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The Specialist Organisation for Clinical Psychologists

Ko au te taupā kīhai i puawai aku moemoeā
I am the only boundary to the fruition of my dreams

Editorial

Dear Colleagues

Another year draws to an end, and it is my great pleasure to bring you this journal. Our theme for this issue was 'Out of our comfort zone', and in line with that, I decided to offer some lucky person the chance to be a guest editor of the journal. I was very surprised that we were not inundated with offers, but very grateful indeed that Nicole Winters offered her help. So, in keeping with the theme of this journal, I am co-writing this editorial with Nicole and stepping out of how I usually do things.

We noticed that this theme does not seem to have been as popular as previous themes, and I was curious if you had any ideas why this might be, or if there were specific themes you did want to see represented. We were keen to hear what you think of whether we should carry on with peer reviewing the journal with a view to being indexed in databases. There are pros and cons for different authors who come from different backgrounds. Thank you to those of you who completed the survey to let us know what you think!

We are immensely grateful for our authors and the wonderful work of our reviewers who anonymously work in the background and often have very thoughtful and helpful comments to make that improve what authors create. If we plan to continue on the path of indexing, then peer review is necessary. We are always in need of reviewers (and authors, by the way!) so please drop us a line if you are keen. Our upcoming theme is 'What we wish we had been taught', but we may change it depending on any suggestions that you might have.

Wishing you and yours the best of the holiday season, and hope you enter 2019 rested and recharged. Look forward to connecting with you in the New Year.

With great warmth
Kumari & Nicole

Troubling Emotions—Reflections on Psychologists' Emotional Comfort Zone

Dr Helen Van Der Merwe

The theme for this edition, 'out of our comfort zone', made me think of my doctoral research into psychologists' emotional practices within the therapeutic relationship. Here I reflect on how being in the comfort zone—or out of the comfort zone—can relate to our emotions as psychologists. What emotions feel right in our professional practice, which ones are troubling, and how do we learn the difference? I argue that there could be benefits to stepping out of our emotional comfort zone and taking a more critical reflective approach. My research analysed data from focus groups and individual interviews conducted with a small sample of early-career practicing psychologists. While I refer to my findings here and provide some extracts as illustrations, this is intended to be a reflective piece rather than an academic article (for a detailed exegesis of the project see Van Der Merwe, 2017 and Van Der Merwe & Wetherell, 2018). Rather than rehash my research here, my intension is to reflect on how it relates to the notion of the comfort zone, and as such it is necessary for me to give an overview of the key findings without providing the context of a literature review. Should the reader wish to understand the context of these findings and my theoretical framework, my thesis reviews theories of emotion, how emotions are constructed in different types of psychological therapy, and the literature on psychologists' emotions within the therapeutic relationship.

Emotional Comfort Zones

First, I want to consider what the comfort zone is and how it came to be. From my social constructionist viewpoint, I suggest our emotional comfort zone consists of socially organised norms and expectations (Harré, 1986; Wetherell, 2012). In fact, I found in my research that there is not one clear set of emotional norms and sanctioned emotional practices. Instead there is a range of distinct (and sometimes contradictory) expectations about emoting as a psychologist. First, there is the notion that the psychologist's emotions should be controlled and not expressed. The role of the psychologist is to act as a detached scientist or a container for the client's emotions. Second, there is the notion that the psychologist's emotions should be natural and not faked or controlled. Here, the role of the psychologist is to provide an authentic, human encounter for clients. Finally, there is the notion that the psychologist should be an emotional chameleon, a multipurpose tool, adapting her or his emotions as required to bring about therapeutic change.

All of these are comforting positions—endorsed, authorised, and validated in the profession. Yet they also contradict each other at key points and produce some difficult dilemmas about how to be with clients. How can one be detached and contained and also express natural human emotions at the same time? Which is more important? How can the demand for authenticity be reconciled with the demand to produce the most effective emotional performance? Take a look, for example, at the extracts below from different participants puzzling about what it might mean to cry with a client. Note that pseudonyms have been used in all extracts.

> **Hayley**: …I personally draw the line at crying. I would never cry in front of a client [Helen: mmm], but I have seen co-workers [Helen: mhmm] leave the offices in tears with the clients [Helen: mmm] and that makes me deeply uncomfortable, and I think that that's…I don't know why I would draw the line there [Helen: yeah] but that's like never for me.

> **Tammy**: I think there might be a time and a place for the occasional tears… [Helen: mmm] and we were talking about that at work today as well whether that's acceptable behaviour or

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not [Others: mmm]. I think sometimes it's okay.
Amy: Yeah I guess…in doing that you're…communicating about emotion with your client [Tammy: yeah] aren't you…and kind of saying that's okay.
Tammy: Being human.
Amy: Exactly, being human, saying it's okay to feel this way.

The container viewpoint and the authentic human viewpoint construct risk in opposing ways. From the perspective of the container, expressing emotion is harmful to the client; as one participant said, expressing emotion is showing that you cannot cope, and this can be damaging for clients. Whereas from the perspective of the human, not expressing 'real' emotion is harmful for the client, as illustrated in the extract below.

Fiona: …but like you were saying before to build rapport and to seem validated [Helen: mmm] and to express empathy like there has to be emotion behind that [Helen: mmm yeah] and you can't really fake that [Helen: mmm]. Well, you'll be doing a terrible job if you're trying to fake it.

There are various attempts to resolve this dilemma, and the notion of the psychologist using their emotions as a multipurpose tool is important here—intentionally walking the tightrope of emotional expression and containment.

Jemima: Therapy is a sort of balance between the instinctual versus actually thinking things through before you act.

Pete: I think you've got to give a bit of yourself without crossing the line.

Fiona: That balance of like professionalism and, and like the risk side versus developing the relationship. It's such a fine line.

The point I want to make here is that our emotional comfort zone as psychologists is not singular or static and there are different patterns of practice, which although contradictory at times, are all constructed as legitimate. The various practices can be linked with different forms of psychological therapy, which themselves are socially and historically located as they were both produced by and served to reproduce the social and political climate they emerged within. Therefore, our emotional comfort zone in 2018 would differ from that of our predecessors because of the changing social and political climate.

Given the feedback loop between how we practice our emotions as psychologists and dominant social power relations (Rose, 1985, 1996), it is also important to think about how 'our' emotional comfort zone might actually reflect the socially sanctioned emotional practices for dominant social groups in terms of structures such as class, gender, and culture. For example, Reay (2005) suggested the "emotions and psychic responses to class and class inequalities contribute powerfully to the making of class" (p. 912). If 'our comfort zone' (the social rules and expectations for how we should be emotionally as psychologists) reflects the dominant social and cultural norms, what does this mean for psychology students and psychologists who come from different class, gender, and/or cultural backgrounds? Does it require more emotional labour for these groups to mould their affective practices into the required ways of emoting? Is there an impact on the retention of psychology students from minority groups? What is the flow-on effect for clients who come from diverse social and cultural backgrounds?

Uncomfortable Zones

Although my research showed variability in the types of emotional practices, it was also clear that there were certain types of emotional experiences that were considered professionally 'risky' and unwanted. Certain emotions were well and truly out of all comfort zones. The participants in my research not only talked about their ideal and preferred ways of emoting, but also about unwanted and troubling emotions, how they managed these, and why they might be particularly disturbing for a psychologist's self-concept. Here, participants spoke about feelings such as hopelessness, anxiety, frustration, and boredom.

> **Helen**: …I was just thinking about like what emotions psychologists commonly experience when they are in the therapeutic relationship. So I've heard anxiety, I've heard shock, I've heard...what else have...sadness, [Jemima: frustration] frustration (laughter from participants) [Sal: yup that's a big one sometimes] Just frustration or anger?
> **Jemima**: Oh yeah some anger. Not as much...for me, me it's more the frustration, occasionally hopelessness.
> **Sal**: Yup hopelessness.
> **Frances**: I think as well there's that kind of "oh my God, am I even helping them." Like I know that's hopelessness, but that kind of sense of...just that banging your head against a wall [Helen: mmm] and is anything I'm doing…working [Helen: yeah].
> **Jemima**: And then related to that sometimes I just feel useless (laughter from all).
> **Frances**: Yeah useless.
> **Jemima**: It's like, "well I suck" (laughs).
> **Frances**: That's when I go off and get good supervision and lots of reassurance (laughter), all of that. That comes in waves I find.

Participants often confessed to having these 'unprofessional' feelings, then hedged them with a more professional or formal discourse, as seen in the extract above where the talk of troubling emotions was bracketed by the more formal practice of supervision. Participants spoke about some emotions, such as frustration, being harder to suppress and sometimes needing to resist the urge to tell clients what they really thought. They suggested that the need to suppress these unwanted emotions in the work context meant that they emerged in their personal lives and impacted on their personal relationships.

> **Kate**: During my first year I <u>particularly</u> remember on a Friday night just feeling like I was carrying...[Amy: oh yeah, yeah] carrying lots [Others: mmm]. And it took me <u>ages</u> to wind down and I remember just being irritable all the time…

All participants said that being able to off load about these emotional troubles with trusted colleagues was helpful in alleviating the build up of emotional pressure.

> **Fiona**: …we're a very tight team [Helen: yeah] and I think that's really, really important [Helen: yeah, Tracy: mmm], that's been the biggest thing, so like I'll go up and have a massive cry [Helen: mmm] whether it's about personal stuff or about client stuff and it will probably be half and half [Helen: yeah] or have a massive bitch.

However, this talk about troubling emotions and informal off-loading with colleagues was marginalised in favour of the more sanctioned formal activities of reflective practice, self-management, and self-care. The expectation that psychologists will form 'genuine' emotional connections with clients means that there is nowhere to 'put' the troubling emotions confessed to because they are constructed as inappropriate everywhere, except as a sign that one has not yet 'learnt how to be'. Psychologists' emotional labour becomes more of a personal project and

the exchange of certain emotions for remuneration is hidden within their subjectivity. Psychologists are expected to embody a perfect, worked over, emotionally limber self, and as psychologists we may feel out of our comfort zone when we do not embody this sort of self.

Since the Enlightenment and the privileging of the scientific method, emotional expression has been equated with irrationality, and the assignment of reason has been used to bolster the authority of dominant groups and emotionality to discredit subordinate groups (Harding & Pribram, 2004). Therefore, expressing strong emotions is likely to be 'risky' for most professionals. I argue that the difference for psychologists is that merely displaying the expected emotions is not sufficient, and we are expected to do what sociologist Arlie Hochschild called 'deep acting' and work on ourselves so that we 'really feel' the required emotions (Hochschild, 1983). I am not arguing that aiming to be emotionally sorted is necessarily a bad thing. However, I think it is troubling that the pressure to embody 'healthy emotions' is not explicitly discussed or open to critique. It is a guilty secret that many psychologists (especially early in their careers) feel like frauds helping others manage their emotions when their own emotions can feel unruly. The expectation that psychologists will be poster people for healthy emotions can make it professionally 'risky' to discuss times when we feel we are not living up to the ideal. While supervisors may or may not be open to discussing their supervisees' troubling emotions, supervisees may not feel comfortable bringing these emotions to supervision. For example, most participants distanced themselves from having experienced emotions such as sexual attraction and anger towards clients themselves and some said that if they hypothetically ever did experience such emotions, they would not be able to talk about them with their supervisors. These emotions are so far out of the comfort zone that they become unspeakable.

Learning About Emotional Comfort Zones

Writing this here and conducting the research more generally was to some extent out of my own comfort zone. Reflecting on the way my own practices could be reproducing dominant social power relations was uncomfortable. I do not think anyone would go into psychology as a career with the goal of reproducing hegemonic power relations. However, writing about these issues and talking candidly about the full spectrum of emotions psychologists experience does feel different now that I am qualified. Having entered the profession, the element of anxiety that I will not be deemed worthy enough to pass the standard has largely been removed. Now, reading back on some journaling of my emotional responses while studying, it is painfully clear that there were very limited safe spaces to talk about these experiences. This was also the experience of many of the research participants, as illustrated in the extract below where a participant reflected on what she would have liked to have been different in her training programme.

> **Amy**: Well for starters I guess just acknowledging...how difficult the work is [Helen: mhmm] in terms of its drain on your energy [Helen: yeah] and emotional resources [Helen: yeah] and for the lecturers facilitators to listen and be open to students' experiences while they are on placements [Helen: mhmm, yeah] and...not judging students for having particular experiences because that is something that I felt [Helen: mmm] did happen [Helen: okay], is that if you...talked about...feeling particular ways while you were on placement that was kind of seen as you weren't coping.
> **Helen**: Mmm and then what would be the repercussions of that?
> **Amy**: Um...well...not positive. Um ultimately you are kind of asked about whether you should continue or whether you are struggling [Helen: mmm]...Like it really was seen as...something that wasn't...it was a sign that you weren't going to be a good psychologist basically if you were having emotions about being on placement and having clients for the first time.
> **Helen**: Mmm and what sort of emotions are you thinking of?

Amy: Oh anything really, but just like I was referring to before, mainly the—how much...it drains your emotional resources.
Helen: (overlap) Draining, overwhelming, stressed [Amy: yup], anxious.
Amy: Yup and how you take on the client's emotions [Helen: mmm] and feel everything that they feel, and so that can trigger a lot of stuff [Helen: mmm] in the psychologist and…I didn't really feel like we were allowed to express that safely [Helen: mmm] with those that were teaching us [Helen: mmm]. So that is a massive thing I think, is just <u>open</u> communication [Helen: yeah], asking us how we're doing and not judging us for our responses [Helen: yeah] and for it not to affect our um our grades [Helen: mmm] or our…the perception of how well we were coping.

Even those participants who said that there was more space for open discussion about emotions within their training still said that the range of emotions discussed was limited, excluding more taboo emotions such as anger or disgust. While participants' reports of how much their emotions were discussed within their training varied, there was a consensus that the emotional work involved in being a psychologist could (and should) have been discussed more candidly. Other authors have noted the reluctance to talk about troubling emotions. Maroda (2009) noted "the client's emotional impact on the therapist is arguably the most neglected area in therapist training" (p. 6). Morstyn (2002) suggested that manualised psychotherapies simply instruct therapists on how to simulate sincerity and play the role of the warm and seemingly genuine therapist. Others have suggested that there could be a reluctance to talk about the emotional labour involved in working with clients resulting from the social expectation for mental health workers to be emotionally detached (Coates & Howe, 2015; Mann, 2004).

Even when psychologists' unwanted emotions are discussed, the options we have for understanding our situation are usually reduced to individualised explanations such as stress and burnout. When the problem is constructed as being within the individual psychologist, it follows that the 'solutions' for managing these troubling emotions are also located there. Alternative assumptions are not considered; for example, it is typically not suggested that an emotional toll could result from being part of an uncertain profession that may or may not be fulfilling a social role, or that an emotional toll could come from working with clients within wider systems that maintain inequality, limiting what can be achieved in psychological therapy.

Stepping out of our Comfort Zone

How can we as psychologists start to move out of our comfort zone to have more open discussions about the full raft of our emotional experiences?

The research participants spoke about the utility of being able to have candid and unfiltered discussions with colleagues about troubling emotions. The benefit of this is also backed up by other research where mental health workers overwhelmingly endorsed talking to colleagues about the emotional labour of the work as a key strategy for managing it (Bondarenko, du Preez, & Shepherd, 2017; de Jonge, Le Blanc, Peeters, & Noordam, 2008; Edward, Hercelinskyj, & Giandinoto, 2017; Kolar, von Treuer, & Koh, 2017). How could this be enhanced? Work places could create the space and promote a more informal sort of peer supervision among colleagues. Participants also spoke about it being hard to find the time to do this when workloads are high and everyone in a service is under stress. Therefore, if work places can maintain realistic workloads then it is more likely that these discussions will occur.

Along the same lines, universities could consider ways to create a safe space for clinical psychology students to have these discussions. It would be hard for such discussions to feel safe if they included university staff involved in the assessment of students. Universities could employ

an external facilitator, or someone experienced in group therapy to facilitate such discussions. I think this would be a valuable investment, given that this is where psychologists start the journey in learning the feeling rules and expectations of the profession. It would send a strong message that universities are opening up the space for critical reflection rather than perpetuating the status quo.

Another step that could be taken is to use existing workplace structures (such as supervision and peer group discussions) and broaden the scope of reflective practice to more explicitly consider the perpetuation of social power relations. If 'unprofessional' or unruly feelings were not understood as purely personal failings (e.g., if wider social contexts were considered), this could help reduce blame or stigma. There could also be a consideration of what might be lost if all psychologists came to embody the perfectly worked-over, emotionally sorted self.

I would hope that if the above changes were made, there would be the flow on effect of expanding the scope of possible actions for managing difficult emotions beyond work on the individual self. This could include taking collective action to improve work conditions. It could also include actions such as lobbying for social change to improve conditions for clients in relation to things such as action on poverty, addressing institutional racism, and pushing for more equitable access to services. This could be done both at a political level and at a service level. Perhaps this feels like stepping out of our comfort zone—the comfort zone created by neoliberal, capitalist society in which we have become so focused on individual striving for self-improvement. It can feel hard to do these things as individuals. However, we are not alone; we are a group of highly educated, and relatively powerful, professionals. Let us use that power for social good that goes beyond individual therapy, as an acknowledgment that the emotions experienced both by our clients and ourselves are more than just biological drives; they are produced by and serve to maintain wider social power relations.

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Putting the Prevention of Problems of Living Into Action in New Zealand: The *Incredible Years* Series of Parent, Teacher, and Child Programmes

Peter Stanley & Lesley Stanley

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction was delivered to the Minister of Health on 28 November this year. The purpose of the inquiry was to set a clear direction for the next 5–10 years for mental health and addiction services in New Zealand. Over 5,200 submissions were received, and there were also 26 public forums and hundreds of other meetings with the public, community groups, professionals, and service users. The Government is now deciding what actions it will take on the report. What follows is a written individual submission to the inquiry, which addresses the place of evidenced-based parent training in the prevention of many personal adjustment problems in young people and adults.

This submission to the New Zealand Government Inquiry into Mental Health and Addiction describes the relationship between pronounced behaviour problems in childhood and an array of personal adjustment problems in adolescence and adulthood. It is argued that evidence-based parent training interventions are a logical, practical, economical, and proven preventative response to this issue, and that early parent training is also likely to have relevance to new and emerging adjustment problems. The *Incredible Years* series of parent, teacher, and child programmes, which is presently available in this country, has substantial research verification and its further expansion is recommended. Suggestions are given as to the steps that would be required to increase programme provision.

Choices, Priorities, and Prevention

The brief of the Government Inquiry into Mental Health and Addiction was admirably broad but inevitably, decisions will have to be made between competing service priorities. A fundamental choice is the amount of commitment that should be given to population and preventative options relative to direct, and individualised, treatment services. Counselling and specialist facilities are essential to mental health and addiction service provision, but unless these reactive services are balanced by relevant preventative programmes, little real progress in reducing client numbers is likely to occur. In an exclusive casualty-repair orientation, waitlists inexorably grow (Cowen et al., 1996), as does the pressure on practitioners and providers, service users, and the community. It is a fact that problems of living (including addictions) can be very difficult and expensive to resolve, and they are always best prevented. Equally, reactive services cannot anticipate, or adequately respond to, changing patterns in mental health needs and to the emergence of new problem behaviours.

Reduction of poverty, increase in housing availability, and other structural improvements are an

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important backdrop to improving individual and societal wellbeing. At a more proximal level, specific programmes can be utilised to intercede in the development and intensification of personal and family problems. However, all preventative interventions are not of equal merit, and the choice of a programme should be in relation to the quality of research evidence concerning its efficacy. Approaches that have not been scientifically tested can waste money, effort, and opportunities; and they can also exacerbate anguish and distress. Empirically-supported practice is synonymous with accountability, and when it is cost-effective and manageable, and respectful and culturally appropriate, it can be taken to truly represent best practice. Furthermore, because prevention occurs early in the development of problem behaviour, the stigmatisation of psychiatric diagnosis and traditional case management may be largely avoided.

Conduct Problems and Parent Training

Persistently disruptive, noncompliant, and antisocial behaviour is one of the most prevalent mental health issues among children and youth in New Zealand, with rates estimated to be 5%–10% (and between 15%–20% for Maori young people) (Ministry of Social Development, 2009; Sturrock, Gray, Fergusson, Horwood, & Smits, 2014). Angry and coercive kids are perturbing for parents and families, troubling for teachers and schools, and can preoccupy special education and health services. Most significantly, longitudinal research on human development shows that pronounced conduct problems in childhood can lead onto an array of adjustment problems in adolescence and adulthood (Fergusson, Poulton, Horwood, Milne, & Swain-Campbell, 2004). Among teenagers, early conduct difficulties can translate into delinquency, bullying, school failure, motor vehicle accidents, teen pregnancy, depression, and suicide. The suffering that these young people inflict on themselves and others is immense; some time ago the financial cost to our community of each antisocial adolescent was estimated to be at least 3 million dollars (Ministry of Social Development, 2007). Similarly, the personal and social price of adult antisocial careers is vastly disproportionate, as pathways culminate in sustained unemployment and benefit dependence, substance abuse and criminality, and incarceration and psychiatric engagements.

Group parent training, in which caregivers are systematically taught child management strategies, is a favoured response to conduct problems in childhood. And when the training has been rigorously tested in evaluation studies, it can have the capacity to reliably interrupt negative developmental trajectories, and break intergenerational cycles of dysfunction and disadvantage (Ministry of Social Development, 2009; Stanley, 2001; Sturrock et al., 2014). Little wonder then, that evidence-based parent training has been described as the success story in helping children's adjustment, and its beneficial impact has even been likened to the discovery of antibiotics in medicine (Stanley & Stanley, 2005). Nevertheless, research justifications may obscure the many additional personal and servicing advantages that can stem from these parenting programmes. For example, the siblings of a child with difficulties are also likely to benefit from the new skills that their parents acquire. For the parents themselves, there can be improvements in relationships more generally and reductions in feelings of personal isolation (Hamilton & Litterick-Biggs, 2008). When several community agencies offer parent training there is a programmatic basis (and a common language) for interagency work that is far in advance of simply sharing information about clients and other similar commitments to service coordination.

The *Incredible Years* Series of Programmes, and its Adoption in New Zealand

The *Incredible Years* series of parent, teacher, and child programmes have two long-range goals: (i) to provide universal and cost-effective training to prevent children from developing conduct problems by promoting social, emotional, and academic competence, and (ii) to provide comprehensive responses for young children who are evidencing conduct problems

(www.incredibleyears.com). In the Parent series, there are three age-related programmes: baby and toddler (1 month to 2 years), preschool (3–5 years), and school age (6–12 years). In weekly sessions of 2–2.5 hours over 14–20 weeks, caregivers address problems in child management, such as ongoing tantrums, and hitting and kicking. In addition to the Parent programme, there is the *Incredible Years* Teacher training, which assists teachers to more effectively deal with disruptive behaviour among students aged 4–8 years. There is also the *Incredible Years* Training for Children (the Dinosaur Curriculum), where young students are directly taught how to behave with others at school; this training can enhance the outcomes of both the Parent and Teacher programmes. Lastly, there are specialist group programmes for the parents and teachers of children aged 2–5 years who are diagnosed with autism.

The extent of the adoption of *Incredible Years* programmes in New Zealand over the last 10–15 years represents a major achievement by our human services. It is estimated that 1,500 group leaders have been trained to deliver the Parent programme and that over 20,000 families and whānau have participated in training groups in this country (Werry Workforce Whāraurau, 2017). Training for caregivers is provided by the Ministry of Education (MOE), Child and Adolescent Mental Health Services, and approximately 70 non-government organisations; Werry Workforce Whāraurau supports the professional development for this Parent workforce (www.incredibleyearsnz.co.nz). Meanwhile, the *Incredible Years* Teacher programme has a significant presence in New Zealand (www.pb4l.tki.org.nz/Incredible-Years-Teacher), and approximately 750 group leaders have been trained. The MOE is also currently supporting the autism programmes (www.pb4l.tki.org.nz/Incredible-Years-Autism), and there is anecdotal feedback that indicates that the Child Dinosaur programme has had some uptake as well.

Incredible Years: **Top Level Evidence and Local Evaluations**

Over the last 30 years *Incredible Years* programmes have been repeatedly proven in randomised control trials, which are sometimes referred to as the 'gold standard' test of programme effectiveness. For example, there have been at least nine randomised control group studies of the Parent programme, which show that more than two-thirds of children originally diagnosed with oppositional defiant disorder/conduct disorder were found to be within the normal range of age-appropriate behaviour at follow-up assessments 1-, 3-, and 10-years later (www.incredibleyears.com/research-libarary/). As a consequence of its comprehensive research success, *Incredible Years* has received multiple endorsements by United States government agencies as a model intervention. Other countries around the world that have been concerned about conduct problems in their child populations, and about the consequent adjustment issues of adults have widely implemented *Incredible Years* programmes. These countries include England, Ireland, Northern Ireland, Wales, Scotland, Sweden, Finland, Norway, Denmark, Russia, Portugal, the Netherlands, Canada, and Australia. More particularly, the programmes have been verified and valued across culturally diverse groups, new migrant groups, and families living in poverty (www.incredibleyear.com). Additionally, cost-benefit analyses by Scott in 2007 suggested that the longer term benefits of the Parent programme may be 10 times its initial price (as cited in Sturrock et al., 2014).

Evaluations have been undertaken of *Incredible Years* programmes in this country. Recent research of interest is the follow-up study of the Parent programme instigated by the Ministry of Health, Ministry of Social Development, and MOE (Sturrock et al., 2014), and a survey of the Teacher programme undertaken by the New Zealand Council for Educational Research (NZCER) (Wylie & Felgate, 2016). The multi-ministry follow-up study appraised the effectiveness of 18-week Parent courses at 30 months post-treatment, and found that the significant gains for child behaviour, parenting, and family relationships that had been evident at 6 months were maintained over the longer term. Two other important findings of that study, which confirmed

an earlier New Zealand pre-and post-test investigation (Fergusson, Stanley, & Horwood, 2009), were that the Parent programme is equally effective for both Maori and non-Maori families, and that both groups reported good levels of satisfaction with it. The NZCER survey of early childhood educators (ECE) and primary school teachers confirmed other local research (Fergusson, Horwood, & Stanley, 2013), this time about the impact and acceptability of the *Incredible Years* Teacher programme. Respectively, 90% of primary school teachers, and 75% of early childhood educators indicated less disruptive behaviour amongst their students. There were also equivalent percentages of the respondents in the NZCER research project (88% ECE and 74% teachers) who reported that they could now manage the behaviour problems that students displayed.

It should be said that, in addition to the formal evaluations of the *Incredible Years* programmes, there are legions of parent and teacher testimonies (The Incredible Years, 2013). For example, a New Zealand caregiver said of the Parent programme:

> For me personally, I have learned that I am not the only one with a child that does not fit in. I am not the only one that has felt that the world is against me and my child. My child's behaviour is not unique, not a result of bad parenting and not personal. I do not have the world's most difficult child...This course provides an essential 'tool box' of techniques that allows both the user and recipient to better appreciate and communicate with one another in a safe and healthy environment, geared for growth. It is truly a course for those who want to invest in their child and family. (Stanley & Stanley, 2005, p. 50)

Emerging Problem Behaviours

New problems of living emerge in relation to social and historical change, and they can be identified with better assessment methods in a context of greater community awareness. It is reported that in the United States, there is now a solid research consensus that students attending high achieving schools (HAS) are at significantly greater risk than most other school pupils of evidencing serious levels of anxiety and depression; abusing tobacco, alcohol, marijuana, and hard drugs; and elevated rule breaking and delinquency (Luthar & Kumar, 2018). This situation has parallels in Australia, where up to one-third of senior students in some private girls' schools in Sydney were reported to be on disability benefits because of stress (Ahmed, 2016). The members of this new at-risk group mostly come from well-educated, high-income, two-parent families, and the schools that they attend excel in academic achievements, extracurricular offerings, and special character. How is that young people who might be considered to 'have it all' have become a high-risk category comparable in problem behaviours to the children of single parents living in poverty? Studies suggest that these teenagers are subject to relentless pressures to excel across multiple domains. Parents, peers, coaches, and schools encourage HAS students to believe that they can enter top professions while performing well in highly competitive sports, and while also being popular and self-assured. This pervasive emphasis on maximising personal status, however, can result in a crippling and empty perfectionism that seeks solace and relief in unhelpful and harming behaviours.

HAS research has revealed that affluent youngsters feel no closer to their parents, and rate their parent-child relationships no more positively, than do low-income young people (Luthar & Kumar, 2018). Neither set of parents is to 'blame' for the circumstances that have arisen for them, as both rich and poor parents are alike in being caught up in particular social systems that often cross generations. Nonetheless, the research evidence on the paucity of relationships that can exist for HAS families does suggest that parent training and support may be as important for them as it is for socioeconomically disadvantaged families. Specifically, HAS parents could benefit from learning how to reduce the emphasis on achievement for their children, and how to contain their children's technology use and substance abuse. More generally, these families could

find programmes like *Incredible Years* Parent helpful to them in adopting a child-centred approach to parenting where young people are valued in and of themselves, rather than on the basis of what they can achieve. It is noteworthy that there are likely to be long-term consequences associated with the difficulties experienced by HAS adolescents, just as there are with conduct problems. Affective problems can lead to depression later, prolonged stress can have health consequences, and early substance use can be predictive of addiction in adulthood. Again, as with other issues of childhood and adolescence, enhancing parental engagement appears a logical, practical, and economical way to respond.

Targeted Services Versus Universal Availability

The reactive services/preventative services question is actually associated with another central issue, which is how children and adults with problems of living come to notice. Reactive services in health, education, and welfare usually attempt to respond to burgeoning client numbers with intake systems, whereby service users are prioritised according some determination of their needs (Stanley & Sargisson, 2012). However, intake processes have inherent biases and some large scale studies suggest that they only operate for a percentage of those people who are experiencing difficulties and who should be receiving help (Growing up in New Zealand News, 2015; Little et al., 2012). In recent years, attempts have been made in New Zealand to rationalise service delivery to children and families by targeting resources on the basis of administrative data and risk indexes. Predictive risk modelling is a prominent example of this approach (Vaithianathan et al., 2012), and while this methodology could lead to data-driven servicing for some young people it also has a significant capacity for stigmatisation. Another alternative entirely would be to ensure that the B4 School Check (Ministry of Health, 2015) is completed by all pre-schoolchildren in this country, and through systematic surveying of this sort, to identify all youngsters and families with needs (Sargisson, Stanley, & Hayward, 2016; Stanley, 2015).

Irrespective of identification procedures, there are good reasons for simply making some preventative services, like evidenced-based parent training, much more available. The importance of competent caregiving to child outcomes is widely acknowledged, but the raising of children continues to be a demanding activity for all parents. Importantly, *Incredible Years* Parent has been shown to reliably raise the competencies of parents and children who do not currently have conduct problems. For example, the New Zealand multi-agency follow-up study found that youngsters considered to be in the 'sub-clinical range' prior to their parents attending the programme still derived considerable benefits from it (Sturrock et al., 2014). Apart from the potential assistance to many more caregivers and children of increasing the availability of parenting courses, there are also likely to be major gains for human service agencies and practitioners when they are given opportunities to participate in preventative work. When human service workers have to constantly focus on the 'worst of the worst' in case work, it is inevitably a dispiriting professional experience, and especially when increasing amounts of resources are required to achieve diminishing therapeutic effects and outcomes (Stanley, 2008). Critically, increased availability of parent training would contribute significantly to equity of access for children across problem types, across socioeconomic status, across ethnicities, and across genders.

The Tasks Ahead

Expanding the present availability of the *Incredible Years* suite of programmes for parents, teachers, and children would arguably be the single most important provision in the Government's new response to mental health problems and addiction. To make this happen, a number of component tasks would need to be completed, including growing the group leader workforces; escalating support to Maori providers of the programmes; clarifying servicing pathways across agencies; enhancing research and evaluation; and establishing communication

and media processes for providers, service users, and the public. Maintaining the integrity of the interventions is central to everything that is done because deviations from the original research protocols can render programmes invalid and ineffectual. With a host of proven programmes for various settings, *Incredible Years* has advantages over other evidence-based parenting training approaches. It can also be applied alongside other intervention systems, and ideally a continuum of supports should be made available to clients. *Incredible Years* is further advantaged in already having large numbers of trained providers and a substantial infrastructure in this country. Nevertheless, it is more than time for the staff, training, and programmes to be supported by a centralised leadership and coordination body, and this might be a stand-alone entity or located in a relevant ministry. In conclusion, there is a special opportunity here for us as a community to prevent, and to positively impact upon, problems of living across childhood and adolescence, and into the adult years.

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Notes on an Experience With a Psychodynamic Reflection Group Intervention For Trainees In Psychiatry

Luis Gustavo Vechi

This paper outlines a psychodynamic reflection group model and exemplifies the model by describing its application in the intervention 'Peer Support Reflection Group' for trainees of the Royal Australian and New Zealand College of Psychiatrists, which took place at Waikato Hospital, Hamilton, in 2017. Literature on psychodynamic reflection groups and Jungian hermeneutics was used to outline this model. The Peer Support Reflection Group plan, participants' verbal feedback on the group, and the facilitator's notes on the group sessions informed this description of the model. The goals for the group intervention were: to acknowledge the importance of their personal selves (personality, motivation, memories, expectations, prejudices) in their vocational journey of becoming a psychiatrist); to cultivate the habit of reflecting about these facets in their professional role as registrars at work; to increase their awareness of the impact of these facets on the institution/work and vice-versa; and to facilitate the integration between the personal and the professional dimensions in the psychiatrist trainee role. The outcome of the Peer Support Reflection Group experience suggested that the group: a) challenged participants' perception on the themes addressed; b) offered structure for the reflection process, allowing for focusing on the topics chosen by the group; and c) indicated 'new ways' of thinking and behaving to address issues and offered support to keep up with the traineeship experience. According to the facilitator, the main challenge for future groups is to find the right avenues to incorporate the group dynamics as an aspect of reflection as proposed by the theoretical model.

Reflection and reflective practice are popular themes in medical education, and have given rise to different models for achieving it, such as checklists, portfolios, and other ways to trigger and document reflection (Ng, Kinsella, Friesen, & Hodges, 2015). The development of reflective learning has been promoted as a core competency during undergraduate medical training (Vivekananda-Schmidt et al., 2011; Duke, Grosseman, Novack, & Rosenzweig, 2015). Students seem to have a good understanding of the purpose of reflection in practice; however, the literature on this topic is limited in terms of demonstrating how reflective learning has been implemented or describing approaches to its development (Vivekananda-Schmidt et al. 2011). It has also been argued that some of the models in which reflection has been applied are distant from original theories and practices of reflection (Ng et al. 2015).

In this regard, this paper outlines a psychodynamic reflection group model, and exemplifies the model by describing its application in the Peer Support Reflection Group intervention for trainees of the Royal Australian and New Zealand College of Psychiatrists, which took place at Waikato Hospital, Hamilton, in 2017. This article is developed in three main sections. The first section outlines the reflection group model, the second section describes the Peer Support

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Reflection Group at Waikato Hospital grounded in the psychodynamic reflection group model. The third section presents a conclusion about the topic.

The literature on psychodynamic reflection groups was used to outline the model. A number of documents informed this paper: a) the Peer Support Reflection Group plan (Vechi, 2017); b) participants' verbal feedback on the group; and c) the group facilitator's notes from each session. Participants' feedback was obtained at the end of every session, and focused on their views on the group in terms of what was (un)helpful and what was liked or disliked. The group facilitator kept notes after each group session, with information regarding the themes addressed in the group, the reflection process, and the outcome of each session.

The Psychodynamic Reflection Group Model

The Peer Support Reflection Group experience in 2017 was planned and facilitated by the present author. This was grounded in the psychodynamic group proposed by Dellarossa (1979) and Jungian hermeneutics (Jung, 1975, 1977; Vechi, 2018) as clarified below.

The modality of a reflection group is a closed group method of intervention that relies on reflection to address common issues and themes experienced by a group of people who share similar activities in an institution. This has been considered an important avenue to mobilise participants' personal resources, increase their awareness of relevant issues, and therefore to improve their sense of agency to address these issues (Coronel, 1997; Edelman & Kordon, 1992; Fernandes, 2000).

Reflection groups have been applied to different situations and institutions, including: in business (Selvatici, 2008) to address workers' work-related stress; in tertiary institutions to increase undergraduates' sense of professional identity (Joaquim, Marcolino, & Cid, 2017); in forensic settings to change staff practices (Olmos & Henriques, 2006); in primary health sector services to change staff practices (Cambuy & Amatuzzi, 2008); in public educational institutions to facilitate new employees' adaptation to their jobs (Santeiro, Souza, Santeiro, & Zanini, 2012); in cardiological intensive care units to promote self-care and communication improvement (Amaral & Oliveira, 2016); and in the training of group psychotherapists to offer a didactic learning experience of group dynamics (D'Amore & Oliveira Junior, 2001).

This group modality was introduced by Dellarossa in Argentina in the 1970s as a subtype intervention of 'operational groups', which were developed by the psychodynamic psychiatrist Enrique Pichon-Rivière in Argentina in the 1950s (Fernandes, 2000). The 'operational group' is a group 'learning' modality rather than a therapeutic one, which is informed by the psychodynamic theory and the operational research groups. The latter were introduced in the United Kingdom in 1938 with the goal of completing different tasks, such as how to better use radars to prevent air bomb attacks in Europe. Inspired by these interventions, Enrique Pichon-Rivière's groups aimed at supporting participants to assign a common task to themselves and work out 'how to do' the task. The emotions triggered in group participants were also a focus, as well as the interpersonal dynamics triggered in the group process (Dellarossa, 1979; Edelman & Kordon, 1992).

Pichon-Rivière's model was first introduced at Litoral University (Universidad del Litoral) in Rosario, Argentina. At the beginning of his work, it was applied to mental health staff teams dealing with complex psychiatric clients. The purpose of this intervention was to enable them to plan and to follow through on their job tasks, as well as to support the group to tackle interpersonal conflicts arising in this process (Pichon-Rivière, 2009). The T-Group methodology developed by Kurt Lewin (1947) was another important foundation for operational groups, and

therefore, for its subtype 'reflection groups'. Lewin's intervention aimed at increasing participants' awareness of self and others through facilitated group dialogue.

Dellarossa's reflection group was originally proposed as a mandatory procedure to be part of the training in group therapy at the Argentinian Association of Psychology and Group Psychotherapy in the 1970s. This was a didactic formative experience, which usually took place in groups with 4–10 participants, who would meet weekly for 75-minute sessions over the 3-year period of their training. The task of reflecting was seen as an operation of the mind, where an object is apprehended considering its context, significance, and the emotions attached to it by one's experience (Dellarossa, 1979).

Dellarossa (1979) proposed that there should not be predefined topics to be reflected on in the group sessions. Nevertheless, he was specific that the trainees' learning experience should be the content on which the focus should be kept. Specifically, he proposed four main areas to be addressed: a) the trainee/lecturer-supervisor relationship; b) trainees' professional role development as group facilitators; c) the impact of the institutional regulations and procedures on trainees' subjectivity; and d) the group process and dynamics. He clearly stated that emphasis should not be given to trainees' individual intrapsychic conflicts or intimate unresolved issues that were far beyond the scope of the work of a reflection group. Dellarossa (1979) originally proposed a psychoanalytic hermeneutics approach to facilitate the reflection process in the group. In his view, the reflection sought the 'latent' unconscious meaning in the participants' narrative in the group. In this regard, the facilitator's role is to identify the hidden meaning to explain participants' functioning in the process of being trained to become a psychoanalytic group facilitator.

When planning and facilitating the Peer Support Reflection Group, the present author used Jungian teleological hermeneutics instead of Dellarossa's hermeneutics, because of the group facilitator's theoretical affiliation to that approach. In this paper, only the aspects of the Jungian hermeneutics that informed the reading of participants' verbalisations in the Peer Support Reflection Group are addressed. Therefore, the complexity and different levels of reading that are allowed for by this approach and some key concepts such as archetype and symbol are not discussed. Jung's hermeneutics were interested in supporting the person to identify where his life is taking him (Samuels, 1993; Williams, 2018). Therefore, the teleological approach does not aim to interpret 'hidden unconscious causes' of one's functioning to explain it (Vechi, 2018). This perspective aimed to understand how one's present functioning contains new possibilities to be and to perceive oneself, others, and the world (Jung, 1975). This kind of reading intends to make up for the unilateral functioning of consciousness, contributing to its expansion in a process which was named 'individuation' by Jung (1977).

Example of the Psychodynamic Reflection Group Model: Peer Support Reflection Group With Psychiatry Trainees

Ten 75-minute sessions were facilitated for a group of 10 participants from different stages of their training in psychiatry with the Royal Australian and New Zealand College of Psychiatrists at Waikato Hospital, Hamilton, in 2017. At the beginning of 2017, a contract was made with the group mentioned above that observed confidentiality, attendance and scope, purpose, and method of the intervention. The goals for the group intervention were to support registrars through the task of reflecting to: acknowledge the importance of their personal selves (personality, motivation, memories, expectations, prejudices) in their vocational journey of becoming a psychiatrist); cultivate the habit of reflecting about these facets in their professional role as registrars at work; increase their awareness of the impact of these facets on the

institution/work and vice-versa; and facilitate the integration between the personal and the professional dimensions in the psychiatrist trainee role (Vechi, 2017).

Following Dellarossa's model, the learning/work experience of the psychiatry trainees' was identified as the content on which to focus in the group sessions, namely: a) the relationship between trainees/lecturers-supervisors; b) trainees' professional role development as psychiatrists; and c) the impact of institutional regulations and procedures on trainees. Addressing the group process and dynamics aspect in the reflection group was paramount for Dellarossa's model as his practice was tailored for a traineeship in group facilitation. Nonetheless, the group process and dynamics, as proposed by Dellarossa, was not a focus in the Peer Support Reflection Group, because this would require a closed group type of functioning with less variance in attendance, as well as more frequent meetings and a clear contract with participants.

Knowing that some group participants would eventually leave the group while others joined it for different reasons at any time during the year, that members' attendance would not be regular, and that the meetings would only be once a month, it was decided that the original reflection group, proposed by the Dellarossa (1979) model, required some adjustment. For example, the first Peer Support Reflection Group session involved choosing topics that were to be addressed in subsequent meetings throughout 2017.

Identifying topics was considered an important measure by the group facilitator and the other group members to keep a meaningful 'thread' throughout the sessions in 2017. These topics were directly related to participants' learning/work experience, and therefore associated with the content that Dellarossa recommended as the focus for reflection groups. The topics chosen were: setting and dealing with boundaries at work; career and life balance; the influence of one's personality on the professional role; resilience in the professional role; conflict management at work; autonomy x dependency as a registrar; are we prepared for the leadership role and responsibilities of the role; media involvement/public knowledge of mental illness; and reflecting upon the year (what was learned, worked, did not work). However, despite the agenda, the group had the prerogative of changing the topic at the beginning of each session. This happened in two sessions as participants decided to work on 'meeting the training requirements' instead of the scheduled topic.

In addition to the chosen topics, the group facilitator also introduced resources to facilitate reflection, such as brief readings or self-report questionnaires. For example, when we addressing the topic 'the influence of one's personality on this professional role', a brief self-report questionnaire on personality was completed by the trainees, and the discussion encompassed that.

Using teleological Jungian hermeneutics to ground the reflection process, participants' non-verbal behaviours and verbalisations, which included their reports of thoughts, feelings, and sensations, were considered. With this approach, reflection in the group became an opportunity for participants to discern 'new ways' to perceive and be, regarding the topics discussed in the sessions. In this regard, as a peer support group, the contribution of the group members was considered key in this process. They were offered the opportunity to facilitate or to co-facilitate sessions, but refused.

The facilitator focused on the tendencies and patterns created by the participants' non-verbal behaviours and verbalisations, to keep the focus of his understanding on the group process and not only on separate individuals. The steps of understanding participants' verbalisations were

grounded in the Jungian scholar Humbert's (1988) proposal of reading to identify the above mentioned 'new ways' required by the teleological approach. The first step was to 'open up with receptivity and acceptance' to group participants' views. The second step was to let the verbalisations penetrate the facilitator to allow himself to 'become pregnant' with the different narratives presented in the group. This was a requirement for the facilitator to make new meaningful associations. The third step was to 'confront' what arose in the facilitator from this process, including his thoughts, feelings, and physical sensations. The group facilitator's supervision supported the facilitator to increase his awareness of transference and countertransference processes to prevent these from being unhelpful in the reading and facilitation of the group.

The group facilitator's understanding of the group informed the subsequent insight-oriented psychodynamic verbal interventions used in sessions to further participants' reflection: observation, clarification, and encouragement to elaborate to facilitate the reflection process as indicated by Gabbard (2014). With the intervention 'observation', the facilitator noted group members' non-verbal behaviour, traces of emotion, or the sequence of moving from one comment to another. This intervention invited participants' collaboration to further making new associations with the topic under discussion. Using 'clarification', the facilitator would reformulate or summarise participants' verbalisations to convey a more coherent view on what was being communicated. With 'encouragement to elaborate', participants were asked for more information about the theme discussed. The facilitator sought participants' thoughts, feelings, and sensations on the topics addressed in the group session.

For example, in the session with the topic 'the influence of one's personality on the professional role', the group facilitator realised that participants' views on this theme emphasised others' personalities as a potential issue for them at work and overlooked their own personality in this regard. The facilitator's reading was shared with the group by using the 'observation' type of verbal intervention. Therefore, participants were invited to think of the unilateral way with which they were taking on the topic. The reflection process allowed the group to include the aforementioned overlooked aspect in their perception of the theme. The implications of their new insights into the topic, on their practice as trainees in psychiatry were addressed. How to change the trainees' practice, considering their learning, was then discussed by the group.

Another example was the session in which the group was addressing the theme 'setting and dealing with boundaries at work'. For the majority of participants, staff difficulty respecting boundaries resulted in unreasonable requests of extra work for the trainees. However, with the reflection process using mainly the 'encouragement to elaborate' and 'clarification' verbal interventions, some participants pointed out that their own need to fulfil others' expectations prevented them from turning the requests down. Ways to manage this unhelpful 'need' and set boundaries were discussed in the group.

A third example comes from the work on the topic 'autonomy x dependency as a registrar'. At the beginning of the group discussion, the facilitator, using Humbert's reading steps, identified that participants' views emphasised the pole 'autonomy at work' as positive and the pole 'dependency' as negative. Using mainly the 'clarification' type of verbal intervention, the facilitator supported participants to acknowledge what was being overlooked and overvalued in their perception of the issue. Some participants realised that a unilateral perspective of 'autonomy' was likely to create isolation for them at work. Therefore, the reflection allowed for acknowledging that some level of 'dependency' is inevitable and required, especially when one is part of a team and deals with complex clients at work.

In the examples mentioned above, participants came up with practical alternatives to implement their learning in their role as registrars in their work setting as part of the group work.

Notes on Peer Support Reflection Group Outcomes

Ongoing verbal feedback from the trainees and the observations of the group facilitator suggested that the Peer Support Reflection Group experience: a) challenged participants' perception on the themes addressed; b) offered structure for the reflection process, allowing for focusing on the topics chosen by the group; c) indicated 'new ways' of thinking and behaving to address issues; and offered support to keep up with the traineeship experience. In this regard, the goals set for that group intervention were achieved.

Nonetheless, participants indicated that the group could have been more careful in choosing the themes to be addressed, as these were not of everybody's interest. This probably happened because there was a turnover in the group during 2017 and new participants were not interested in the topics chosen at the beginning of the year, and not willing to indicate new ones. In addition, participants also recommended in their feedback that group members could have been more engaged and active in the group discussions. Attendance inconsistency was also indicated as a problem to improve the depth of reflection in the group.

From the facilitator's perspective, the method used in the group supported participants to move from a 'complaint or passive stance' to a more helpful one as reflection in sessions enriched their perspectives on relevant matters to their learning and practice as trainees in psychiatry. The method also allowed group members to come up with practical new ways of addressing old problems in their training. However, it was unclear if these initiatives were actually implemented or if the level of change reported by participants in the group persisted. It remains a challenge for future groups to find the right avenues to incorporate 'group dynamics' into the reflection process, as proposed by Dellarossa (1979). This will require a closed group format and participants willing to reflect on the relationship dynamics that take place within the group.

Before wrapping up, it is important to note the limitations of this paper. First, the outcomes outlined above for the group relied only on the participants and facilitator's feedback on the group experience. No other instrument or follow up on the impact of the work on participants' members were used. Second, this paper did not present other relevant psychodynamic group models for training psychiatrists, such as Balint groups. Hence, no comparison was made between other psychodynamic models for training psychiatrists with the Peer Support Reflection Group.

It is expected that readers' reflection on this article may point out other ways of taking on the topics explored in this paper. This creative experience in the reading of this paper, announcing new ways of viewing and doing this article, can give them a taste of the teleological approach experienced in the Peer Support Reflection Group.

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Use of the Social Responsiveness Scale (2nd ed.) in the Assessment of Autism Spectrum Disorders

Chris McAlpine

The prevalence of autism spectrum disorder (ASD) in childhood in the UK is estimated to be 1.7% (Williams, Hastings, Charles, Evans, & Hutchings, 2017). Child development services in New Zealand are struggling to assess children in a timely way. Available research clearly indicates the importance of early diagnosis and treatment. However, there is no specific screening or diagnostic tool that has been validated in New Zealand (Ministries of Health and Education, 2016). Some tools take longer to administer; for example, the Autism Diagnostic Interview Revised (ADI-R) takes 1 hour to deliver. Not all children may need the 'gold standard' of

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diagnostic tools. The guidelines recommend that clinical judgment may be aided by assessment tools, checklists, and rating scales. The Social Responsiveness Scale second edition (SRS-2) 2012 is a brief tool that is easy-to-use as part of a comprehensive assessment. However, the SRS-2 is not discussed in the New Zealand guidelines.

The SRS-2 is a commonly used measure in the assessment of ASD in European countries (Ashwood, Buitelaar, Murphy, Spooren, & Charman, 2015). A recent study involving 14,844 patients across 66 sites from 31 countries investigated psychometric measures being used in the assessment of ASD in different services (both clinical and research) across Europe (Ashwood et al., 2015). Of the eight measures reviewed in that study, the Autism Diagnostic Observation Schedule was most commonly used, followed by the ADI. The SRS-2 was ranked fourth out of the eight measures.

Summary of the SRS-2

- The SRS-2 is a 65-item Likert Scale that objectively measures ASD symptoms.
- There are four forms of the SRS-2 spanning age 2.5 years through to adulthood. The pre-school (2.5–4.5 years) and school age (4–18 years) versions can be completed by both parent and teacher.
- Adults can rate themselves, and there is a separate form for relatives or significant others to complete.
- The scale takes approximately 10–15 minutes to complete and 5–10 minutes to score.
- The SRS-2 total score serves as an index of the severity of social deficits in the autism spectrum
- The scores describe the degree of certainty in classification and degree of severity of impairment.
- There are currently no New Zealand norms for this measure. However, there is a large body of research supporting the reliability and validity of this measure; more than 30,000 cases have been reviewed.

My Experience Using the SRS-2

The SRS-2 was not a measure I was familiar with until 2016, when I presented a paper on assessing ASD using psychometric measures at the 2016 Paediatric Society of New Zealand Annual Scientific Meeting (McAlpine, 2016). However, I have been using this tool as a measure in my role in a multi-disciplinary assessment team (MDAT) team assessing ASD for the last 2 years. Clinically, I have found it easy to use. The ratings of certainty in classification and degree of security of impairment have fitted well with my clinical judgment.

Often, parents of children I assess feel that they themselves might be on the autism spectrum. After gaining their consent and identifying which symptoms the parents feel that they have, a discussion occurs as to whether they would like to complete the adult version of the SRS (Constantino & Gruber, 2012). Alongside this, collateral information is obtained from a significant other who completes the Relative Other Form. It is made very clear that this is not a formal assessment, but a process to decide if a referral for further assessment may be warranted. Time is taken to discuss the results and referral for further assessment if indicated. Interestingly at the 11th Autism Europe International Congress in Edinburgh Scotland in 2016 that I attended, a presenter commented that if you are an adult with ASD, in all likelihood you have not been diagnosed.

Within our MDAT team, our community and general paediatrician uses the SRS-2 as part of the assessment process and has encouraged colleagues in his wider paediatric team to do the same. I

also believe it has utility in other assessment services, for example in Child and Adolescent Mental Health Services. The SRS-2 is easy to use, and quick to administer and score. This scale may be useful for some assessments that do not require the 'gold standard' tools. Since discovering this measure in 2016, reviewing its popularity in Europe and my clinical experience of using it over the past 2 years, I believe its use should be considered by other clinicians in New Zealand. It would also be beneficial to review its use when the next New Zealand ASD guidelines are updated

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Psychologists as Leaders: Insights

Consistent with the NZCCP Strategic Plan and supporting our membership, an area 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 Malcolm Stewart and Kris Garstang.

Malcolm Stewart

What have been your leadership roles, past and present?

My main current leadership role is as president of the NZCCP. My previous leadership roles included being the Professional Leader-Psychology at Waikato District Health Board (DHB) and later at Counties Manukau DHB. Past psychology leadership roles have included different branch and national positions in the NZCCP, president of the Aotearoa New Zealand Association for Cognitive Behavioural Therapy, a council member and journal editor for the New Zealand Pain Society, and (many years ago) chairman of Youthline in Wellington.

However, I think it is useful to be aware of two types of leadership: **Formal mandate leadership,** where your influence comes through having a particular title (e.g., President, Manager, Leader, Coordinator) or explicitly delegated authority; and **Informal mandate leadership** where your influence is not through a formal position but because of your credibility and the respect others have for you (Stewart, Butcher, Garstang, & Howard, 2017)[1]. Many psychologists who do not take formal leadership roles contribute majorly through informal

[1] Informal mandate is often given by colleagues rather than organisations, although informal leaders are often recognised and used by organisations too. Psychologists who are not in formal leadership roles often have considerable informal leadership mandate (if they accept it) because of the respect in which they are held for their skills, knowledge, and personal qualities.

leadership. In times when I have not had formal leadership roles, many opportunities for informal leadership have arisen and have made for a satisfying, if busy, working life. Some examples of this are leading research/evaluation projects, re-designing services, providing clinical leadership, staff training, influencing team culture, supporting struggling teams, and mentoring managers.

Since early in my psychology career, I have combined leadership roles with clinical practice because I have wanted to make a difference at an individual level and at a system level. I was first appointed to a DHB professional leader role only 3 years after completing my clinical training[2], but because I had a strong focus on system thinking, a strong sense of what psychology can and does offer, and a broad and inclusive leadership style, (I believe) that this worked well from both the psychologists' and the managers' perspective.

What is your approach to leadership?

There are many different styles of leadership on a number of different dimensions (e.g., authoritarian vs. collaborative; strategic vs. operational; and, unfortunately, inspirational vs. demotivating). Different people have their own style, although (like many aspects of life) having flexibility around your natural style does help to cope with a broader range of situations.

I would characterise my natural leadership style as being strategic, collaborative, and facilitative. Strategically, I believe I have a broad view and like 'thinking outside the box' to find new ways to solve issues. I am less naturally a details person (can be, but it is not my interest) and tend to be at my most effective when partnering with someone who is better at 'dotting i-s and crossing t-s' and following through with persistence. I strongly believe in collaboration, although I worry sometimes that we end up not moving things forward because people get nervous that for them to initiate action is non-collaborative. My way of trying to avoid this dilemma is to take responsibility for making a start and try to not be 'precious' about it if others then have very different ideas in response to my start. I also work to be strongly facilitative of colleagues. As a leader I want to give people the confidence to move forward with things that they are passionate about. Psychologists and others are full of good ideas that can make a difference, but are (understandably) not always confident to put them into action. Giving people the backing to be confident (or at least to know they can say "well Malcolm said it was a good idea" if it does not work out) is often enough for people to go and do great things. As psychologists are generally competent and committed people, offering this kind of support rarely backfires on the leader!

One psychologist described my leadership style as "not as much a builder as a gardener—someone who prepares the soil well, plants the seeds, and then supports those seeds (helping to clear away weeds and impediments if needed) to grow and flourish." This is consistent with how I see my style. However, I also work hard to address areas of contention. "Be prepared to go towards the heat" is a useful bit of advice I got. If a bush in the garden is smouldering or on fire, it is worth finding useful ways of putting the fire out, rather than having it damage the bush and the rest of the garden. However, that is my style, and many other leaders will have different styles. I am a strong believer in the concept of 'person-environment fit'. People with different leadership styles will be just what is needed in different roles within different organisational/team cultures, so there is scope for psychologists with all sorts of styles to be able to contribute to leadership.

[2] I had a career in biomedical engineering (medical electronics) before training in psychology, so was around 30 years old when I finished my clinical psychology training.

How did you learn about leadership?
Prior to becoming a psychologist I had done a Diploma of Management through the New Zealand Institute of Management. This was a useful qualification that gave me knowledge and skills about management including theory of management, organisational function, accounting, and human resources. My main reason for doing the management diploma was so I could understand what my managers were trying to do (I was involved in some union activity), but I have found the learning from it has been very useful in throughout my career. Leadership and management are different, but it is worth understanding organisational function and the world view, ways of working, and drivers of management if you are in a leadership role, or (as it is for most employees) if it is sometimes useful for you to 'manage up' to do your job well. I thought that the NZCCP workshops last year by the US Society for Psychologists in Management provided excellent knowledge about management and leadership.

While I have been in leadership positions I have been put through quite a number of leadership courses by employers. The quality has been widely variable and the learnings often not profound. The training and understanding you get from clinical psychology training is in many respects a very strong basis for developing leadership, if you think carefully about how you would apply those learnings to the leadership role. I sometimes do a presentation for groups of psychologists about 'treating the organisation as the client' and using our understanding and skills to help organisations make meaningful change in the same way we do individual clients. From a scientist practitioner perspective, there is also a large literature about leadership (and a small literature about leadership by psychologists), which has useful ideas. One example is Moran (2011), which applies the principles of acceptance and commitment therapy to developing effective, resilient, and skilful leaders and managers.

What are some of the major things you have learnt about leadership?
There are many things, but here are six things that I mostly learned early in my leadership career and that have been amongst the most important:

- **Integrity is a most important aspect of leadership.** Being seen as a person of integrity can make a lot of difficult situations able to be negotiated successfully. Leadership roles can create situations where there is pressure to act (or be seen as acting) with less integrity, but I have found that having the courage to keep your 'good heart' and 'moral compass' intact is ultimately appreciated and recognised most of the time.
- **Leadership and change can be a long and winding road.** Often the things that it seems obvious to us should happen now are not obvious to others. This can cause frustration and giving up. Sometimes the way to make progress is by being prepared to help achieve some steps which are not exactly what you want, but which can take you part of the way, even if not in a straight line—and to be patient and persistent (Stewart, 2017).
- **Keep focused on outcomes.** In many organisations, processes often lack or lose clarity about their actual goal. I have often found that asking the questions "What are we actually wanting to achieve here?" and "Will what is proposed actually achieve our goal?" have been very useful, if not always welcome, ways of making processes more effective.
- **'Holding the pen' is useful.** As psychologists, we are often quite clear thinkers and good wordsmiths. Being the person who does the writing, whether it is writing the minutes or writing the first draft of a proposal or business plan, is often a useful way of helping to shape subsequent action.
- **People are typically more interested in what you think than why you think it.** In a leadership role, as in clinical practice, people generally put trust in your expertise without you necessarily needing to justify it to the 'nth' degree. Through our training we are socialised into explaining each step of our thinking quite explicitly. You will go through your own decision-

making process to come to a conclusion, and will be able to justify your reasoning if needed, but it often detracts to 'over-explain' in advance of being asked.

- **Procrastination driven by perfectionism is an enemy of effectiveness.** And this is something I find I still need to fight against! In leadership good enough is good enough. Producing something which may not be perfect in a timely fashion is often far more useful than producing the 'perfect' result too late to be of use or taken into account.

Do you have any final thoughts?

With our focus on evidence and wisdom, psychologists have a lot to offer in leadership (Stewart, Bushnell, Hauraki, & Roberts, 2014), with either a formal or informal mandate. Psychologists are often a bit diffident about taking up this challenge, but I have found it an amazing way of making a big difference to what I can achieve, and a source of a lot of satisfaction, interest, and growth. I am very thankful to all the people over the years who have given their trust and support in ways that have made it possible for me to lead.

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Kris Garstang

What leadership roles do you currently hold?

I currently run my own private practice with fellow director, Helen Inkster. I have owned the practice for around 15 years now, but for a long time I was not doing a lot of leadership there. I was just head down, seeing the clients while I worked in a leadership role for a local non-governmental organisation (NGO). I am pleased to say that that state of affairs has changed for the better, and since completing a health services management degree, and since Helen joined me in the practice, we have embraced a strategic planning process firmly focused on our vision of increasing access to psychological therapy in the Nelson region. We are currently working with our local primary health organisation and general practices to install clinical psychologists in their surgeries on a weekly basis, providing free, good quality therapy to patients of the practices. This is very much an informal leadership role and has involved leading by example and through our relationships rather than having any formal position that determines how primary care services will be delivered. I am also the current vice president of NZCCP.

How did you end up as a leader, what path took you that way?

As most do, I stumbled into it. A chance phone call from a colleague to someone else in my office led to me taking on a consultancy role at Te Whare Mahana Trust, who had lost their psychologist and needed some clinical leadership for their residential dialectical behaviour therapy (DBT) programme. I felt prepared for that role by a previous role covering parental leave for a year in Melbourne, where I cut my teeth leading a DBT programme for community mental health service there. I enjoyed the consultancy for Te Whare Mahana so much that I took on the clinical manager's role there when it was offered to me a year later. To my surprise, I found that I actually enjoyed managing people and budgets, and from there enrolled in a Masters of Health Services Management at Massey University, which I completed at the end of 2016. The

study I did during this programme helped me develop my interest in primary mental health care and formed the basis for our current integrated mental health clinics.

In terms of my role for the college, I came to this role in the way that many on the National Executive do, through volunteering at our local branch. In my case I had been chair of our local Nelson branch, and then took on the chair of the Board of Membership and Professional Standards, which is a small Nelson-based committee that currently sits in Nelson. I ended up with a seat on the National Executive because of this, and then stepped into the Vice President role when Malcolm Stewart moved out of it to become President. Taking on leadership roles for the College has been hugely rewarding and my management study has often been useful for this work with health management topics such as leadership, private practice and service delivery arising as part of our strategic plan and work with other national bodies.

What extra training did you undertake, if any? What was it like 'learning the ropes'?
When I started as clinical manager at Te Whare Mahana, I focused heavily on financial management skills by attending a course for NGO staff about understanding your organisation's finances, and also had monthly meetings with our accountant who tutored me in running the budget and using this as effectively as I could to keep staff and clients well cared for. Later, I enrolled in Massey's Masters of Management (Health Services) by distance. Learning the ropes was easier than I thought it would be. I was most nervous about managing staff but found that my clinical skills gave me all I needed for having challenging conversations with staff members about performance or health issues. I really enjoyed running a budget and using our funds to benefit staff and clients. The hardest thing, and I think this is true for all managers, was managing my time as there is always a seemingly infinite list of tasks with various priorities.

If you have had any 'failures' along the way, how have you dealt with these and what did you learn from them?
So many it's hard to know where to start. Also it is hard to tell them apart from successes sometimes, as it is true that you learn more from your failures from your successes. My biggest fails involve not managing my energy well and getting too tired and worn out at times. I learned, again, to pace myself and leave some energy for my family and myself. I had some hard lessons about being transparent with staff during times of organisational change and the perils of keeping secrets, although there will always be time when managers have to keep things themselves until the timing is right to discuss change. My latest lessons come from finding who will support you to do the work you're passionate about and working with those people as you can, sometimes without the permission of institutions around you who may be slower to move on new ideas and concepts.

Who supported or encouraged you as you entered leadership roles?
I am part of what we call our 'knitting group', a local group of senior psychologists who get together about once a month and sometimes even do some knitting. A little like a 'Lean In' circle, the knitting group encourages members to step up to leadership opportunities while also taking care of themselves. I think that members of the knitting group have supported me through almost all of my decisions about leadership roles providing support and the necessary prompting to step up when it's right. My other main supporter through my time as manager at Te Whare Mahana and beyond was my supervisor at the time, Dr Claire Dowson, who brought her own management experience to the table and invaluable amounts of empathy for the challenges of the role.

What advice do you have for clinical psychologists considering moving into leadership roles?
My advice would be to treat the opportunities presented as chances for growth rather than being scared off by all the things you do not yet know how to do. Clinical psychologists are smart people and have the capacity to learn the nuts and bolts while bringing enormous skill of their own to leadership. The benefits of many management roles outweigh the costs by fact of the difference you can truly make in others' lives by carrying a bit of extra power to change things for the better.

From your experience, what are the challenges and advantages of taking on formal or informal leadership roles?
Having had both, formal leadership has the advantage of formalised power to make (some) decisions and sometimes in terms of budgetary discretion. My own experience was that this was highly advantageous compared to soft power or informal leadership roles.
Informal leadership involves a little more finding your way around systems and harder work to influence systems that you may not have any formal power over. The benefit is of course your autonomy and not having to toe any party lines. My advice for those seeking to lead in their communities as private practitioners is that, if you think a project is likely to succeed and that you have the relationships and necessary resources to go ahead that it's better to get on with it rather than wait for someone to give you permission.

What do you see as important skills/competencies of leaders?
As any leadership course will say, I think that self awareness and relationship skills come first. Clinical psychologists are mainly highly skilled in these areas. The rest of the skills can be learned. These include all the technical things like budgets, human resources processes, performance management, setting direction, and communicating your vision.

If yours is a management role, to what extent does it require leadership skills or tasks?
As a director of our practice I lead in partnership with my co-director. We set the strategic direction for our practice and communicate our vision of increasing access to psychological services to our staff and our colleagues in other organisations that we work in partnership with. We do this through regular meetings, casual conversations, and through media and speaking opportunities as they arise. Producing research on our work will we hope also help us communicate out vision for the future of psychological services in our region.

If not, how is your position as a leader different from a management role?
In my role on the National Executive committee for the college, my role is primarily a governance role, although given the small nature of the college there is lots of work to produce as well and management skills are handy for many things.

NZCCP Travel Grant Report: Australian and New Zealand Addiction Conference (Gold Coast, Australia)

Nicola Brown

As a recipient of a 2018 NZCCP travel grant, I was fortunate to attend this event in May 2018. This conference (www.addictionaustralia.org.au) is run annually in Queensland in late autumn, covering addiction prevention, treatment, harm reduction, service provision, mental health issues/comorbidity, and systematic responses to all types of addiction.

I elected to attend this conference because of three observations from many years of clinical practice:

1. **Behaviour change is hard for many people.** No matter how well-intentioned someone is, no matter how clearly a goal may align with their intentions and values, the reality of altering habits is often *much* harder than people—both clinicians and clients—predict. As those car park machines at the airport say, 'change is possible', but in my experience, it is seldom a straightforward A-to-B scenario. I wanted to hear what people working in the fields of addiction consider most beneficial for enhancing clients' chances of success.

2. Women aged 40 years and older (within my sample of clients at least) appear to be **drinking more alcohol** than previously, and often show limited insight into the potential or real impacts on their health and functioning. There is some evidence that this trend of increasing 'hazardous drinking' is occurring in New Zealand for both men and women aged 45 years and older (Ministry of Health, 2016; Wellplace NZ, n.d.). I was hoping to learn ways to most effectively help clients who wish or need to change their patterns of alcohol consumption.

3. Another issue frequently raised by my clients (in relation to their own behaviour or that of those around them) is **technology use and overwhelm**. Spending more time than they intend online or on smartphones, online gaming and gambling, and pornography use are now common features of my conversations with clients in private practice. My third aim was to understand more about behavioural addiction and technology, particularly treatment options for people who find their patterns of behaviour around technology use hard to change.

Themes

I noticed four themes throughout this event:

1. Substances and behaviours that are particularly problematic right now tend to be those designed to stimulate and distract (e.g., methamphetamine/ice, technology) as opposed to those that sedate (e.g., cannabis).

2. The important roles played by 'lived experience' mentors in treatment programmes, and the need for human connection, empathy, and strong therapeutic alliance in terms of outcome successes. Sessions were particularly powerful when people spoke about their own experiences of recovery from substance addictions, and the ways in which they used their knowledge and wisdom to help others going through addiction (many recovery programmes have group therapy programmes facilitated by lived experience mentors).

Nicola Brown is a clinical psychologist who works in private practice at Psychology Associates in Dunedin. She is also a certified executive and organisational coach who helps individuals, teams, and organisations to identify what matters most and get that done, without wasting their own and each other's time.

3. Various sessions highlighted the importance of asking about *many* possible forms of addiction, including: over-the-counter medication use, behavioural addictions (e.g., porn, gambling, gaming), and patterns of addiction in family of origin, including work addiction. Clients may be initially unlikely to volunteer this information, because of the significant roles played by stigma and shame and the normalising of problematic behaviours within families and communities.

4. Treatment needs to meet people where they are at and be provided in ways they can access. Increasingly, technology-based approaches to treatment are being used, out of recognition of the need to reduce as many access barriers as possible. For example, the very comprehensive website *Cracks in the Ice* (2018), a resource for health and education professionals and loved ones needing to learn about crystal meth (ice). This website includes downloadable information sheets, a community toolkit, and great resources for health professionals (e.g., *Insight brief intervention tool,* a useful structure for talking about all kinds of problem substance use) (Insight, 2018).

Key Takeaways

Availability and use of drugs in New Zealand

Associate Professor Chris Wilkins of Massey University gave a fascinating keynote on availability and use of drugs in New Zealand. His report was based on a large Facebook survey of drug availability, drug prices, and people's reported need for help in urban and rural New Zealand (NZ Drug Trends, 2018). This research found that methamphetamine was reported to be more readily available in New Zealand than cannabis (54% said meth was 'very easy' to obtain, 14% reported cannabis as 'very easy' to obtain). Other messages were that there is something of a 'cannabis drought' in some areas, and smaller towns may have proportionally higher availability of methamphetamine than urban areas.

Codeine dependence

Associate Professor Suzanne Nielsen (Monash University) presented a keynote on codeine dependence and legislative changes in Australia in response to this. Codeine (and products containing codeine) is no longer available without a prescription in Australia; this is apparently due to change in New Zealand from 2020. In Australia 58% of people who develop codeine dependence do not have any alcohol and other drug (AOD) history, and problematic patterns often start with legitimate use of a codeine product following surgery or an injury. She outlined how those reliant on codeine can take between eight and 100 tablets per day.

Opioid misuse can cause significant medical harms, and in the United States it is estimated that on average, 115 people die each day due to opioid overdose. There are numerous barriers to treatment: stigma, perceptions of drug treatment and those who access it, people in need are unlikely to seek conventional AOD treatment services, and a lack of knowledge among health professionals may prevent them/us from identifying problematic use.

Problem gambling

A number of sessions focused on harms from gambling, and comorbidity between problem gambling and substance use disorders. Louise Kelly (Mental Health First Aid) described how 1.1% of Australians meet diagnostic criteria for a gambling disorder, and for each of these people, six others are affected by the problem gambler's behaviour and its consequences. Gerard Moloney (Lives Lived Well) emphasised the importance of asking about gambling, as its impacts are less visible than those of substance abuse, and it is a highly normalised behaviour; 70%–80% of the Australian adult population gambles every year. In his research, 75% of all problem

gamblers have had a problem with alcohol, 38% have had a problem with a drug, and 20%–30% of people in treatment for substance use have problem gambling as a coexisting issue.

Professor Matthew Rockloff (Central Queensland University) presented a keynote on the impact of gambling. He identified that 85% of the harm caused by gambling comes from what people consider to be low- or moderate-risk gambling behaviours. Gambling disorder is now listed under Substance-Related and Addictive Disorders in the Diagnostic and Statistical Manual of Mental Disorders fifth edition (American Psychiatric Association, 2013). Useful screening tools to identify problem gambling are the NODS-CLiP (Psychology-tools.com, n.d.) and the Problem Gambling Severity Index (CAMH, n.d.).

Technology and sex addiction

There were many worthwhile sessions for me at this conference, but the absolute highlight was a workshop by Steve Stokes (Steve Stokes Counselling and Consulting, NSW) on technology and sex addiction. He defined behavioural addiction as a pathological relationship with a mood-altering behaviour, and talked about how 'the enemy for sex addicts is in their minds'. There is a triad of particular challenges for online and technology-based addictions: sexually explicit material is easy to access anywhere and anytime, it is highly affordable (often free) and people can access it in complete anonymity. He discussed a range of predisposing and precipitating factors that might lead to someone developing a pattern of problematic online sexual behaviour. He outlined how problematic use of technology for stimulation escalates and common consequences for both the individual and their loved ones (e.g., withdrawal from or loss of relationships, loss of interest in real-life sexual experiences, increased interest in deviant sex which may lead to acting out of fantasies, impaired work performance and attendance, loss of time for other activities, isolation and shame, legal implications, and increased risk of others in household being exposed to material they have accessed online).

Stokes also emphasised how treatment of online sex addiction requires a range of creative interventions, including setting up practical barriers to accessibility (such as switching from a smartphone to a 'dumb' phone and setting up the highest possible levels of security on devices), and if necessary hiring a technology expert to filter and block access to sources of problematic material. He shared an extensive range of resources for working in this area, including books, podcasts, Youtube clips, and websites, and the Sexual Addiction Screening Test (Psychology-tools.com, n.d.). He is happy to provide further training in this field for anyone interested. He was a very informative and entertaining speaker; this session was very well-received (in fact we all stayed in the room at least half an hour after it had officially ended!) and it was worth travelling to the event for this session alone.

Conclusion

In summary, the Australia and New Zealand Addiction Conference was a very enlightening and useful event to attend and I recommend it for anyone working with clients who experience difficulties with substance or behavioural addictions. I would like to express my sincere gratitude for the NZCCP travel grant that allowed me to attend, and I also received support from the conference organisers (in the form of a discounted registration) as a delegate attending from overseas.

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NZCCP Travel Grant Report: Australian Psychological Society College of Clinical Neuropsychology Conference

Nic Ward

Earlier this year I was fortunate to receive a travel grant from NZCCP to facilitate my attendance at the Australian Psychological Society College of Clinical Neuropsychology (CCN) Conference in Brisbane. The organisers of this conference had invited members of New Zealand Special Interest Group in Neuropsychology (NZSIGN) to be part of this year's conference.

Eight New Zealanders took this opportunity to present at the conference. Six of us combined our presentations to deliver a symposium entitled *Neuropsychology Developments Across The Ditch*. Janet Leathem presented on early developments in neuropsychology in New Zealand, in which she covered the work of prominent New Zealand neuropsychologists such as Dorothy Gronwall, Jenni Odgen, Lynette Tippett, and Margaret Dudley. She also discussed the post graduate qualification in clinical neuroassessment that ran from 2001–2006. I followed with a talk about recent developments in neuropsychology in New Zealand, in particular the establishment of NZSIGN and the development of the neuropsychologist scope of practice.

This was followed by mention of various current neuropsychology projects in New Zealand. Two of these were discussed in more detail. Sanchia Logie and Kath Murrell presented on the development of an enhanced neuropsychology service at Starship Hospital, and Petina Newton and Snezana Mitrovic-Tosovic presented their role in developing and running memory clinics in the Auckland area.

(Petina, Nic, and Snezana)

Alice Theadom was an invited New Zealand speaker at the conference. Her presentation on the long term impacts of mild traumatic brain injury (TBI) included the findings of the (Brain Injury Outcomes New Zealand in the Community (BIONIC) study (Feigin et al., 2013). This study collected data on all mild TBIs occurring in the Hamilton and Waikato area in a 1 year period (2010–11) and has now also collected 1 year, 2 year, and 4 year follow-up data. (8 year follow-up data will be collected next year). These studies present a unique window into outcomes for clients with mild TBIs in NZ (especially as these injuries occurred before the development of ACC concussion clinics). The findings demonstrated that a substantial proportion of clients with TBI still experience significant symptoms (as measured by the Rivermead) at 1 year, and that some of the symptoms still persist at 4 years, even compared with non-head injured controls (e.g., their symptoms do not reflect normal base rate experiences of headache and fatigue). Cognitive effects were also seen on testing following mild TBI, most notably for complex attention. For many clients, these effects did not resolve completely until the 4 year follow-up. Alice concluded that it is currently uncertain what the neuropsychology behind delayed recovery is, and whether it is injury specific or more to do with psychological adjustment to injury.

(Nic and Alice)

This led nicely into the presentation by keynote speaker Julie Suhr from the University of Ohio. I found her workshop one of the most relevant to my clinical work. She presented an extended version of the common sense model of illness to explain neuropsychological presentations in mild TBI, mild cognitive impairment, and attention deficit hyperactivity disorder. She discussed how we all develop a personal representation of illness and how this affects our coping strategies and illness outcomes when we fall ill. We then go on to develop an 'illness identity' when injured or sick that has implications for our functioning in terms of how we perceive symptoms and react to them, both emotionally and behaviourally, and how we view the severity of the consequences of these symptoms (Leventhal, Meyer, & Nerenz, 1980). Julie presented a wealth of research that supported her expansion of this model (Suhr & Wei, 2017) to explain the course of an individual's experience following these diagnoses. To me, this model seemed particularly effective at explaining the variety of presentations and recovery pathways for our clients presenting with mild TBI.

Matt Richardson also travelled to Brisbane from Dunedin to present his workshop on Nocebo Hypothesis Cognitive Behavioural Theory for functional neurological disorders. He has presented this twice in New Zealand through NZSIGN, and there are plans for a third workshop in Wellington next year. Matt's workshop was well attended and received in Brisbane.

Dr Nic Ward has worked in Brain Injury assessment and rehabilitation for most of the 16 years that she has lived in New Zealand. She has also worked on various research projects, as a Clinical Educator and Lecturer at the University of Canterbury, and as a Clinical Psychologist with children and adolescents

Many Australian clinical neuropsychologists were excited to hear about his 90% success rate at treating these difficulties (Richardson, Isbister, & Nicholson, 2018) and were keen to work with Matt to trial his method in Australia as well as New Zealand.

(Matt)

Other sessions I enjoyed included:

1- Dana Wong and Sandy Grayson: How to run an effective memory skills group using a (slightly modified) version of the Australasian Society for the Study of Brain Impairment manualised programme 'Making the most of your memory'.
2- A symposium on family violence and neuropsychology.
3- How to develop behavioural management skills across subacute services.

As always at good conferences, choosing which session to attend was sometimes difficult, with multiple esteemed presenters on the podium at conflicting times. Outside of the conference sessions, I really enjoyed the opportunity to get to know my New Zealand colleagues better, including New Zealand neuropsychologists attending the conference (Corne Mackie, Kay Cunningham, Christina Russo, and Helen Paton) as well as the other Kiwi presenters. The warm Brisbane evenings made for enjoyable socialising in the beautiful South Bank area. In addition, the jet lag and early sunrises meant that a run around the botanical gardens was very achievable before 9am—not my usual style!

I was also able to make further links with members of the CCN with whom I have had dealings over recent years but not met in person. Simon Crowe (outgoing chair of the CCN) was very welcoming and supportive of NZSIGN, and introduced me to the new chair Amy Scholes, whom I look forward to working with as we develop a Memorandum of Understanding between

NZSIGN and the CNN. Their organisation has 380 full members, so hopefully we can learn a lot from them about ways to grow and develop NZSIGN. Karen Sullivan and Debbie Anderson were a pleasure to deal with as conference organisers, and I was able to meet Peggy Bain, head of the NSW branch of the CCN, who had been a great source of advice in the early days of NZSIGN.

Clinical neuropsychology in Australia is different to the model used in New Zealand, in that neuropsychologists do not have the same level of clinical psychology training that most of us do. Nonetheless, speakers at the conference reflected on the shift away from simply assessment and medico-legal issues to more of a rehab and intervention focus in their work over the last two decades. In this, we share a desire to be of use to our clients, not just in qualifying their difficulties, but in working with them to move through the areas of challenge to be able to meet their goals in life.

Huge thanks must go to the NZCCP and my employer Laura Fergusson Trust for enabling me to take up this opportunity, and to the other New Zealand presenters for taking the time and finding the resources to present our work to our colleagues 'across the ditch'.

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Report on the Health Informatics NZ Conference, Wellington, November 2018

Leigh Anderson

With the support of the NZCCP I was able to attend the Health Informatics NZ (HiNZ) conference in Wellington in November. Promoting future-focused professional practice is one of the NZCCP's strategic directions, and ensuring that clinical psychologists and our clients are able to use and benefit from new technologies in our practice is an important component of that direction.

Health informatics is the science behind the convergence of healthcare, information technology, and business. The practice of health informatics covers the storage, retrieval, sharing, and optimal use of data relating to human health, and how we use this knowledge for problem solving and decision making. As broad as that sounds, the conference was even broader, incorporating artificial intelligence (AI), robotics, cybersecurity, mobile health, virtual reality, and

Leigh Anderson is Dr Leigh Anderson is a Fellow of the NZ College of Clinical Psychologists (FNZCCP) and is the current convenor of the Canterbury NZCCP branch. She is working in private practice in rural and urban North Canterbury. She has had a range of roles over the past decade including with the local DHB and Department of Corrections, working in both mental and physical health. Living in a rural area, her curiosity in equitable access to healthcare for those outside of main centres has seen her investigating the impact of digital technologies.

workforce. While I was probably the least technologically able or connected person in the room, I went because my interest in how rural and isolated communities can access healthcare has highlighted the increasing use of digital platforms in health and mental health. An important question for clinical psychology is how are we positioning and/or educating ourselves about the rapidly evolving landscape that digital is bringing?

There was a huge amount of information presented over the 2 days of the conference and a pre-conference allied health forum. Following are a few key themes that were relevant to clinical psychologists.

1. Are we digitally literate? Professions are moving to incorporate digital literacy and competency, and informatics as part of their training. For example, nurses are linking it to their core competencies as part of their registration requirements (see https://doi.org/10.17608/k6.auckland.7273037.v2). As a profession, what are we doing, or what will we do to develop our skills in this area?

2. Are our practice and clinical tools up-to-date? As I went around the booths in the exhibition hall I would ask "I am a psychologist in private practice. Is what you do (i.e., sell) applicable to me?" For the majority of cases the answer was no, but sometimes I was asked questions about client management software, how I take and store notes, how I collect business-relevant data and how I share information. All good questions for us all to ask ourselves when thinking digital and business. Generally, the response to my hand-written notes and filing cabinet was one of shock, horror, and dismay. Definitely 'old school'.

The lack of digital systems that could benefit my patients/clients, myself, and my practice—online booking and billing, psychometrics (online and tracked over time), service review tools (workloads, outcomes, attendance, etc.) was clear. My 'analogue' system is too unwieldy to cope with such things. So, how professional (or even, scientist-practitioner) am I being? I know that at some stage I will need to digitise, but am uncertain about how to do that. Clouds? Portals? Security? Subscription or pay for service models? Interoperability? While there is probably no one system that would work for all clinical psychologists, identifying systems that will work for us will be important, and may be a useful contribution of the College.

3. Are we as a profession herding or being herded? There is stuff happening now which will affect us, but that we have absolutely no part in shaping. We need to think about whether that needs to change. For example, the Ministry of Health (MoH) have standards for organisations collecting data about allied health staff work, primarily in DHB settings. Who knew? (https://www.health.govt.nz/publication/hiso-100652018-allied-health-data-standard). The MoH also have a plan for digital health and are seeking people for technical working groups. Are we aware of this, and are we putting our hands up so we have a part in shaping our destiny? (https://www.health.govt.nz/system/files/documents/pages/digital_health__2020_overview.pdf).

4. How can we keep relevant? There were a number of presentations that demonstrated that what we may like to think of as psychologist's work may not require us at all. Although not part of the HiNZ conference, I noticed recently that John Kirwan is advocating the use of AI therapists (https://www.stuff.co.nz/national/108408161/john-kirwans-plan-to-use-ai-to-develop-digital-mental-health-coaches). Unqualified health coaches (one who was a hairdresser, for example) or personalised digital support are helping people to make positive changes to their health and wellbeing without needing a psychologist. While this is a good thing (e.g., improving access to service, lower costs), it does make me wonder where we fit as a profession, what we

offer, and how we market ourselves. I think it is important that the digital technologies such as AI, and even teletherapy, are seen as an adjunct rather that replacement for face-to-face services. So, how do we incorporate AI and other technologies into our practice? How do we help to guide decision-making about when a skilled practitioner should be involved? Are we helping to develop, or inform, development, of alternative technologies and/or coaching programmes? How do we demonstrate our value? Mental health nurses seemed to have a more significant role in provision and design of services than psychologists.

5. Useful resources are already out there. Many resources that are useful to clinical psychologists are already out there—do we know about them? As just one example, https://www.healthnavigator.org.nz/ investigates and reviews New Zealand-specific content and apps. It is a useful website to know about, use, and contribute to.

Phew! It was a big few days and I am still trying to sift through it in my head. Clinical psychology could gain a lot from increasing its involvement with health informatics. This conference was a great way to get to grips (or at least identify) some of the issues and possibilities. Hopefully the College can be helpful in moving some of this forward for clinical psychology in New Zealand.

Book Review

Title:	**ACT Questions and Answers: a Practitioners Guide to 150 Common Sticking Points in Acceptance and Commitment Therapy**
Author:	Harris, R.
Publisher:	Oakland, USA: Context Press, 2018
Reviewer:	Ele Porteous

ACT Questions and Answers: a Practitioners Guide to 150 Common Sticking Points in Acceptance and Commitment Therapy is exactly what the title says. With the exception of Chapter One, which outlines the 'Choice Point' tool, each other chapter takes one aspect of acceptance and commitment therapy (ACT) and presents a number of common questions or sticking points that might arise in relation to that topic. The topics cover all aspects of therapy, from elements of the ACT hexaflex to other therapeutic processes that can be part of ACT, such as 'Surprising Self-compassion'; 'Exasperating Exposure' and 'Freaky Functional Analysis'. ACT is an increasingly popular therapy that has just had its 250th randomised controlled study published, culminating 30+ years of research. Russ Harris is a peer-reviewed ACT trainer who has reportedly trained nearly 30,000 health professionals in ACT and has written several books on ACT for both practitioners and clients. This book is not an introduction to ACT; rather it assumes readers are at least moderately proficient in the practice of ACT.

As a mum to an infant, it took me several weeks to read the book; a chapter here and there when I could manage it. At first I really enjoyed it. I have been using ACT as my primary modality for a few years now and it was refreshing to have a reminder of how to do ACT well. The book also highlighted a couple of bad habits I had developed, which were good to have identified. However, from about halfway, I felt it became very repetitive. In essence, Harris's advice could be boiled down to three points: 1) make sure you have obtained informed consent to do ACT, 2) make sure you and your client have shared behavioural goals for therapy, and 3) use your core

Dr Ele Porteous, DCP, MNZCCP, is a clinical psychologist currently working at Saint Kentigern College. She has experience in adolescent mental health and at Starship Children's Hospital. She has a young daughter and this book was read and the review written in a series of 20 minute blocks during her infrequent catnaps across the day

counselling skills (e.g., be validating, be flexible, be honest). He acknowledges this repetitiveness quite openly within the book and devotes a chapter each to point one and point two so readers know exactly how to follow this advice. Alongside these three points there were also several other titbits useful for specific situations, but I am not confident that I would remember them if those specific circumstances came up. I will never read it cover to cover again, but I can imagine myself returning to this book for specific questions and topics when I am stuck. Ultimately, I think this is how it was designed to be used.

Many of the questions raised are ones I would have taken to supervision, asked in my ACT peer supervision group, asked colleagues, or asked on an Association of Contextual Behavioural Science (ACBS) thread. I expect in most cases, had I done this, I would have been given very similar answers to those Harris provides in this book. For people who do not have access to these other resources, or for a concise place to get advice before asking others, this book would be a useful resource.

I have read several of Harris's books now, including *ACT Made Simple* directed at practitioners, as well as *The Happiness Trap* and *The Reality Slap*, written for consumers. His books are very easy to read and understand, with a chatty style. This book is even more relaxed and chatty than the others. Every chapter title involves alliteration that reminded me of the 'Horrible Histories' books I read a child. He jokes in one chapter about how we owe him a beer for his help, and my personal favourite was his answer to the question "Should we target all experiential avoidance?" which started with "Noooooooo!"

A common critique I have heard of Harris's approach, based on his books and trainings, is that he is very 'techniquey' and scripted. Personally, I found this helpful when I was first learning ACT, but now that I am more confident in myself and in my execution of ACT, I rely less on the spoon-fed scripts, metaphors, and exercises. Despite rolling out more metaphors, scripts, and exercises throughout the book, Harris does direct the reader to find their own style. However, my opinion is that he could have emphasised this more, as some of his answers did read a little like a one-size-fits-all.

Overall, I do believe this book is useful and I am happy to give it space on my bookshelf. It has drummed home to me the importance of informed consent and behavioural goal setting, which I needed. I am sure I will refer to it often as it compiles a lot of information in an easy to access format. However, if you already have a reasonable knowledge of ACT and you are looking to learn something new, this might not be the book for you.

No conflicts of interest to declare.
Acknowledgement to Russ Harris for providing me with a copy of this book.

Book Review

Title:	**The Little ACT Workbook. An Introduction to Acceptance and Commitment Therapy: a Mindfulness-Based Guide for Leading a Full and Meaningful Life**
Authors:	Sinclair, M., & Beadman, M.
Publisher:	Bath, England: Crimson
Reviewer:	Peter Stanley

The uptake and endorsement of acceptance and commitment therapy (ACT) by practitioners has been significant, and this is not surprising given its support in over 150 randomised trials. However, ACT is not easy for some clients and therapists to understand. This is probably because of the counter-intuitive quality of the approach, and because it requires an appreciation of how the component processes of ACT work together to achieve good outcomes. *The Little Act Workbook* is intended as a self-help book, and it is careful to address the inherent limitations of trying to respond to personal difficulties as if they are problems to be solved. It also condenses the six dimensions of the ACT hexaflex into three key instructions: *Wake up! Loosen up! Step up!* What follows is a brief explanation of these injunctions; and this review is in the spirit of the present text "to create a no-nonsense, straight-to-the-point and bite-size introduction to some really big and important ideas" (p. 12).

Wake up! The first requirement to living a fuller life is to understand that the human mind is primarily a thinking and a problem-solving instrument. While this makes it really helpful with predicting and planning, communicating with others, and dealing with complex practical matters it becomes distinctly unhelpful to us in when we are preoccupied with our pasts or our futures, when we judge ourselves and others harshly, and when we decide that our thoughts should be rigid rules for how we should behave. Hence, the second condition for having a richer life is to be in the present moment; to let the mind's endless chatter and its continual evaluations pass by us like leaves on a gently flowing stream. Nevertheless, we are encouraged to notice and to acknowledge our thoughts and emotions. In fact, there is a part of the mind that exists for this very task. Our observing self stands apart from experience and it is able to say to us, "At this moment I notice I am having this particular thought (or fear, or impulse) again."

Loosen up! Authors Sinclair and Beadman ask us to imagine the mind as a computer system, and they appeal to us to gently lift our heads from *inside* the computer and, instead, to begin *watching* the screen. However, it is more than a step up for someone to start to see his or her intrusive thoughts, emotions, and urges merely as mind chatter. The facts are, that many of us hit 'the feel good button' when we encounter adversity, and for the purposes of feeling good right now there is such an array of drugs and other distractions available to us. By contrast, to have our lives on track and to achieve fulfilment in the longer term, demands willingness. And a person who is displaying willingness is not simply stepping forward to tolerate his or her fears. This individual is effectively leaping towards a more meaningful life, irrespective of mental and emotional concerns. Whether this works for any of us is a matter of trial and error, and such a pragmatic approach stands in contrast to other mainstream therapies that prioritise symptom relief, or disputing what is in our heads, as a prelude to new actions. Similarly, ACT is also contrary to common sense responses to upsetting thoughts and feelings as it enjoins us to loosen

Dr Peter Stanley is a retired counselling psychologist. Peter says that he became fluent in two therapy systems in his career. He deployed applied behaviour analysis with child and family clients and acceptance and commitment therapy with adults and himself.

up, rather than to tighten up (or to toughen up), when we encounter problems of living.

Step up! The inspiration for action is knowing what you want. It is about values; how we choose to behave, and how we would prefer to be. Values are at the core of acceptance and commitment, so this therapy gives significant space to identifying and to clarifying what a client really cares about. Many practical exercises have been created for this purpose, but there are also some general observations that apply. Values are distinct from goals, as they are a direction rather than a destination. Most certainly, they are not concerned with the pursuit of emotional states like contentment or self-esteem. Equally, performances associated with them are not dependent on an audience's reaction, or on other people's judgements. As it happens, our values are most evident when we freely, and completely, engage with a particular activity or some other people. In effect, the essence of ACT, and of this system of living, could be considered as being expressed in this sentence: "I'm having these really difficult thoughts, sensations and emotions, AND I'm willing to take them with me as I move towards the things that matter to me in life" (p. 134).

The Workbook is probably part of a larger popular movement to distil complex intellectual arguments into accessible summaries. Sinclair and Beadman do this, and they do far more. The tone of their book is encouraging and supportive; it includes a host of practical exercises and provides a compendium of further reading and other resources. Most importantly, it seems capable of challenging the ACT novice to review his or her habitual ways of responding; and especially where these include 'quick-fix' and 'fix-it' strategies. It is likely that many readers of this book will benefit from it and they will move towards fuller and more meaningful lives. As the authors of *The Little ACT Workbook* say "there is nothing 'little' about ACT at all" (p. 12). Rather, the title of the book reflects the determination of these writers to provide a simple, concise, and useful text about this therapy for clients and clinicians, and they have eminently succeeded in their ambition.

NZCCP

National Education Training Timetable

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

TRAINING TIMETABLE

NZCCP Events

LOCATION	MONTH	PRESENTER/ CONTENT
Christchurch	19 February	The Power Threat Meaning Framework, with Dr Lucy Johnstone, UK
Sydney	5 April	NZCCP/ACPA joint conference: *"The Contemporary Clinician: combining ancient wisdoms, cultural traditions, and modern advances"*
Sydney	6 April	ACPA/NZCCP joint preconference workshop: *MiCBT: Advanced Skills* with Dr Bruno Cayoun
Auckland	12-13 May	NZCCP national conference: *"The Heart of Psychology: Our people, our land, our future": "Te Pū o te Whatumanawa: ko te iwi, ko te whenua, ko te anamata"*
Auckland	14 May	NZCCP post-conference workshop, with Rob Muller

Other Events

LOCATION	MONTH	PRESENTER/ CONTENT
Auckland	9-13 Februarv	International Conference on Mindfulness (ICM) Asia Pacific 2019
Auckland	15 February	Tribunal Conference 2019
Auckland	27 February-1 March	Level 1 Schema Therapy Training "The Model, Methods, And Techniques"
Christchurch	7-10 March	NZ Pain Society Annual Scientific Meeting
Wellington	23-24 March	Attachment in Clinical Practice
Auckland	9-10 May	Group Schema Therapy: An Introduction For Personality Disorder, Complex Trauma, and Other Challenging Populations
Auckland	13-14 May	Experiencing Schema Therapy from the Inside-Out: 2-Day Self-Practice/Self-Reflection
Auckland	14-16 August	Level 2/Advanced Schema Therapy Training "Beyond The Basics"
Christchurch	22-24 November 2019	ISSTD Conference