman you work with, like, or love cares about gender equality, then please try to make sure your eyes do not glaze over, or that you get too defensive, or take the piss. It has been a tough 3000 years, we would just like to experience the same level of respect and pay you enjoy, and contrary to popular opinion, the job is not yet done.

Conclusions

While these shifts in behaviour seem small, they are actually radical. As psychologists, we know how difficult it is to change behaviour, but when change occurs it has a profound effect on a person and the system in which they live. These small shifts are manageable and build up over time to create a different social reality for both men and women. If the 80% of female psychologists challenge the gender roles that continue to define them, what would be the impact on the wider system? Would we be in a situation where we are having a crisis as to our ongoing role in healthcare? Would the skills and techniques of our profession be so misunderstood, undervalued, and misappropriated by other professionals? Would our discipline be so invisible in the wider sphere? And, what would be the impact on our clients? Would we be better able to define and speak to the distress of women and identify the roles of grinding poverty, lack of adequate and affordable child care, and the ongoing physical and sexual violence embedded in our culture? Would we be able to offer our young men an alternative model of masculinity where their emotional needs would be honoured and nurtured? What would happen if psychologists, having mastered the impact of gender in their own lives, began to acknowledge their role in treating a distressed society? Great things, we think.

Conflicts of Interest

There authors have no conflicts of interest to declare.

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Leadership Training for Clinical Psychologists in Aotearoa New Zealand

Kris Garstang

This article is a modified extract of a report written for the National Executive Committee of the NZCCP. The report aimed to inform and guide future leadership training undertaken by the College.

What is Leadership?

The term leadership has as many definitions as there have been people trying to define it (Bass, 1990). A simple definition is that "leadership is a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2007, p. 3). Complicating the act of definition is the changing notion of leadership over time. Although leadership has traditionally been thought of in terms of individual power exercised through hierarchical positions of authority (preferably by a charismatic or "heroic" leader) new definitions tend to emphasise the relationship between leaders and followers. This new relational concept of leadership suggests a different skill set for leaders that includes the ability to influence others, build strong relationships, and share power with others (Piggot-Irvine, Henwood, & Tosey, 2014). This relates to the strong emphasis in current health literature on the shared nature of leadership, where each member in a group is responsible for sharing leadership (MacPhee, Chang, Lee, & Spiri, 2013; Piggot-Irvine et al., 2014). Informal models of leadership support this view of leadership existing outside organisational hierarchies, and have been embedded in current clinical leadership frameworks that emphasise the degree to which all clinicians need to be willing to shoulder responsibility and show leadership to best meet patient needs (Swanwick & McKimm, 2011).

Leadership and Management

It is often remarked that leadership differs from management, with the implication that it is the former in which clinical psychologists are most interested. But, what are the differences? One view is that managing involves "organising, controlling, and planning," whereas leaders take on the "long-term, big-picture, and strategic work" of an organisation (Piggot-Irvine et al., 2014, p. 3). Others contrast the two roles more starkly, suggesting that management "strives for control and predictability," whereas leaders use influence to ensure their organisation thrives in a changing, dynamic environment (Belasen, Eisenberg, & Huppertz, 2015, p. 2). Despite this contrast, many authors have commented that the two roles are linked. Managers are expected to provide leadership as well as maintain day to day control of organisations (Piggot-Irvine et al., 2014), with constructs such as the "master leader" suggesting that a balance between the two roles is possible (Belasen et al., 2015). Swanwick and McKimm (2011) go so far as to say that, in health at least, leadership and management should not be separated as both are needed for organisations to be effective. They also note that "most clinical leaders are appointed to management positions from which they are expected to lead" (p. 23).

Opportunities and Obligations

Psychologists will need to obtain different skills depending on their leadership roles, with those in management roles needing skills to help with the "planning, organising, coordinating, commanding, and controlling" tasks of management (Legge, Stanton, & Smyth, 2006) as well as leadership skills that may include skills in influencing others, setting directions, and managing change (Swanwick & McKimm, 2011). Psychologists should not ignore management positions as opportunities for leadership, even if it means stepping out of their comfort zone. In a rousing

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article on clinical leadership, Swanwick and McKimm (2011) stated that taking on leadership and management roles is not just an option but an obligation for all clinicians today (p. 26). Ruling out management positions means that clinical psychologists must maintain informal leadership positions, or compete for the very limited number of formal leadership roles available to them in the public sector. Management roles also provide opportunity to exercise leadership, not just clinically but at a systems level, meaning effecting change for a greater number of clients. Engaging in a wider variety of leadership roles has also been suggested to be linked to greater degrees of job satisfaction (Holland, 2001).

Leadership Development

Deciding on a particular approach to take in leadership development will depend on an organisation's particular definition of leadership. Many organisations have developed their own frameworks (Goodall, Bastiampillai, Nance, Roeger, & Allison, 2015; NHS Leadership Academy, 2011; Swanwick & McKimm, 2011), which will be discussed later. Most authors are clear that leadership development is something that should occur across a clinician's career and beginning during university, although health professionals are generally not well prepared for leadership by their clinical training (McKimm & Swanwick, 2011; Stoller, 2014). In New Zealand at least, leadership is not generally taught as part of health professionals' training, and partnerships between clinical programmes and management schools at universities are not currently evident.

Leadership development may contain various initiatives, such as fellowships, development schemes, mentoring, coaching, membership of leadership organisations, and leadership training (the focus of this report) (McKimm & Swanwick, 2011). Leadership training should take into account the student's level of experience, with junior clinicians perhaps requiring skills such as "time management, achievement, and emotional self-control," while education on topics such as "negotiation, conflict resolution, change management, and teambuilding" are more suited to more experienced clinicians (Stoller, 2014, p. 236).

Clinical Leadership in Health Today

The focus on clinical leadership in health is growing internationally (McKimm & Swanwick, 2011). Locally, we have seen significant moves to support clinicians being involved in health leadership through a number of policies and government reports. The government has introduced a national governance policy that determines clinicians will be involved in governance across all areas and levels of healthcare (Gauld & Horsburgh, 2015). We see calls for a growing emphasis on leadership in other reports and documents, including those coming from the National Health Board (National Health Board, 2010), Ministry of Health (Ministry of Health, 2014) and Health Workforce New Zealand (Health Workforce New Zealand, 2011). In the mental health care field, significant changes are predicted. The Mental Health Workforce Service Review promotes a vision of a 250% increase in access to mental health services by 2020, with much of this increase for those with mild to moderate conditions being delivered in primary health settings (Health Workforce New Zealand, 2011). Treatment guidelines recommend a combination of both medical and psychological interventions (New Zealand Guidelines Group, 2008), but significant shortages in the mental health workforce (Health Workforce New Zealand, 2011) will make it difficult to deliver on the government's goals for mental health care. Clinical psychologists will need to step up into positions of leadership and management for their skills and knowledge to be used in the new mental health environment.

Barriers to Leadership

Despite a growing desire for clinical leadership in health, lack of training is considered a real barrier to clinicians successfully taking on leadership roles (Thorn, Mosher, Ponton, & Ramsel, 2015) Clinicians may be unwilling to step into leadership roles (Ratcliffe, 2010), and allied health

professionals find it particularly difficult to be recognised as leaders in health because of existing traditional professional hierarchies (Gauld & Horsburgh, 2015). Anecdotally, clinical psychologists say that lack of leadership roles, poor pay, and problems with not considering themselves leaders exist as barriers to leadership. Kelly and Finkleman (2011) noted that psychologists' training, designed to produce "scientists and individual practitioners" (p. 198), does not prepare us well for management positions, and the emphasis of our training on thorough analysis, written reports, and complete information fit poorly with the quick pace of work required in management. Stoller (2014) echoed these sentiments, suggesting that health professionals' clinical training often encourages a deficit-based focus that is at odds with the need to consider wide ranging opportunities as leaders. He adds that scientifically-based training can emphasise individual achievement rather than focus on organisational goals. Thorn, Mosher, Ponton, and Ramsel (2015) suggested that part of the problem is that few psychologists expect to become leaders in their careers, and are therefore ill prepared if the opportunity does arise. Leadership training, which has the potential benefit of seeing oneself as a potential leader, may help in this case.

Psychologists as Leaders

There is a significant body of literature that emphasises the benefits of what is called "the psychologist manager" (Kelly & Finkleman, 2013; Thorn et al., 2015). In particular, Kelly and Finkleman (2011, 2013) highlight psychologists' "humanistic training, high ethical standards, and networked leadership style" (p. 196); but warn that, although psychologist managers draw on many skills from their psychological training, it can take time to learn to apply these skills in their new leadership roles and that good training can ease this transition (Thorn et al., 2015). Daiches, Verduyn, and Mercer (2006) also warn that clinical psychologists "cannot expect to learn management skills by osmosis" (p. 110). Leadership and management roles are challenging enough positions, even for those with MBA-level training (Hay, 2014).

Clinical Leadership Frameworks

We turn now to look at the way in which different health professionals have chosen to define leadership. Leadership frameworks provide organisations with a basis from which to determine the leadership skills and competencies their members can benefit from obtaining. One example that may be useful for the NZCCP to consider is the British Psychological Society's Clinical Psychology Leadership Development Framework (Skinner & Toogood, 2010). This document details specific steps that clinical psychologists at all levels can take to develop leadership skills. The framework aligns to the UK's National Health Service (NHS) Clinical Leadership Competency Framework (NHS Leadership Academy, 2011).

The NHS Clinical Leadership Competency Framework comprises five competency headings: demonstrating personal qualities, setting direction, improving services, working with others, and managing services. Each heading contains four specific competencies. For example, the managing services heading contains competencies such as planning, managing resources, managing people, and managing performance. Other professions use different frameworks and models. For example, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) bases their training on a model produced by the Royal College of Physicians and Surgeons of Canada (CanMeds model) (Goodall et al., 2015). This Model defines the six roles of the medical expert that include professional, communicator, collaborator, health advocate, scholar, and manager.

Similar to the CanMeds model, New Zealand and Australian nurse practitioners have developed a competency framework that embraces the scope of their practice and includes clinical leadership as one of three key roles for their profession (Gardner, Carryer, Gardner, & Dunn,

2006). They define clinical leadership in their role as that which "influences and progresses clinical care, policy, and collaboration through all levels of health service" (p. 608). Canadian nurses' leadership training is based on a relational model of leadership (MacPhee et al., 2013). Day and Harrison's (2007) multilevel leadership identity model includes three levels of leadership development. These levels include self-leadership development (including critical reflection skills), relational leader identity development (including the ability to foster positive work relationships), and collective leadership, which focuses on team development and fostering the collective power of the team.

For any organisation, a leadership framework brings clarity to the otherwise broadly defined concept of leadership. Such frameworks also describe specific competencies that can be used to structure leadership training and help choose from the wide variety of topics commonly taught.

Provision of Health Leadership Training

After considering some of the frameworks that various organisations use to structure leadership training, we now turn to learning more about the provision of leadership training. Because leadership training is such a vast area, we narrow our focus to leadership training in the health sector. We begin by considering training offered to multidisciplinary groups and later look at training for specific professional groups.

Multidisciplinary leadership training. In healthcare settings, leadership training ranges from 1 day workshops to master's or doctoral programmes, and tends to incorporate competencies associated with management, including financial competencies, clinical governance, and human resource management (McKimm & Swanwick, 2011). As mentioned, the UK NHS has invested heavily in leadership training. It offers training for those in leadership roles at different levels through its leadership academy (NHS Leadership Academy, 2015). Mirroring the stepped care approach taken for mental health care, online leadership training is provided at the entry level, with longer term face-to-face training available at five other levels of leadership.

In a critique of the programmes, McKimm and Swanwick (2011) suggest that for leadership training to be effective, participants need to be supported by the organisation and system they work within. Training needs to be supplemented with longer term opportunities for growth, including mentoring, networking, and experiential learning. Edmonstone (2013) criticised the NHS approach by suggesting that it is too heavily reliant on the notion of the leader as an individual in a formal role, ignoring more contemporary relational models of leadership and the influence of informal group leaders. His criticisms are useful warnings for those wishing to deliver leadership training. It is important not to overlook these key aspects of leadership in today's clinical settings.

Another example of leadership training for health professionals comes from the US Cleveland Clinic Leadership Academy. This academy takes a multidisciplinary approach to leadership training that acknowledges the gap in leadership training for most health professionals (Stoller, 2014). The Academy recommends starting early in an individual's career and uses a spiral curriculum whereby students come across similar topics in greater depth at different points in time. Competencies taught include emotional intelligence, communication, teamwork, and change management. Topics are covered at times relevant to the learner's career stage.

In New Zealand, Te Pou funded multidisciplinary leadership training programmes for mental health professionals until recently, but currently only fund leadership training for mental health nurses. Courses in health services management are available through several universities at either diploma or master's levels (e.g., Massey University, 2015). Te Pou also supports membership in

the International Initiative for Mental Health Leadership, which holds conferences every 18 months and provides networks and support for leaders in the area (Te Pou o Te Whakaaro Nui, 2015). A brief online search also showed that various private providers of leadership training also exist, although these are not specifically targeted to health sector employees.

Leadership training in psychiatry. It is worth looking at how other professional groups have provided leadership training, especially those practicing in similar areas to clinical psychologists. For example, the RANZCP have a continued emphasis on leadership development and offer training to members using the CanMeds model (Goodall et al., 2015). An easy way that members and other healthcare professionals can access free leadership and management training is via e-learning modules on subjects including management, leadership, communication, and conflict management. These are freely available on the RANZCP website (The Royal Australian and New Zealand College of Psychiatrists, n.d.).

Leadership training in nursing. Nurses have successfully made the transition into management despite numerous barriers (Gage & Hornblow, 2007; Lewenson, 2015). Recently, four 1-day workshops on leadership and management for nurses were held around New Zealand, and included the application of key characteristics of effective leadership to clinical practice and work setting roles (Massey University, 2015). Postgraduate leadership courses for nurses are also run by several universities, with funding available for mental health nurses from Te Pou (Te Pou o Te Whakaaro Nui, 2017).

Leadership training for psychologists. Literature specific to leadership training programmes for psychologists can be difficult to find. However, Thorn et al. (2015) detail the Transition Institute's programme, which supports psychologists in the US transitioning to leadership or management roles. The Institute has a 1.5-day programme, held as a precursor to the Society of Psychologists in Management's annual conference. Participants receive three follow-up coaching sessions after attendance. The programme covers four modules, including leading self, leading and managing others, managing resources, and strategic management. Content is evidence-based and uses the worthy leadership model (Thompson, Grahek, Phillips, & Fay, 2008). This model of training may suit New Zealand-based psychologists. From a practical perspective, a pre- or post-conference workshop would be more accessible than ongoing postgraduate study, and training tailored to psychologists avoids the teaching of leadership competencies already attained through clinical practice.

Other literature on training clinical psychologists to become leaders is focused on cross disciplinary training. For example, Holland (2001) suggests that greater capacity for leadership can be acquired by training in a second discipline such as management, public health, or public policy. He suggests that broadening one's range of skill and knowledge, rather than taking a path of increasing specialisation in one's career, can enhance job satisfaction. Secondary disciplines may also guide psychologists towards leadership roles where they could effectively work on macro-level public health issues or contribute to public policy formation. Chu et al. (2012) present a good example of a specific cross training model, the public psychology doctoral training model, which combines clinical psychology and public policy skills for graduates wanting to focus on work in the public sector in the US. In New Zealand, good opportunities for cross training in management, public policy, and public health exist for psychologists wishing to take leadership in these specific areas.

In the UK, currently dominated by the teachings of the NHS leadership academy, The White Hart Course provided leadership training for clinical psychologists from the 1980s until recently (Daiches et al., 2006). Problems getting funding for attendance mean their programmes were

recently suspended, and little information about the specific content of the programme is available (C. Northey, personal communication, October 6, 2015). However, given the previous successes of this model and the similarities between the UK and New Zealand practice of clinical psychology, this programme may be worth further exploration for psychologists' leadership training locally.

Conclusion

Through its strategic planning process, the NZCCP has made the decision to address the leadership capacity of members and the profession. Underlying this decision is the limits on leadership currently faced by members of the profession, both in terms of the limited number of formal leadership roles available and a desire to have a greater voice at a national policy level. The government has called for major changes in mental health service delivery, but despite a concerted effort by the College, clinical psychologists often lack the mechanisms for involvement in decision making at both local and national levels.

The government has expressed a desire to involve clinicians in leadership, and has channelled funding into mental health leadership through Te Pou. However, allied health professionals have typically struggled to be recognised as leaders (Gauld & Horsburgh, 2015). Clinical psychologists have also been conservative in their approach to leadership roles, opting to stick with traditional roles rather than stepping into roles not reserved especially for members of their profession.

This report challenges clinical psychologists to consider leadership opportunities more broadly. Swanwick and McKimm's (2011) notion of the obligation of all clinicians to involve themselves in leadership at all levels, including management, is considered a useful point of view for the future of leadership in the profession. Psychologists possess many leadership skills already, but will need to gain further skills to feel comfortable in a more diverse range of leadership roles. Because leadership training can incorporate such a broad array of skills, it may be useful to develop a leadership competency framework, or include leadership within a broader competency framework as the RANZCP and practice nurses have done.

Many training options for the College exist and future research into local and overseas options will be necessary. Although leadership training will help members develop skills and foster leadership identities, it cannot be an isolated event and must be part of an ongoing commitment to leadership by the College. Training options should therefore be ongoing and supported by the other leadership initiatives considered in the strategic plan, including mentoring and career reviews, profiles and role modelling, and financial backing for members to attend leadership training.

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A Psychologist's Journey in Leadership

Lukas Swart

There is a general assumption among members of the public that a psychologist entering the workforce will eventually end up being a leader. This assumption is based on the perception that psychologists possess the attributes, disposition, knowledge, and skills to be leaders because of their training. In my experience as a senior manager in a government department, managers or team leaders are more often than not on the lookout for potential leaders who fit into the culture of the workplace, and who have shown they agree with the values and general direction of the organisation. Or perhaps they realise that psychologists possess learned skills that are transferable to management or supervisory activities with a little bit of thought and additional training. Another potential reason is that these managers or team leaders believe that the psychologist will contribute to the creation of a positive, healthy, and productive workplace. My experience is that psychologists may not intentionally seek to get involved in leadership as a career path, but rather get involved in leading activities they feel competent and confident in, or where they feel that they can contribute to the benefit of the organisation that they work for or their colleagues.

In this article, I discuss my own journey towards becoming a leader, and introduce influential leadership models and concepts. It is hoped that this will provide insight for aspiring leaders, but also assist psychologists to inspire our health professional colleagues for the greater benefit of our clients.

Dipping my Toes Into Management

In his book, *The 8th Habit: From Effectiveness to Greatness*, Stephen R. Covey (2005) wrote, "Leadership is communicating to people their worth and potential so clearly that they come to see it in themselves" (p. 98). This quote struck a chord with me when thinking about an influential past leader who showed confidence in me, way beyond expectation, and who was willing to offer opportunities afforded to few. He saw more in me than what I saw in myself. Those opportunities stretched me and unlocked something inside me that I did not know I possessed. I was led down a pathway to management and leadership, even though that was never my intention. I was happy being a psychologist, making a positive difference in the lives of those who struggled to cope with the challenges that life threw at them. However, requests came to me to fill in for a manager who could not attend a meeting, and then I was asked to lead specific pieces of work, which in turn led to bigger leadership assignments. I became enthusiastic and passionate about these opportunities and challenges, and put my best effort forward. These one-off events led to my first appointment as manager/leader. I then started to realise that I had the ability to manage and that I could get people to do things (e.g. work harder and smarter as the need for psychological service increases). Some may describe my style in those early years as very authoritative, commanding, and controlling. However, I was trying to do things right and I firmly believed that management was about coping with complexities. For example, managing staff performance and relationships with stakeholders, as well as getting things done. I soon realised that demanding that staff do tasks does not necessarily equate to productive and happy employees. That was when I started to read books, and attend leadership seminars on how to lead people rather than manage them. The following leadership models, frameworks, and ideas

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hugely impacted my abilities to lead.

Personal Foundations

The most influential book on leadership in shaping my career as a psychologist in a senior leadership position was *The Spirit of Leadership* by Peter Cammock (2009). In that book, he made a clear distinction between organisational leadership (based on rationality) and personal leadership (based on "soul"). The rational elements of organisational leadership include intellect (IQ, cognition), task knowledge (envisioning) and skill. Personal leadership, comprising emotion, spirituality, and character, provides the leadership foundation. The connection between the elements of leadership is best portrayed in the diagram below.

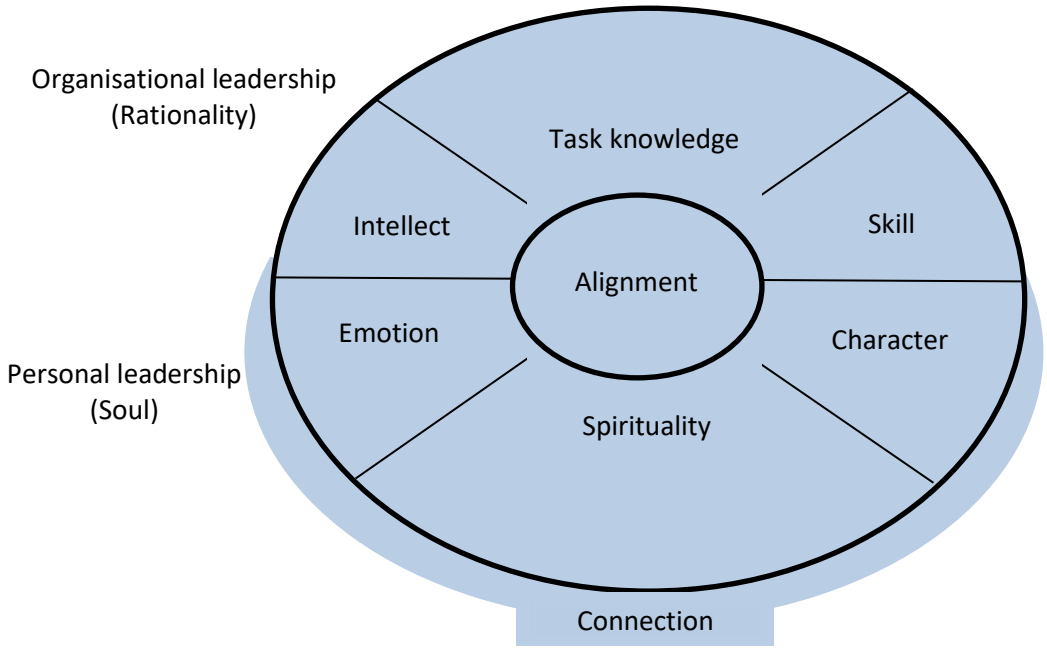

Figure 1. The soul and leadership. From *The Spirit of Leadership* (Cammock, 2009, p. 18).

Requirements to be successful as a leader are a sound mind and technical task competence driven by a clear vision. However, leadership requires a level of energy, passion, and commitment that goes well beyond technical capabilities. By incorporating the soul-based elements into our leadership approach, we become more authentic. This authenticity is based on our beliefs and values that give meaning to our existence, not only as a human, but also as a leader. In the workplace, the focus then changes from being output driven to a more complete focus on outcomes. This not only benefits our client group, but also the staff that we lead, and hence, the organisation at large. Cammock (2009) stated that the integration of the rational and the soul-based elements of leadership are ultimately required if we want to engage in leadership.

Emotional Intelligence

Leadership is also influenced by emotional intelligence. In their book, *The Emotionally Intelligent Manager*, David Caruso and Peter Salovey (2004) stated that emotions are important and are relevant in our everyday lives, whether at work or home. When we pay attention to what emotions are signalling, chances are that we may be able to get out of a tough situation, prevent something bad from happening, or help bring about positive changes.

The following diagram shows the function of an emotion.

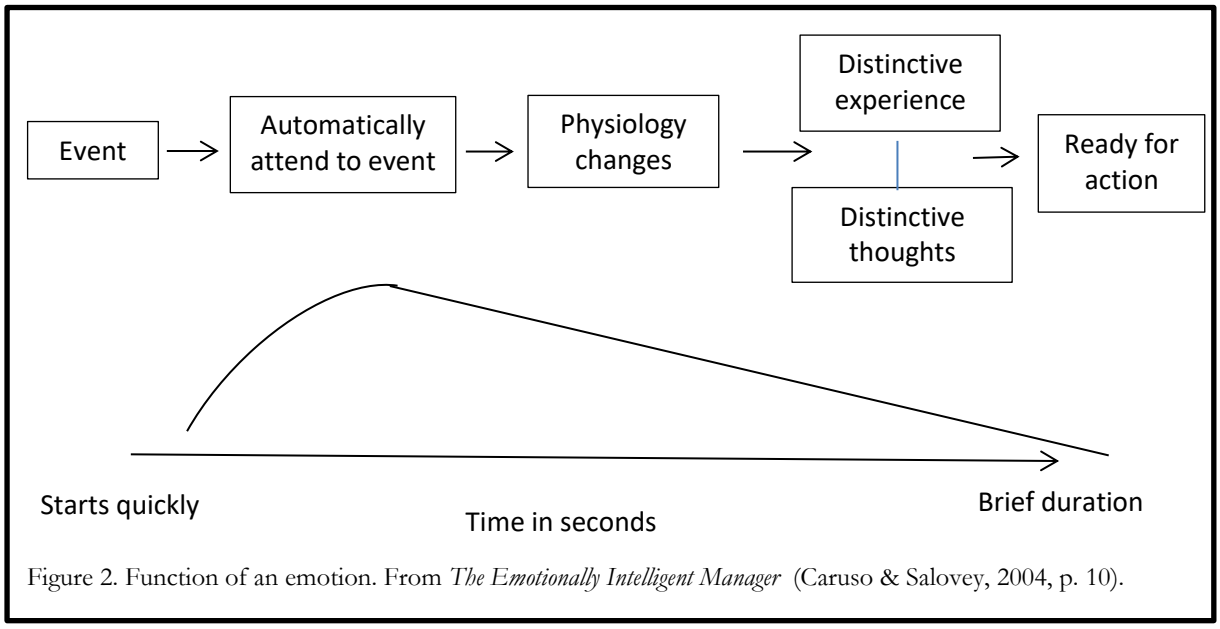

Figure 2. Function of an emotion. From *The Emotionally Intelligent Manager* (Caruso & Salovey, 2004, p. 10).

Caruso and Salovey (2004) developed the emotional blueprint model based on John D. Mayer and Peter Salovey's (1997) work, *Emotional Development and Emotional Intelligence.* The model, also referred to as the ability model of emotional intelligence, provides a framework to help us understand emotions and how to manage them effectively. They view emotional intelligence as "actual intelligence" consisting of four related abilities:

1. Read people—Identify emotions. This ability stresses the accuracy of awareness and helps us identify how people feel in a specific situation or setting.
2. Get in the mood—Use emotions. This ability assists you in realising how your emotions can help you and how emotions are congruent with your thinking. Therefore, it is important to understand how feelings influence thoughts.
3. Predict the emotional future—Understand emotions. This ability helps you to understand why you feel the way you feel and to predict how feelings will change as various events unfold.
4. Do it with feeling—Manage emotions. Since emotions convey important messages, it is in our best interests to be open to emotions as this informs the decisions making process. Leading others requires us to pay attention and to determine how we can include their emotions in our thinking and decisions. Leaders can then also help others in using their emotions as an invaluable guiding tool to direct their thinking and behaviour.

There is a strong, positive relationship between a leader's emotional intelligence and employee engagement. To be effective, leaders must have a solid understanding of how their emotions and actions affect the people around them. The better a leader relates to and works with others, the more successful he or she will be. Taking time to become more self-aware, self-regulated, and empathetic are important elements in motivating people and keeping them engaged.

Improving Thinking

The new generations coming into the workforce want to develop personally and enjoy diversity and change. Because they value freedom and independence, they require a different type of leader, a leader who helps them to fulfil their potential at work. In his book, *Quiet Leadership,* David Rock (2007) stated, "It is time leaders learn how to improve people's thinking. Many employees are highly capable individuals who will thrive on this approach. They want to work

smarter, they want to be smarter and they are crying out for help" (p. xxiii). He developed a model called six steps to transforming performance, which describes new ways for leaders to interact, give feedback, influence, stretch and grow, and bring out the best in others. The six steps are: 1) think about thinking; 2) listen for potential; 3) speak with intent; 4) dance toward insight; 5) CREATE (current reality, explore alternatives, and tap their energy); and 6) Follow-up.

These six steps provide signposts to follow whenever we enter a conversation with the intent of helping another person change, manage better, or to be more thorough, motivated, organised, focused, or self-aware. The six steps provide a pathway for leaders to follow when they want to improve performance without telling people what to do: "This new way—the way of the Quiet Leader—saves time, creates energy, and transforms performance" (Rock, 2007, p. 34).

Promises of Leadership

In their book, *Mastering Leadership*, Anderson and Adams (2016) talk about how leaders are not born, but cultivated over time to meet and exceed our high expectations of them. They identified four universal promises of leadership: 1) set the direction and create meaningful work; 2) engage all stakeholders and hold them accountable for performance; 3) ensure that processes and systems facilitate focus and execution; and 4) lead effectively—maintain relationships of trust to achieve and sustain desired results.

Keeping these promises is paramount, both on the transactional and transformational sides of leadership. Transactional leadership relates to setting strategic direction, keeping the organisation on track, and producing results, whereas transformational leadership relates to setting a vision, providing inspiration, and guiding people in meaningful work. To meet these transactional and transformational expectations, a leader is required to be committed to their own development, as well as to the development of the people they lead.

Let Your Light Shine

The purpose of this article has been to give you, the reader, insight into the theories and models of leadership that shaped my thinking and ultimately supported my transition from manager to leader. The literature abounds with theories and models on leadership, but assessing your strengths and development priorities relevant to the leadership role will help you find the theories and models that suit you best. I firmly believe that as psychologists, we have the attributes, disposition, knowledge, and skills to become leaders in the workplace, whether in large corporations, health sector, education sector, corrections, non-government organisations, or even private practice.

We have a contribution that can add to the quality of the workplace, whether informally through our work as psychologists, or through more formal leadership roles. The challenge is to have the courage to act on those leadership opportunities as they arise. My hope is that the information shared in this article will provide a starting point for those psychologists wishing to engage with leadership.

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On Being the Change we Want to Facilitate in Others

Averil Overton

Clinical psychology is based on the scientist practitioner model, and as such, is a relatively new and evolving discipline. A valuable aspect of the scientist practitioner model is that it makes room for a number of different therapeutic perspectives, the requirement being that it is evidenced-based; that is, derived from theory and research. In this reflection paper on the theme of *promoting change through leadership,* I am reflecting the views of psychodynamic clinicians in the field of clinical psychology. Although clinical psychology students have not generally been required (or maybe even particularly encouraged) to engage in their own psychological development or therapy in general training programmes, typically the personal development of trainees in psychodynamic training courses is an intrinsic aspect of the training.

A strong proponent of an ongoing emphasis on personal development of the therapist is Patricia Coughlin, a leading intensive short term dynamic psychotherapy (ISTDP) practitioner and trainer. In this paper, I have drawn heavily on her latest book *Maximizing Effectiveness in Dynamic Psychotherapy (2017).* Throughout this volume, Coughlin emphasises that it is both what the therapist does and who he/she is that matters. She argues that skill development alone, without attention to the person of the therapist, will not suffice for the development of clinical excellence. In her view, teachers and supervisors must include the personal development of therapists in training in addition to teaching theory and technique, if they wish to enhance the effectiveness of the training (Coughlin, 2017, pp. 147–149). She states that the personal development of the therapist is a key and yet increasingly neglected part of clinical skill acquisition. She suggests that therapists lead by example; that is, that they embody the changes that they wish to facilitate in their patients or clients.

This aligns with the work of Wampold and Imel (2015), who in their revised edition of *The Great Psychotherapy Debate, the Evidence for What Makes Psychotherapy Work,* devote an entire chapter on "therapist effects," which they call "an ignored but critical factor." Other chapters in the book look at therapist interventions (adherence to specific methods) and the therapeutic relationship. The emphasis on common factors supports a growing research body that suggests it is common factors across treatment modalities (not specific treatment methods) that account for most of the variance in treatment outcomes. Many of these are concerned with the characteristics and actions of therapists (Wampold & Imel, 2015, pp. 47 and 209).

Earlier work of Wampold's (2011) stated that therapists who are committed to their own personal development are authentic, emotionally available, and highly engaged in their work (cited in Coughlin, 2017). Coughlin cites numerous research papers that suggest the most effective therapists are confident but humble; lifelong learners with high levels of skill and expertise who are simultaneously open to feedback and flexible but systematic in their approach. She says that these therapists are masters at handling negative emotions, and are courageous in handling conflict directly and non-defensively. Finally, they are ambitious and push themselves and their clients to work hard, and endure discomfort in the pursuit of exceptional results. In other words, they are not content with mild or moderate improvement, but make an effort to obtain the best possible outcomes for clients (Coughlin, 2017, p. 149).

Averil Overton is a clinical Psychologist who has been working (mainly) in private practice in Christchurch for nearly two decades. Earlier this year she completed the three year core training course in ISTDP and this year she begins advanced level training in Melbourne.

Coughlin says that in our field, we talk about *what* we do (e.g. cognitive behavioural therapy [CBT], eye movement desensitisation and reprocessing, emotion-focused couples therapy) and *how* we do it (e.g. make interpretations, challenge pathological beliefs), but rarely articulate *why* we do it. Coughlan (2017, p. 7) states that questions such as "What do you stand for?" and "What are you committed to in your work with patients and why?" are essential questions for all therapists to answer. She cites work from Simon Sinek (2011), stating that in his work with truly outstanding individuals and companies, Sinek found that those who greatly outperform their competition do so not because their products are less expensive or even more effective, but because they are clear about *why* they do what they do. Coughlin says Sinek asserts that consumers do not buy what you do, they buy *why* you do it, stating, "I would suggest the same is true for psychotherapists. Being passionate, committed, and clear about *why* you do what you do inspires confidence and **enhances leadership."** Coughlin cites Wampold (2011) to suggest that these are two important factors associated with positive therapeutic outcomes.

Coughlin also cites Norcross and Orlinsky (2005), who provide corroborating evidence that suggests clinicians with no personal experience in their own therapy had the lowest rates of therapeutic progress and the highest rates of regression or stagnation in the therapies they conducted. She says that despite knowing this, we have neglected the personal development of our trainees for several decades, and states that trainees are no longer required or even encouraged to engage in their own therapies or other experiences designed to enhance self-awareness and growth (Coughlin, 2017, p. 11).

For me personally, this raises the question of how has this widespread neglect of the personal development of the therapist occurred? Maybe discussion generated by the much cited Transdiagnostic Unified Protocol[2]) sheds some light on the matter. In an online journal article, Peter Roy-Byrne (2017) looks at the influence of the medicalisation of psychological distress on the field of psychotherapy. He says the 1980 DSM-III marked a shift from earlier more transdiagnostic psychodynamic and physiologic causal mechanisms in the previous DSMs. It represented a significant shift towards biological and genetic aetiologies for mental disorders. This change in theoretical orientation by the American Psychological Association was one that favoured naive empiricism rather than theory in the psychological mechanisms involved in generating psychiatric symptoms. As such, it paved the way for an outpouring of research using primarily CBT and related behavioural techniques to address various mood and anxiety disorders. Roy-Byrne argued that this led to the balkanisation of the psychotherapeutic landscape with multiple different therapies springing up to lay claim to the same territory. He likens this proliferation of empirical research to a comment made by the Red Queen to Alice in Wonderland "*Now, here you see, it takes all the running you can do, to keep in the same place"* (1871).

Roy-Byrne says that the Transdiagnostic Unified Protocol brings us full circle back to the pre-psychopharmacological era, when psychotherapy was similarly driven by broader transdiagnostic categories of disorder linking causality to hypothesised neurotic conflicts (i.e. core emotional issues) as opposed to aetiologies that were thought to be primarily biological and genetic.[3]

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[2] The Transdiagnostic Unified Protocol for the treatment of anxiety and depression related disorders referred to as "emotional disorders" was initially developed by David Barlow and a team of researchers at the Centre of Anxiety and Related Disorders, Boston University, over a decade ago. Research remains ongoing and is revising the therapy landscape. A fuller description of the protocol is beyond the scope of this paper.

[3] A full study of changes in emphasis in psychotherapy over time is beyond the scope of this paper. However, a reviewer noted: *Some believe that the problem is deeper than described above and that the rise of behaviourism and the desire for treatments that sat within a particular variation of the scientific method was a large part the change in direction. Within this framework the therapeutic dyad was one-way; a person with a problem and a therapist with a potential instrumental answer. The relational was not present; it was not a two-person psychology so the therapist's mental health (within reason) was not an issue. The cognitive revolution*

While the Transdiagnostic Unified Protocol retains CBT protocols in terms of a focus on behaviour and cognition, there is a shift in emphasis to prioritise emotional avoidance and the repetitive maladaptive behaviour patterns that develop as a result of this avoidance. However, it does this largely by trying to understand the meaning and motives for both. On this point, it is worth noting that psychodynamic traditions see symptoms as the simultaneous expression and concealment of the underlying emotional problem (i.e. internal dynamic conflict/s). To address the symptoms alone and focus on their removal without addressing the underlying mechanism generating the symptoms is likely to just move the expression of the underlying struggle, or symptoms, to another area. Think of Lady Macbeth's hand washing. The symptom (hand washing) symbolically referred to her feeling tainted by the blood on her hands. The hand washing might be called obsessive compulsive disorder today but in this case[4] was actually a manifestation of the underlying emotional problem (guilt) as she tried to wash the blood of Duncan from her hands, saying "out damned spot." The symptom of hand washing reveals her guilt (in this case conscious guilt), but it is also a way of concealing or avoiding facing the unpleasant experience of guilt by shifting the focus of attention into a repetitive ritual that turns the unfaced guilt into self-punishment.

It is many years since I have worked in the public mental health system (MHS) so there will be others more able to make well-informed comments on the implications of this in the MHS. However, is there a danger that socio-political forces with their cost-cutting measures of managed care, short symptom-focused intervention approaches, and the move to more fiscally prudent methods of treatment in the public sector could endanger our profession? Psychologists are more expensive technicians than some other allied mental health workers, so might this, alongside the push for computer-generated therapy programmes, put our profession at risk? I would be interested to learn more of this from clinical psychologists working within the MHS, as I know it is an area under discussion.

Could an increased emphasis on the *therapist as person* help us to carve a new spot in the leadership of the field of mental health by being the change we want to facilitate? Coughlin cites Abbass (2004) and Katzman and Coughlin (2013) to suggest that while much research remains to be conducted on effective ways to train therapists to achieve superior results, preliminary studies suggest it can be done (Coughlin, 2017, p. 11).

The theme of this journal is promoting change through leadership. Good leaders lead. Good leaders do not expect those whom they lead to go where they themselves are not prepared to tread. As therapists, rather than technicians, do we need to be prepared to expose ourselves to the same processes we expect our patients to undergo? Alongside personal therapy, Coughlin suggests that personal clinical supervision is a vehicle for teachers to help them learn to deal directly with their own anxieties, defences, and inner conflicts as they arise in their work. After all, if we are not aware of our own counter transference (i.e. our own inner blind spots, blocks to understanding, and defence mechanisms against our own avoided feelings) then how can we recognise them in our patients? (Coughlin, 2017; personal conversation, 2016, 2017).

The idea of the therapeutic or working alliance has long been important to psychotherapy generally. Technique and relationship factors are seen to be inextricably intertwined, and therapists who have a method they believe in are skillful in applying it systematically and flexibly

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followed on from this and has only been seeing more recently the person of the therapist. We need look no further than our own discipline to find an answer to why the person of the therapist was forgotten.

[4] This is intended as an illustration and is not intended to be generalised in an overly simplistic way to all cases of obsessive compulsive disorder; some cases of which can have, for example, a biological substrate.

are more effective in creating alliances (Coughlin, 2017; Wampold & Imel, 2015). A strong alliance promotes the kind of emotional bond required to build trust and facilitate a therapeutic process. As such, the therapeutic relationship is seen as the vehicle for change as well as the delivery system for the treatment.

Aspects that undermine the therapeutic relationship are when therapists view their patients as pathological, failing to recognise their strengths and underestimating their capacity. Also damaging to the alliance is the use of overly structured interventions, inappropriate self-disclosure, and excessive use of silence and interpretations. Therapist characteristics associated with the development of a poor working relationship are passivity, rigidity, emotional detachment, and a domineering or authoritarian style of interaction. Even if a therapist possesses highly refined skills and a method of proven efficiency, if they cannot engage the patient in a joint effort, their knowledge and skill will go to waste (Coughlin, 2017).

In psychodynamic therapy traditions, the therapeutic alliance is divided into conscious and unconscious components. The conscious aspect of the working alliance is similar to that recognised in other therapeutic methods. It involves achieving agreement about the nature of the problems to be addressed and the goals to be achieved. However, in dynamically-orientated psychotherapies, there is a focus on coming to a joint understanding of the internal mechanisms that generate the problems. The therapy "task" then follows from this and is the means by which internal change is achieved so that the goals can be attained. Coughlin (2017, p. 153) says that often patients view their problems and the solutions to their problems as external to themselves. A fuller description of this is beyond this paper, but developing an internal focus is, in psychodynamic terms, essential to lasting change. For example, when a client understands that avoidance and repression of feelings is the primary mechanism for creating their symptoms, then approaching and experiencing these feelings becomes the obvious task and behavioural change is the outcome of the internal shift.

The unconscious therapeutic alliance (UTA) is an important healing force that therapists in the psychodynamic traditions aim to harness to activate patients to healthy psychological growth. The UTA is synonymous with a person's own innate drive for healing and wellbeing, and may be analogous to the physical immune system. Activating this requires doing defence work to reach the person stuck in a pattern of symptom expression underneath their psychological defences, known as resistance (for a fuller exploration of this please see Alan Abbass's book *Reaching Through Resistance, Advanced Psychotherapy Techniques,* 2015).

Psychological defence mechanisms[5] are fascinating and worthy of a separate article. In brief, defences are often patterns of behaviour, thinking, and feeling that may in some instances become entrenched characteristics, and therefore be what I believe Freud initially referred to as "character armour," that arise in response to incompatible ideas or forbidden feelings. Automatic patterns of avoided emotions, which begin initially in childhood often as a safe refuge, later become a prison. It is not the emotions that cause the problems but the avoidance of these emotions that then go underground and convert into symptoms; psychological and often also somatic. Psychological defences are myriad and fall into different categories, but for the purposes of this paper I would like to make three points. Firstly, we all use defence mechanisms and some are more adaptive and mature than others. However, because they are automatic and

[5] The concept of defence mechanisms comes from psychoanalysis. The patient is in conflict between the defences and the (repressed) forbidden contents of the mind: memories, ideas, wishes, emotions. This is the "dynamic" element that exists in both psychoanalysis and modern dynamic psychotherapy. There is a struggle within, as one part of the mind resists repressed incompatible ideas, images, and impulses from becoming conscious (Sandler, 2016).

unconscious, if we are unaware of them they can cause blind spots in our work as therapists. Secondly, in psychodynamic therapy the term "defence mechanisms" is used synonymously with the notion of "unconscious" resistance. Dynamic psychotherapy focuses not only on conscious processes of the therapeutic or working alliance mentioned above, but also the unconscious processes that are occurring implicitly, often outside of conscious awareness. Initially, the therapist aims to make the role of these defence mechanisms in symptom generation explicit. Thirdly these defence mechanisms often unwittingly sabotage the therapeutic process and are also often responsible for treatment failure. Therefore, an initial focus on defence work in its many different forms is required to allow the activation of the UTA, which surfaces when the resistance is deactivated. The UTA provides important information, memories, links, and insights from the patient's unconscious. Often this information is important, relevant information that the patient has previously forgotten to mention or suddenly puts together in light of a current situation.

Therefore, once the resistance is no longer in the driver's seat and is replaced by the UTA, it is the UTA and not the therapist's formulation that leads the way as to what needs to be addressed in therapy. Of course, the therapist's formulation is important, but this needs to be flexible and open to new information that often only the client can supply. In his helpful reference to ISTDT, Nat Kuhn (2014) noted that a strong therapeutic alliance is fostered when it is clear to the client that the therapist wants to listen more to the client than to themselves (or their own notion of what the client is conveying). The therapeutic alliance is fostered when the therapist honours the client's other-ness and potential for individuation.

Coughlin (2017) draws on the work of others, such as Abbass and Town (2013), to argue that training programmes that expose trainee therapists to their own inner processes via a strong but collaborative alliance in a trusting (but challenging) atmosphere in which high expectations for clinical excellence prevail tend to get superior results. That is, therapists who are prepared to attend to their own personal development alongside their professional development will be better able to facilitate change in their clients.

Coughlin's idea that being committed to such a process of personal development alongside clinical skill acquisition is not for the faint hearted. I can attest to this. Several years ago, I enrolled in a small core training group in ISTDP, where for 3 years, four times a year, Patricia Coughlin, Jon Frederickson, and two other ISTDP teachers met with 10 trainees (all senior clinicians) in Melbourne for blocks of intensive training. Having enrolled, I went as a lamb to the slaughter having absolutely no idea what I was letting myself in for. At times the ride was rough. Most of the intensive training blocks involved actually showing videotapes of our therapy work to the teachers for one-on-one supervision in front of the group. Initially, this was a pretty scary prospect since mostly as therapists we work behind closed doors with only our clients as witnesses to, and at times victims of, our work. What became rapidly apparent was that what people said they did and what they actually did in sessions were often quite discrepant.

As trainees, the scrutiny involved rapidly brought to the surface our own defence mechanisms and blind spots, and initially there were some painful experiences for *some* of us. I speak for myself here, not the group at large, but my experience was that in addition to support and encouragement from some, there were some less than pleasant encounters with others. However, this was all grist for the mill and the mixed feelings[6] that emerged in the group

[6] For Coughlin and other ISTDP practitioners, being able to experience all of our feelings towards others is an overarching psychotherapy goal. That is, not to split feelings so as to feel just warm feeling or just angry feelings towards people we are close to. The idea being if we just have positive warm feelings toward someone *we are close to*

facilitated enormous personal growth within and between us. At the end of that 3-year period, I believe that we had all evolved hugely at a personal level as a result of putting ourselves "on the line" with each other and openly and honestly discussing our experiences of each other, sometimes in more kindly way than other times.

Now looking back on these past 3 years, I can truly say it has been one of the hardest and most challenging things I have ever done both intellectually and personally, BUT also one of the most satisfying and fulfilling things I have done so far in my life. And as for the other members of the group, they now feel like brothers and sisters in arms for life. As a result of our ability to be increasingly vulnerable and humble in our interactions with each other, the initial prickly skirmishes some of us had with each other were replaced with authentic connection and a general sense of having each other's best interests at heart.

As a result of my ongoing experiences with training and supervision in dynamic psychotherapy I have learned much about myself as well as some therapy techniques. I believe that both of these learning streams have increased my confidence and competence as a therapist; although as a life-long learner, I have, of course, a way to go yet. Sadly, there are no magic wands or easy answers in the work that we do, and although I have no reference for this, Coughlin, Frederickson, and others repeatedly told us that even the very best of therapists achieve a maximum of 70% success in treatment outcomes. Although the *person of the therapist* is a large part of the equation in outcomes, as consistently shown in Wampold's work over the years, we are only part of the equation. However, in her latest book, Coughlin notes that more recent findings show that therapist variables are now a greater part of the variance than the patient variance. Earlier they were thought to be about equal.

Some Things I Learned as Part of my Personal Development and am Trying to Incorporate as Part of my "Deliberate Practice"[7]

My notes following therapy sessions were frequently two-fold: progress notes regarding the therapy work and notes to self. Common themes that came up for me in these notes to self are:

- "***Ask don't tell.***" This is especially hard when one has sooo much wisdom to impart and so many ideas about how to improve people's lives.
- "***The patient needs an experience not an explanation.***" This phrase, often quoted by one of our trainers during our course, came originally from analyst Freida Fromm-Reichman. It overlaps the above point somewhat. When I find myself explaining and generally talking rather than listening, I know that my anxiety has become triggered and I am in defence mode, and therefore not present and engaged with the client's mind. And by the way, I do believe in psychoeducation and try to provide written resources to help with this. This allows clients to assimilate and raise what seems to be pertinent to them (rather than us).
- ***How many minds are in the room?*** Our role is to facilitate a process in the client, not to be in the driving seat directing the traffic in their life. This is particularly tricky with clients with character defences of compliance who are so adept at setting traps for therapists by nodding at the right moments and hanging on to every word, seemingly enthralled and

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then we are not relating to the whole person. Being able to tolerate mixed feelings and still be close to people is seen as a mark of maturity.

[7] The idea of deliberate practice is based on *Deliberate Practice for Psychotherapists: A Guide to Improving Clinical Effectiveness* (Tony Rousmaniere, 2016), which extrapolates from the work of K. Anders Ericsson (1993) on the role of deliberate practice in the acquisition of expertise in the area of performance generally, to the field of psychotherapy.

dazzled by our brilliance and eloquent phrasing. With the help of my training in supervision I am now getting better at sidestepping my own need for ego-gratification and realising that often in these instances I do not have a client in the room but a person re-enacting a pattern from earlier times where to gain approval they needed to please and agree with an authority figure.

- ***"Therapy is an inside job."*** This refers to the idea of developing an internal focus which has as its therapeutic task an exploration of the mechanisms operating within the client, rather than those in the client's current life (i.e. the spouse, the boss, or the mother-in-law) being the problem. I often catch myself inadvertently engaging in externalising problems to "out there" by listening to and reinforcing too much story (by getting out of role and laughing or even empathising inappropriately).
- ***I cannot help everyone.*** My cheerleading, pushing bricks up-hill days are thankfully coming to an end. In my private practice work, I am there to offer help and to try and facilitate change in people who are there seemingly of their own volition. Mind you, this is not to be taken for granted, and I now routinely check that this is actually the case, as often ultimatums from partners or the desperation of others (including other treatment providers) has led to the client's presence in the consulting room. It is my job to try and help clients identify and turn against defences that might be causing ambivalence or symptom syntonicity, but ultimately it is their choice whether they accept my help to free themselves from these binds or not. As Jon Frederickson said,

  > If you find yourself in a tug of war with a client let go of the rope. The conflict needs to be located within the client. If we argue with the client then this enables them to externalise the conflict and avoid their own inner conflict. (2016)

  Instead of arguing we can point out the consequences of continuing the way they are. (This is hard for me because I am a very able and experienced arguer. According to my mother this started as soon as I could talk!)

- ***I am not an oracle, rather a human being, doing my best, but fallible, so occasionally*** *(note defence of minimalisation)* ***I am wrong.*** A couple of tongue in cheek Jon Frederickson definitions of therapy and therapist here: **Therapy**: Big mess meets littler mess. Just hope that you are the littler mess on the day; **A therapist**: a person who needs to spend hours and hours in therapy.

Atul Gawande, a surgeon and public health researcher, wrote an article for the New Yorker in 2012 called "failure to rescue." He described how many medical and other professionals faced complexity and uncertainty in the course of their day, and that mistakes were inevitable. He went on to extrapolate that in a medical setting, it is not the mistakes that are the main problem necessarily, but the failure to rescue. I frequently make mistakes in my therapy sessions. Small errors of judgment, failures to listen properly, interrupting, over-ruling, and at times (cringe) telling people what their experience is. But now I try and catch myself, and sometimes say things like, "there I go, telling you what you are feeling. Please pull me up if I do that again." This sort of comment usually generates a more relaxed atmosphere in which the client becomes less self-conscious about potentially saying what they might perceive as the wrong thing.

Conclusion

In this reflection paper, I have looked at the topic of *therapist as person,* and drawn on the work of dynamic psychotherapists to suggest that a renewed emphasis on the "therapist" aspect of the therapeutic dyad may help facilitate therapeutic change. I have borrowed the words of one of my mentors and supervisors, Patricia Coughlin, to make the point that we be (or model) the change we wish to facilitate in our clients/patients. And this is the leadership aspect on which I wish to

place emphasis. To a large extent, my own reflections on this subject have been sparked by my own training experiences in dynamic psychotherapy in the past 3–4 years, particularly in supervision, which is a large part of the training and continually encourages self-reflection. Alas, I do not have data to show proven increased efficiency in treatment outcomes, but my own subjective experience is that the work I now do with people is deeper and the change more lasting. Also, on the whole, I no longer run out of steam or things to explore with people after the initial few sessions. Attention to the client's internal dynamic processes keeps the interactions fresh and alive (dynamic). If the resistance is dealt with, the material brought to sessions by the client's UTA determines where the focus of the session needs to be.

Post Script

An easy to read, highly individualised, general introduction to some aspects of dynamic psychotherapy is to be found in *Tea with Freud: An Imaginary Conversation about How Psychotherapy Really Works* (Dog Ear Publishing, 2016), in which the author, psychiatrist Steven B. Sandler, holds a series of imaginary meetings with Freud to discuss the evolution of psychoanalysis into Sandler's preferred mode of short-term dynamic psychotherapy and to present case material for Freud's supervision. The author's main stated intention in writing the book is to "explain psychotherapy to the general reading public" and do so in a style that holds the reader's attention; hence, the fictional aspect. The fantasised meetings feel alive, and the exchanges with Freud, authentic. Although the book has shortcomings (in that it is only one variant of modern derivations of Freud's classic psychoanalytic theories, and fails to recognise this), it gives the reader an overall good grasp of the flavour of short term dynamic psychotherapies.

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Leadership by Psychologists in the Secondary Healthcare System: A Stocktake in New Zealand District Health Boards

Malcolm Stewart, Mike Butcher, Kris Garstang, Fiona Howard

Psychologists frequently have professional and personal skills that can contribute strongly to providing clinical and managerial leadership within the health sector. However, it has been argued that they are under-represented in positions where they could usefully contribute. A survey initiated by the Future Psychology Initiative of the DHB Professional Leaders and Psychology Advisors was undertaken to explore the presence of psychologists in formal leadership roles in New Zealand's District Health Boards (DHBs). This indicated a small but widespread and growing presence of psychologists in leadership positions in DHBs. Leadership by psychologists is mostly in mental health services, and is fairly strongly focused on intra-disciplinary leadership. However, there is some presence in cross-professional, clinical/team, and managerial leadership. Leadership presence is mostly across the upper-middle to lower levels of organisational leadership, with relatively little representation at the executive leadership level. These results indicate psychologists have a developing presence in leadership in the secondary healthcare system, and suggest strategies that may assist with consolidating and extending this trend. Initiatives are being planned and/or undertaken to increase the ability and readiness of psychologists to assume such roles. This data may form a benchmark by which the success of these initiatives can be measured.

Introduction

Leadership is the process of influencing people to work jointly towards common goals (Stincelli & Baghurst, 2014). There is a growing focus on clinical leadership in health (McKimm & Swanwick, 2011). In New Zealand, organisational and government policy are frequently supportive of increased clinician involvement in health leadership. Government policy indicates that clinicians should be involved in governance across all areas and levels of healthcare (Gauld & Horsburgh, 2015), and an increased focus on clinician leadership in health is a key theme in numerous documents (e.g., Health Workforce New Zealand, 2011; Ministry of Health, 2014; National Health Board, 2010).

Despite the current focus on health leadership by clinicians, psychologists are frequently under-represented in health leadership roles. This situation may be influenced by training, attitudinal, and organisational barriers to leadership by psychologists. There is a lack of pre- and in-service training to prepare psychologists for leadership roles (Thorn, Mosher, Ponton, & Ramsel, 2015). Psychologists' scientist-practitioner training commonly focuses on working at an individual level, and can be an impediment to the fast-paced and organisation-wide focus required in management roles (Kelly & Finkleman, 2011; Stoller, 2014).

Attitudinally, there are few role models for psychologists in leadership, particularly senior leadership positions. This may stop psychologists considering leadership as part of their career path. Thorn, Mosher, Ponton, and Ramsel (2015) stated that many psychologists simply do not expect to become leaders and so do not prepare for, or consider taking on, leadership opportunities. In the New Zealand District Health Board (DHB) context, often the only psychologists seen in leadership roles are psychologists' professional leaders, with management

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and other senior clinical leadership roles filled by medical and nursing staff. From an organisational perspective, there are generally few leadership roles available to psychologists, and limited financial incentives (even sometimes financial disincentives) to take management or leadership responsibilities. The traditional professional hierarchies that exist in healthcare can make it difficult for allied health professionals to be recognised as leaders (Gauld & Horsburgh, 2015). In DHBs and some other New Zealand contexts, there is a flat and/or poorly defined career structure without the steps typically available to nurses (e.g. nurse manager, associate nurse manager, nurse educator) or medical staff (e.g. clinical director, chief medical officer).

It may be that New Zealand psychologists are underestimating their potential to take on health leadership roles. Psychologists have professional and personal skills that enable them to contribute strongly to providing useful clinical and managerial leadership in the health sector (e.g. Skinner & Toogood, 2010). Factors such as their "humanistic training, high ethical standards, and networked leadership style" are distinct and valuable assets in their management and leadership potential (Kelly & Finkleman, 2011, p. 196). The collaborative and self-agency enhancing approach that psychologists generally use in their clinical work is similar to the approach needed for transformational leadership (Kaslow, Falender, & Grus, 2012).

Despite their relative absence from explicit leadership positions in organisations, psychologists frequently undertake leadership roles of a different kind. Two types of leadership mandate, formal and informal, are often important in the successful function of organisations. A formal mandate is the influence and leadership derived from exercising authority formally conferred by the organisation, such as through a particular job title, role description, or explicitly delegated authority. An informal leadership mandate is leadership carried out by individuals who do not possess formal authority or power within the organisation but who influence and guide others based on the credibility and respect they hold (Peters & O'Connor, 2001). An informal mandate is often conferred bottom-up (e.g. by other colleagues) rather than top-down, although informal leaders are often also recognised and used by management. Formal and informal mandates have different advantages, disadvantages, and ways they can contribute to an organisation (Pielstick, 2000). Savvy teams and organisations will value and use both formal and informal leadership resources. However, informal and formal leadership can at times work at cross-purposes, or one may undermine the ability of the other to create effective and useful change.

It has been observed that psychologists are frequently more comfortable with informal leadership roles (Thorn, et al., 2015). Because of their training, skills, and other characteristics, they are frequently conferred informal leadership roles. This "easy fit" with informal leadership may in part explain their comparative absence from formal leadership roles. However, the skill base of many psychologists also enables them to contribute positively in formal leadership roles. For example, the complexity of modern health systems and the recognised importance of leadership for supporting good function in complex organisations (Schneider & Sommers, 2006) suggest that psychologists' analytic and interpersonal skills can offer much through both formal and informal leadership activities.

The Future Psychology Initiative was established to identify and implement strategies to ensure that psychology is robust, resilient, and relevant in the New Zealand health sector into the future (Du Villier et al., 2015). One of five action areas established by the Future Psychology Initiative to achieve these goals is increasing leadership by psychologists. As relatively little is known about participation in leadership by psychologists in the health sector in New Zealand, a survey-based study of leadership by psychologists in DHBs was developed. The objectives of this study were to:

- identify how many psychologists are in leadership positions in DHBs;

- describe the kinds of leadership roles psychologists currently undertake, including:
  - the focus of the role (clinical leadership, professional leadership, or management)
  - the numbers of psychologists in leadership roles at different organisational levels
  - the scope of the role (mental health, physical health, or both)
  - a stocktake of the specific roles psychologists undertake;
- assess the change (growth or reduction) in the number of psychologists in leadership roles in the last year; and
- establish benchmark data that can be used to assess the change in the presence of psychologists in leadership roles in DHBs in future years.

While the importance of informal leadership roles is acknowledged, this paper focuses on formally mandated leadership roles in DHBs.

Methods

Participants

Participants in this study were professional leaders–psychology or psychology advisors (hereafter referred to as psychology leaders) for all DHBs in New Zealand. Responses were received from 14 psychology leaders from 16 (80%) of the 20 DHBs (one psychology leader covered three DHBs). Of the four remaining DHBs, one psychology leader did not respond and the other three (all smaller DHBs) did not have anyone in this type of role.

Materials

A three-part survey was developed to answer the questions described above.

1. **Role description.** Psychology leaders were asked identify all formal leadership roles performed by one or more registered psychologists in their DHB. For each of these roles they were asked to record: the number of psychologists performing that type of role; whether the role primarily had a professional leadership (i.e. providing leadership mostly to psychologists), clinical leadership (i.e. leadership of clinicians from a range of professions), or management (i.e. management rather than professional or clinical leadership) focus; and the organisational level of the role. The organisational levels were defined as executive leadership team (e.g. board member, CEO with whole-of-DHB span, or director/executive director of allied health); senior leadership (e.g. general managers, clinical directors of a division such as mental health; professional leaders); service level (e.g. managers/clinical directors for a subsection of a division such as a CAMHS service, or a middle management role); and individual team leadership (e.g. a team leader/manager, clinical leader for a team, or a formal leadership role with a narrow scope).
2. **Change in leadership by psychologists.** Psychology leaders were asked to indicate the number of psychologists who had moved into and out of leadership roles within the last year in their DHB.
3. **DHB and service size.** Psychology leaders were asked to indicate how many psychologists worked in mental health, how many psychologists worked in physical health services, the total number of mental health staff, and the approximate population served by their DHB.

Study Design and Procedures

This study consisted of a cross-sectional analysis of leadership roles undertaken by psychologists in DHBs at a single point in time (early 2016). The survey was emailed to psychology leaders by a member of the DHB Psychology Leadership Group. Responses received from psychology leaders were reviewed, and any interpretational difficulties were clarified with the source of the data. The most common reason for clarification was because position titles are used differently in different DHBs, and so a more detailed description was sought to allow consistent categorisation with similar positions from other DHBs.

Analysis

The primary analyses of quantitative data in this study were descriptive, with some exploration of correlations between variables using Pearson's or Spearman's correlations as appropriate.

Results

Leadership Roles Undertaken by DHB Psychologists

Fifty-seven psychologists were identified as being involved in leadership roles across the 16 DHBs. The number of psychologists in leadership roles in different DHBs ranged from 1–13 (median 2), with strong correlations between the number of psychologists in leadership roles and the number of psychologists employed by the DHB ($r = .89$, $p < .001$) and the size of the DHB as measured by the population served ($r = .79$, $p < .01$).

Overall, 8% of psychologists in the DHBs were in leadership positions. The percentage of psychologists in leadership positions among DHBs varied from 4%–17%, with no relationship between the percentage in leadership roles and the size of the DHB ($r = -.33$, n.s.). The types of roles psychologists were involved in are shown in Table 1. The predominant focus for more than half of psychologists' leadership roles was professional. A quarter of roles had a clinical focus, and a smaller group had predominantly management-focused roles; 90% of those with a professional focus were providing oversight primarily for psychologists, with the remainder providing professional oversight to allied health professionals more generally. In addition, 53% of all psychologists' leadership roles were psychology leader/deputy psychology leader roles. Most psychologist leadership roles specifically covered mental health services or mental and physical health services, reflecting (but also exceeding) the large proportion of DHB psychologists (78%) who are employed in mental health services.

The organisational level at which psychologists in leadership positions were employed is also shown in Table 1. Relatively similar numbers of leadership roles held by psychologists were at Organisational Level 2 (senior leadership: 32%), Level 3 (service level: 33%), and Level 4 (team level: 35%), with no psychologists reported at Organisational Level 1 (executive leadership).

Table 1
Current Leadership Roles Undertaken by Psychologists in 16 District Health Boards

Role type	Positions N	DHBs N	Services covered N			Organisational level
			Mental health	Physical health	Both	
Professional focus (58%)						
Director of Allied Health	3	3	3			2
Professional Leader	14	15	5	1	8	2
Deputy Professional Leader	16	4	16			3
Management focus (25%)						
General Manager	1	1	1			2
Service Manager	2	2		2		3
Team Leader	7	5	7			3–4
Clinical focus (18%)						
Clinical Director	3	3	3			2–3
Clinical Leader	11	4	10	1		3–4
Total (%)	**57**		**45** (79%)	**4** (7%)	**8** (14%)	

Notes: Organisational Level: 1= executive leadership team, 2= senior leadership team, 3 = Service Level, 4= individual team leadership.

Changes in Numbers of Psychologists in Leadership Roles

In the previous year, 11 psychologists had moved into leadership roles and four had moved out of leadership roles across the 16 DHBs. This equates to a net increase of 14% of psychologists in leadership roles during the previous year. No changes were reported at Organisational Level 1. Net increases of one psychologist at Level 2, five at Level 3, and one at Level 4 were reported.

Discussion

This study explored the formal leadership roles undertaken by psychologists in New Zealand DHBs. It indicated that psychologists have a presence in leadership, although with a median of two psychologists per DHB and an average of 8% of psychology staff in any formal leadership role, it is coming off a low base. It has often been observed that psychologists are reluctant to take up opportunities for formal leadership (Thorn, et al., 2015). A number of barriers to them doing so were discussed in the Introduction. However, the 14% increase in psychologists in leadership in the last year suggests that this presence is growing, and that there is at least some organisational support for such growth. These results indicate the importance of training psychologists to take leadership and management roles, and developing other initiatives to engage psychologists sustainably in such roles. Such training and initiatives have been started by the professional bodies. The government, training institutions, and employers may also have significant roles to play in developing the leadership contribution of psychologists.

This study showed that leadership by psychologists is still strongly focused on intra-disciplinary (i.e. other psychologists) leadership and in the mental health sector. This may link to self-limiting perceptions of the types of leadership roles for which psychologists are equipped, because of the reasons previously described (e.g. Thorn et al., 2015), and may relate to organisations tending not to consider psychologists for broader leadership roles. It may also relate to conditions (e.g. reduced pay) that discourage or preclude psychologists from considering such roles. This implies that increasing psychologists' contribution to broader health leadership will require "consciousness raising" as to their potential leadership in broad roles, both among psychologists and senior leadership. It may also require changing organisational factors that discourage or preclude psychologists from engaging in leadership roles. However, while nominally being focused on intra-disciplinary activities (e.g. maintenance of the psychological workforce and enhancing the quality and safety of its practice), roles such as professional leader often contribute to broader clinical and organisational activities. Therefore, training to prepare psychologists to take on broader leadership roles (including high-level leadership and management) may be of considerable value.

A specific area in which psychologists may provide important leadership for other disciplines in the next few years is in supporting non-psychologist staff to safely and effectively deliver psychological therapies of various levels of sophistication, and matched to client need through a stepped care approach (Earl, 2010). The success of this approach requires good supervision and oversight of staff delivering therapies, and accurate matching of clients to the appropriate level of treatment. Psychologists are in a good position, and have been frequently used, to provide such oversight and allocation functions (Stewart, Bushnell, Hauraki, & Roberts, 2014). Providing this kind of leadership is a powerful way of extending a psychologist's impact beyond their own therapy room, while remaining close to the core competencies of psychologists trained to undertake psychological therapies.

In the past, psychologists have capably fulfilled a wide variety of senior leadership roles in DHBs, including DHB Board Chair, DHB CEO, General Manager–Mental Health, and Director of Area Mental Health Services. Until recently, there may have been little direct support from the psychology profession or its members to assist people to gain these roles or to sustain them.

Organisations such as the Society for Psychology in Management (www.spim.org) in the US aim to provide this kind of support and assist psychologists to develop in these roles. The results of this survey indicated that it may be worth New Zealand psychologists thinking about how to support psychologists to enter and sustain similar roles. Leadership training, mentoring, and interest groups are among methods that have been proposed, and which are beginning to occur.

While there are substantial variations among members of any discipline, the social sensitivity often important for psychologists' work in clinical roles means that they may, more than some other disciplines, desire specific assent from other parties (management and/or colleagues) before stepping into a leadership role (which could perhaps be characterised as "psychologists will lead if it is all right with everyone else"). Others explicitly offering such assent and encouragement may increase psychologists' motivation and ability to contribute in either formal or informal leadership roles. A less flat career structure for psychologists may also assist with encouraging psychologists to take on leadership roles.

Psychologists in mid-level management roles frequently talk about feeling punished and/or ostracised by their psychological colleagues for taking on such roles. This can make it difficult for them to sustain these roles. Psychologists often claim that other psychologists in leadership positions disadvantage their psychologist subordinates to avoid any accusation of professional favouritism more than do leaders from other disciplines such as nursing or medicine. While not wishing to establish patterns that distort effective organisational function, psychologists establishing a mind-set in which they support leaders who are psychologists, and psychology leaders who are unafraid to support psychologists and psychological perspectives as appropriate may increase the willingness of psychologists to step into, and remain in, leadership positions.

This study focused on the formal mandate/leadership roles taken by psychologists in New Zealand DHBs. However, the impact of informal leadership is also significant. Stincelli and Baghurst (2014) identified three important themes that support effective informal leadership: 1) individual competence (e.g. ability, knowledge, willingness to lead, providing a positive example, confidence, and ability to influence others), 2) organisational culture (e.g. provides encouragement and opportunities and open to ideas and questioning), and 3) situational requirements (e.g. organisational goals, the abilities and skills needed within the organisation, and the effectiveness of the company in using staff). Psychologists are frequently comfortable and active as informal leaders in their teams and organisations, even if they do not take formal leadership roles. Recognition of the importance of informal mandate/leadership and training in how to be effective in such roles may be a useful direction for developing the function of psychologists. Assisting organisations to create an environment in which informal leadership is valued and plays a constructive role is also likely to be useful.

A limitation of this study was that it makes observations comparing leadership by psychologists with that of other professions (e.g. medicine, nursing, physiotherapy, social work) that are often based on experience and anecdotal evidence. A comparative study of leadership characteristics (e.g. training, expectations, motivations, personality, and leadership style) of members of different professions was beyond the scope of this study. Such a study could assist with optimising the management contribution made by all professions. This study was limited to psychologist leaders in DHBs, and excluded leaders in other types of health services or other social service sectors. Comparisons of psychologist leaders in other types of health and social services may provide a knowledge base for increasing effective leadership by psychologists.

In summary, this study shows that psychologists are relatively rare in leadership positions in DHBs. However, there is some growth in the number of psychologists in these roles, and

potential for further growth that could be of considerable benefit to the health system. Psychologists, psychology leaders, employing organisations, training institutions, and the professional bodies all have a potential role in developing strategies by which this potential can be used both to build and sustain a better health system and to ensure that psychology remains a robust, resilient, and relevant discipline into the future.

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Leadership Peer Group, Canterbury

Lindon Pullan, Catherine Gallagher, Suzanne Hall, Liz Waugh, Nic Ward

For those of us who end up in leadership roles, well, we often seem to just end up there! Ironically, given our education, training history, and commitment to research-based practice, we do not necessary follow a formalised process in becoming leaders. With this in mind, in 2010 a small group of us were reflecting on how underprepared we were for the different challenges of leadership—a bit of a shock when we are a profession that is all about guiding people! Managing

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clinical demands was familiar ground to us as senior psychologists, but in psychology (and for the typical psychologist's personality!) there are some unexpected tensions and growth when leadership authority is mixed with clinical issues, not to mention the additional challenge of working across multi-service groups and teams. We thought that meeting, sharing our challenges (both personal and professional), and learning from each other would be very worthwhile. Since 2013, we have met on a roughly bi-monthly basis for an hour and a half. We have fluctuated in numbers as members have come and gone. We have welcomed psychologists who are new leaders, and have recently been joined by another professional who is a clinical leader from another profession. At present we have six members, a number that works well as often at least one of us cannot attend.

We air any agenda items at the start of each meeting. These are typically about how to apply leadership principles or experiences to new situations, as well as reviewing changes we have made across time. Common areas of discussion are the crossover of clinical and leadership responsibilities, getting the balance right between empathy and the needs of the service, and of course, getting to air our self-doubts in good company! Leadership is a very personal journey no matter the amount of well-considered intent and good support available, so we have included some reflections that might just inspire you to form a leadership support network too!

Our Reflections…

C: Clinical Practice Manager. It is my job title…but what does it actually mean? Similar to other psychologists who have been around a while, leadership positions have come my way. You may argue, who better to be leaders, as we are supposed to have good communication skills and understand people. I wish it were this simple!! In moving into this role, I tried a bit of the good old "scientist practitioner model" and looked it up. There was a lot of information on the clinical area in which I was working. There was also a lot of information about leadership and management. What was lacking was a combination of the two. I found myself in the role of a clinician working therapeutically with clients, as well as leading, supervising, and having clinical oversight all in the space of a day. I then looked to supervision to see if I could find the one person to support me to meet all these needs. I am lucky enough to have had support from some fantastic supervisors, but once again…no one was completely in my shoes. Our peer supervision group quickly became an important avenue for support. We have created a safe space to talk, learn, challenge, reflect, and offload about the joys and tribulations of clinical leadership. In our busy professional lives, it is important to spend our time doing useful things, and I find the time spent with my colleagues valuable and real and it helps me feel more grounded and effective in my leadership role.

S: When I began my current role as Clinic Manager, it was with energy, enthusiasm, and some degree of trepidation. Although I had led a small clinical service some time ago, I had more recently spent a substantial period in private practice and in clinical roles alongside other psychologists. Part of my reservation about this position came from recalling issues I had found challenging in a previous similar role, as well as from some new challenges in the management area with which I had much less experience. Being invited to be part of the clinical leadership peer group with others in similar circumstances had an immediate impact that normalised my concerns moving into this role. It provided access to other members' wealth of relevant experience, problem-solving, and perspectives that was both supportive and practical. Even the knowledge that others had set up a group to explore issues associated with this role was helpful. There were varying degrees of experience with issues and reflections that helped my thinking, responses, and positively influenced the way I moved forward. While there were commonalities in our work, the different services represented provided contact and awareness of other support available in the community. Combined, group members' issues, viewpoints, and resulting

possibilities to move forward provided rich information and support that means development in my role feels like it has made solid gains in the right direction.

L: I moved into the role of Clinic Director in our university clinic nearly 5 years ago. This was my first appointed "management" role, having previously ended up in either team leader type positions or as an acting manager by accident more than design. In many of these previous leadership positions, there were things I would have liked to do differently on reflection, or with the benefit of more understanding of my own personality foibles! I really want to be a good leader, supporting the team while meeting our broader programme and university strategic goals. But how to do this?! Our clinical leadership peer group was a fantastic first step. I really appreciated taking some time every few months to reflect on myself as "leader," and review challenges faced and successes achieved. Discussing this with other clinicians that I respect, and hearing their thoughts, opinions, and approaches to similar issues has been so helpful. I think we challenge each other, moderate our more fervent opinions, and encourage each other well. It is certainly a group of colleagues that I value meeting with, and would recommend the process to others.

N: My current post as Team Leader was created earlier this year because of expansion in psychology provision at Insight. Consequently, this is a new post both for me and the service I have worked in for many years. Soon after I started in this role, I was invited to join the clinical peer group. Since then, this group has been an extremely useful venue for me to explore the issues and challenges of my development in this role. The group allows me to time to reflect on my new responsibilities and what I need to learn to carry them out competently. As with many of us in similar positions, I have yet to receive specific training in leadership (although I will be attending the upcoming NZCCP training, thanks to the Committee for organising this), thus having the time and space to think about what team leadership might look like in our service is invaluable to me.

L2: If there is one thing I have learned from being in leadership roles, it is very easy to get lost in the details and demands. This is good on some days, when being task focused helps things along, but can backfire when a more relational presence is required. Having time engaged in some form of leadership reflection or discussion has been very important to me to keep that awareness, and to put down personal roots in leadership when, at the heart of it, I am far more comfortable being a clinician. Our clinical leadership peer group is an important part of that grounding and solace and, as the saying goes, you are the sum of the five people you keep close!

Welcome: The Science and the Art of Clinical Psychology in Mind

Chris Howison

This is a slightly abridged version of an address given by Chris Howison at a March 2016 NZCCP Canterbury Branch ceremony welcoming newly graduated clinical psychologists to the profession.

On behalf of the NZCCP, I offer congratulations for your success in the Diploma examination. You have worked hard to reach this point and now there are new and exciting beginnings ahead of you as independent practitioners.

I remember three decades ago the relief at having passed the Diploma, tempered with trepidation and uncertainty about my future as an independent practitioner. For graduates,

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surviving in clinical practise is often a first goal, and this is much easier if you seek the nurturance and care of your colleagues, for "a burden shared is a burden halved." This will help you not only survive but also flourish. You will witness many changes over your career: in yourself, your profession, and in the world. On this journey you will all experience and construct different versions of reality.

You are in what has been called the century of the brain. Indeed the 2003 Reith Lectures entitled "The Emerging Mind" opened by reminding us that over the last 300 years:

- With the Copernican revolution, humans lost their place at the centre of the Universe, then
- with the Darwinian revolution, we lost our place on top of the great chain of being as the most important species, and then
- with the Freudian revolution, we lost our place as possessors of purely rational minds.

Now we are poised for the greatest revolution of all, understanding the human brain. But that will not be the full picture.

Many years ago I wore a t-shirt on which was written the joke "Of all the things I've lost, the thing I miss most is my mind." For me, this turned into a reality when I lost my Mind for a short time during a period of brain illness last year. However, on its return I became more cognizant of the important role that the brain plays in our life, for there are no minds without brains, even if there may be brains without minds. As Steven Pinker succinctly put it, "The mind is what brains do," and for most of us, that will be the primary focus of our future professional endeavours.

Reflecting on change, I wonder if I should begin every address with the statement "everything I am about to tell you is a lie," as a reminder to myself and others to remain sceptical of what you are told. Today's truth rapidly becomes tomorrow's myth. However despite my College colleagues' description of me as "a jaded and cynical old fart" when inviting me to address you today, I would encourage you not to become so, but rather remain scientifically sceptical, for the truth is out there and we must find purpose in its discovery.

You have gained scientific knowledge, but there is much more to be learned as you combine this with the art of psychotherapy. You are already well equipped in this endeavour, for you have scientific psychology as the cornerstone for understanding of the physical, biological, and social/cultural sciences. However, I encourage you to enrich this understanding through reading broadly to guard against prejudice and a narrow world view, with works such as:

- evolutionary theory and psychology as espoused in *Evolutionary Psychology: The New Science of the Mind* by David Buss,
- interpersonal neurobiology, as in Alan Schore's *The Science and Art of Psychotherapy*,
- integrated approaches to psychology, such as *A Unified Theory of Psychology* by Gregg Henriques, and through
- ecological approaches such as Fritzjoff Capra's *The Systems View of Life*.

However, science is but half the picture. The other half to the human story being the arts. As complexity scientist Stuart Kauffman reminds us in *Reinventing the Sacred*: "Miracles are what we take for granted."

When you can see the extraordinary in the everyday things around you, you will be connected to the mystery and wonder of life. A spiritual connection with nature is much needed, but in our world, and in our practice, we can remain mostly disconnected from it.

The New Zealand College of Clinical Psychologists was founded in 1988 and aims to promote the skills of its members and assist in educating the public. We are sure that you have much to contribute to the College and look forward to your entry into the College as part of your membership of the profession.

Psychologists as Leaders: Insights

Consistent with the NZCCP Strategic Plan and supporting our membership, one of the areas of focus is to **build the leadership capability of our members**. As part of this, insights from NZCCP members who have moved into leadership roles will be regularly featured in NZCCP publications as a way of sharing information about pathways into leadership. The following are from Deb Moore and Willem Louw.

Deb Moore

What leadership roles do you currently hold?
Currently, I am Professional Advisor Psychology (0.2 FTE) for Nelson Marlborough Health (NMH), and senior clinical psychologist for the rest of the time. I also belong to the DHB Psychology Leadership Group, which meets twice a year. As there is no equivalent in physical health in NMH and a very small proportion of psychology FTE, I am always available to assist with any matters relating to psychology outside of mental health as well. I recently completed three terms as president of NZCCP, until resigning in 2017. This was also a role that I was encouraged into taking on by my peers.

How did you end up as a leader, what path took you that way?
I was invited to apply for the advisor role after the previous person resigned. I had experience working in different areas of the MHS which helped—CAMHS, adult inpatient and outpatient and so on. I always had an interest in the contribution that psychologists could make, and was keen to promote this. When I first started my career, mental health was very much a medical model. Making psychologists more visible and the rest of the service more aware of what we could contribute has been part of this journey for me.

What extra training did you undertake, if any?
What was it like "learning the ropes"? I completed some NMDHB in-house management training modules, and also attended a 3-day Catapult management course in Martinborough which was interesting. However, most of the learning was on the job. At first it felt quite overwhelming at times (e.g. suddenly attending management meetings) and not being up to date on various things, but this became easier along the way.

If you have had any "failures" along the way, how have you dealt with these and what did you learn from them?
Initially I had three roles: professional advisor, clinician, and coordination of the outpatient service. It quickly became clear that this was not going to work, and there were a lot of challenges around the changes I had been asked to implement and the existing team, as well as having too much on my plate. It was a very stressful time being caught between these roles and the different expectations of me. I was less interested in the operational side of the coordinator role, although this was the part that took the most time. After I asked to be relieved of the coordinator role, I was bemused to be replaced by a fulltime, very efficient nurse.

Who supported or encouraged you as you entered leadership roles?
I had the support of MH management and some of my colleagues. It can be very challenging managing the different expectations and boundaries of these roles, and having access to someone in a mentor-type role is invaluable. I was fortunate in that the General Manager of the MHS was a clinical psychologist, and had vast experience and understanding of what psychology could offer. This made the strategic side of the role a lot easier, and provided support at the higher levels of management.

What advice do you have for clinical psychologists considering moving into leadership roles?
People often refer to shifting into management as "going to the dark side." Psychologists have such a wide range of knowledge, expertise, understanding, and skills around people, systems, managing change, and so on, but there is often a reluctance to put ourselves forward into these roles. At the same time, there are limited career opportunities (especially in DHBs) if we are not willing to take these steps and give it a try. For example, I was asked to represent allied health on the DHB-wide Clinical Governance Group, which I have done for the last couple of years. This is an opportunity to fly the flag for both allied and mental health, as the physical side of the hospital has a tendency to sometimes forget about both of these when issues and decisions are underway. I think the constant questions and reminders in meetings are having an impact now.

From your experience, what are the challenges and advantages of taking on formal or informal leadership roles?
Our clinical work as psychologists is often individually focused on therapy, and leadership roles require that we look more broadly than the clinical, across wider systems, locally and nationally. It is also important to speak up at every opportunity, so as to inform and educate others about what we can offer. Our strength in working from an evidence-based practice model is very useful when it comes to these wider discussions, and drawing attention to what research tells us, rather than just floating by ideas.

What do you see as important skills/competencies of leaders?
I do not think the required skills for leaders are too different from what we bring as psychologists: ability to listen, understand, respect, support, encourage, motivate, strategise, enhance change, and see the bigger picture. As managers, we need to be mindful of not being too partisan around our own group, as everyone in the workplace has a role. Current focus on working to the top of scope has provoked interesting discussions about what it is that psychologists actually do as distinct from other roles and capabilities in the health system, and whether there are some aspects of the psychologist role that could be delegated in some way.

If yours is a not management role, how is your position as a leader different from a management role?
My role as advisor is part of the MH management structure, and alongside colleagues in social work and occupational therapy, we bring the voice of allied health to the table. While not holding a budget other than test materials, I advise on anything to do with psychology across the service, this includes: recruitment/employment, dealing with any performance problems that may come up (thankfully this is rare); ensuring the psychology workforce is supported to do their job; and advocacy for psychology in times of tight budgets and high demands. There is increased pressure on health services, particularly mental health, in the community as well as specialist services. It is going to be important that psychologists engage and influence decisions, rather than hiding in our offices. The Psychology Workforce Task Group has provided an opportunity for wider issues to be addressed and discussed at high levels, and the work that has been done in

this group is being recognised in various other national forums (e.g. National DAHs, regional training hubs).

Willem Louw

What leadership roles do you currently hold?
None at present. I am in full time private practice. I served in the role of associate professional lead-psychology from August 2014 to February 2017 at Counties Manukau Health (CMH) DHB. I left CMH in early October 2017.

How did you end up as a leader, what path took you that way?
I started working at CMH in early 2011, and in 2012 approached Malcolm Stewart, who was then Professional Lead–Psychology at CMH. I asked Malcolm who I could approach as a mentor to help prepare me for leadership roles in the DHB, and what leadership roles there were for psychologists. Malcolm advised that there was only one formal leadership role in psychology, which was his position, and suggested that I think broader than just formal leadership and broader than just psychology. He encouraged me to use whatever skills, opportunities, and freedoms I had to make a positive difference in the various contexts in which I worked, to constantly observe and record the outcome of those efforts, and then share my work in professional forums (e.g. monthly psychology meetings, journal clubs). At this time, I was working in a kaupapa Maori community mental health clinic and had already embarked on psychological service improvement initiatives. After my discussion with Malcolm, it seemed that the best option was not to seek a mentor and be coached into a leadership role (since none was available). To become a leader in the field in which I practiced, put my hand up for opportunities to participate in service improvement activities, and took informal leadership roles in those forums. One year later, Malcolm resigned from the DHB. Marleen Verhoeven had been working informally as the associate professional lead (APL) for many years, and just before Malcolm resigned he managed to create a formal position for the APL-Psychology. I am sure that this was a result of Marleen's hard work over many years that demonstrated this role was valuable and import at CMH. I applied for the position of professional lead in early 2014, but was unsuccessful, with Marleen taking the position and leaving the APL position vacant. I applied for the APL position and was successful.

What extra training did you undertake, if any? What was it like "learning the ropes"?
I had regular meetings (monthly) with Marleen, who had worked in the APL role for many years and could advise me on lessons she already learned in this role. I undertook project management training, and advanced Excel spreadsheet training (very useful), and listening to audiobooks such as *Influencer* and *Crucial Conversations* by Joseph Grenny et al.

If you have had any "failures" along the way, how have you dealt with these and what did you learn from them?
It is invaluable to have a safe forum to discuss and analyse failures. I discussed these with Marleen (professional lead and previous APL) and my clinical supervisor at the time, who could help me see that the failures were probably less disastrous than I imagined and tomorrow is another day. It is essential to accept that mistakes will happen, and should not be motivation to never take risks.

Who supported or encouraged you as you entered leadership roles?
My partner (as the role took up some family time on occasion), my psychology colleagues and colleagues from other professions, my supervisor, and the professional lead.

What advice do you have for clinical psychologists considering moving into leadership roles?
Make a serious attempt to answer the question "how can we improve what we are doing?" Look for relevant answers in many places and across disciplines. Once you are, start to see some sensible answers, and talk to people who are already in leadership positions and who can influence your field of work.

From your experience, what are the challenges and advantages of taking on formal or informal leadership roles?
Challenges:
a) Systems are very resistant to change.
b) Good outcomes result from changing the right things. It is not obvious what those things are, and it requires experimentation and goodwill plus trust from the people involved.
c) Taking too much responsibility for others' wellbeing and success.
d) Having too much confidence in your own ability alone to effect change.
e) Burn-out and self-flagellation in the absence of good supervision and collegial support.
Advantages:
a) Opportunity to make a positive difference on a larger scale.
b) Opportunity to develop your communication and leadership skills (making difficult decisions that will not please everyone, and finding ways to include everyone's voice, not just people who share your vision/opinion).
c) Opportunity to learn diplomacy and political savvy.

What do you see as important skills/competencies of leaders?
a) Patience and non-impulsive reaction when confronted with a challenge.
b) Compassion with, and commitment to understand, differing viewpoints.
c) Understanding core business and attending to that without getting side-tracked on peripheral noise.
d) Kindness to self and others.
e) Ability to stay with the facts and fact based opinion.
f) Commitment to delivering the best possible service/product, while prioritising work satisfaction and a high quality of work life for people that you serve.
g) Understanding the needs of the people you serve (clients and colleagues).

If yours is a management role, to what extent does it require leadership skills or tasks?
My role was not a management role.

If not, how is your position as a leader different from a management role?
A leader influences, motivates and enhances clarity for new psychologists and professionals from other disciplines about what we do and do not do; they develop the field and improve practice. A manager provides the best possible structural (salaries, leave requests, office, and IT requirements, sensible workload) and motivational support (constructive feedback, clear communication of operational procedures to attain organisation vision).

When an Evidence-Based Behavioural Intervention (Parent-Child Interaction Therapy) for Severe Child Conduct Problems is not Successful: Can Augmentation With Attachment, Attributional, Emotional Coaching, and Mentalising Strategies Promote Change? A Case Conceptualisation of a Family in Turmoil

Bev George

As a clinical psychologist working in an Infant, Child, and Adolescent Mental Health Service (ICAMHS), I work with many families with young children struggling with relational, emotional, and behavioural well-being. Presenting problems include anxiety, emotional dysregulation, oppositionality, aggression, and difficulties in relationships with parents, siblings, and peers. Presenting problems may be conceptualised as child behavioural problems, including oppositional defiant disorder (ODD) and conduct disorder childhood-onset type, as well as attachment disruptions (insecure and disorganised attachment). In fact, while attachment difficulties are not always present in ODD and conduct disorder, insecure attachment is present in most individuals with these diagnoses (Theule, Germain, Cheung, Hurl, & Markel, 2016). It has been my experience that when *both* conduct problems and attachment disruptions are present, treatment for families tends to be longer, more difficult, and less efficacious.

Child conduct problems are common; they are estimated to occur in 5%–10% of New Zealand children (Fergusson, Boden, & Hayne, 2011), with higher rates (20%) for Maori children (Advisory Group on Conduct Problems, 2009). Further, they are the most common reason families seek child mental health treatment, and are the most reliable precursor for a broad spectrum of psychiatric disorders and poor outcomes in adulthood (Dadds, 2012). New Zealand longitudinal studies indicate that conduct disorder places children at increased risk for mental health problems, suicidality, substance use and abuse, teen pregnancy, criminal behaviour, imprisonment, inter-partner violence, and poor physical and dental health (Fergusson et al., 2011). Therefore, early identification and intervention for childhood-onset conduct problems is a national priority (Advisory Group on Conduct Problems, 2009).

Interventions for Child Conduct and Attachment Problems

In New Zealand, evidence-based treatments recommended for 3–8-year-olds with conduct problems are behaviourally based and include parent management training programmes, teacher management training programmes, classroom-based interventions, and (for severe conduct disorder) treatment foster care (Advisory Group on Conduct Problems, 2009). Behavioural parenting interventions aim to improve parent-child relationships, promote prosocial behaviour, and reduce child behavioural problems. Their key components include increasing parent-child play, improving parental observation skills, and teaching positive parenting strategies such as differential adult attention and aversive consequences (time out from positive attention) for specific negative behaviours (Troutman, 2015). The evidence-based parent management training programmes recommended in New Zealand include the Incredible Years programme, Triple P, the Oregon Social Learning programme, parent-child interaction therapy (PCIT), and the Forehand and McMahon parenting skills programme (Advisory Group on Conduct Problems, 2009). The intervention used with the family discussed here, PCIT, is an intensive behavioural parent training programme for children aged 2.5–7 years that works to enhance the parent-child relationship, and assists parents in reducing children's problematic behaviours through didactic live parental coaching by means of a bug-in-the-ear microphone and a one-way mirror (see

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McNeil & Hembree-Kigin, 2010). PCIT has a strong evidence base for treating behavioural and emotional disorders in a variety of family contexts, including maltreating families and foster parents (Lieneman, Brabson, Highlander, Wallace, & McNeil, 2017). PCIT has been adapted for children aged over 7 years (McNeil & Hembree-Kigin, 2010), but no randomised controlled trials have yet been conducted in this age range (Lieneman et al., 2017).[8]

While behavioural parent training is the most effective psychosocial intervention for child conduct problems (Brestan & Eyberg, 1998) and has been shown to reduce conduct problems by up to 80%, its effectiveness reduces with increasing child age (Fergusson et al., 2011). Furthermore, up to one-third of families receiving such treatments do not see improvements (Scott & Dadds, 2009), there is a high drop-out rate, and the level of effective in-home strategy implementation is unclear (Piotrowska et al., 2017). Moreover, manualised evidence-based behavioural treatments struggle to cater for the heterogeneity in children with conduct problems (Dadds, 2012).

Given the limitations of evidence-based behavioural treatments, researchers and clinicians are increasingly proposing augmented formulations and interventions that are strongly founded on, and hold true to, behavioural principles, but that add elements from other theoretical approaches. For example, Scott and Dadds (2009) discussed how skilled clinicians can integrate useful elements from attachment theory, structural family systems theory, cognitive-attribution theory, and shared empowerment/motivational interviewing in behavioural parent training. Fonagy and Luyten (2017) suggested a role for targeting mentalising (the capacity to keep mental events in mind) for children with conduct disorder. Datyner, Kmonis, Hunt, and Armstrong (2016) presented support for adding a brief adjunctive emotional training module to PCIT. Troutman (2015) focused on augmenting behavioural parent training with attachment theory in an integrative parent coaching approach.[9] As reviewed by Troutman (2015), attachment and behavioural interventions have much in common: they address child difficulties through targeting parental interactions with their children, fostering parent-child play, and developing parental observational and positive parenting skills. These therapies chiefly differ in the parenting skills they target. Attachment therapy emphasises sensitive responsiveness to child distress and need, whereas behavioural therapy focuses on contingent responses to child behaviour (Troutman, 2015). Troutman's book details how, with careful consideration of underlying principles, the two approaches can be integrated into PCIT coaching.

Attachment therapies, including watch, wait, and wonder (Muir, 1992) and the 20-week Circle of Security programme (Powell, Cooper, Hoffman, & Marvin, 2014), also have an established evidence base in promoting secure attachment and ameliorating insecure attachment (see Troutman, 2015). The Circle of Security programme includes visual schematics and easily understood terminology to promote sensitive parental responding; it supports parental observation and understanding of child need, alongside reflection regarding parental strengths and struggles in meeting these needs (Powell et al., 2014).[10] Attachment interventions also have their limitations. Larger improvements in parenting and child attachment security are found with

[8] Training in PCIT is available in New Zealand from Tania Cargo, who is the Regional Coordinator for PCIT Aotearoa-New Zealand. I am accredited as a Level 1 PCIT trainer by PCIT International, and have co-coordinated a PCIT clinic for 4 years.

[9] I would like to thank the NZCCP for granting me the NZCCP Research/Study award to attend training with Dr Beth Troutman in September 2017. Her training and approach inspired this article.

[10] For these reasons, the Circle of Security model of relationship is my preferred way of delivering attachment coaching to parents, and was used for this family. To give the reader a sense of this model, I will use Circle of Security terminology throughout this article. Circle of Security training (a 10-day training and a DVD psychoeducational programme) is regularly offered in New Zealand by its developers. I have completed both trainings, and regularly co-facilitate Circle of Security psychoeducational groups.

interventions that specifically target parental sensitive responding (Scott, 2008; Troutman, 2015) and infants and younger children (Troutman, 2015). Furthermore, attachment studies have not specifically targeted children with clinical levels of conduct problems (Troutman, 2015) and are not recommended for older children with conduct problems (Scott & Dadds, 2009).

Augmenting PCIT for an Individual Family

Earlier this year, I was invited to work with a family with entrenched child conduct problems and attachment difficulties.[11] As a rule, my first choice of intervention for such a family would be an evidence-based treatment, such as Incredible Years, Triple P, or PCIT. However, standard PCIT delivered when the client ("Troy") was aged 4 years had not been sufficiently effective. Parental ratings of Troy's behaviour remained in the clinical range, there was a lack of parental confidence in managing his behaviour outside the clinic, and negative internal and stable child attributions persisted. Furthermore, Troy, now aged over 7 years, was outside the evidence-based age range for standard PCIT. Moreover, the family had engaged in additional behavioural and attachment parenting programmes, including in-home behavioural support. Consequently, I considered that a more comprehensive biopsychosocial understanding of Troy and his family was needed to provide for an individually-tailored augmentation to parent coaching within a PCIT framework. My aim was to address conceptualised barriers to change, to increase the likelihood of success with PCIT (using McNeil and Hembree-Kigin's [2010] older child PCIT protocol).

Purpose of This Article

My purpose with this article is to share my conceptualisation and work with this family in the hope that it builds on the augmented approaches proposed by Scott and Dadds (2009), and demonstrated by Beth Troutman (2015) and Eva Kimonis (e.g. Datyner et al., 2016). I further hope that this discussion of a family with limited response to treatment will contribute to the advancement of our understanding of, and support for, "real world" families presenting with disordered conduct problems that constitute the one-third of clients that do not benefit from behavioural treatments (Scott & Dadds, 2009). With these goals in mind, I first briefly describe what I know of the family and the numerous interventions they have undertaken. Second, I present a limited review of the literature pertinent to the development and maintenance of conduct and attachment problems in this family, by means of a biopsychosocial formulation. Third, I present a conceptualisation of important treatment targets for this family, along with a description of the concomitant augmentations to PCIT that were undertaken. Finally, I discuss current treatment outcomes, along with my reflections about the utility, limitations, and future directions of augmenting PCIT.

Troy

"Troy" is an 8-year-old New Zealand European boy, who lives in an economically advantaged home with two parents, "Adam" and "Sarah," his sister "Bella" who is almost 2 years his senior, and his brother "Harry" who is almost 2 years his junior. Adam and Sarah are intelligent, professional, caring parents with good extended family and community supports. Troy was born full-term and was a medically well and "good-natured" baby. Sarah underwent a difficult emotional journey in forgiving family of origin experiences during her pregnancy with Troy, and reported "mild" post-natal depression for a few months following his birth. Sarah reported noticing a change in Troy from a "happy" to a "determined" boy at 9 months of age, at which time she was pregnant with Harry. She recalls him showing strikingly low levels of frustration tolerance. She reported that from age 13 months, Troy was "difficult," "violent," and "a hitter and a biter." Harry's arrival increased sibling aggression between Bella and Troy, especially when Sarah breastfed Harry. Sarah reports "freezing" in these moments. She recalls Troy's emotional

[11] I would like to express my gratitude to Troy's parents for giving me permission to share their story, which they hope will help other families (the family's personal details have been changed for the purpose of anonymity).

and behavioural dysregulation at home and kindergarten increasing at this time. The family (and extended family) concern that Troy was a temperamentally difficult child was strengthened during this period, as was the wondering about whether he had "something wrong with him" or was even "possessed." While trying their best for him, they considered relinquishing their care of him.

Bella left kindergarten when Troy was aged 3.5 years, resulting in increased anxiety for Troy such that he was moved to a new kindergarten. There, his aggression escalated and he did not establish friendships as he had at the previous kindergarten. When Troy was 4 years old, his parents engaged in treatment with a developmental psychologist/attachment expert. Later that year, Troy was referred to ICAMHs with presenting issues of low frustration tolerance, noncompliance, explosive unpredictable anger, chronic negativity, aggression towards all family members (kicking, hitting, scratching, hair pulling, spitting, and statements about wanting to kill them), and self-statements such as "I don't like being me." Connors Parent Rating Scales (Conners, 1989) indicated that attention deficit hyperactivity disorder (ADHD) symptoms were in the average range, but oppositionality was at the 97th percentile. Maternal report on the Child Behavioural Checklist (Achenbach & Elderbrock, 1983) indicated clinically significant externalising problems (aggression and oppositional defiance). Parental distress as reported on the Parenting Stress Index (Abidin, 2012) was at the 99th percentile. Troy's parents were sending Troy outside the house as a consequence for misbehaving, and Adam was using physical discipline as a last resort, particularly in response to Troy's aggression towards siblings.

At this stage, Adam and Sarah engaged in standard PCIT with me, regularly completed the home practice, and after 11 sessions had met mastery criteria for specific positive parenting skills in both the child directed intervention (CDI) and the parent-directed intervention (PDI) phases of treatment.[12] They demonstrated these skills (including effective use of time out) with proficiency at three in-clinic sibling sessions that involved cooperative play between Bella, Troy, and Harry. A reward system for sibling cooperation was set up at home. Adam reported that the scripted discipline procedure helped him to stay calm and to relinquish physical discipline. Adam's ratings of Troy's behavioural problems on the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pinkus, 1999) dropped 43 points, whereas Sarah's only dropped 10 points. Despite their apparent competency in behavioural parenting skills and Troy's increased compliance and cooperation with time out, neither parent's ECBI ratings fell into the nonclinical range. Sarah noted that, while she had seen improvement in Troy's behaviour, she could not disentangle her ratings of Troy's behaviour from her "mood," which she found to be impacted by Troy's "mood." Both parents expressed continued anxiety about Troy's negative impact upon his siblings and their family, together with doubt about his long-term wellbeing.

It appeared that despite behavioural change, Troy's parents continued to attribute internal, global, and stable dispositional difficulties to Troy. Such attributions have been linked to negative parental affective and behavioural responses to child behaviour and to negative outcomes for children (Sawrikar & Dadds, 2017), and the decision was made with the family's ICAMHS key-clinician to directly target parental attributions and self-efficacy. It was hoped that these interventions would assist Troy's parents to hold more optimism, enjoy a more relaxed relationship with Troy, and support them to consistently use the authoritative parenting techniques they had developed in PCIT. Thus, my involvement with the family in the PCIT

[12] CDI involves a daily special parent-child play time involving labelled praise, reflections of child verbalisations, descriptions of child behaviour, and enjoyment of playing together. Ignoring of mild, inappropriate behaviour is practised. CDI enhances the parent-child relationship. PDI includes the use of effective commands and a scripted time out procedure for noncompliance and breaking house rules, including verbal and physical aggression. Sibling sessions can be included (see McNeil & Hembree-Kigin [2010] for a full description of PCIT).

Clinic ended. Sarah responded to a post-PCIT Clinic feedback survey, with a request for in-home PCIT coaching. This was subsequently offered but was not taken up.

During Troy's fifth to seventh years, his parents continued to seek assistance from ICAMHS and other agencies, but the proposed attributional work did not occur. However, Sarah engaged in individual therapy and Troy engaged in two separate instalments of individual play therapy as well as biofeedback sessions, and a period of individual weekly NGO-mentoring. The family also engaged in several community-based behavioural parenting programmes, including extensive in-home specialist behavioural support for 2 years. Gluten-free diets, vitamin C, magnesium, probiotics, fish oil, and homeopathic remedies were undertaken. With parental agreement, Oranga Tamariki was involved, but no additional supports were provided.

Assessments over these years indicated mixed evidence for ADHD and autism spectrum disorder (ASD). Troy has both of these diagnoses, alongside ODD. A cognitive assessment at age 5 years placed his abilities in the average to high-average range. His parents understand him to have an attachment disorder which would best be categorised as disorganised/controlling-punitive/ambivalent (D/C)[13] (see Troutman, 2015 pp. 24–29 for a brief description of attachment patterns, or Main [2000] and Hesse and Main [2000] for detailed accounts). Troy has regularly used melatonin for sleep problems, and has trialled Ritalin, Risperidone, Fluoxetine, and Dexamphetamine. Troy has received support from the Ministry of Education's early intervention team from kindergarten to the present. Troy attends a government school with 5 hours/day teacher aid support in a separate classroom, and limited, carefully-managed peer-interactions. To foster relationships with peers, Troy's parents have arranged for weekly interactions with two older (13–14 years) socially skilled playmates. To provide respite for the family, Troy spends time with paternal and maternal grandparents.

A review of Troy's ICHAMS file revealed Adam's absence from the home on business trips tended to exacerbate Troy's behavioural challenges and Sarah's difficulty setting limits; whereas short-term improvements were associated with positive one-to-one time between Troy and his parents (when on a camping trip with his parents, when engaged in standard PCIT, and doing daily home-based special play times). Various medications and dietary changes were often reported to have an initial positive impact, which was not sustained.

Adam and Sarah are intelligent, resourced, and dedicated parents. With a severe and chronic parenting challenge, there was a decline over the years in their wellbeing, optimism that treatments will be effective, and capacity to continue to implement positive parenting strategies. Many interventions were tried and judged ineffective/given up on. Adam and Sarah's attributions for problematic internal and stable child characteristics appear to have been strengthened by the many treatment failures they experienced. Over time, there was a related increase in Troy's isolation within the family (spending most of his time on an iPad) and an escalation in his distress, anxiety at separating (particularly from Sarah), and his controlling and aggressive responses that allowed him to avoid demands at both home and school. Consequently, Troy's socio-emotional skills were poorly developed. Sarah described the household as a "warzone" in which she is constantly hypervigilant to "abuse" from Troy, whom she described as like a "wild animal." Both Adam and Sarah find interactions with Troy increasingly unpleasant and exhausting, and struggle to engage with him with warmth in daily special play times, allowing him to spend most of his free time alone on his iPad. Sarah acknowledged her level of wellbeing dictates her parenting style, which can be warm and responsive, "frozen" (nonresponsive), permissive, or mean. Adam described a similar swing

[13] Ambivalent/resistant attachment is the most common secondary pattern of attachment for disorganised classification, occurring in 46% of cases (van Ijzendoorn, Schuengel, & Bakermans-Kranenberg, 1999).

between warm and firm parenting to more rough "man-handling" of Troy, especially when trying to prevent injury to Bella and Harry. At these times, Troy's siblings were told that Troy is "dangerous" and to leave the room. Adam and Sarah know that they are inadvertently reinforcing Troy's aggressive behaviours, but feel unable to use behavioural management strategies because of their own level of exhaustion, and for fear of aggression and property damage.

Troy's entire family experiences chronic stress. Harry is exhibiting behavioural difficulties, particularly noncompliance, and has difficulty separating from Sarah. Bella expressed distress about the home situation. Troy expressed anxiety about being expelled from the family.

Biopsychosocial Conceptualisation Delineating Factors and Processes Considered Pertinent to the Development and Maintenance of Troy's Behavioural and Attachment Difficulties

As posited by Borrell-Carrio, Suchman, and Epstein (2014), it would be impossible for any biopsychosocial model to incorporate all possible contributing factors. Further, as discussed in Dodge and Pettit's (2003) biopsychosocial model of the development of adolescent conduct problems, no single factor is sufficient to forecast an individual's outcome. Rather, an individual's likelihood of developing conduct problems is difficult to predict because of the correlations and reciprocal influence between risk factors, and their additive and interactive effects (Dodge & Pettit, 2003). The pathway to conduct problems is heterogeneous (Fonagy & Luyten, 2017). In this context, I offer my formulation, not as a general comprehensive or explanatory model of child conduct/attachment problems, or as an integrative model, but rather as a heuristic framework for delineating some of the factors and processes I consider likely to be pertinent to Troy.[14]

[14] Use of an integrative heuristic framework and the consideration of the level of individual behavioural repertoires is taken from the paradigmatic behavioural model, developed and refined by Arthur Staats (1968, 1996).

Figure 1. A Biopsychosocial Conceptualisation of Troy's Emotional, Relational, and Behavioural Challenges.

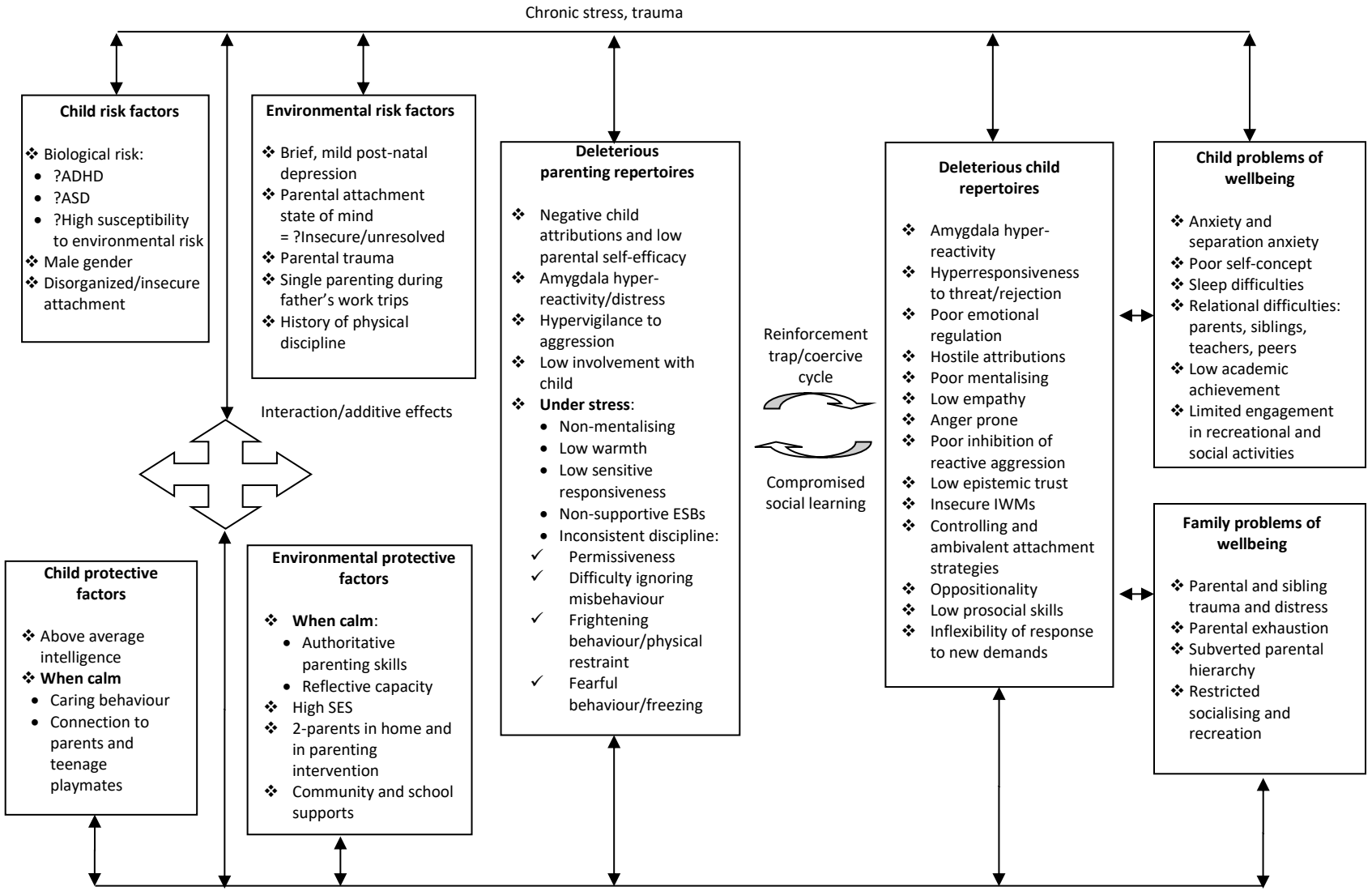

Figure 1 illustrates how child and environmental risk and protective factors are posited to mutually influence each other, and contribute to the development of both parental and child interactional repertoires. As this is a model of maladjustment, only deleterious repertoires are presented. In turn, these parent and child deleterious repertoires interact with each other, contributing to, and maintaining, Troy's and his family's problems of wellbeing through a coercive cycle and compromised social learning.

Child Risk Factors

Child risk factors for the development of conduct disorder include certain genetic, neural, endocrine, and psychophysiological dispositions (Dodge & Pettit, 2003), including a high susceptibility to environmental risk (Fonagy & Luyten, 2017).[15] Belsy and Pluess (2009) detail several child characteristics related to increased susceptibility to negative parenting practices including high physiological reactivity to stress, negative emotionality, impulsivity, and anger-proneness. Boys have a heightened vulnerability to parent-child coercion (Dodge & Pettit, 2003) and a higher risk for neurodevelopmental conditions, including ASD and ADHD (American Psychiatric Association, 2013). Furthermore, ADHD presents increased challenges to parental capacities to provide consistent and responsive parenting (Johnston & Jassy, 2007), whereas ASD has been associated with increased risk for disorganised attachment (van Ijzendoorn et al., 1999). Insecure, and especially disorganised, attachment is prospectively linked to conduct problems (Fonagy & Luyten, 2017). Disorganised attachment at 12–18 months of age is associated with externalising behaviours (aggression, oppositionality, disruptive behaviour), poorer cognitive and social development, and symptoms of post-traumatic stress disorder between the ages of 2 and 9 years (Troutman, 2015). Disorganised attachment is a major risk factor for child psychopathology (van Ijzendoorn et al., 1999).

The interactions between child risk factors and deleterious child and parental repertoires are complex: For example, Kochanska and Kim (2012) found that early insecurity of attachment is a catalyst for toddler anger, which in turn provokes parental power-assertive discipline, which then predicts child oppositionality, and callous and aggressive behaviour.

Environmental Risk Factors

Troy's family were not subject to many of the familial and sociocultural risk factors found to be strongly associated with conduct disorder (e.g. low education single-parent households, divorce, low income, unemployment, exposure to aggressive peers and neighbourhood violence)(Dodge & Pettit, 2003). However, some environmental risk factors are present for this family. The rate of disorganised attached is doubled in the presence of perinatal maternal depression, whereas rates with a maltreating caregiver are 50%–90% (Troutman, 2015). Parents' "attachment state of mind" (i.e. their attachment style with regard to their own caregivers) has been shown to be strongly associated with their children's attachment classification. Unresolved parental attachment state of mind is linked to child disorganised attachment (van Ijzendoorn et al., 1999), most likely through the child's experience of witnessing brief periods of parental dissociation (stilling, freezing) (Abrams, Rifkin, & Hesse, 2006).

Notably, parental attachment state of mind is more strongly associated with child attachment outcome than behavioural observations of parental sensitive responsiveness to their children (van Ijzendoorn, 1995). Van Ijzendorn (1995) described this phenomena the "transmission gap," and it has led to arguments for interventions targeting parental reflective functioning (such as the Circle of Security programme) in the hopes that improved parental reflection or mentalising capacity might mediate child security of attachment (Cassidy, Jones, & Shaver, 2013). Fonagy

[15] It is possible that Troy has this susceptibility, along with many of the following risk factors.

and Target (2005) describe these capacities for reflective functioning as involving a parent's curiosity about, and capacity to imagine, the internal world (thoughts, feelings, needs, desires, motivations) of both self and the child, and a realisation that one can only guess at, but not directly know, another's experience. They further posit that it is through the experience of being mentalised by a parent, that a child will come to understand and express his own experience and emotions, thereby developing emotional regulation. In this way, as proposed by Fonagy and Target (2005) and Slade, Grienenberger, Bernbach, Levy, and Locker (2005), parental reflective capacity may bridge the transmission gap.

Poor maternal reflective capacity has been linked to child disorganised and ambivalent-resistant attachment, and to maternal insecure and unresolved attachment state of mind (Slade Grienenberger, Bernbach, Levy, & Locker, 2005). These authors suggest that a parent with a preoccupied state of mind with regard to attachment to their own caregivers, "cannot think about mental states but rather is buffeted by them," whereas a parent with a unresolved state of mind is "profoundly dysregulated by mental states" (p. 294).[16] Troutman (2015) adds that preoccupied parents tend to keep the therapy focused on negative emotions and resist the help they ask for (p. 90), whereas unresolved parents tend to struggle to manage their distress. Troutman (2015) noted that an unresolved state of mind can easily be masked by parental competence, but is more evident in discussions regarding attachment-related trauma or loss.[17] Sarah and Adam's attachment state of mind had not been directly assessed, although there are some indicators of a preoccupied/unresolved attachment state of mind for Sarah. Troy's high levels of aggression and parental challenge are likely to exacerbate difficulties in parental mentalisation.

Child Protective Factors

Child protective factors include factors that reduce the risk of negative outcomes given high and low risk, and factors that reduce the persistence of early behavioural problems, and/or promote wellbeing (see Vanderbilt-Adriance et al., 2015). Recent re-conceptualisations of the vulnerability-stress model (e.g. Belsky & Pluess, 2009) posit that individuals vary in their neurobiological susceptibility to environmental influence (both adversity and support), and thus their development of stress-reactivity. Masten (2001) delineates key global resiliency or protective factors associated with child well-being, some of which are present for Troy (intelligence and connections to competent, caring adults within the family and community) while others need further development (self-regulation skills, positive self-concept, and motivation for self-efficacy in the environment).

Environmental Protective Factors

Two environmental protective factors were present for Troy's family that have been shown to be negatively associated with child conduct problems: high neighbourhood quality (defined as high social cohesion and low crime) and parental community involvement (Vanderbilt-Adriance et al., 2015). In addition, there were two family protective factors; specifically, father-involvement in treatment and parental cooperation in parenting (Piotrowska et al., 2017).

When in a supportive, one-to-one setting with Troy (such as the PCIT Clinic), Adam and Sarah demonstrated several parenting practices that constitute parental protective factors, including warm, responsive parenting that is authoritative, and avoids the use of power (Fonagy & Luyten, 2017). Authoritative parenting (i.e. high warmth, high positive/assertive control) has consistently

[16] Child ambivalent attachment has been linked to preoccupied state of mind in adulthood, while child disorganised attachment is associated with adult unresolved/disorganised state of mind.

[17] See Hesse and Main (2000) for descriptions of child and parental disorganised attachment, and Main (2000) for ambivalent child and preoccupied adult attachment styles.

been found to be linked to child well-adjustment, including less symptomatology, and greater prosocial, academic, and social competence (Scott, 2008). It is also considered a protective factor with respect to antisocial behaviour (Masten, 2001). In PCIT terms, parents would be warmly practicing CDI and PDI skills. In Circle of Security terms, this equates to parents being "bigger, stronger, wiser, and kind," getting the balance between following a child's need, and taking charge positively when necessary.

Sensitive parenting also appears to ameliorate child risk. For example, sensitive parenting between the ages of 4.5–15 years has been found to reduce callous and unemotional traits in boys, and predict secure attachment in girls with initially low levels of inhibition control (see Fonagy & Luten, 2017). These authors proposed that sensitive parenting and rewarding attachment relationships promote empathy, emotional-self-understanding, development of child mentalising capacities, and commitment to prosocial values and morals. Johnson et al. (2017) used the term emotion socialisation behaviours (ESBs) to describe parental supportive responses to their children's emotions, discussions of experienced emotion (particularly negative emotion), and a culture of emotional expressiveness within the family. Johnson et al.'s (2017) meta-analysis found parental ESBs to be linked to child attachment security and socio-emotional development including empathy and emotional regulation. For Troy's family, replacing the coercive cycle of parent-child interaction with rewarding parent-child attachment relationship that promote ESBs was conceptualised as a key intervention target.

A secure parental state of mind with regard to attachment involves the capacity to coherently describe and regulate personal thoughts and feelings about attachment relationships to family of origin (Slade et al., 2005). This capacity has been shown to be associated with parents' capacities to do the same for their children (to mentalise and make sense of child's behaviour), and with security of child attachment (Slade et al., 2005).

Deleterious Parenting Repertoires

Children's relational, emotional, and behavioural difficulties have long been conceptualised as occurring within the parent-child relationship (Scott & Dadds, 2009). While child characteristics (e.g. ADHD) can present increased challenge to parenting, specific parenting responses have been associated with the development of child oppositional and aggressive behaviour (Johnston & Jaffy, 2007). These include reactive and less responsive parenting, and child-blaming attributions. Scott (2008) summarises specific parenting behaviours found to be strongly linked with child aggression and behaviour problems: high criticism and hostility, harsh punishment, inconsistent discipline, low warmth, low involvement, low encouragement, and low supervision. The authoritarian style of parenting (low warmth, high conflict, and coercive, punitive control attempts) is linked to the worst adjustment outcomes for children, and should be addressed in parenting interventions targeting all levels of severity (Scott, 2008).

Scott and Dadds (2009) discussed how coercive parenting behaviours reinforce child maladjustment from both a social learning and an attachment lens. According to these authors, from a social learning perspective, parents can reinforce a child's problematic behaviours through giving in to them and/or through modelling coercive and aggressive behaviour. In Circle of Security language, the first instance would involve a "weak" response, and the second a "mean" one.[18] From an attachment perspective, Scott and Dadds (2009) suggested that a parent who struggles to provide a child with comfort and soothing in times of distress (safe haven) and/or support for the child's exploration of the world (secure base), will face aversive clinging

[18] The Circle of Security parenting programme (see Powell et al., 2014) encourages parents to engage in "bigger, stronger, wiser, and kind" (warm and firm, authoritative) parenting. It describes "mean" as letting "bigger, stronger" predominate, and "weak" as letting "kind" predominate.

from the child (ambivalent attachment). Parental rejection and negative reactions to the child's aversive proximity seeking will result in the same coercive cycle. Furthermore, it becomes harder for the parent to become positive (show delight in the child in Circle of Security terms), and thus the most "attachment-rich dynamics" (including hostility, rejection and ambivalence, p. 1444) available to the child involve discipline, thereby evoking more child misbehaviour. Such a coercive process can lead to maltreatment, a risk factor which itself is associated with an increased rate (48%) of disorganised attachment (van Ijzendoorn et al., 1999). Furthermore, frightening parental behaviour may be more salient and unpredictable in typically low-risk households (van Ijzendoorn et al., 1999).

Scott and Dadds (2009) also noted how the parental hierarchy can become undermined in families with severe behavioural challenge. In Circle of Security terms, a "weak" (fearful, helpless, or permissive) parenting position results in the child taking charge of the interaction, by means of controlling and/or caregiving behaviour (see Powell et al., 2014). Troutman (2015) noted that parents in insecure ambivalent dyads find it difficult to set limits and be in charge, fearing that such discipline may harm their relationship with the child. For low risk, middle-class families, child disorganisation has been associated with brief periods of parental freezing, which constitutes a loss of a parental safe haven/secure base (Abrams et al, 2006).

As reviewed in Troutman (2015), parental sensitive responsiveness involves getting the right balance between responding to a child and letting the child self-regulate, and is a key parenting behaviour associated with secure attachment. Inconsistent parental responding in ambivalent dyads may be related to parenting stress and/or an unconscious parental wish to keep the child focused on the attachment relationship. Inconsistent responding results in a child being hypervigilant to parental availability and unable to relax and accept parental comforting. This results in a child experiencing more separation anxiety, and displaying distress and anger during separations from, and reunions with, parents, with parent-child interactions tending to involve a struggle, negative emotions, and aggression (Troutman, 2015). This relational dynamic appeared to be present for Troy.

Parents of children with conduct problems develop problematic attributions about their children's misbehaviour, including that it is intentional, controllable, malicious, and a sign of significant mental illness, or that it is some form of deserved parental punishment (Scott & Dadds, 2009). Conversely, parents tend to dismiss children's good behaviour as transient, specific to one situation, and externally caused (Scott & Dadds, 2009). Negative attributions about child behaviour play a role in the commencement and maintenance of coercive parenting behaviours and maltreatment, and in negative child outcomes (Sawrikar & Dadds, 2017). Furthermore, these attributions are related to reduced parental self-efficacy, greater parental negative affect and helplessness (Sawrikar & Dadds, 2017), and poor parental implementation of parenting (Scott & Dadds, 2009). Negative maternal self-appraisals of parenting competency during pregnancy have been associated with maternal perception of challenging infant temperament (higher negative reactivity and lower soothability) during a child's first year of life (Verhage, Oosterman, & Schuengel, 2013).

In considering the deleterious parenting repertoires that developed in Troy's family, it appeared that many occurred only during times of child aggression and oppositionality where parental distress was high and capacity to mentalise was low. Unfortunately, the occurrence of these behaviours in an otherwise low risk household may be more salient and thus more reinforcing of Troy's deleterious repertoires. Furthermore, the frequency of Troy's aggression increased the occurrence of deleterious parenting responses.

Deleterious Child Repertoires

Fonagy and Luyten's (2017) model describes separate developmental pathways to, and different biopsychosocial processes involved in, the development of conduct disorder with high versus low callous and unemotional (CU) traits. According to these authors, low CU deleterious child repertoires can include attachment disruptions, amygdala hyper-reactivity, increased vigilance to threat and rejection, anxiety, and impulsive, reactive oppositional patterns of aggression.[19] Deleterious low CU child repertoires may also include: impaired mentalising and emotional understanding of self and others; a hostile attribution bias; poor development of empathy; reduced adoption of prosocial values and morals; and inhibition of aggressive responding and low epistemic trust.[20] With the under-development of mentalising and prosocial skills, children with conduct problems have a very limited repertoire response and thus show inflexible responses to new environmental demands (Fonagy & Luyten, 2017), thereby perpetuating the coercive cycle and experiencing compromised social learning.

As Fonagy & Luyten (2017) noted, mentalising and attachment are intricately linked. Cassidy et al. (2013) described the development of secure internal working models (IWMs), or relationship scripts, posited by attachment theory (Bowlby, 1969). Through consistently experiencing sensitive responsiveness and comfort when distressed, a child develops a mental representation or script linking distress to directly cueing need and receiving comfort. As the child acts on these IWMs and seeks comfort and experiences physiological regulation, the IWMs are strengthened.[21] The IWMs of children who experience detrimental parenting responses may involve scripts of parental unavailability, lack of (effective) comforting, and/or fear-inducing responses. These insecure IWMs determine their attachment behaviours. Children with an ambivalent attachment style show heightened negative emotions and attachment behaviours in an attempt to get attention from their inconsistently responsive parent (van Ijzendoorn et al., 1999). Such children sacrifice exploration and play to remain "passively or angrily focused" on their parent (van Ijzendoorn et al, 1999, p. 225).[22] However, children with a disorganised attachment have not been able to develop a consistent script or strategy to evoke parental responsiveness in times of stress, as the caregiver is both a potential source of comfort and fear (van Ijzendoorn et al., 1999). When their attachment system is activated, such children engage in contradictory behaviours, freezing, and stereotypical behaviour (e.g. repeated hair-pulling when distressed despite the presence of a caregiver) (see van Ijzendoorn et al., 1999). Disorganised attachment is associated with the "problematic management of stress" (p. 242) including dissociation, inability to develop emotional regulation, and controlling behaviour which represents a child's attempt to control of an anxiety-provoking situation (van Ijzendoorn et al., 1999). Furthermore, it predicts aggression in school age children (van Ijzendoorn et al., 1999). As delineated in Figure 1, Troy exhibited a large number of these deleterious repertoires with high regularity, resulting in frequent negative parent-child interaction patterns and chronic stress for all family members. This resulted in limited opportunities for emotional socialisation. Accordingly, targeting Troy's IWMs through augmented CDI parent coaching in sensitive responsiveness was considered a key target for intervention.

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[19] Repertoires specific to children with high CU traits have not been included in this formulation as Troy was understood to have conduct disorder with low CU traits. He was observed to show hyper-reactivity to maternal distress (freezing, getting angry), high threat perception and affect-dominated misperceptions of others, along with reactive aggression, and disruptive behaviour to achieve parental interaction. See Fonagy and Luyten (2017) for a differentiation of these subtypes.

[20] Epistemic trust is fostered through secure attachment such that children trust others as sources of knowledge and teaching.

[21] In Circle of Security terms, the child "comes in" to the parent's safe haven and receives protection, comfort, and organisation of their feelings (i.e. the child's inner world is mentalised by a parent).

[22] In Circle of Security terms, this would be a limited top of the circle schematic, or limited autonomy within relationship, which often relates to separation anxiety.

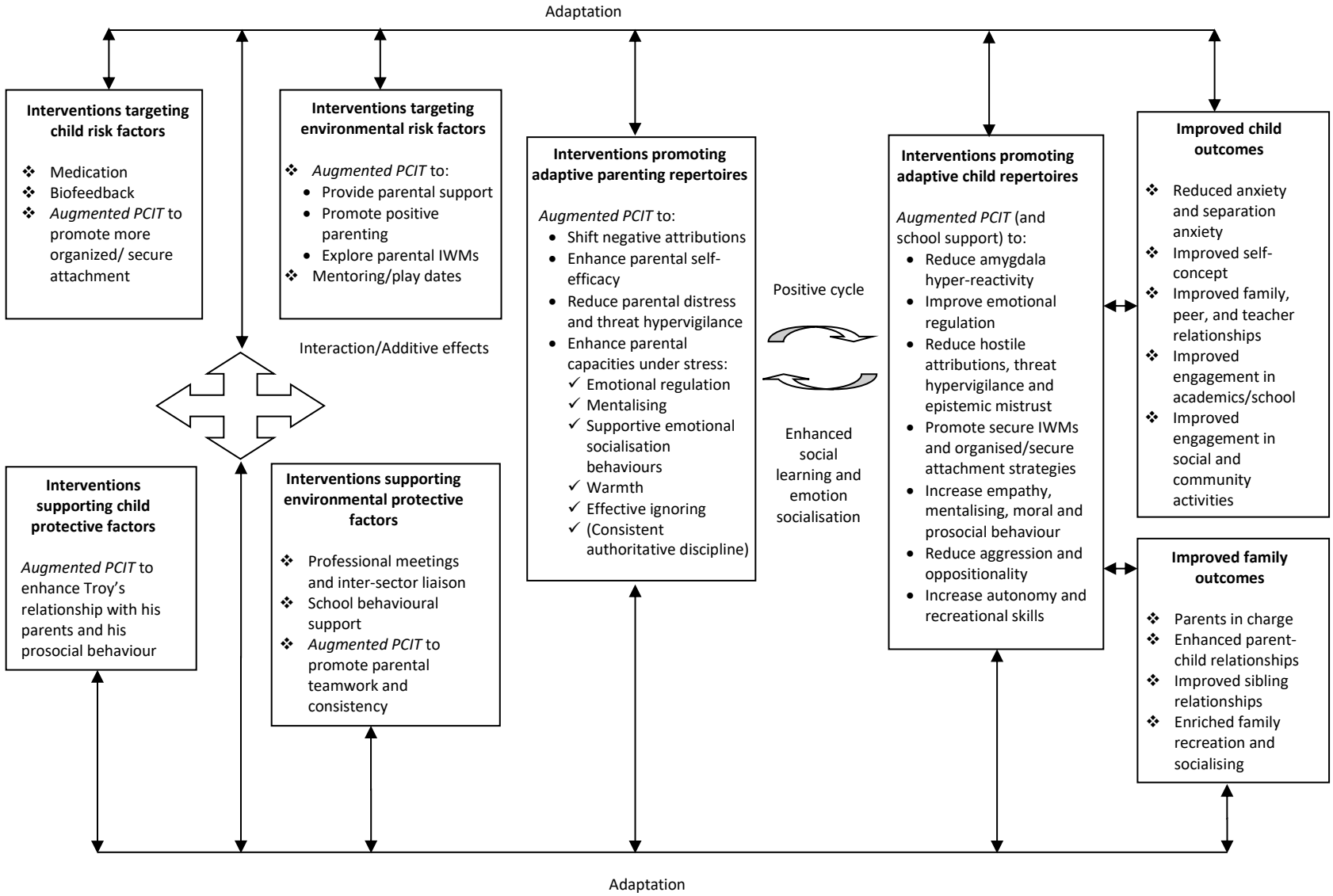
Child Problems of Wellbeing

According to Masten (2001), child maladjustment pathways include disruptions to adaptive human processes involving parent-child relationships, brain and cognitive development, emotional and behavioural regulation, and the motivation for engaging in learning and the environment. As detailed by Fonagy and Luyten (2017), pathways to conduct disorder involve disruptions in all of these processes, resulting in emotional problems including anxiety/separation anxiety, relational difficulties, aggression, reduced benefit from extra-familial (particularly school) social contexts, reduced epistemic trust and engagement in learning, and low academic attainment. These problems of wellbeing were all present for Troy.

Family Problems of Wellbeing

Child emotional and conduct problems increase parenting demands, and are associated with a range of family difficulties including financial burden, family irritability, embarrassment, shame, sadness, fatigue, conflict (parent-child, marital, and sibling), caregiver strain and physical illness, and restrictions on family social contact, personal freedom, and work (Meltzer, Ford, Goodman & Vostanis, 2011). Parents of children with conduct problems report high levels of family turmoil and adversity, as well as elevated stress and emotional/behavioural difficulties among siblings, particularly younger siblings (Kilmer, Cook, Taylor, Kane & Clark, 2008). In addition, child disruptive behaviour has been associated with maternal anger, confusion and fatigue, increased mother-reported life stress and depressive symptoms, and marital discord and scapegoating of children (Elgar, McGrath, Wachbusch, Stewart, & Curtis, 2004). Green, Loeber, and Lahey (1992) presented findings from a 3-year longitudinal study that child conduct disorder predicts a reversal in family hierarchy over time, suggesting a gradual abdication of parents being in charge. Sarah and Adam described experiencing almost all of these family difficulties.

Figure 2. Treatment Formulation for Troy and his Family's Emotional, Relational, and Behavioural Wellbeing.



Selected Targets for Intervention

As can be seen in Figure 2, augmented PCIT was deemed to provide an opportunity to support change in multiple components of the biopsychosocial model, including reducing child and environmental risk factors, supporting child and family protective factors, and promoting more adaptive parent-child repertoires and interactions, thereby leading to improved child and family outcomes.[23] These goals are in accord with the dual aims of resiliency research; namely, to enhance adaptive repertoires and change harmful processes (Masten, 2010).

Before effective discipline strategies could be implemented for Troy (the PDI phase of PCIT), change in some aspects of the biopsychosocial formulation were considered crucial:

1. Increased parent-child positive involvement, along with heightened warmth and security of the parent-child relationship;
2. Reducing the reinforcement trap by decreasing attachment-rich, emotional, and coercive responses to Troy's disruptive and aggressive behaviours, and promoting more secure attachment strategies.
3. Enhanced parental observational skills and increased sensitive responsiveness to Troy's attachment needs (particularly delighting in him, and providing him with a safe haven and comfort and organisation of his feelings);
4. Enriched parental mentalising of self and child (leading to the possibility of exploring parental IWMs/unresolved trauma and attachment state of mind);
5. Strengthened parenting confidence and self-efficacy, along with more positive child attributions and a more optimistic future narrative.

If these "bigger, stronger, wiser, and kind" changes could be effected in the parental domain, it was formulated that parental authority would begin to return to the household and pave the way for the PDI phase of PCIT. It was also intended that, through parental change, Troy would experience reduced anxiety, improved self-concept, more secure IWMs and attachment strategies, and enhanced social learning and emotional socialisation opportunities. This would allow for the development more adaptive socio-emotional repertoires (see Figure 2 for a comprehensive treatment formulation). As emotional regulation was considered a crucial factor to change the coercive cycle, and in keeping with Eva Kimonis' augmentation of PCIT (Datyner et al., 2016), a child-specific intervention was added focused on improving Troy's emotional understanding, regulation and adaptive expression.

Therapeutic Approach to Target Identified Treatment Objectives: Augmented PCIT

As Troutman (2015) noted, parenting evokes strong emotions and reversion to previously used deleterious responses, despite having learned more positive parenting strategies. This is more likely in chronically stressed families with high levels of behavioural challenge, such as Troy's. For such families, live coaching of parenting responses may be especially useful to support new procedural memory/positive parenting responses in both behavioural and attachment terms (Troutman, 2015). I have found that live parent coaching through a one-way mirror and a bug-in-the-ear device also allows a therapist to be a safe haven/secure base for a parent, mentalise and verbally describe the parent and child's experience, and comment on parent and child

[23] As my work with Troy took place in a community mental health setting (not as part of a research study with tight experimental controls), Troy's family engaged in concurrent treatments including "brain biofeedback" sessions, medication (a brief retrial of Risperidone, which was not found to be helpful), school behavioural support, inter-sectorial collaboration, and ongoing paid playdates with teenage mentors. These treatment components are included in Figure 2.

positive behaviours and interactions, thereby promoting more positive attributions of the child and greater parental self-efficacy. For these reasons, the core therapeutic approach chosen for Troy's family was live PCIT (CDI) coaching, carefully augmented with emotion training, attachment theory, mentalisation practices, and attribution theory. These augmentations are discussed below.

CDI Augmented With a Token Economy

As the first phase of standard PCIT, CDI targets many of the treatment objectives set for Troy's family (particularly targets 1 and 2). In CDI, interactions are child-led and there are no parental demands. Differential attention is used to ignore nonaggressive misbehaviour (in Troy's case spitting and swearing were included because of their high frequency), and to reinforce prosocial behaviour through specific labelled praise. Once parents reach the mastery criteria for CDI, the family move on to PDI, which involves effective command giving and use of time out.[24] Given Troy's age (over 7 years at the start of augmented PCIT), high rates of oppositionality and aggression, limited positive interactions with his parents, refusal to engage in special play time at home, and the subverted family hierarchy, it was uncertain whether Troy would engage in CDI with his parents. To reward engagement, and to reduce the likelihood of aggressive behaviour in session, sessions were kept to about 45 minutes. Further, sessions were divided into six segments, and Troy received a token for each section in which he participated without aggression to the toys, himself, or others. Tokens were traded in at home for financial credits in an iPad game.

Structure of the parent-child sessions. As described above, the 45 minute sessions were divided into six sections. In sections 1 and 6, I interacted with the family in the play-room. In sections 2, 3, 4, and 5, one parent joined me behind the one-way mirror while I coached the other parent's interactions with Troy. As per PCIT protocol, section 1 involved a brief discussion of home practice. Section 2 consisted of 10 minutes of augmented CDI (see below). The third section comprised a parent-led emotion training activity. Sections 4 and 5 involved Troy and his other parent, and replicated sections 2 and 3. The final section of the session involved a mentalising activity and encouragement of standard CDI homework (i.e. daily 10 minutes of home CDI with each parent).

Attachment psychoeducation, coaching, and reflective functioning: Circle of Security augmentations. Standard CDI involves a parent-only session in which positive parenting and play therapy skills are taught to parents. These skills are then coached in subsequent parent-child CDI sessions. A similar format was used to teach and coach sensitive responsiveness. Circle of Security concepts, together with a schematic mapping child attachment needs and parental responses that promote security of child attachment (see Powell et al., 2014, p. 17) were discussed in a parent-only session. Then, as outlined in Troutman's (2015) work, coaching statements during CDI included both standard (behavioural) CDI coaching statements and attachment coaching. Standard PCIT coaching statements provided a refresher for Adam and Sarah, who had previously mastered CDI and demonstrated retained skills. Attachment coaching drew parental attention to Troy's emotional experience and difficulties (and more recently, his successes) with coming to them directly with his emotional vulnerability and need. It also involved direct suggestions for emotional languaging of Troy's experience; provision of nonverbal and verbal expressions of warmth, delight, and comfort; and parental statements of pleasure in, and appreciation of, Troy's exploration of the toys and seeking parental support. Examples of behavioural coaching statements used are: "Great job praising his generous sharing. Troy will share more because you praised him for it," and "Awesome ignoring of his spitting. If

[24] This phase is more difficult with children over the age of 7 years, and often requires the developmentally-adjusted adaptations to time out suggested by McNeil and Hembree-Kigin (2010).

you continue to ignore it, in time he'll spit less." Exemplars of attachment coaching statements include: "Well done for keeping calm (during Troy's standing on the tissue box) and warmly welcoming him back to you on the couch"; "Nice organising his feelings by labelling his frustration"; and "He's looking for your eyes…(then, when parent-child eye contact is made), Lovely eye-contact and smile. You are showing Troy real delight in just being with him."

As is used in the 20-week Circle of Security programme, video review of carefully selected moments of parent-child interaction were used to allow for calm observation and reflection on attachment dynamics. This was done in three parent-only sessions interspersed between regular parent-child sessions. As per Circle of Security protocols, moments of both parental strength and struggle were selected. The former provided opportunity to enhance parental self-efficacy, while the latter allowed for supportive reflection around temporary loss of sensitive responsiveness in moments of high child challenge and reduced parental mentalising. Opportunities to discuss possible links to family of origin patterns of responding to attachment need were provided. Increasingly difficult attachment moments (including moments of maternal freezing and Troy's expressions of genuine distress/crying and anger/aggression) were processed as Adam and Sarah were judged ready. Throughout the video review, as with all interactions with Adam and Sarah, it was my goal to hold a non-judgmental, supportive, and mentalising stance.[25]

Mentalising augmentations. In addition to holding a mentalising therapeutic stance towards each family member's unique experience, the promotion of mentalising within the family was targeted by means of live coaching statements (e.g. "Troy looks upset. I wonder what's going on for him. Perhaps you could take a guess and check it out with him"). During video reviews, Adam and Sarah were prompted to reflect on what might be going on for Troy, and for themselves during the viewed moments of interaction. They were also encouraged to explore their in-the-moment experiences while watching the videotaped interactions.

Perspective-taking, as a concept, was introduced to the family by means of an exercise in exploring figure-ground illustrations and acknowledging the validity of different points of view. Mentalising practice was explicitly undertaken in the final section of each parent-child session. Each family member guessed what another family member had found to be the most fun and the most challenging aspects of the session. They each then check out the accuracy of their conjecture with that person. Not-knowing another's perspective was normalised and modelled, and direct verbal expression of experience and checking out another's experience was encouraged.

Attributional augmentations. To enhance parental self-efficacy, coaching statements intentionally included praise for skilled behavioural and attachment-based parenting responses. Furthermore, child improvements attributable to parenting responses were commented on (e.g. "Troy is showing more vulnerability and talking with you about his feelings more because you are providing a safe haven for him," "Your ignoring of Troy's swearing is really paying off. His rate is much lower today," and "Your handling of that situation was bigger, stronger, wiser, and kind. Well done! It's helped Troy to relax and accept comfort from you." These types of comments were intended to shift parental attributions of Troy's difficult behaviours from internal, stable, and global attributions (i.e. there is something fundamentally wrong with Troy that cannot be changed) to more positive attributions (i.e. Troy has yet to learn how to express his needs and feelings in adaptive ways, and is stuck in negative patterns of behaviour). This more optimistic narrative was explicitly discussed with Adam and Sarah, and was reinforced

[25] A mentalising therapeutic stance involves an attitude of not-knowing another's experience, together with a patient, non-judgmental and curious exploration of that experience, and acceptance of individual differences in perspective (see Bateman & Fonagy, 2010).

through provision of a therapist-made, illustrated children's story specifically written for Troy which simply described a similar family's journey to improved well-being.[26] This story was read several times, in-session and at home. Positive child attributions were further targeted through video reviews and coaching comments drawing attention to Troy's positive qualities and intentions.

Emotional training augmentation. Sections 3 and 5 of the parent-child sessions involved working through a series of emotional training activities. These were intended to support Troy's emotional understanding of others and empathy (through careful analysis of facial expressions[27]), expression of his own feeling state, and emotional regulation techniques (through in-session and home reading of emotional and relational themed books, as well as in-session practice of emotional-regulation strategies such as breathing, squeezing cushions, stretching, and sensory noticing). To circumvent Troy's hypothesised epistemic mistrust, children's books and computer apps (e.g. a breathing app with biofeedback and an emotional recognition app) were included to teach skills.

Additional augmentations to standard CDI. To facilitate generalisation of prosocial skills to the home and encourage sibling cooperation, Adam and Sarah were encouraged to re-commence their use of a previously used, pooled token economy for their three children targeting "friendly" behaviour (a warm fuzzies jar). To further target Troy's negative self-attributions and attachment insecurity, a 10-minute addition was made to one parent-child session. Troy's eighth birthday was celebrated in session with a wall-collage of photographs of Troy and each parent. This stimulated positive family discussion about Troy's early years.

Contextual interventions (common in PCIT), undertaken alongside Troy's ICAMHS key clinician, included inter-sector liaison (including sharing PCIT skills and targets with school personnel); referral to Oranga Tamariki and to the Ministry of Education's Intensive Wrap Around Service (IWS); and two professionals' meetings involving ICAMHS, school and Oranga Tamariki staff. Regular ICAMHs multi-disciplinary team liaison between Troy's paediatrician, child psychiatrist, key clinician ,and the PCIT team supported a coordinated treatment approach.

Family Response to Augmented PCIT

Augmented PCIT to date included five parent-only sessions and 12 parent-child sessions. There have been some encouraging changes that relate to the key targets of intervention described above.

1. Troy is spending more positive time with his parents. Adam and Sarah initially joined his iPad play surreptitiously. More recently, Troy has approached Adam to involve him in his game.
2. Troy is regularly seeking out his parents in their bed in the morning for snuggle time.
3. Troy is asking his mother to read the in-session books and materials taken for home practice.
4. Troy is complying with parent-led activities in session, and is trying out some of the emotion regulation strategies with parental support.
5. Troy is engaging for longer in the in-session mentalising discussions, involving both easy and difficult experiences. He is also demonstrating acceptance of differences in opinion.

[26] The story was entitled *A Prickly Tale* and described how a child had grown prickles all over his body (preventing positive parent-child interactions) and how his parents helped him to remove the prickles.

[27] Taken from Eva Kimonis' PCIT adaptation for callous and unemotional traits—the coaching and rewarding emotional skills [CARES] protocol (see Datyner et al., 2016).

6. Troy is verbally sharing with his parents more of his inner experience (emotions, anxieties about school), and is showing more vulnerability to them. In one session in which he discussed a school-related worry, he spontaneously cried (a reportedly rare occurrence) and received nonverbal comfort from Sarah (Sarah was not able to provide verbal comfort, despite supportive coaching).
7. Troy recently made an in-session coded statement which he then translated as "Troy is cool."
8. Troy's swearing and spitting (outside periods of distress) reduced in-session and now rarely occurs during the walk down the long hallway to the playroom. Parental skill and confidence in ignoring these behaviours has increased in session.
9. Troy's hair pulling in-session has stopped.
10. Troy's spitting at me has reduced. His eye contact and reciprocal conversation with me has increased. On one occasion, he smiled and waved goodbye to me.
11. Troy has been separating from his dad at school without swearing at him, instead saying "bye dad."
12. Troy successfully separated from his parents and engaged in two play dates with same-aged peers, and has had one sleep over with a church friend. These are new achievements for Troy.
13. Troy is showing more vulnerability and relational connection with his teacher aid (e.g. he recently told her he missed her when she was away on a course).
14. Adam and Sarah are reporting enhanced recognition of their falling into reinforcement traps at home, and are more openly discussing their parenting struggles. Sarah is seeking support for further individual therapy for herself.

Despite these positive signs, Troy and his family are still in turmoil. The deleterious child and parental repertoires, reinforcement traps, and compromised social learning are still at play during times of stress. Troy struggles to cope with the presence of his siblings, preferring to spend time alone with his parents. Consequently, Troy and his family are anxious, fatigued, and chronically stressed.

Current Family and Treatment Status

Adam and Sarah recently stated that although they value the PCIT strategies, they are currently unable to implement them 95% of the time, and are "doing more harm than good" in parenting Troy. They have asked for more supports, including in-home parenting support. Accordingly, referrals have been made to Oranga Tamariki and the Ministry of Education's IWS. It is hoped that the addition of these supports will allow for continued in-home CDI practice, and movement towards authoritative parenting and effective discipline at home. A professionals and family meeting has been coordinated by IWS and it remains to be seen whether PCIT, or more specifically, PDI, will compromise part of the next phase of treatment.

Practicality, Utility, and Limitations of the Provided Augmented PCIT

PCIT's sequential coaching of relationship enhancement (CDI) and then effective discipline (PDI), easily allowed for a staged approach to augmentation. The six areas thought crucial to target to promote positive change in this family were well-matched to CDI's aims and processes. PCIT's live coaching approach meant that the augmented targets were facilely incorporated. The strong therapist-parent relationship and trust that builds through live coaching allowed for the processing of emotionally challenging material (e.g. attachment themes and parenting struggles) introduced by the augmented components. Further, the direct observation of child positive and

challenging behaviours, and parenting strengths and struggles, facilitated honest exploration of attachment dynamics, mentalising failures, and unhelpful attributions and processes.

The augmented CDI provided to Troy and his parents coincided with some indicators of improved attachment dynamics. Parent-child positive involvement increased and Troy began to invite his parents into his play. Parental provision of physical and emotional comfort, and their organising of Troy's feelings (i.e. provision of a safe haven) strengthened, and Troy's adaptive expressions of distress and attachment needs increased. Troy's behaviour at separations has improved, and he has shown new capacities to separate from his parents (i.e. his secure base) and engage in the world outside his family (i.e. play dates and sleepovers with peers). There are also some signs of improved emotion recognition and expression for Troy. However, he continues to struggle with emotional regulation, and is easily triggered to anger and aggression. Gains in parental self-efficacy, mentalising, and positive child attributions appear nil to small.

There were several limitations to the augmented PCIT provided to Troy's family. First, only the augmented CDI phase was completed; the necessary return of parental authority (chiefly targeted in PDI) has yet to occur. Consequently, this intervention would be more accurately described as augmented CDI. Secondly, by adding sections 3, 5, and 6 to the parent-child sessions, and including five parent only sessions, the provided "dose" of CDI was reduced. Third, the addition of multiple elements (attachment coaching, emotional training, and mentalisation practice) into parent-child sessions resulted in small "doses" of each of the added interventions. These doses may have been too small to have effected change. The addition of fewer, more potent, augmentations might have been more effective. Fourth, the addition of the emotional training module involved parent-led interactions. In standard PCIT, parent-led interactions (compliance training) is delayed until PDI, leaving CDI a purely child-led experience. Fifth, the use of PCIT for a 7–8-year-old is outside the established evidence base for this treatment. Sixth, as specific assessments of each targeted domain were not employed (e.g. attributional measures, assessments of parental reflecting capacity and attachment classification), qualitative or categorical changes in these domains could not be measured. Only clinical observations and parent/teacher reports of change were included. Similarly, post-intervention ECBIs have not yet been returned, so cannot be compared to pre-treatment ECBIs (which were well in the clinical range). Finally, as augmented PCIT took place alongside other parent-selected treatments (a short and unsuccessful retrial of Risperidone, brain biofeedback and peer mentoring), it is not possible to attribute the observed improvements described above to the augmented PCIT.[28]

Conclusion and Future Directions for Augmenting PCIT

The heterogeneity in child onset conduct disorder and its associated broad-spectrum disruptions to child socio-emotional development, parent-child interactions, and family functioning, mean that a one-size-fits all approach to treatment will not work for some families. For the one-third of families who do not show improvement with evidence-based behavioural interventions, theoretically compatible augmentations are needed (Scott & Dadds, 2009). In my opinion, the complexity and heterogeneity of *both* child and parental presentations should be considered to allow for carefully matched augmentations. Troutman (2015) presents a useful method of conceptualising and working with parental attachment state of mind in parent coaching. Similarly conceived and used pre-treatment assessment of parental attributions and reflective capacity would be useful additions to behavioural treatment programmes. They could guide which (if any) augmentations to standard treatment are needed. Further exploration of the most effectual method of delivering augmentations would be useful (i.e. via additional treatment modules, or interspersed throughout live coaching or videotape review). Investigations of effective doses of

[28] This article's purpose is to describe a piece of clinical work; it is not intended as a single case design.

augmentations would also be valuable. Detailed clinical case reports of augmented treatment methodologies would yield productive ideas for the development of sophisticated randomised control trials.

For young children with conduct and attachment difficulties, family change needs to be driven by change in parental responding. Troutman's (2015) clinical examples and my experience with Troy's family, demonstrate the ease and utility of integrating behavioural and attachment parent coaching in PCIT. As mentioned, it has been my experience that when attachment difficulties and child onset conduct disorder co-occur, treatment outcomes are poorer. This suggests that one avenue for future research would be to investigate how pre-treatment child (and also parent) attachment categorisation impacts response to standard PCIT. Further, the relative effectiveness of standard PCIT versus PCIT augmented with attachment coaching could be investigated for conduct disordered children with/without, comorbid attachment difficulties.[29] Similar investigations could be conducted comparing standard PCIT with specifically-augmented PCIT for clients identified to have negative parental attributions or low reflective capacity.

PCIT research is already expanding to examine the additive benefits of PCIT and emotion coaching for pre-schoolers, and is using physiological measures of emotion regulation (Lieneman et al., 2017). Similar investigations for older children in the older PCIT age range would be useful to expand treatment options for families with entrenched low CU conduct problems and poor emotion socialisation.

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Therapists' Perspectives of the Therapeutic Needs of Stepfamilies in New Zealand

Ariana Krynen

Stepfamily researchers have given almost no attention to therapists' experiences of working with stepfamilies. This doctoral thesis study aimed to address this gap in the literature using interviews conducted with 12 therapists in New Zealand experienced in working with stepfamilies. In particular, this study aimed to investigate New Zealand therapists' perspectives on the difficulties with which stepfamilies present to therapeutic services, the approaches they use in working with stepfamilies, and the therapeutic and support service needs of stepfamilies in New Zealand. This paper presents an overview of findings in relation to the study's aims. Implications for future research are briefly discussed.

Introduction

Considerable research and clinical contributions have been made to better understand stepfamilies, and the unique challenges they face (for a review see Ganong and Coleman, 2017). Stepfamily relationships and functioning are influenced by experiences associated with separation and divorce (Ganong & Coleman, 2017; Pryor, 2014), as well as stepcouples' expectations of stepfamily living (Ganong, Coleman, & Weaver, 2002; Smith 2008). In the largest longitudinal study of divorce and remarriage, Hetherington and Kelly (2002) found that stepcouples often attempt to form a family based on norms associated with the "nuclear" family (i.e. two parents and their child/ren), and experience difficulties in achieving this. However, stepfamilies are more complex than first-time families (Ganong & Coleman, 2017; Pryor, 2014). Couples in stepfamilies must simultaneously develop the stepcouple relationship, maintain parent-child relationships, build effective co-parenting relationships, and develop the stepparent-child relationship (Browning & Artelt, 2012). Much of the international (e.g. Ganong & Coleman, 2017; Hetherington & Kelly, 2002) and national research (e.g. Cartwright & Seymour, 2002) suggests that a key challenge for stepfamilies is to develop stepparent-child relationships that are acceptable to both the child/ren and the stepparent. Recommendations in regard to developing this relationship include acknowledging the importance of parents to children and the need for stepparents to slowly develop a relationship with stepchildren before taking on a parental role (Ganong & Coleman, 2017; Hetherington & Kelly, 2002; Pryor, 2014).

Researchers (e.g. Ganong & Coleman, 2017; Hetherington & Kelly, 2002) have often referred to the views of well-known stepfamily therapists (e.g. Visher and Visher, 1996; Papernow, 2013). However, there has been no research attention given to understanding stepfamily therapists' experiences of working with stepfamilies. We also know little about the therapeutic and service needs of stepfamilies in New Zealand. This study attempted to address these gaps in the literature. The research questions guiding this study were: i) what are the difficulties with which stepfamilies present to therapeutic services in New Zealand; ii) what therapeutic approaches and interventions are used by therapists in New Zealand to assist with these difficulties; and iii) what are the therapeutic service needs of stepfamilies in New Zealand.

Ariana Krynen recently completed her Doctorate in Clinical Psychology at the University of Auckland. She is currently working as a Clinical Psychologist in a child and adolescent mental health service in South Auckland.

Methods

Recruitment

Ethical approval was obtained from the University of Auckland Human Participants Ethics Committee. Potential participants were found through an internet search of individuals who advertised as providing therapeutic support services for stepfamilies in New Zealand and those who were recognised as having specialist stepfamily knowledge and experience. These individuals were sent an invitation to participate in the study via email or post. Participants were also recruited through an advertisement distributed via the New Zealand College of Clinical Psychologists' email list.

Participants

Demographics. Twelve individuals experienced in providing therapeutic services to stepfamilies participated in this study. There were four male and eight female therapists, aged 43–67 years (*M* = 56.0 years; *SD* = 8.3 years). All were of European descent. Six therapists were based in the Auckland region, three in Christchurch, two in Wellington, and one in the Bay of Plenty.

The therapists came from a variety of professional backgrounds. Five therapists were counsellors with two describing themselves as family therapists, three were clinical psychologists, three were social workers, and one was a general-registered psychologist. On average, the therapists had provided therapeutic services to stepfamilies for 18.5 years (*SD* = 8.0 years; range = 6.5–31 years). Three therapists had previously facilitated stepfamily groups. Three therapists had authored books related to stepfamilies, three had facilitated workshops for professionals on working with stepfamilies, one had a website dedicated to providing information for stepfamilies, and four had lectured on family therapy at New Zealand tertiary institutions. Three therapists had attended formal training or workshops on stepfamilies.

At the time of the interview, 11 therapists were in private practice, and one was working in a non-government organisation. Five therapists had previously worked with stepfamilies in the public health system. Two therapists reported only working with stepfamilies; one facilitated a group for stepcouples, and one ran workshops. The therapists' clients were predominantly of European descent, with all but one therapist having this ethnic group comprise 75%–90% of their work.

Data collection

Interviews. Four therapists were interviewed in person, and eight via telephone or Skype. A semi-structured interview schedule was followed using largely open-ended questions. The interview explored the therapists' experiences and perspectives of the common difficulties with which stepfamilies present, the main therapeutic approaches and interventions they use, and their views on the service needs of stepfamilies in New Zealand. Interviews lasted for 40–100 minutes (*M* = 65 minutes).

The therapists were guaranteed confidentiality and anonymity of any quotes that were used. One therapist, an author in the field of stepfamilies, requested acknowledgement of her quotations.

Data Analysis

Interviews were transcribed by a professional transcriber. NVivo 10 software assisted with data management. Data from the interviews were divided into four sets. Thematic analyses were conducted on two of these datasets: presenting difficulties and therapeutic interventions. The data in each set were analysed thematically by the first author using the methods described by Braun and Clarke (2006). Following familiarisation with the data in each set, units of data were examined, and systematically coded for content and meaning. The codes were then examined for

their relationship to each other, and sets of related codes were grouped, leading to the development of the initial proposed themes. These were then examined by both the first and second authors, inconsistencies were identified and adjusted, and the themes were finalised. The data related to therapeutic support-seeking behaviours and therapeutic service needs included quite brief comments. These were collated using a method of categorical analysis (Bowling, 2002). This was also reviewed by the second author.

Results

Findings from the qualitative analyses are presented below, beginning with those related to stepfamilies' support seeking-behaviours and presenting difficulties. This is followed by the analysis related to the main therapeutic interventions employed by the therapists. Finally, therapists' perspectives of the therapeutic and support service needs of New Zealand stepfamilies are presented.

Seeking Therapeutic Assistance

Stepcouples' support-seeking behaviours. All of the therapists described stepfamilies as experiencing the same difficulties that can be found among first-time families, namely communication problems and problematic parenting approaches. However, the unique challenges arising from living in a stepfamily were noted as often underlying the problems for which the stepcouple sought support. As one therapist highlighted,

> *They will come with a whole panoply of issues, but a lot of those issues can be subsumed under the fact that they are trying to navigate problems that come about because they have blended families together.* (Participant 10)

Many therapists mentioned that children were often identified by the stepcouple as the main source of difficulty. In addition, many therapists observed that women typically initiated contact, which was hypothesised to occur because of the socialisation of women. In addition, many therapists observed that stepfamilies were often at breaking point when they sought assistance. Therapists noted that stepfamilies may not seek support earlier because of a range of reasons including the time it takes to recognise they need support, and to avoid feelings of failure and stigma associated with therapy. However, many therapists also noted they did not observe any significant differences between stepfamilies and first-time families in their support-seeking behaviours. Encapsulating this, Participant 5 stated, "I don't think anybody finds it easy to go and talk to a complete stranger about your most intimate private life."

Presenting Difficulties

Four main themes emerged from the therapists' observations of stepfamily presenting difficulties.

Unrealistic expectations about stepfamily life and relationships. Most therapists observed that stepfamilies hold unrealistic expectations, including hopes and dreams, about stepfamily living. Common misconceptions included the stepcouple anticipating that everyone will like and get along with each other, and that the stepparent and stepchildren will quickly develop a loving relationship. These misconceptions were seen as arising from stepfamilies' attempting to act like a first-time family. As Jan Rodwell explained,

> *I would say that the most common issue is they go in with that expectation and behave as though [having a first-family] is what they've got and they don't…The expectation is…loving instantly and expecting to discipline, expecting households to go in certain ways rather than a whole process of negotiation of everyone's roles, relationships, expectations…They just think we are doing "family" and we know how to do that, but*

it's this nuclear family model.

Stepfamilies were described as often being unprepared for the adjustment and commitment required to navigate the challenges associated with being in this type of family unit. When faced with these unexpected challenges, stepcouples were seen as sometimes experiencing panic, a sense of failure, reduced self-esteem, and/or interpersonal conflict, while the children were described as struggling with the stepcouple's expectations of wanting to become an instant, happy family, and adjusting to family changes.

Lasting impacts of the original family. Most therapists highlighted that relationships with former spouses and feelings associated with the original family can create problems for stepfamilies. For example, most observed that some stepparents felt threatened by their partner's former spouse. In addition, some noted that the actions of former spouses, such as trying to "win back" their ex-, could lead to stepparents feeling "quite a lot of jealousy, a sense of vulnerability and threat, as well as trust issues in the new partnership or the new marriage" (Participant 4).

Some therapists also spoke about co-parenting challenges, including those related to Court-ordered financial and child care arrangements. Further, therapists described children as having difficulty adjusting to their parents' separation and transition into the stepfamily. They could also feel guilty and disloyal to the other parent if they form a relationship with their same-sex stepparent. As one therapist described,

> *Children very often have that conflict about "if I am loyal to my new stepparent, I am betraying my biological parent.* (Participant 3)

Stepparent role challenges. Therapists observed that the strong relationship between parents and children often leads stepparents to feel alone and on the outer of the family unit. Contributing to this, some stepparents reported feeling as if their stepchildren were deliberately excluding them from the family, or interfering with the stepcouple's relationship. One therapist explained,

> *From what they describe, you could only describe it as [if] they've been actively targeted by a stepchild, either in a hurtful way, or in an excluding way…Sometimes directly saying "you're not my parent, you are not my mother, I won't listen to you"…sometimes making choices to exclude the stepparent.* (Participant 4)

The therapists also described stepparents as having mixed feelings toward their stepchildren, including jealousy and anger, for which they felt guilty. Stepparents expressing negative feelings about their stepchildren leads to loyalty conflicts for parents, and conflict between stepcouples. Further, some therapists described parents as struggling to meet and balance the needs of their children and partner.

Problems in parenting together. Many therapists observed that stepparents and parents often have different perspectives and practices in relation to parenting. In addition, several problematic parenting styles were seen to occur, including over-compensatory parenting by divorced parents, and polarised parenting among stepcouples.

The majority of therapists thought that the stepparents they saw felt some ambiguity regarding the stepparent role. While some were hesitant to adopt a parenting role, others had the expectation that the stepparent would take on a role similar to that of a parent. Further, it was observed that some stepmothers found themselves responsible for the care of stepchildren

because of gender expectations. As one therapist explained,

> *I think it's challenging for women; they kind of get cast into the role of being the female. Because she's the female in the house, she's therefore the carer…for these kids who aren't her biological kids. Therefore, somehow she needs to be the mother and everything that that entails…I think maybe this kind of goes back to the way we tend to socialise people along gender lines, especially women as being caregivers*. (Participant 12)

The therapists noted that without first establishing a relationship, stepparents who adopt a parenting role are often met with resistance from children, although this can be dependent on the age and developmental stage of the children. Such misconceptions that stepparents can adopt a parenting role soon after forming a stepfamily were seen as being based on nuclear family norms.

"What Works": Main Therapeutic Interventions

The therapists referred to a range of theoretical orientations and modalities that guided their therapeutic practices. Half of the therapists used family systems theory in their work, and one-quarter referred to using behavioural, strengths-based and/or solution-focused approaches. Other theoretical orientations and modalities included emotion-focused therapy, differentiation-based and developmental approaches, Imago therapy, self-compassion work, narrative therapy, and cognitive behavioural therapy. The two group therapists reported having a child-focused orientation.

Most therapists (75%) reported solely working with, or having a preference for working with, the stepcouple. Three therapists also described sometimes including both divorced parents in interventions related to co-parenting. The therapists' rationale for preferring to work with the stepcouple was based on family systems theory, as stated by Participant 4,

> *The belief I have about how families as systems seem to adjust best and do best is when the adults are making efforts to bring about changes in that family system, then they are able to bring about changes for children. I believe that you can effect change for a child through effecting change for a parent.*

The remaining therapists (25%) involved children in their therapeutic work. Two therapists described initially working with the adults, with the children attending in later stages of the intervention. The third therapist reported that they included children in approximately 5% of their work with stepfamilies. One stated that their rationale for involving the children was to give "kids buy-in and a voice in interventions" (Participant 11).

Three main themes emerged in relation to the therapeutic interventions adopted by the therapists, which are presented below.

Increasing awareness and insight into stepfamily challenges. This theme encapsulated the assessment phase of intervention with stepfamilies. The therapists spoke about assessing for common stepfamily difficulties, as well as any unique individual and family differences, to develop an approach that meets the stepfamilies' needs. This process was viewed as helping to facilitate both the clients and therapists' awareness and understanding of the stepfamily's difficulties, strengths, and culture. As one therapist said,

> *Paying attention to the culture of the family is pretty fundamental. When I say the culture, I mean not just the ethnic culture but the way this family is, who they are. It's always what I used to say to students, "assess don't assume.* (Participant 10)

The therapists emphasised that stepfamilies are "way more complex than the original nuclear family, and [stepfamilies] need to be seen accordingly" (Participant 12). In particular, most spoke about not working with stepfamilies according to the nuclear family model, including during this assessment phase. Further, some therapists emphasised that therapists need to be cautious about what stepfamily subsystems they work with in their practice. This is because of the harmful interactions that can occur between stepfamily members, particularly between the stepparent and children, due to having not yet developed a strong bond and effective communication.

Working with unrealistic beliefs and expectations of stepfamily life and relationships. Some therapists emphasised the need for all therapists to be aware of commonly held misconceptions about stepfamilies, and help clients develop realistic expectations. This included providing psychoeducation on how long it takes to adjust to living in a stepfamily, that stepparents do not have to love their stepchildren, as well as challenging the myth that women should naturally adopt responsibility for childcare.

Most therapists also spoke about using psychoeducation to illustrate that the difficulties described by the stepfamily are typical of many stepfamilies. This shifts the stepfamily's beliefs from there being something wrong with them, or their family, towards an understanding that their particular difficulties are also shared among other stepfamilies, thus normalising their situation,

> *Sometimes there are things that are useful for people to know. For instance, when they are blaming each other wildly…I might ask, "How do you understand it? I've seen five stepfamilies in the last month telling me the same thing." You see how that gets out of individual blame and into "it's something about stepfamilies." And so they are then released from this.* (Jan Rodwell)

The two therapists who ran groups and workshops for stepcouples described the group process itself as having a powerful normalising effect, whereby "people feel supported and not alone" (Participant 2, stepcouple groups). Finally, some therapists spoke about facilitating the stepcouple to develop self-compassion, and adopted a strengths-focused orientation in their work to enhance resiliency and empower stepcouples to navigate challenges.

Assisting with skill development. Most therapists talked about using psychoeducation and skills from the first-family literature in their work with stepfamilies, such as "children's development and what they need, the parental coalition, and the couple relationship" (Participant 5). However, all of the therapists emphasised that most of the session content differs because of the "different body of knowledge and understanding" in relation to the structure and functioning of stepfamilies (Participant 10).

The therapists discussed providing psychoeducation and skills to assist stepfamilies in building and enhancing relationships, including the parent-child, stepparent-child, and stepcouple relationships, as well as the new stepfamily culture. This included recommending that parents have frequent uninterrupted time with their children to help counteract the perceived loss for children when their parents enter a new relationship. In addition, stepparents and stepchildren were encouraged to spend time together to develop areas in common. As one therapist said,

> *I work with the idea of reducing the triangulation that goes on between a parent, stepparent, and a child. I encourage stepparents to build some time with a child that they don't think they have anything in common with, and find things for them to do together.* (Participant 8)

The therapists also spoke about supporting stepcouples to develop effective parenting practices.

This included encouraging parents to take initial responsibility for disciplining the children, whereby "the stepparent acts as a kind of proxy for the biological parent, but they are not parenting in their own right" (Participant 5). Further, in relation to the co-parenting relationship, parents were encouraged to develop a "business relationship" with their ex-spouse. (Participant 11)

Therapeutic and Support Service Needs of Stepfamilies in New Zealand

Some therapists said they are aware of individuals who specialise in providing therapeutic services to stepfamilies, as well as some non-government organisations that provide group programmes for stepcouples. However, most therapists reported that, to their knowledge, stepfamily-specific services are not available or easily accessible in New Zealand. Most therapists noted that there are a number of barriers to stepfamilies accessing available services. A common factor identified was the affordability of private therapists who offer specialist services,

> *I think we certainly have the practitioners out there. We have people well-trained including in the specialist area of working with families and working with stepfamilies, but it's where to access them if you can't pay for yourself, and by that I mean pay privately.* (Participant 4)

Many therapists thought that a large proportion of stepfamilies are unable to afford these private therapists and services. However, it was also noted that services for families generally were difficult to access.

When asked what services should be available for stepfamilies, some described the need to have a "one-stop shop with a whole range of services," including government-funded "family therapy, couple therapy, exes co-parenting, and mediation" (Participant 1). Many identified support groups as another beneficial form of support, which stepcouples may be more likely to attend as they are more financially accessible and perhaps viewed as less stigmatised than therapy. The therapists also emphasised the importance of subsidised or free therapeutic services being funded by the government so that lower-income stepfamilies can access the assistance they require. Highlighting this, some therapists noted that the recent discontinuation of free counselling and mediation provided through the Family Court has had a considerable impact, as highlighted in the following quote,

> *The Family Court used to provide counselling for any couple struggling, whether they had children or not, and that was a godsend for stepfamilies. I think it's a tragedy that that has been discontinued…I think there is a terrible dearth of free counselling available for stepfamilies.* (Participant 5).

In addition, some therapists identified the importance of having stepfamily specialists across different services, or "a national organisation that could work collaboratively with local agencies to support the needs of stepfamilies" (Participant 6, stepcouple groups). Further, some therapists suggested that a publically available directory of services that offer therapeutic services for stepfamilies across New Zealand could be developed.

Some therapists highlighted the importance of clinical supervision for those working with stepfamilies, and the need for university programmes and workshops to provide training on how to work with stepfamilies. This was recommended to address the gap in the number of therapists who are knowledgeable and skilled in this area. Therapists also mentioned the importance of providing education to increase understanding and awareness of the unique differences of stepfamilies compared to first-time families, and the challenges they experience. Many therapists suggested that this could be facilitated through online information providing evidence-based advice and suggestions for common stepfamily difficulties,

I think it's crazy not to do something about educating the public about how hard it is and where to go for help and some basic tips. The government could fund a website with lots of useful information on it and so on. (Participant 5).

Finally, some therapists suggested that the "shallow, clichéd, and not very sophisticated" messages of stepfamilies portrayed in the media (Participant 1) need to change to help prevent the development of unrealistic views on what stepfamily living entails.

Discussion

Overall, the difficulties with which New Zealand stepfamilies present to therapeutic services, as identified in this study, largely reflect the existing international literature on stepfamily difficulties (e.g. Ganong & Coleman, 2017). Further, the approaches adopted by the therapists in their therapeutic work appear to align with international literature, including the importance of realistic expectations about stepfamily relationships (Hetherington & Kelly, 2002) and the stepcouple developing effective parenting practices (Papernow, 2013; Visher & Visher, 1996). The therapists in this study also spoke about the lack of stepfamily-specific services in New Zealand and the barriers they face in accessing available services. To meet the needs of stepfamilies, therapists recommended that a range of services be available, including: a service for stepfamilies offering family therapy, exes' co-parenting, and mediation; support groups; and a national organisation devoted to supporting stepfamilies. Further, education provided to wider society to increase understanding and awareness of the unique differences of stepfamilies was also seen as desirable.

The findings of this study may inform the provision of therapeutic services provided to stepfamilies, both nationally and internationally, to enhance outcomes for these families. However, more research is needed to evaluate therapeutic interventions for stepfamilies experiencing difficulties to develop evidence-based therapy practises that are effective for these families in their many variations and complexities. There is also evidence of some cultural differences in stepfamily expectations and practises (Ganong & Coleman, 2017); therefore, it is important to develop understanding of the difficulties experienced by, and the therapeutic approaches that are appropriate for, Māori and Pasifika and those from other cultural groups.

Conflicts of Interest

None to declare.

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Book Review

Title:	**Getting unstuck in ACT: A clinician's guide to overcoming common obstacles in acceptance and commitment therapy**
Author:	R. Harris
Publisher:	New Harbinger Publishing: Oakland, CA, USA (2013)
Reviewer:	Peter Stanley, PhD, counselling psychologist, Tauranga

In 2014 I attended an introductory workshop with Russ Harris on acceptance and commitment therapy (ACT) and it made a big impression on me. There were aspects of this course that were unique in my experience. Firstly, while there could have been up to 100 people present, Russ was able to successfully provide individual psychotherapy training to a gathering that was this large. A second distinctive aspect was an ACT case demonstration on the second day. Russ called for volunteers and a woman came forward who had repeatedly experienced major trauma; she was presumably unknown to the trainer. The therapy session seemed magical, as he took her from strong expressions of emotion to committing to some new actions in less than an hour, and all this happened before an audience made up of psychologists, medical practitioners, counsellors, and others.

The ability to use this therapy system is not easily obtained, and Russ Harris himself says that it usually takes 2–3 years of study and practice to become proficient with ACT. It is one thing to understand the model (and another thing again to understand relational frame theory that underlies it), but success with ACT is in the application, and in its flexible and fluid use in particular. It is easy for practitioners to become "stuck" with clients, and the purpose of the present book is to address the obstacles that can be encountered on the path to proficient practice. With scripts, strategies, and recommended exercises, Russ shows how therapists can respond with ACT to mandated clients, unmotivated clients, abusive clients, and those clients who are highly distressed, distractible, dissociative, coping with a difficult decisions, or grieving.

Russ Harris emphasises that therapists who are stuck with clients have access to the same processes as their clients for moving forward. They may need to be more present, open up, and do what matters. Certainly, this is more preferable (and workable) than reacting to a client with some sort of conceptualisation or label that proclaims that he or she "has the problem" and is damaged. As the author puts it, "we build the strongest therapeutic rapport when we defuse from our unhelpful thoughts, make room for our own discomfort, act in line with our values, and engage fully with the client" (p. 14). Significantly, Russ says that he will usually only permit two sessions of total "stuckness," with no increase in psychological flexibility, before referring on to another practitioner. A more typical last resort, however, is to assist the client develop self-compassion through mindfulness and acceptance skills. Again, these processes are as relevant to the stumbling therapist as they are to halting client, and in both cases they can make room for new beginnings.

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This author's special ability is in making ACT principles accessible, and he has done this in a number of publications, including *The Happiness Trap* (2008) and *ACT Made Simple: An Easy-to-Read Primer on Acceptance and Commitment Therapy* (2009). The present volume is a practice aide, and it will really only have meaning when there is an intention, or ongoing commitment, to engage as an ACT therapist. Even then, there needs to be a reasonably high level of dedication to assimilate the numerous steps and strategies, and the many subtleties and sidesteps that this text presents. Nonetheless, as indicated, ACT is in the "doing." When therapists aspire to levels of competence that can allow them to speedily enact behaviour change processes with clients, then *Getting Unstuck in Act* by Russ Harris may be a very useful resource to have.

Book Review

Title: **Stuff that Sucks**
Author: Ben Sedley
Publisher: Little Brown Book Group, London, United Kingdom (2015)
Reviewer: Kimberley Sutherland

When I sat down to read this book, from the beginning I felt immediately drawn in by Ben's style of writing, where it felt as if he was right there in the room, chatting to me. *Stuff That Sucks* is written for adolescents who are struggling with psychological difficulties, based on concepts derived from acceptance and commitment therapy (ACT). The style of writing is informal and relatable to adolescents. It is packed with creative ideas, insights, and metaphors to help young people navigate through societal demands and difficult emotions.

It starts by validating the reader's emotional experience (which I found incredibly soothing after a frazzled Saturday afternoon). This is followed by a breathing exercise written in such a way I felt compelled to do it! I thought this was clever, as it mindfully relaxes the reader into the next chapter. What follows is an adolescent friendly description of different emotions in their rawest form, unhelpful thoughts ("I'll fail at everything," "I suck") and negative personal labels. Ben also provides a very good, simplified explanation of how brains work, from a Stone Age perspective. The reader is then taught how to manage/accept emotions, understand and connect with what really matters to them and take action. Big questions, particularly relevant to young people are also explored such as "what's the point of it all?"

In the spirit of ACT, this book is highly experiential; however, unlike other books, I found myself actually carrying out the exercises (which helped me reconnect to some of my own forgotten values). I put this down to Ben's informal style, where I felt he was right there, encouraging me along.

Ben also addresses issues that are particularly difficult for adolescents (and adults) of today. This includes society's unhelpful messages, fitting in, feeling trapped by others expectations, and self-identity. Given the rise of mental health difficulties in adolescence, this book is certainly timely. I would absolutely recommend this book to my adolescent clients who are struggling, as well as any therapist who has an interest in ACT but is not sure where to start.

Kimberley Sutherland is a senior clinical psychologist working in private practice and at the CCDHB in Wellington. She is trained in advanced ACT therapy.

Book Review

Title:	**Out of the Woods. A Journey Through Depression and Anxiety**
Author:	Brent Williams
Illustrator:	Korut Öztekin
Publisher:	Educational Resources Ltd., NZ (2017)
Reviewer:	Margaret McConnell

Out of the Woods is a personal account of author, Brent William's, struggle to overcome the depression that overwhelms him in his middle age. The compelling illustrations of this graphic novel immediately draw the reader into the depths and darkness of his despair. While he seems to be stuck in the woods of his own negative thoughts and emotions, a positive character emerges who begins to challenge his thinking, introduces the idea that his thoughts are taking him deeper into the woods, and encourages him to start taking better care of himself. He fruitlessly searches for physical causes for his low mood and struggles to overcome it by himself, until his helpful guide shows him how isolating himself from others and withdrawing is exacerbating his depression to the point where he develops suicidal thoughts. His guide urges him to seek help, and he reluctantly goes to his GP who tells him that what he is experiencing are all the symptoms of major depression. However, he feels depression is a weakness and insists that he can overcome it without medication. The guide explains what is happening to the neurons within his brain with the aid of some very effective illustrations depicting how stress chemicals are affecting his brain, heart, and immune system, and contributing to the pain he is feeling. Then he experiences his first panic attack. The fierce impact of this is graphically portrayed so that the reader feels his fear and terror as he is besieged by unknown demons. Fortunately his guide appears to assure him he is safe, and helps him breathe till it passes.

Brent then takes us along on his journey exploring different strategies to deal with his depression. He tries to engage with a psychologist but fails to connect. He begins monitoring his mood and journaling. His guide shows him his library of negative thoughts which contains many volumes with titles such as "my failings" and "shameful things and unresolved conflicts," which he adds are mostly works of fiction. The link is made between negative feelings of guilt, self-loathing, and fearfulness to anxiety, depression, and exhaustion. He improves his self-care with healthy eating, and learning skills of slow breathing, relaxation, and mindfulness. After several unsuccessful attempts with therapists offering different approaches to treatment, he finds the one that feels right to him. Within this safe environment, memories emerge of his critical, abusive father who he could never please. While he continues with regular therapy, he experiences the roller coaster ride of fluctuating mood and makes more lifestyle changes incorporating regular exercise and reconnecting with music, the natural world, and supportive friends, and rebuilding his relationships with his children.

The direct, simple text, together with the beautifully crafted graphic images employing skilful use of colour to convey emotion, gives the reader a powerful insight into the emotional turmoil of battling depression and anxiety. It is experiential as well as informative and educative, and provides an introduction to the spectrum of strategies helpful in managing these conditions. It is of considerable value to anyone living or working with depression or anxiety, whether they are clients, partners, families, friends, co-workers, health professionals, or students. Understandably, it is particularly well targeted for middle aged men who like Brent, struggle to recognise and

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acknowledge their battle with negative mood. Above all, it offers that most important ingredient for therapeutic change; hope that with perseverance and appropriate support positive changes can be made.

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
Auckland	8-9 February	Paul Stallard/Adapting CBT for the treatment and prevention of emotional disorders in children
Wellington	20-21 February	Matt Villatte/Mastering the Clinical Conversation: Language as Intervention
Auckland	22-23 February	Matt Villatte/Mastering the Clinical Conversation: Language as Intervention
Nelson	17-18 March	NZCCP National Conference: Nurturing change: Moving children and adults through adversity
Nelson	15-16 March	NZCCP pre-conference workshop: John Briere/*Working with dysfunctional avoidance and self-endangering behaviors in adolescents*

Other Events

LOCATION	MONTH	PRESENTER/ CONTENT
Dunedin	8-9 February	Workshop in Suicide Prevention
Wellington	26 February	NZ-SIGN workshop: Neuropsychological Feedback
Christchurch	7-10 March	Practitioner Training - Emotionally Focused Therapy Externship
Wellington	7-8 May	Acceptance and Commitment Therapy 2 Day workshop
Auckland	22-24 August	Level 2 (Advanced) Schema Therapy Practitioner Training "Schema Therapy - Beyond the Basics"