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**He hononga tangata e kore e motu; ka pa he taura waka e motu.  
Waiho i te toipoto, kaua i te toiroa**

*Unlike a canoe rope, a human bond cannot be severed. Leave it close together, and not wide apart.*

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## Editorial

Dear Colleagues

Our theme for this issue is “Relationships” and I hope that you enjoy our contributors’ wonderful offerings. I really wanted to have us thinking about all manner of relationships, and, to that end, am pleased that there are contributions drawing our attention to political, couples, family, and child relationships. I’d love to hear your thoughts—send an email to [office@nzccp.co.nz](mailto:office@nzccp.co.nz) for Letters to the Editor.

As I write this, Ant, my second son, is almost 12 weeks old. I’ve been really captivated by the relationship between him and my older son, Bear (aged 2 years). Bear is starting to put more words together and is so keen to “hug Unt,” “sit me,” “kiss Unt,” and, unfortunately, poke Ant and squish him. It is these thousands of daily interactions though that shapes their relationship together.

In the same way, aren’t we in such an amazing profession that we can engage in interactions that offer people opportunity to connect in ways they may never have experienced? Aren’t we privileged that through our relationships, we can offer

healing and freedom from mental prisons? I would love to hear your thoughts about the therapeutic relationship.

Tremendous thanks to all our contributors, reviewers, Audrey our proofreader, and Caroline-the-Magnificent. We would not have this journal without you. As many of you may be aware, we are in the process of moving to more formal peer review status, and require each contribution to be evaluated by two reviewers. The volume and breadth of contributions means that we’ve had to approach members who are knowledgeable in those areas to be reviewers. I appreciate that all of you are busy and that you may not have volunteered for this. I thank you all for your contribution to our professional practice. If you would like to review for us and haven’t yet been approached, please let us know!

Wishing you an enjoyable reading of the Journal and a warm winter.

Kumari

Kumari blogs about gardening, psychology, and life:

[www.kumarifernandoblog.wordpress.com](http://www.kumarifernandoblog.wordpress.com).

The journal has a facebook page (Journal of the NZ College of Clinical Psychologists)—we’d like you to like us!

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## A Day in the Life: Psychologist Meets Politics

Karen Kyne

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Before my engagement with the NZCCP Committee in Wellington, I would have considered myself a bit of a tree-hugger, with liberal/lefty-type tendencies and very little interest in the world of politics. Over the past few years however, I have come to see how the decisions made in the upper echelons of the political world affect my work every single day. When a talented physiotherapist quits the rehab team to work privately (because the public workload is too high and the pay too low), I think “politicians!” When my client cannot access the kind of support he needs because the funding is for a fixed purpose, I think “politicians!” When the psychology workforce loses some of its diversity due to lengthy training with minimal financial support I think...Actually I probably cannot write that.

Anyway, after many dealings with the political world while involved with the NZCCP, I recently found myself attending the Health of the Older Persons Strategy Meeting with the Ministry of Health. I would like to share how this meeting went. However, this means honestly reviewing some of the frustrations I experienced in association with the process, and admitting to a somewhat displeasing discovery I made about myself. Firstly, the process was one in which it was very difficult to cover all of the areas that I had hoped. Groups were separated to discuss disparate areas of interest and I could not be everywhere I wanted to be. Within the groups I was part of, I discovered that give me a passion and a soapbox and I can be really overbearing! This might not be a surprise to those of you who know me and have become acquainted with the politically opinionated animal lurking within. I’m just glad that I have such good friends, because I am pretty sure I did

not make any at this meeting.

Anyway, the process adopted means that I can only really talk about what happened in the groups in which I participated. The first exercise was developing a vision statement. My sceptical self stepped in at this point and loudly suggested that this was an exercise in advertising; the creation of a no-cost slogan for the Ministry. Not an activity with a true purpose in terms of action for change. But, I tried to appreciate the importance of establishing an ultimate goal. Every group developed a vision statement and I guess that what will eventually be presented to the nation will be either the best one, or a variation on a number of “visions” presented. The group I was in came up with something along the lines of “a society that optimises the health, wellbeing, and potential of all its members.”

There were then a variety of “theme” headings based on areas in which the Ministry thought changes could be made and the kind of health service that is wanted. These were: people-powered, close to home, value and high performance, one team, and smart system. All a bit vague I know, but the premises were defined after everyone had chosen a group. At a bit of a loss, I jumped into the value and high performance group, thinking that this was a good definition of psychological intervention. So, we started with trying to define what a high performance and value for money health system would look like. Wanting to focus on the value that psychology brings I suggested a focus on evidence-based intervention, placing a high value on the retention of experienced and knowledgeable allied health staff and avoiding the duplication that occurs in the assessment and provision of support services.

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We then had to choose three possible areas from a list of 36 areas of concern, and present one clear and defined strategy that would improve the health of older people. And this is where it started to get tricky—try to get eight people to agree on this, and then to agree on one strategy for each. Not the most productive or enjoyable strategy, especially as I had by then realised that my carefully prepared list of issues and evidence-based interventions was about to come to little or nothing. The three areas that my group chose (and yes, this is where the political animal revealed itself) were “maximising the rehabilitation potential,” “promoting age friendly communities,” and promoting the provision of suitable, affordable and diverse accommodation options for older people.” Within these small areas of possible change, I was able to put forward strategies that included “improving the access of stroke rehabilitation teams to psychological services,” “developing and retaining key allied health staff in rehabilitation teams,” and “including psychogeriatric team input to the design and development of rest homes and dementia units.” Some of the issues related to each of these ideas were discussed and presented (for example, psychologists’ understanding of the impact of the environment on behavioural and psychological symptoms of dementia).

I was also able to read some of the other teams’ initiatives before the meeting ended, and was glad to see that the “flexible application of support funding based on consumer choice” was one of the proposed strategies (as this was on my list). Another strategy that caught my eye and gained immediate approval was “polypharmacy reviews,” whereby all patients aged over 65 years and taking more than five medications would be red-flagged to their GPs and a medication review advised.

So, even though it meant sacrificing any possibility that I would be considered a quiet and unassuming team player (which is what I usually aim for), I would like to think that being involved has meant that some issues relevant to psychologists and what we bring, or could bring, to the health of older people might make it into the final strategy. Who knows? The experience also caused me to once again focus my attention on our Code of Ethics, and what the phrase “Social Justice and Responsibility to Society” actually means to me. The Code defines it as:

Psychology functions as a discipline to promote the well being of society. In New Zealand, the Treaty of Waitangi is a foundation document of social justice. Psychologists, both as individuals and as a group, have responsibilities to the community and to society in general. The principle of Social Justice is about acknowledging psychologists’ position of power and influence in relation both to individuals and groups within communities where the psychologist is involved, and in the broader context. It is about addressing and challenging unjust societal norms and behaviours that disempower people at all levels of interaction (p. 25).

I would go on to add that with our focus on empiricism, we often find ourselves in possession of unique knowledge about the relationship between social factors and individual wellbeing, in addition to having an evidence-based understanding as to how change can be effectively enacted. So I would challenge all of us to use this knowledge to better the society in which we, our families, and our clients live, even when this means stepping out of one’s comfort zone.

I began an unexpected journey of self-discovery by asking a seemingly straightforward question: What is competent clinical practice? While pondering the research in this area, I fell over another question I had never asked myself: What exactly is self insight in terms of clinical practice, and how accurate can we be? These answers led me to yet another question: If self assessment can be flawed and humans have “blind spots,” what steps should be taken to practice competently? Then, if individuals have blind spots, what could that mean for organisations, communities, and nations? One by one, these questions highlighted my blind spots and pushed me from a reasonably long-term insular and individualistic perspective of clinical practice to considering the role of psychologists from network, community, and societal perspectives. I began to consider psychology from a leadership perspective.

My reading on competent clinical practice emphasised the importance of good supervision and the need for feedback from a diverse range of colleagues, both inside and outside my inner circles of trust. However, surprisingly, the recognition of my blind spots prompted professional regret. Throughout my career, I have been the type of clinician who wanted nothing more than to work with one client (individual or group) at a time. I never viewed myself as, nor desired to be, a strategic thinker or communicator, and seldom considered I had a role at a community or global level. I defined strategic thinkers and communicators in our discipline as individuals who actively seek to be engaged in their agency, or network of

agencies and communities, so that their voice is heard when decisions about the future of psychology are made. I happily left that kind of thinking and action to others, content to discuss concerns about the ever increasing demands from the community, the profession, and society with my supervisor or close colleagues. I had been blind to the transformational aspects of leadership and the role psychologists could play.

The irony is that I am fast approaching the end of my career, and have just recognised how unfortunate my insular view has been to my development and my profession. I am sharing my regret and articulating a “call to arms,” in the hope that psychologists everywhere will begin the process of engagement within agencies, across agencies, nationally, and internationally. Do not simply wait for a strategic thinker and/or leader to step up and do the work like I did. Recognise that you have the expertise (or knowledge) and power to make a difference. Acknowledge that you are a potential leader and strategic thinker. Lead by engaging and networking in your agency, community, and beyond when opportunities arise. Join the conversation. Read outside your discipline. Be curious. Engage with a network of psychologists and community leaders; shape the future of psychology while helping address the needs of our communities. I realise now that clinicians simply cannot afford to practice while disregarding these “calls” as I did. We have a responsibility to join the multidimensional conversations about the complex issues facing our communities.

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To underscore my call for engagement, relationship building, and innovation in and out of psychology, I share some of the innovative perspectives and practices I have stumbled across.

According to C. Otto Scharmer (2013), a MIT senior lecturer, “We live in a time of massive institutional failures, collectively creating results nobody wants. Climate change, AIDS, poverty, violence, and terrorism—The foundations of our social, economic, and ecological wellbeing are at risk.” As examples, he points out current problems in the Middle East, Europe, and the United States. Scharmer (2013) believes that “our collective failure is that we are blind to the deeper meaning of leadership and transformational change” and notes that these blind spots occur in our everyday social interactions. He believes that leaders are blind to the “source dimension” of leadership, which is the quality of the attention, or inattention, that a leader (or human) brings to any situation. Certainly, the things I have chosen to attend to, or not attended to, have shaped my work as a clinician.

John Gerzema (2013) believes that people want leaders who are prepared to engage in a social, interdependent, and transparent fashion. He discusses the example of Dr Ijad Madish, a Berlin-based scientist who found it difficult to discuss issues and problems with his research. Dr Madish created ResearchGate, a website where scientists can openly discuss their findings and concerns. According to Gerzema, being transparent about our difficulties supports innovative problem solving.

Madhumita Venkataramanan (2014) wrote about a pioneering response to violence developed by Gary Slutkin, a professor of epidemiology and public health at the University of Illinois in Chicago. Reportedly, Prof. Slutkin was shocked into action after two particularly tragic deaths of children in Chicago. He applied epidemiological strategies to the problem of violence, and in

2000, tested these theories in one of the most violent neighbourhoods in Chicago. He organised social action to communicate the neighbourhood’s objection to violence. Shootings reportedly dropped from 43 in 1999 to seven in 2003. “Interrupters” were also trained to help prevent outbreaks before violence could occur. Dr Slutkin engaged the community, professionals, and others who wanted to make a difference. Together they worked to achieve positive outcomes for their community.

Dr Nadine Kaslow (2014) and colleagues propose creating competent communities of psychologists. These networks could include an inner core of colleagues, a collegial community of individuals from a variety of professional settings, and collegial acquaintances. They recommend these networks be diverse in terms of cultural backgrounds, professional training, and theoretical perspectives, as greater diversity supports improved problem solving. Dr Kaslow and colleagues noted that these concepts also need to be embedded in the training of psychologists and supported in our supervision and modelling (Kaslow, 2014).

Finally, Peter Hawkins and Robin Shohet’s book *Supervision in the Helping Professions* (2006) described with startling clarity what I, in my clinical silo, knew but had never actioned:

It seems inevitable that you will year on year be asked to do more at a higher quality with fewer resources in a more disrupted and disturbed world. The question is what can we do together to step up to this challenge? I do not believe that our choices in response to the global challenges are either denial or powerlessness. Neither do I believe that heroically doing more, trying harder under greater pressure will be sustainable. The challenges are beyond individual leadership or individual coping mechanisms. We need to work together and that means far greater levels of

collaboration and combining than ever before... (pp. 9–10).

I wonder what we might accomplish if we develop and diversify our networks, and increase our engagement with other psychologists and professionals from other disciplines? I wonder what innovations might be possible, what solutions are waiting for us? Certainly, the answers we find will lead to more questions, but that is how the journey begins.

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## Co-Rumination: When Sharing Problems Becomes Problematic

Johannah Betman

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*All around the world, individuals can be found sharing their problems with those in their social networks. How this sharing occurs varies greatly, with some communication styles having more positive outcomes for the individual and their relationships than others. One style individuals may chose to engage in when sharing their problems is co-rumination. In terms of effectiveness, co-rumination can be a double-edged sword, resulting in positive consequences for one's social relationships and negative consequences for the individual (Rose, 2002). In this article, co-rumination will be defined and research on the paradoxical consequences of co-rumination will be reviewed. Gaps in the literature will be highlighted, and how clinicians may benefit from being aware of co-rumination will be explored.*

### Co-Rumination—What is it?

Co-rumination is defined as “extensively discussing and revisiting problems, speculating about problems, and focusing on negative feelings” with another individual (Rose, 2002, p. 1830). Two core components of co-rumination are self disclosure and rumination. Self disclosure refers to the sharing of one’s personal thoughts and feelings (Asher, Parker, & Walker, 1996). In the context of co-rumination, self disclosure has a negative

focus, with negative thoughts and feelings about a problem discussed. Rumination refers to the process of repetitively thinking about the causes, consequences, and meanings of depressive thoughts, feelings, and symptoms (Nolen-Hoeskema, 1991). Like rumination, co-rumination involves a repetitive, non-solution focus on problems. Unlike rumination, co-rumination is an external, social, conversational process, where ruminative thoughts are excessively shared and discussed (Rose, 2002). In addition, unlike rumination, the repetitive nature of co-rumination is encouraged, not only by the individual, but by the individual they are talking with (Rose, 2002).

### Consequences of Co-Rumination

Sharing problems with others contributes to closer relationship bonds (Asher et al., 1996) and higher quality relationships (greater helping and greater conflict resolution) (Rose, 2002). Ruminating on problems has also been found to contribute to greater levels of depression and anxiety (Nolen-Hoeskema, 1991; Spasojevic & Alloy, 2001). With self disclosure and rumination both being components of co-rumination, it would follow that the consequences of co-

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rumination would be two-sided. Supporting this, co-rumination has been found to both strengthen one's relationships and worsen one's mood (Rose, 2002; Rose, Carlson, & Waller, 2007).

### **Review of the Literature**

The co-rumination literature has a narrow research base, with the majority of studies having explored co-rumination in the context of adolescent same-sex friendships. Results from these studies indicate co-rumination is associated with greater friendship satisfaction as well as greater levels of internalising symptoms (e.g., depression and anxiety) (Hankin, Stone, & Wright, 2010; Rose, 2002; Rose et al., 2007; Smith & Rose, 2011; Stone, Hankin, Gibb, & Abela, 2011; Stone, Uhrlass, & Gibb, 2010). These consequences have been found to hold over time (Stone et al., 2011).

In an effort to extend co-rumination's narrow research base, a growing number of studies have started to explore co-rumination in adult same-sex and opposite-sex friendships. Consistent with the adolescent literature, co-rumination in adult same-sex friendships has been found to be associated with greater relationship bonds and greater levels of negative emotion (Byrd-Craven, Geary, Rose, & Ponzi, 2008; Byrd-Craven, Granger, & Auer, 2011; Davila et al., 2012). In contrast, the consequences of co-rumination in adult opposite-sex relationships have been found to be more varied (Barstead, Bouchard, & Shih, 2013; Calmes & Roberts, 2008). For example, Calmes and Roberts (2008) investigated the consequences of co-rumination across four different relationship settings. They found: 1) Co-ruminating with a same-sex friend predicted greater relationship satisfaction, as well as greater depressive symptoms for females, but not for males; 2) Co-rumination with a parent was associated with significant anxiety; 3) Co-rumination with a same-sex roommate or a romantic partner did not predict relationship satisfaction or any symptoms of depression or anxiety (Calmes & Roberts, 2008).

### **Sex Differences in Co-Rumination.**

Sex differences in the use of co-rumination as a communication style have been observed, with girls found to co-ruminate more than boys (Rose, 2002). Rose (2002) proposed this finding may have implications for our understanding of depression, explaining why girls experience closer friendships than boys, yet these friendships do not appear to protect them from also experiencing greater levels of depression and anxiety.

However, there are mixed findings in terms of sex differences in the consequences of co-rumination. On one hand, Rose (2002), Rose et al. (2007), and Stone et al. (2011) reported significant sex differences in the consequences of co-rumination with a friend, with females experiencing greater negative consequences. Hankin et al. (2010) and Stone et al. (2010) found no significant differences in the effects of co-rumination for males and females. Two possible explanations for these discrepant findings have been offered. First, there is a well established 2:1 sex ratio in the frequency of depression that emerges in early adolescence. Before this age, no sex differences in depression are indicated (Hankin et al., 1998; Rose, 2002). At the same time, increased use of co-rumination as a discussion strategy is thought to emerge in early adolescence, as girls are increasingly encouraged to develop a stronger interpersonal orientation than boys (Rose, 2002; Simonson, Mezulis, & Davis, 2011; Smith & Rose, 2011). Given this literature, Stone et al. (2010) noted that one possibility for the absence of a sex difference in their study might have been their younger sample, which included children as young as 9 years. Secondly, it is also possible that sex differences in the consequences of co-rumination differ across different relationships. As evidence of this, Calmes and Roberts (2008) found sex differences in the consequences of co-ruminating with a friend, but not co-ruminating with a parent, roommate, or romantic partner.

### **Contributors to Co-Rumination**

Increasingly, studies are exploring why some people are more negatively affected by co-rumination than others. Rose et al. (2014) highlighted the importance of the content and passivity of co-rumination. They found dwelling on negative emotion was associated with internalising symptoms, while rehashing, speculating, extensively talking about a problem, and mutual encouragement of talking were associated with positive friendship adjustment (Rose, Schwartz-Mette, Glick, Smith, & Luebbe, 2014). Stone and Gibb (2015) highlighted the role of ruminative thinking, noting co-rumination predicted greater rumination which predicted greater depressive symptoms. Balasamo et al. (2015) concluded co-rumination may be associated with depression through the activation of certain cognitive schemas. Hruska, Zelic, Dickson, and Ciesla (2015) found co-rumination contributed to greater levels of stress, which in turn predicted greater internalising symptoms. Guassi (2016) highlighted the importance of relationship quality, noting co-rumination among college roommates was not associated with depressive symptoms when the quality of the relationship was high.

### **Gaps in the Literature**

While the consequences of co-rumination in adolescent same-sex relationships are well established, further research is required to help us fully understand the consequences of co-rumination among adults and in the context of various relationships. In particular, there is a significant absence of literature exploring the consequences of co-rumination in the context of romantic relationships. Given that one of the most significant relationships adults develop is that with their romantic partner, better understanding the consequences of co-rumination in this context appears to be important.

Furthermore, while co-rumination is a dyadic process, the majority of available studies sought information from only one

member of the dyad. Only two studies (Byrd-Craven et al., 2008; Byrd-Craven et al. 2011) used an experimental design to compare co-rumination with an alternative, more adaptive discussion style. To more fully understand the contributors to, and consequences of, co-rumination further studies using an experimental design and gathering information from both members of a dyad would be beneficial.

### **Implications for Clinical Work**

Given what we now know about co-rumination, two implications for clinicians are raised. First, clinicians would benefit from thinking about whether co-rumination may be a maintaining factor for their client's depression and anxiety. If this is the case, clinicians would benefit from highlighting for clients that talking with others about their problems is helpful as it builds support and brings us closer to others. At the same time, clinicians should also highlight that when discussing problems with others, it is important to keep dwelling on what has happened to a minimum and instead, look at increasing the time spent exploring what can be done to solve the problem, or if it cannot be solved, to accept the problem. This is because the more they think about and focus on the negatives of what has happened, the bigger those negatives will appear and the more easily they will come to mind. In contrast, focusing on the solution or deciding to accept a problem and move on will shrink the problem so it is more tolerable. To support clients with this, it may be helpful to spend a session in therapy exploring communication styles and looking at building an alternative communication style to co-rumination.

Second, clinicians would benefit from thinking about the possible impact of a client's co-rumination on therapy. For example, therapy may be harder for clients whose communication style is to dwell on problems, as it is in contrast to and unfamiliar with the structured goal directed communication style of therapy. Being aware of this may help us understand our

clients more, and work towards shaping and reinforcing solution-focused or acceptance-focused discussion.

Furthermore, given that communication is an interactive process in which one individual influences the other and vice versa, it would follow that working with a client whose communication style is to co-ruminate, may see the therapeutic discussion drift towards a co-ruminative style. Being aware of this means the therapist can watch out for co-rumination in sessions, name it, and discuss it with their client when they see it. For example, “I can see you tend to want to drift towards discussing the impact your argument with your partner had on you this week. While this is important, we also want to focus on what you can do to address this problem with your partner so that you can reduce the negative feelings you experience when thinking of this problem.”

### Summary and Conclusion

When thinking about how best to talk to others about our problems, a clear trade-off regards the costs and benefits of the communication style of co-rumination is highlighted. On one hand, co-rumination contributes to the strengthening of one’s relationships. On the other, it is shown to worsen one’s mood. With this in mind, what we can do as clinicians is make our clients aware of this dialectic, and work with them on developing alternative, more adaptive communication styles.

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## Practical Tips for Couples Therapy: Doing What Works

Nicole Pray

### Enter at Your Own Risk: Choosing to do Couples Therapy Work

Tolerating the collective suffering of a couple entering couples therapy can be difficult for anyone, let alone a relatively inexperienced psychologist. Both partners feel angst about airing their private failings in front of a complete stranger, and they often share a distinct loneliness or disconnection from each other. And there is that venomous self-protection that serves to cover heartfelt despair and hopelessness about the situation they feel must improve but fear it almost certainly will not.

It sounds like an intro to another episode of *Days of Our Lives*, but it is not. This depiction will be familiar to almost anyone venturing to improve the lives of couples in distress. When I first started working with couples, I felt out of my depth, overwhelmed at times by the tension in the room. I wanted so badly for them to just be happy, to appreciate each other for who they each were. Grasping at any minor sign of reprieve, I would jump on opportunities to help them soften their stance and see beyond the prickliness of their partner’s comments. But these moments seldom

presented themselves, and my couples (as well as me) were becoming exhausted by the endless battle for righteousness.

### What a Difference Experience Makes: This is Actually Fun

Seventeen years later, I experience my couples in an entirely different light. I am more solidly grounded in an understanding of the dynamics that drive relationships. I was originally based in the States, learning integrative behavioural couples therapy (IBCT) as a co-therapist to my supervisor, who learned under the original authors, Christensen and Jacobson. At the time, the IBCT model seemed to benefit many of my couples, and I found the combination of acceptance and change techniques a good fit for the dialectical world of interpersonal relationships in general.

Since my doctoral programme, I have continued to update by attending a wide selection of training offered across the States by other leaders in the couples therapy field. I have searched for solutions within every cookie jar—having received training in several of the well-researched treatment models—from attachment theory

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and Sue Johnson's emotion-focused couples therapy, to Imago couples therapy, Schnarch's sexual crucible, Abrahm Spring's recovery from affairs, and Gottman's love lab...Even Dr Baer's recipe for *real love*.

What I have learned is that there are indeed many solid frameworks for understanding and navigating the complexities of our relational worlds. Traversing several of the major models of couples therapy has its advantages and disadvantages. After all, one has to pick a direction and stick with it, right? I certainly draw on elements of all of them in practicing with couples. But mostly, I think the models have helped me to trust myself to intervene early and frequently, and to provide a basic framework that allows my couples to do things differently than they have in the past.

I am quicker to pre-empt the destructive comments, the barbed insults, and the threats. It becomes easier to see the invisible layer of need and the inevitable dance steps that partners make in their desperate bids for love and acceptance. I see the childhood wounds that start it all, and I now understand my own place in that dance, as therapist and facilitator, to help change the music toward connection.

Having experienced plenty of what relationship life has to offer, I have also acquired more of my own relational wisdom, and this gives me more confidence in my role as a relationship consultant. Knowing the vicissitudes of my own relationship dance steps well enough, I have a greater humility and respect, I am also more able to tolerate the pain that couples bring into the room.

My commitment to the relationship between two people can invite a sense of safety and hope into the process. Striving to create an atmosphere where mistakes are allowed, my couples learn that they can bring more of themselves into the room. I share my own failings and follies as a therapist and as a person, and this allows me to bring my full

energy into the process, to create a holding environment that allows for taking risks and having fun.

### **Some of What I Have Found Helpful**

Some of the lessons learned over the years might be worth repeating, even if they only serve to provide a backdrop for the humility that I think is required to operate as a couples therapist. (Personal caveat: Much of what I talk about has been drawn from Imago couples therapy, emotion-focused couples therapy, IBCT, the Gottmans, and the other approaches mentioned earlier; I attempt to credit them where appropriate, but there is quite a bit of crossover in terms of how the models and theories work).

#### 1) Building back the positive bank account

My couples learn right away about why they struggle, how other couples struggle, and how they can interrupt and change their struggle. Starting from the first session, they are led through exercises to help change their dynamic. Right from the start, couples are suffering from deficits in their positive emotional exchanges. The "relationship bank account" has suffered multiple withdrawals and very few deposits. So we begin work on changing that.

Having a healthy respect for the power of positive reinforcement can serve to bolster any couple's greatness together. According to research by John and Julie Gottman, the well-known ratio of 5:1 (positive to negative), is what leads to a happy and thriving couple. A sustained glance, a touch on the shoulder or arm, a comment about how one's partner is dressed, or about their voice, are just some examples of positives. Appreciating their willingness to help out or admiring their dedication to work are just some of the ways we can appreciate our partner for who they are. Partners who maintain a 5:1 minimum positive to negative ratio are able to sustain their strong bond. Any less than this can lead to trouble.

## 2) Re-romanticising the relationship

Restarting the exchange of positive feedback can sound easy, but takes considerable direction and accountability to maintain it. Many couples will have let go of making frequent positive comments, or even taking time to turn toward each other to listen fully. Most will have let go of doing many of the caring things that communicate a sense of specialness and caring toward their partner.

And so begins the re-romanticising phase (drawn from Imago couples therapy), and this involves re-starting the efforts and caring behaviours that were so prevalent during the courtship phase of the relationship. Partners will become aware of what they do that makes their partner feel cared about and loved, and they will begin doing these things with greater frequency over time. This might include making them tea, picking up their dry cleaning, or introducing them to friends at a party, or it could involve flowers or initiating a hug or kiss or holding hands when they walk together. Remembering a special date, writing a note, or thinking to call during the busy workday are other examples. Such behaviours become the signal to partners that they are important to one another and that love is present, and couples will need help re-starting these old behaviours and maintaining them over time.

## 3) Reducing reactivity

I find that couples who are in high distress will respond quite well to an exercise developed for Imago couples therapy, called the Zero Negativity Days Exercise. Couples are given the challenge to contain their own negative reactivity with their partner for 24 hours. This means they must observe and catch all of their own negative reactions or thoughts about their partner, shifting their attention to a more positive mind-set. Both are challenged to catch all of their own negative private thoughts and assumptions about their partner. When they learn how difficult a task this is, partners build more

tolerance and understanding for themselves and each other. Realising how hard it is to eliminate their own negative reactions for even an hour at a time can serve to develop insight and reduce blame for one's partner when they fail to contain their own reactivity.

## 4) Communication

Couples learn new ways to talk with one another. Slowing down the conversation is perhaps the most essential element to providing safety. I find that Imago dialogues serve to slow the pressure and tension associated with relating at a deep level about our innermost hurts and longings.

Deepening their connection through guided verbal exchanges, couples learn to share their deepest fears and needs while becoming available to listen to and learn about their partner's true feelings. The conversation is slowed down considerably, and partners are prompted to mirror back what they have heard said, so that emotional reactivity is lessened. Partners are able to hear what has been said, without becoming side-tracked by their own internal story. Reactivity is lessened and partners are more connected, present together.

Whenever reactivity occurs, partners are brought back into the present moment, given prompts to help them re-engage with what was just said, putting aside the noticed pain until later. In doing so, safety is created in the room, and partners are able to stay connected to and aware of each other, rather than distracted and separate. Verbal exchanges using Imago template dialogues help couples to reach the resolution they had not been able to until this point. Couples learn to keep the safety that is needed between them to deepen and turn toward each other while facing difficult scenarios together.

I cannot emphasise enough that this type of exchange is the heart of successful communication. When couples stop turning toward each other to share, there has been a

breach in the relationship that will repeat itself into perpetuity. Such breaches represent a threat to closeness, as unshared feelings set the stage for avoidance, distance, and unhappiness. Couples learn that they can indeed share safely with one another, feeling heard and knowing each other more fully than before.

5) Lucy and Paul: Overdeveloped caregiving as a passion-killer

Nurturance and caregiving can feel wonderful and can add to closeness between any couple. However, when caregiving assumes more of a parent-child type caring, the couple can face gradual erosion of their romantic bond. Overdeveloped caregiving can happen when one partner's laziness around doing their own share is enabled by the other's silence about it.

Lucy and Paul have been married 12 years. Lucy tends to do all of the shopping and housework, and manages most of the children's affairs after working all day. She had assumed most of these tasks when she was an at-home Mum, but continued to do more than her share after returning to work. Her husband Paul was unaware but perhaps also enjoyed the downtime this afforded him, which allowed him to spend more time playing on the computer at night or going out with mates after work. Lucy grew tired and resentful internally, making snipes at Paul's being incapable or lazy when friends were around.

However, Lucy secretly enjoyed the attention she got from friends and family who offered concerned comments about her tiredness or overworked state. In this way, her doing more than her share served to distance them, where Lucy received her affection and caring from concerned friends or family, needing less from Paul. Over time, she grew less interested in physical intimacy with Paul. Often too tired, she stopped initiating and shut down Paul's bids for sexual intimacy. She had forgotten that their previously healthy sexual relationship

was founded on the efforts they both made toward it. Frustrated, Paul withdrew even more of his efforts around the house, which served to build Lucy's resentment.

Overdeveloped caregiving can be a passion-killer in a relationship. A common trap that couples fall into is the one where partners become accustomed to looking after their loved one's needs for emotional security to such an extent that feelings of desire and passion cease to exist.

I have seen many couples where one partner has unconsciously become the caretaker for the other's emotional needs, which eventually leads them away from being each other's lovers and recipients of desire. Doing everything in their power to ensure the other does not become upset or irritated, this partner becomes a mind-reader, searching intently for signs of disturbance in the peace, and looking to provide everything so that the person does not feel upset. I work with my couples on creating and sustaining a healthy level of differentiation, where each member is seen by the other as a distinct and autonomous individual who has their own drives and fears.

6) Differentiation and desire: Mary and Dave

Our needs for security and safety seem to run counter to needs for passion and desire. Being attached, one could argue, is the opposite of being desirous, which seems to result in part from some combination of being separate and/or distinct and thus being capable of craving or lust.

Seeing our partners as unique and separate from us allows for deeper connection between us both. If I can see and appreciate that the distress my partner's critical tone conveys when, upon entering the house at night, he reminds me that I am late (my having just come home from an errand I ran for him after work). Perhaps my knowing him the way I do helps to ease my own

reactivity in that moment, partly because I am aware his underlying fear stems from a past hurt which he has shared with me. I am lucky to remember that his reaction in that moment represents *his* experience and *his* story and emotional trigger, and it does not have to be *mine*.

In this way, the Gottmans suggest I have become aware of my partner's unconscious "love map," appreciating him as a separate being whose feelings and needs are ultimately quite different to mine. I see our *differences* as positive, rather than interpreting them as problematic "defects" which I have to put up with (*differences, not defects*, according to ICBT experts, Christenson and Jacobson).

Mary and Dave were married 16 years and had become slowly estranged over the last 10 years, particularly after their second daughter developed an eating disorder and Mary's attention became more focused on her daughter's health. Dave's family of origin experiences involved considerable conflict while he was growing up, and Dave learned to distance himself from situations where tensions arose. Keeping his feelings to himself so as not to stir the already stressful situation, Dave grew lonelier and more separate, reminding him of older feelings he suffered as a child, when his parents' fighting left he and his siblings alone to worry.

Mary exhausted herself looking after her daughter's wellbeing, meanwhile feeling ignored and unsupported by her husband, whom she silently developed resentment towards. Their sexual life became virtually non-existent, and neither felt equipped to raise the difficult issues with one another.

Therapy therefore focused on helping them dialogue with one another in a new way, so that they could start to see each other as unique individuals, each with their own experience. Having missed one another's attention, they were both ripe for the kind of romance-building exercises and

discussions about sexuality that had been missed for so many years. Re-finding each other in this way, Mary and Dave deepened their connection and sense of intimacy, giving them both greater strength to tackle the stressors of raising a family together.

7) Recovery after the affair: Tim and Jennifer find a new relationship together

An all-too-common pattern among young parent couples is to find themselves dissatisfied and disillusioned with family life and faulting their partner for one or more traits or behaviours that were perhaps previously tolerated, or even adored. Having turned their attention to the myriad responsibilities associated with early childrearing, they are shocked to find their own romantic relationship in ruins. Tim and Jennifer had been together 2 years before having their first child, and their marriage faced serious challenges following the birth of their second child, 2 years later. Jennifer found herself occupied with raising two toddlers alone, while Tim worked longer hours to sustain their lifestyle and new mortgage.

As with many young couples, there were rarely times for the couple to connect, and the romance of their early years was absent. Jennifer struggled to keep up with the children's needs for bathing and feeding before bedtime, and Tim allowed her to take a lead role with parenting when he felt less capable, but this led to even greater distance as Jennifer struggled upstairs with the children but Tim felt lonelier as he saw the bond between she and the children grow stronger.

As is common in these situations, both Tim and Jennifer became less focused on making efforts to look attractive or appealing for one another. Having less time for self-care and fitness, each had become focused on the demands of parenting and financial security, leaving them little time for exercise or proper eating. They nearly gave up on



developing their sexual relationship, assuming there would have to be time for this later. But later never came, and by their sixth year of marriage, Tim became involved in an emotional affair with a co-worker.

Therapy for this couple involved helping them to recognise that the problems in the relationship began much earlier than they expected. As with most couples, seeking help does not come until many years too late.

Having experienced her father being unfaithful with her mother, Jennifer was distraught about whether to end the marriage, but simultaneously fraught with guilt and responsibility to her children who needed their father. Both learned about how affairs develop with couples and how their own lack of connection had been a source of pain for both partners.

Recommitting to each other was necessary but a difficult step, with each of them fearing the loneliness of feeling unloved might continue. Both agreed to a transparent relationship agreement, where all calendars, emails, and telephone accounts were shared, where any questions were answered and whereabouts were known to each of them. Both worked to write the terms of a new relationship contract, where the expectations were clarified and priorities were defined. They each made room in this new contract for spending time doing things they found fun and light. Rediscovering their original connection, they began laughing together again, taking time for activities and self-care which had been neglected.

Tim and Jennifer learned to dialogue about the pain of loneliness they each felt. By using an Imago template for dialogues, they no longer became side-tracked by trigger issues, and instead shared deeper feelings that led to greater sense of connection rather than distance. Tim opened up to Jennifer about feelings of insecurity and abandonment from when his first girlfriend

and mate were caught cheating on him in high school. Jennifer understood Tim's feelings at a deeper level than when he had shared this before, and Tim was able to ask her forgiveness for the first time in a way that was genuine and heartfelt, which she could begin to trust he meant.

#### 8) Investing in the relationship

Many couples are unaware of the amount of time and energy required to sustain and deepen a connection between two people over time. Having invested unconsciously in the relationship during the courtship phase, partners are less aware of the slower erosion that occurs when life events turn them toward other obligations and stressors. Couples therapy provides them with education about the importance of watering their collective garden, making sure the grass stays greener for them both to thrive and grow within.

Date nights and romantic weekends really do go a long way to helping build back connection. The basic principle of proximity does in fact apply here. Couples feel strained by the demands of parenting and busy work-life, let alone pressures to care for extended family and unexpected life events. It can be daunting to commit to finding the time or support necessary for them to take time out together. On the other hand, not doing so will almost always lead to distance.

#### 9) Closing EXITS: Committing to the relationship

Another barrier to investment is avoidance. When couples face built-up pain from old wounds, they learn a habitual pattern of avoiding what causes that pain, ultimately leading them to avoid each other. Maybe one partner spends more and more time with the kids, looking after their needs and falling asleep with them in their beds during the night-time routine. Perhaps the other partner stays up late on the computer, and neither come together to talk about their loneliness and unexpressed feelings.

In this way, late-night computer time or paying extra attention to the children can become ways each partner avoids sharing feelings with each other directly.

EXITS are talked about in Imago couples therapy, where couples share about their EXIT behaviours with one another, and make commitments to close down their EXITS. Couples learn to acknowledge if there is a way they have avoided talking to their partner about feelings they have, such as talking instead to friends or family late at night on the phone or spending extra time at work. Or it may be that alcohol use is a way they have learned to avoid sharing their feelings directly. Types of exits which cannot easily be closed down include affairs and physical abuse cycles. These are referred to in Imago as catastrophic exits.

Learning to turn off the computer and agreeing to make time before bed can help go a long way toward fostering the sense of togetherness that a couple has been missing. Committing to sharing their feelings more directly with one another, there is a sense of togetherness created. Partners feel safer when they see each other willing to take the same steps toward closing the distance between themselves.

10) The myth of the super couple: It is just us that are struggling

The myth is that there are “problem couples” out there, and that relationships in distress are something that only *other* couples experience. It is simply not true that there is a perfect couple out there who is engaging in loving, non-reactive, highly sexually charged, and completely emotionally differentiated relating *all* the time. Distressed couples can feel very isolated and damaged, and they may feel despairing when it appears that their friends, family, or others around them are not having these problems. I want to assure couples that all couples face difficulties, and that this is the nature of relationship. We are two different people, with two different backgrounds, two

different sets of needs and priorities, and two different interpretations of what is happening. Of *course* we are going to face struggles to adjust to life together. That is inevitable. And it may seem that others are not facing the same struggles, but that just is not true. It just happens that the friends are not having exactly the same problems, at exactly the same time.

We all face relationship challenges and we all suffer at times in our relationships. Helping couples learn the basic foundations of relationships that last can give them a better way to face the pain they suffer from *together* rather than *apart*. In IBCCT, Jacobson and Christensen remind us, pain *with* blame leads to separateness and disconnection...pain *without* blame leads to togetherness.

The greater learning about each other that occurs as part of couples therapy can be a rewarding and exciting start to a new kind of relationship, one that is much more conscious and less reactive. In this way, couples find deep and lasting connection, both to themselves and to each other.

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## Before I Accept a Referral for Couples Work, What do I Need to Work Safely? *An Insider's Guide for the (Un)wary*

Marianne Quinn

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April 2016, and John and Julie Gottman were in town for a 2-day seminar preceding the NZCCP conference. I lined up, along with 114 others, to hear these two well known researchers and clinicians (and life partners) unpack the secrets of the “Masters’ of relationships”<sup>1</sup> (as opposed to the “Disasters’ of relationships”).

John Gottman’s work is known to most therapists who work with couples. Regardless of your orientation, several bits of information from his long term research into what makes for successful long term relationships (the Masters) are foundational in a successful therapy.

But before we go there, a note of caution: As stated by John Gottman, couples work is not for the untrained or the merely well intentioned. If you think that you do not know what you are doing, you are almost certainly right! In fact, just going to see a therapist about relationship issues has been shown to predict separation, when often this was neither a necessary or desirable outcome (Doherty, 2002; Gottman, 2016). More on this later.

So what is helpful? Firstly, couples’ work requires a paradigm shift. It is not about doing individual work in tandem in the room—your client is *the relationship between these two people*. To do that well, you need a body of theory that helps you understand the needs and longings of those in front of you, a good understanding of relationship

dynamics—including your own patterns and resultant blind spots—and an ability to work with process, resisting the seduction of problem solving. As John and Julie Gottman emphasised in their recent Wellington workshop, most couples (69%) have core differences that are actually “insoluble/perpetual” problems. The therapist’s job is not to fall into the trap of “solving” the problem but to help the couple find ways to *manage* these differences. *How* they do this is key to how they will succeed as a couple.

In other words, conflict is inevitable and often growth producing. The couple who can debate/fight while maintaining good will towards one another, even finding humour in their situation, will survive and even strengthen their relationship (Gottman, 2016).

Good will and friendship are key ingredients in a successful partnership. In research going back 30 years and replicated many times since, Gottman discovered a vital statistic: in couples who survive, the ratio of positive to negative statements was **5:1**, while in distressed and eventually disengaging couples, the ratio was **0.8:1** (Gottman, 1996, 2016). As he explained, even when distressed, couples make “bids for repair” sadly, in very distressed couples, these bids often misfire and/or are not taken up. Participants can be too full of their own pain to notice that their partner is reaching out, wanting to connect.

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Gottman's early research led to the identification of what he termed the "Four Horsemen of the Apocalypse": behaviours that predict relationship breakdown through fuelling a toxic environment between the couple. These are:

**Blanket criticism** ("you always/never"), including blame, character attack, name calling and so on.

**Contempt** (including sarcasm), the worst of the four, because it conveys disgust and derision, which makes resolving differences almost impossible. Contempt often contains rage at the other, fuelled by long-simmering negative thoughts about the partner.

**Defensiveness** makes it difficult to move on, since "accusations" usually contain some truth.

**"Stonewalling,"** frequently used by men. While it is a way of avoiding addressing matters, and sometimes of gaining/keeping power, it creates frustration and despair in the other partner.

Gottman has also shown that *how* a "difficult discussion" starts strongly influences how it continues. Both John and Julie teach couples to "soften the start up" (other approaches have different names for this process). In short, if your aim is connection, an ambush is rarely the way to go. The Gottmans' also suggest we encourage people to treat their partner with the same respect we might a stranger (or a good friend—funny how often that is not the case!).

So, is knowing this sufficient to do good couples work? Hardly. But it might help you to do more of what Gottman referred to as *relationship friendly therapy*. All too often, a client will present a view of their partner in individual therapy that can lead their therapist to conclude that the absent person is the main reason for their client's unhappiness. This is often what the client believes too: their own contribution to the relationship dynamic is missing from the equation. Due to "negative sentiment

override" (Gottman, 2016), unhappy couples have been shown to notice only 50% of their partner's positive interactions (as rated by trained observers). Gottman's research shows how we tend to retell our relationship history when the relationship is ailing, attributing our own errors to temporary, fleeting circumstances, while we see our partner's as due to lasting, negative personality traits or character flaws (Gottman, 1996, 2016). The risk is that having concluded that the problem was all the "other," clients may well go in search of another relationship "that will better meet their needs" and more often than not, as demonstrated in the statistics of second marriage breakdown, be disenchanted. (Sobering fact: the rate of breakdown of third marriages is even higher).

The problem is that individual therapy often exists in a bubble of idealising: the client basks in the warm understanding of their therapist, who for a whole (50 minute) hour, shows empathy and concern, often more than they feel they get at home. Meantime, the therapist's empathic attunement may have them (often unconsciously) siding with the client against the absent partner, with far reaching consequences for the relationship. No matter how well intentioned, such uninformed therapy can be frankly harmful (Doherty, 2002). To be effective, the client's own attachment history, their relational style, the ways they protect themselves and their relational "triggers" all need to be made more conscious. This is best achieved when working in the room with both members of the couple, and in their more conscious contact with each another between sessions.

For the past 10 years I have stretched into the relationship paradigm and it has been a rewarding journey. I have been certified as an Imago relationship therapist for some years now, and have completed many days of EFT training, incorporating aspects of that model into my work. I give a summary of Gottman's research to every couple I see. Attending the first two days of the Gottman

training was valuable in that John and Julie summarised the research as to what works, and also confirmed that the locus of attention needs to be the relationship *between* the couple. This means *attending to process*: problem solving alone is a dead end. On the other hand, helping the couple nurture their friendship, find the “dream within the scream,” identify their contribution to the difficulties they experience, recognise bids for repair, and to be able to respond to these are key interventions.

I am also grateful to John Gottman for his acknowledgement that while there is some empirical support for a few models of couples work, none of these models have been tested on the sorts of couples who tend to present to see us, but rather, on the “couple equivalent” of “anxiety treatments as demonstrated with 19-year-old psychology students.” We have some clues, and also a long way to go!

My challenge to us as a profession is to accept that couples work is a specialist area

and that without specialist training, we may be worse than ineffective—we may well be actively harmful. The good news is that there is various training available in New Zealand at this time: search them out, find the one that fits you. And in the meantime, refer couples who contact you—or individual clients whose primary focus is their relationship—to those with training in this area. This way, everyone benefits. Premature separation is a treatment failure with drastic consequences, not only for the couple involved.

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## Family Connections™ in New Zealand and Australia: an Evidence-Based Intervention for Family Members of People With Borderline Personality Disorder

Roy Krawitz, Anne Reeve, Perry Hoffman, Alan Fruzzetti

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### Abstract

*This article provides an overview of the history, content, and current Australasian status of Family Connections™, an intervention for families of people with borderline personality disorder (BPD). The intervention has a substantial published evidence base and has been running for almost 15 years under the auspices of the National Education Alliance for Borderline Personality Disorder (NEA-BPD), the major international BPD advocacy organisation. Family Connections™ is a 12*

*× 2 hour grassroots manualised programme run by family and/or professionals. The programme combines psychoeducation about BPD, skills training drawn largely from dialectical behaviour therapy, and peer support. Three pre-post studies have demonstrated statistically significant decreases in participants' subjective experience of burden, distress/depression, and grief, and statistically significant increases in participants' subjective experience of mastery/empowerment. These changes were either sustained or further improved at 3-month*

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*follow-up. Family Connections™ programmes have been running in more than 10 New Zealand cities since 2010 and in Australia since 2015. The programme has substantial waiting lists (e.g., 650 in Australia).*

*When you understand, you cannot help but love. You cannot get angry. To develop understanding, you have to practice looking...with the eyes of compassion. When you understand, you love. And when you love, you naturally act in a way that can relieve the suffering of people.*  
(Thich Nhat Hanh, 2005)

## **Introduction**

### **Definitions**

The term “family members” includes family members and significant others for ease of reading.

“People with BPD” is intended to be a factual description of people who would meet DSM V diagnostic criteria for borderline personality disorder (BPD) if they were formally assessed. For simplicity, we used people with BPD.

### **Background**

Family Connections™ is an intervention for family of people with BPD. To date, there are three published studies demonstrating the programmes’ effectiveness. The intervention has been running for nearly 15 years under the auspices of the National Educational Alliance for Borderline Personality Disorder (NEA-BPD), the largest international BPD advocacy organisation. Typically, Family Connections™ is a 12 x 2 hour manualised programme run by family and/or professionals. The programme combines psychoeducation about BPD, skills training drawn largely from dialectical behaviour therapy (DBT), related family skills, and peer support. Attendance is free. In New Zealand there may be a small fee to contribute to venue hire and photocopying of manuals, but Australia has an absolute “for free” policy. Family Connections™ programmes are led by two leaders; either

two family members, two professionals, or a family member/professional combination. The programme was developed as a grassroots programme intended to be run by family members. The NEA-BPD provides family members and professionals with free training and support. Research (see below) supports the idea that either family or professionals may successfully lead Family Connections™, with studies showing similar results when family or professionals (or a combination) were leaders. The standard pathway to becoming a Family Connections™ leader (both family and professionals) is to attend the programme as a full equal participant, and receive a recommendation from the programme leaders to attend a 2-day Family Connections™ leader training, and then be authorised by the NEA-BPD as a Family Connections™ leader. Detailed descriptions of the history, development, rationale, and content of the programme are available elsewhere (Hoffman et al., 2005; Hoffman Fruzzetti, & Buteau, 2007).

The Family Connections™ history started with the US National Alliance for Mental Illness (NAMI) programme “Family to Family,” for family of people with a range of mental health conditions. Those who attended the NAMI programme found it excellent, but as it was not specifically for family of people with BPD and did not include skill building per se, some family members felt the programme did not address the specific needs of family of people with BPD. In the US, family members (Dixianne Penney and Patricia Woodward) and professionals (Perry Hoffman and Alan Fruzzetti, two of the present authors) collaborated in developing the Family Connections™ programme.

The remaining two (Australasian) authors became involved in Family Connections™ from different perspectives. Roy Krawitz brought Family Connections™ to New Zealand after providing a 1 hour psychoeducation session for family members where family members, despite

having more information, were more distressed at the end of the presentation than when they arrived. This experience of the effect of education delivered without skills training and support is consistent with research findings (Hoffman et al., 2003). Anne Reeve's involvement resulted from unsuccessful attempts to find any professional assistance or support. Anne turned to the Internet and found Family Connections™. Her first-hand experience of the benefits of the programme resulted in her bringing it to Australia to share with others in similar circumstances.

In 2014, the NEA-BPD reported (personal communication) that Family Connections™ was running in 16 countries and had 1200 people on the waitlist in the US. The first New Zealand programme ran in 2010; with a leaders training conducted in 2012. By 2015, there were six New Zealand Family Connections™ centres running programmes, with a further six centres moving toward offering the programme. The first Australian programme was run in 2015, after leader training in Melbourne and Adelaide. Over the last year, 18 Family Connections™ programmes have been run in Australia, and further leader training will take place in Sydney in 2016. Australia has over 650 people on the waiting list. People living in places where the programme is not available can apply to NEA-BPD to join a teleconference Family Connections™ programme that is technologically anchored in the US.

### **Rationale and Content of the Programme**

Individuals with BPD experience high levels of suffering. Their families are also suffering (Bailey & Grenyer, 2014; Lawn & McMahon, 2015). Bailey and Grenyer (2014) found that families of people with BPD showed higher levels of distress than families of people with schizophrenia. Research has also shown that, in general, having a family with higher levels of emotional involvement predicted improved outcomes for the person with BPD, as

measured by hospitalisation rates (Hooley & Hoffman, 1999). Although further study is required, that study provides some scientific support for family who wonder about whether their level of involvement is helping or hindering the person with BPD. Family Connections™ believes that substantial stigma exists for families—surplus stigma; or perhaps, even quadruple stigma: Stigma of having a mental health condition; stigma of having BPD; stigma of being a family member of someone with a mental health condition; stigma of being a family member of someone with BPD (Lawn & McMahon, 2015). By its welcoming stance, Family Connections™ hopefully provides an initial structure to contribute to reducing this stigma. Within this structure, peer families who attend the programme can provide a validating sense of “me too,” with family members often stating something like, “I know you people get it [and don't judge me] because you have been where I have been.”

Family members are taught the simple conceptualisation of effective communication being about the transactional nature (i.e., reciprocal nature) of accurate expression of internal experience plus validation. This conceptualisation provides family with both a plausible causal understanding and an achievable solution to work toward.

Family Connections™ is anchored in three core principles:

1. Psychoeducation about BPD.
2. Skills training with individual skills drawn largely from DBT, and family and relationship skills developed within a DBT framework for compatibility.
3. Peer support.

The present authors conceptualise a rough breakdown of the skills as: validation 40%, mindful attention to self/others 15%, acceptance (of what can't be changed) 15%, emotion self-management (e.g., self-soothing, self-validation, opposite action) 15%, interpersonal skills 10%, and observing limits 5%. The validation (also

taught throughout programme), mindfulness, acceptance, and emotion self-management skills comprise the bulk of the skills, and are taught first to maximise capacity to regulate emotions. The reason for this is that research and experience has shown that when emotions are regulated, people can better use their thinking skills and are therefore better placed to make wise decisions. Once these skills have been taught, the programme moves on to interpersonal effectiveness skills (including further validation, relationship mindfulness and problem management skills—the latter drawn from behavioural couple and family therapy), and observing limits. Observing limits describes how a family member may choose to limit their involvement with the person with BPD, or stretch their limits to wisely accommodate their values.

### **Research**

Shenk and Fruzzetti (2014) demonstrated statistically significantly more invalidation and less validation in parents of clinic versus non-clinic adolescents, with correlations with statistically significant predictive ability in the expected directions for adolescent emotional dysregulation and relationship satisfaction. Another study (Fruzzetti & Payne, 2015) showed that teens with rather severe problems, including suicidality and self-harm, reported statistically significant reductions in parent invalidation and increases in parent validation after parents had attended a Family Connections™ programme.

Three pre-post studies of Family Connections™ have been published to date (Hoffman et al., 2005; Hoffman et al., 2007; Rajalin et al., 2009). One study (Rajalin et al., 2009) involved a slight adaptation (9 weeks; additional focus on suicide prevention education). The first two studies (Hoffman et al., 2005; Hoffman et al., 2007) were conducted in the US where programme leaders were family members, and the third study was conducted in Sweden, where the programme leaders were professionals. The results were consistent across the three

studies. The first two studies included follow-up data collected at 3 months post-programme, but the third study did not collect follow-up data. Across the three studies, about 88% of participants were parents, 9% were spouses/partners, and 3% were siblings; the mean age of participants was 55 years, and the mean age of the person with BPD was 25 years. Two studies (Hoffman et al., 2005; Hoffman et al., 2007) reported a mean attendance of 10 of 12 sessions (83%) with a 12% drop-out rate. The main measures were subjective ratings on scales measuring burden, grief, depression, and mastery. Hoffman et al. (2005) reported statistically significant positive changes for burden, grief, and mastery but no change for depression. The second study (Hoffman et al., 2007), which had a slightly larger sample size, demonstrated statistically significant improvements for depression, as well as replicating the first study's findings of improvements in burden, grief, and empowerment. Both of these studies found that the changes were either sustained or improved at the 3-month follow-up, with no rating showing deterioration at follow-up. Rajalin et al. (2009) demonstrated statistically significant improvements in distress and burden, and a non-significant improvement in depression. Given the small scale of that study (n=13), the results were indicative of substantial effect sizes in keeping with the other two studies.

### ***Future Research***

A replication pre-post study is underway in New Zealand, with data collected but not yet analysed. Related studies are near completion in Ireland and the US. The explicit goal of Family Connections™ is to assist family member mental health and well-being; at the same time, it is hoped that improved family member well-being will play a role in increasing the likelihood of improved well-being for the person with BPD. Randomised controlled studies are the next research step in confirming and extending the validity of Family Connections™ as an evidence-based



programme. Such research is currently underway.

### Conclusions

People with BPD and family of people with BPD have high levels of documented distress and morbidity. A number of evidence-based interventions have been developed to address this distress and morbidity, with Family Connections™ being one such intervention for family members. Family Connections™ can be a stand-alone intervention or can be provided alongside other evidence-based BPD interventions and/or interventions where the person with BPD and family attend together. Three published pre-post (and follow-up) studies have demonstrated the effectiveness of Family Connections™ as an intervention for families of people with BPD in decreasing participant suffering and promoting participant mental health. These programmes have been delivered in the US for nearly 15 years, in New Zealand for 7 years, and in Australia for 1 year (where 650 people are on the waitlist).

### Conflicts of Interest

The authors are not aware of any conflicts of or competing interests.

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### **Abstract**

*End of life choice legislation is a topical subject in New Zealand following several recent high profile cases. This occurs as an increasing number of countries and states legislate in favour of euthanasia laws. A parliamentary Health Select Committee enquiry was recently established in New Zealand to consider submissions on the subject. In my own submission I focused primarily upon the issue of risk for vulnerable people in end of life choice decisions. I suggested that carefully considered assisted dying legislation enhances rather than detracts from the rights and wellbeing of the vulnerable. A slightly amended transcript of my original submission is presented here.*

### **Submission**

I am a registered clinical psychologist specialising in pain and trauma, clinical lead for a leading South Island pain service, lecturer at the University of Otago Medical School, and member of the New Zealand College of Clinical Psychologists. The opinions stated here are my own, but from discussion I know they are shared by many of my professional colleagues.

As a clinician, I am used to helping people live with fairly catastrophic life circumstances, including suffering intense chronic pain that is resistant to analgesia. I know people can often find existence worthwhile even in situations of severe duress. It is also the case that mental health professionals will effectively use force in some situations to override the expressed will of a person's present self to die—largely on the basis that this person's many future states of self are likely to be grateful for the intervention. Such decisions are made in light of our best current scientific understanding of the human condition.

However, based upon my clinical experience

and understanding of the relevant literature, I believe there are some situations where the highly probable course of suffering justifies carefully considered end of life choice legislation. There are legitimate concerns that must be addressed, but I have not seen sufficient reason to deny people this last act of compassion and self-determination. I know I would certainly want this dignity of choice for myself, and for those I most care about. I note that models of assisted dying legislation have been implemented around the world without major catastrophe, and results can and should inform theoretical speculation. The Oregon “Death with Dignity” legislation enacted in 1997 is one commendable example.

I observe that much opposition to assisted dying legislation has been proposed from people with value perspectives (often religious ones) that fail to recognise the reality of a modern pluralism and diversity of values about what “harm,” “care,” and a “good death” might mean to others. The right to self-determination is often devalued in such perspectives, despite a very large body of research supporting the transcultural importance of self-determination as a core human psychological need (e.g., Deci & Ryan, 2000). From the accepted legal perspective of modern healthcare ethics and human rights, a patient's self-determination is not over-ridden except when a patient lacks mental competence. Rejecting a patient's right to assisted dying is inconsistent with principles and practices of modern healthcare ethics and human rights in closely related domains such as the legal right to refuse life-saving treatment.

*Mark Ottley is Clinical Lead for Pain Services at Southern Rehabilitation, also working with trauma and general adult mental health issues and specialising in complex personality assessments.*

Objections to assisted dying also include concerns which are arguably more widely appreciated. Many of these may be summarised as the concern that assisted dying legislation will increase risk of harm to vulnerable members of society. Any socially conscientious person would be concerned about how such legislation might affect those in conditions of least privilege in society. However I find this objection insufficient to oppose assisted dying legislation for the following reasons:

1. As statistics show (Battin, van der Heide, Gazini, van der Wal, & Onwuteaka-Philipsen, 2007), there is no good evidence that vulnerable classes of society partake in assisted dying at a higher rate than more privileged classes.
2. As with other significant medical and healthcare decisions, informed consent procedures and psychological or psychiatric screening mechanisms are a protective buffer for patients in general and the more vulnerable in particular. Such procedures help ensure decisions are not the result of coercion, misinformation, or transient mood states. Such mechanisms are comprehensive and effective, though not perfect. However demanding perfection would be unrealistic and ignore the fact that such mechanisms are already judged sufficient in other similar life or death situations.
3. I also observe that the argument against assisted dying on the basis that this protects the vulnerable, is effectively just condemning one class of vulnerable persons to profound suffering (those with grievous health conditions), to prevent a hypothetical harm to others. Even if persons so condemned had consented to this practice, no good evidence supports the assertion that this hypothetical harm exists (point 1), or

that other safeguards are insufficient (point 2).

4. Denying vulnerable populations assisted dying is a form of medical paternalism and further restriction of an individual's capacity for self-determination. It is degradation not protection. If one genuinely wants to help such people, then in the first instance greater funding for appropriate mental health and social services should be provided, rather than denial of a choice that the privileged often choose for themselves.
5. Denying assisted dying means desperate people are in some circumstances forced to act sooner than they would otherwise choose to ensure they are still physically able to self-determine such actions. In this way denial of assisted dying legislation increases the number of premature, lonely, and stigmatised deaths (e.g., Weaver, 2014). Such an enforced situation is a present reality, and one future generations will lament as an approach lacking in both reason and compassion. We can and should do better by supporting appropriate carefully considered assisted dying legislation, with monitoring of outcomes and improvements in implementation made where indicated.

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As relationships is such a vast area I decided to focus on peer relationships, an area of interest of mine due to working with young people with first episode psychosis. Although I did not search by age, the majority of the articles are focused on adolescents, with children's peer relations also featuring.

The articles below indicate the importance of peer relationships and show the influence our peers have on the decisions we make, our romantic relationships, our use of substances, how adolescents feel about being friends with their parents on Facebook, and some interesting research on how ADHD and co-rumination impact on peer rejection and victimisation. I included

an article exploring the idea of involving important friends as an intervention with young people with psychosis.

The importance of looking at the quality of the peer relationship is demonstrated by the idea that peer support is not automatically a positive experience. The style of discussing problems ruminatively, as seen in co-rumination, is linked to increasing risk of depression in those experiencing peer victimization (Guarneri-White et al., 2015). Adolescents take more risks and focus on immediate rewards when with peers than on their own (Silva et al., 2016), indicating peer support can promote more risky behaviour and alcohol use (Wang et al., 2016).

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Silva, K.; Chein, J.; & Steinberg, L. (2016). Adolescents in peer groups make more prudent decisions when a slightly older adult is present. *Psychological Science*, 27(3), 322–330.

Adolescents make more reckless decisions when with peers than when alone, which poses a challenge for organizations that place adolescents in situations in which risky and myopic decision making is problematic. We asked whether the effect of peers on adolescents' decision making is mitigated by the presence of a slightly older adult. We examined whether target subjects' risk taking was greater when they were in groups of 4 late-adolescent males (ages 18–22) than when they were in groups that mixed 3 late-adolescent males with 1 slightly older adult (age 25–30); risk taking in both of these

conditions was compared with that of adolescents tested alone. We found that adolescents took more risks and expressed stronger preference for immediate rewards when they were grouped with 3 same-age peers than when they were alone. When 1 adolescent was replaced by someone slightly older, however, adolescents' decision making and reward processing resembled that seen when adolescents were tested alone. Adding a young adult to a work team of adolescents may improve group decision making.

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Boisvert, S., & Poulin, F. (2016) Romantic relationship patterns from adolescence to emerging adulthood: Associations with family and peer experiences in early adolescence. *Journal of Youth and Adolescence*, 45(5), 945–958.

The present study identifies and describes romantic relationship patterns from adolescence to adulthood and examines

their associations with family and peer experiences in early adolescence. In a 13-year longitudinal study, 281 youth (58%

*Holly Wilkins is a consultant clinical psychologist who has been working at the Early Intervention Service, Capital and Coast DHB with young people aged 13–25 years who are experiencing first episode psychosis in the greater Wellington region for the last 7 years.*

girls) identified all their romantic partners each year from the ages of 16–24. Dimensions of family relationships (family cohesion, parent-child conflict) and peer relationships (peer likeability, social withdrawal, close friendships, other-sex friendships) were assessed at age 12. Latent class analyses brought out five distinct romantic relationship patterns and significant associations were found with

family and peer relationships in early adolescence. These five romantic relationship patterns appeared to follow a continuum of romantic involvement, with romantic relationship patterns situated at both ends of this continuum (later involvement pattern and intense involvement pattern) being associated with more interpersonal experiences in early adolescence.

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Wang, C., Hipp, J. R., Butts, C. T., Jose, R., & Lakon, C. M. (2016). Coevolution of adolescent friendship networks and smoking and drinking behaviors with consideration of parental influence. *Psychology of Addictive Behaviors, 30*(3), 312–324.

Friendship tie choices in adolescent social networks coevolve simultaneously with youths' cigarette smoking and drinking. We estimate direct and multiplicative relationships between both peer influence and peer selection with salient parental factors affecting both friendship tie choice and the use of these 2 substances. We utilize 1 sample of 12 small schools and a single large school extracted from the National Longitudinal Study of Adolescent to Adult Health. Using a Stochastic Actor-Based modeling approach over 3 waves, we find: (a) a peer selection effect, as adolescents nominated others as friends based on cigarette and alcohol use levels across samples; (b) a peer influence effect, as adolescents adapted their smoking and drinking behaviors to those of their best friends across samples; (c) reciprocal effect between cigarette and alcohol usage in the

small school sample; (d) a direct effect of parental support and the home smoking environment on adolescent friendship tie choice in the small school sample; (e) a direct effect of the home smoking environment on smoking across samples; (f) a direct effect of the home drinking environment on alcohol use across samples; and (g) a direct effect of parental monitoring on alcohol use across samples. We observed an interaction between parental support and peer influence in affecting drinking, and an interaction between the home drinking environment and peer influence on drinking, in the small school sample. Our findings suggested the importance of delineating direct and synergistic pathways linking network processes and parental influence as they affect concurrent cigarette and alcohol use.

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Mullen, C., & Fox Hamilton, N. (2016). Adolescents' response to parental Facebook friend requests: The comparative influence of privacy management, parent-child relational quality, attitude and peer influence. *Computers in Human Behavior, 60*, 165–172.

Smartphones greatly reduce parents' ability to monitor their children's online activities. A recommended surveillance technique is to "friend" adolescents on social networking sites (SNS) such as Facebook. However, adolescents use these sites to experiment with adjusting their self-image based on friends' feedback, so is it possible for them to simultaneously satisfy the very different

expectations of both peers and parents? This study explores adolescents' attitudes to parental presence on Facebook using Communications Privacy Management theory (Petronio, 2002) as the theoretical framework to investigate the relative influence of privacy management, relational quality and peer pressure. The study was conducted among 262 secondary school

children living at home and recruited via their schools. Results showed that while privacy management and peer influence were significantly related to adolescent attitudes to parental presence on Facebook, only attitude to parental presence on Facebook and parental-adolescent relational quality predicted friendship status. A picture emerged of adolescents very much in control of their SNS privacy who were

largely indifferent to parents on Facebook. There was however, a sizable, peer-influenced minority, opposed to parental presence, for whom friendship may be counter-productive. While this study uncovered many unique associations relating to adolescent-parental Facebook friendship, further qualitative research is recommended to provide a deeper understanding of this complex subject.

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Stenseng, F., Belsky, J., Skalicka, V., & Wichstrom, L. (2016). Peer rejection and attention deficit hyperactivity disorder symptoms: Reciprocal relations through ages 4, 6, and 8. *Child Development, 87*(2), 365–373.

Attention deficit hyperactivity disorder (ADHD) predicts poor peer relationships. What remains unclear is whether poor peer relationships affect ADHD symptomatology. Hence, reciprocal effects of peer rejection and ADHD symptoms were examined in a community sample of 962 Norwegian children at ages 4, 6, and 8. Results showed that ADHD symptoms at age 4 predicted more peer rejection at age 6,

and that peer rejection at age 4 predicted more symptoms at age 6. However, when conducting analyses on ADHD subtypes, hyperactivity-impulsivity and inattentiveness symptoms were adversely affected by peer rejection at ages 6 and 8, whereas peer rejection was unaffected by such symptoms, indicating that the effect of peer rejection on ADHD symptoms was most robust. Mediation relations were also identified.

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Guarneri-White, M. E., Jensen-Campbell, L. A., & Knack, J. M. (2015). Is co-ruminating with friends related to health problems in victimized adolescents? *Journal of Adolescence, 39*, 15–26.

Co-rumination, or the tendency to revisit and endlessly discuss problems and negative events, has been linked to depression and other emotional difficulties (Rose, Carson, & Waller, 2007). The current study examined the moderating effect of co-rumination on the relationship between peer victimization and depression, anxiety, PTSD symptoms, and health problems in 108 adolescents aged 10–15 years. Adolescents and a parent completed measures of

adolescents' peer victimization, co-rumination, depression, and health problems. Results indicate that adolescents who are both peer victimized and engaged in high levels of co-rumination were at highest risk for psychological problems. Co-rumination also moderated the relationship between peer victimization and physical health problems via general depressive symptoms (i.e., moderated mediation).

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Maniglio, R. (2015). Association between peer victimization in adolescence and cannabis use: A systematic review. *Aggression and Violent Behavior, 25*, 252–258.

Cannabis use and bullying or other forms of adolescent peer aggression and victimization can cause severe consequences when they coexist in the same youth. Studies addressing both these conditions were reviewed. Fourteen databases were searched. Blind assessments of study eligibility and

quality were conducted. Twenty-six studies including 1,181,684 participants and meeting minimum quality criteria that were enough to ensure objectivity and to not invalidate results were analyzed. Across studies, there was conflicting evidence for a significant relationship between cannabis use and peer

victimization in adolescence. Studies including larger samples and/or considering a broader definition of victim status were more likely to find a significant association. Evidence for mediating or moderating mechanisms was scant. Studies assessing the temporal ordering of the two events offered some evidence for bidirectional and causal paths suggesting the existence of an interactive process, in which prior

victimization may predispose a youth to use marijuana as a coping strategy or self-medication mechanism; substance use, in turn, may place the youth at a greater likelihood of exposure to dangerous persons or situations. Both cannabis use and peer victimization need special attention because they are common in adolescent populations and can be related to each other through reciprocal influences.

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Harrop, C., Ellett, L., Brand, R., & Lobban, F. (2015). Friends interventions in psychosis: A narrative review and call to action. *Early Intervention in Psychiatry, 9*(4), 269–278.

**Aims:** To highlight the importance of friendships to young people with psychosis, and the need for clinical interventions to help maintain peer relationships during illness. To structure a research agenda for developing evidence-based interventions with friends. **Method:** An argument is developed through a narrative review of (i) the proven efficacy of family interventions, and (by comparison) a relative absence of friend-based interventions; (ii) the particular primacy of friendships and dating for young people, and typical effects of exclusion; and (iii) reduced friendship networks and dating experiences in psychosis, in pre-, during and post-psychosis phases, also links between exclusion and psychosis. **Results:** We put

forward a model of how poor friendships can potentially be a causal and/or maintenance factor for psychotic symptoms. Given this model, our thesis is that interventions aiming to maintain social networks can be hugely beneficial clinically for young people with psychosis. We give a case study to show how such an intervention can work. **Conclusions:** We call for “friends interventions” for young people with psychosis to be developed, where professionals directly work with a young person’s authentic social group to support key friendships and maintain social continuity. An agenda for future research is presented that will develop and test theoretically driven interventions.

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## NZCCP Strategic Plan: Supporting and Developing Leaders’ Insights

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Consistent with the NZCCP Strategic Plan and focussing on supporting our membership, one of the areas of focus is to **build the leadership capability of our members**.

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

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### Helen Lenihan

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#### Current Role

I am the Director of a charitable trust, the Kauri Trust. I have been working in this role since January 2014. I have 15 staff in my

team. We are providers for out of home care for the Ministry of Social Development, and also have an alternative education programme for girls in west Auckland.

### **Path to Leadership**

I have often found myself in leadership roles, at school, university, and working in community mental health. In a group or team, I can assess, plan quickly, and guide others to understand their role in a situation. I am cool headed when things get stressful. This natural inclination has created a path to leadership. The first time my leadership skills were recognised formally was in my last year of high school when I was asked to sit on the student council. Through university I found myself in “informal” leadership roles, giving voice to issues and supporting others. As a psychologist practicing in a community mental health team I was seconded into the clinical coordinator role. During this time, I began actively to think about how I could practice as a psychologist and take on leadership roles. It ultimately led to me taking up the position as Director at Kauri Trust.

### **Training**

Moving from mental health to the social and not-for-profit sector was a steep learning curve. I did as much training and reading as I could. I completed papers at Unitec that focused on different aspects of not-for-profit management. I attended conferences, worked with a leadership coach, and sought out supervision that recognises and supports my role.

Learning the ropes was exciting and challenging. I was supported to trust that the skills that I had developed as a clinical psychologist were applicable and needed in leadership. I could be authentic and genuine, strategic and articulate, and I could validate people. In terms of human resources, financial administration and management, strategic planning, and governance, I still have lots to learn.

### **Dealing With Failures**

The most challenging aspect of my role has been to understand the dynamic of leadership. It is not all about coaching and facilitating others. There are times when a

strong directive approach is required. This is not a natural place for me and I am still anxious every time I have to work in this way. Failures have come out of avoidance and being unclear about what I need to do. I have learnt that coaching, supervision, and support outside the organisation is essential for understanding my role and how I can approach challenging situations.

### **Support to Enter Leadership**

Both of my parents were in leadership and management roles. They have been very supportive and my dad is the person I speak to when things get tough at work. My psychology colleagues have always been very supportive giving me feedback and encouragement. Clinical supervision is also a place of support for me.

### **Advice for Others**

I would encourage people to give leadership roles ago. Be clear about your clinical practice, and self-reflection and awareness is essential. Our relational skills are helpful and do not be afraid to formulate why your staff are acting that way.

### **Challenges and Advantages of Leadership Roles**

A significant challenge for me is that I am the boss. I have to make the ultimate decisions and this requires bravery and wisdom. Sometimes this is lonely work.

The advantage is that I can effect change in a way that I have never been able to do before. I can steer the organisation, change the lives of the young people we serve and support my staff by applying psychological theory and practice. It is fun!

### **Skills of Leadership**

I believe that authenticity and developing relationships that empower and nurture are the skills of the modern leader. The capacity to listen and validate staff, having clear expectations and modelling expected behaviour are also important skills.



### **Extent my Role Requires Leadership Skills**

My role would be 70% leadership and management and 30% clinical. After 9 months of trying to complete all the clinical

tasks required in the organisation, I realised I needed help and developed a clinical lead role. This has freed me up to focus more on the management tasks of the role.

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## **Rachel Prebble**

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### **What leadership roles do you currently hold?**

I am currently a Service Development Manager at Hutt Valley DHB, with my focus being the management of projects under the Acute Demand Network. The Acute Demand Network is a mix of leaders from across the health sector in the Hutt Valley who are working to integrate how we respond to increasing demand for urgent care; and to identify and initiate changes in models of care and service provision.

I am also part of the Allied Health Scientific and Technical (AHS&T) Leadership Team at Hutt Valley, working on a range of sub-regional projects (with our neighbouring DHBs) to introduce a career framework for allied health professions, a quality framework and measures across AHS&T, and a programme to develop our professional leaders in allied health as a high performing team.

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

I have had a bit of an eclectic career path, which has involved working in a number of different contexts, both clinical and non-clinical, in the public, private, and volunteer sectors, and in different parts of the world. However, I think to some extent, it comes back to a personal drive to make a positive contribution in whatever I am doing, being slightly obsessive (not an uncommon trait in psychologists) and deriving great pleasure from seeing people (and teams of people) be the best they can be (also common to psychologists). I lead in a variety ways outside of work too—coaching sport, leading a choir and so on. I am one of those people who cannot sit quietly when there is a problem to solve or an idea to explore!

### **What extra training did you undertake, if any? What was it like “learning the ropes”?**

I think my learning process has been a bit eclectic too. Early on in my career, I was working in the voluntary sector in Russia and was very fortunate to have access to mentoring with a management consultant with a health background (and access to her library from the Harvard Business School) for 2 years. I think that piqued my interest in leadership, but the work I was doing was a bit like jumping in the deep end leadership-wise, so I had an amazing opportunity to learn the ropes there too. Working with an entirely volunteer workforce certainly focuses the mind on how to get people excited about what you can achieve together.

About 4 years ago I was working in a clinical role and I went to a meeting of my team where the need for service improvement was discussed. I went in as a clinician in the team and came out as the project leader. I was asked by the team to step up, as I had been informally leading some change in the psychology part of the team and that had been well received. I was able to access training in project methodology and another period of mentorship, both of which were invaluable in developing my confidence and competence to lead.

### **If you have had any “failures” along the way, how have you dealt with these and what did you learn from them?**

Inevitably, things do not always go according to plan and for all sorts of reasons. Your job as a leader is to do everything you can to make whatever you are leading successful, so it is about trying to think through all the permutations and

attend to all the different perspectives. You can only do your best and sometimes things just don't work out the way you had hoped, so you need to be resilient to that.

In my experience, the most common failure is one of communication. I think a big part of leadership is to have straightforward relationships with people, which have integrity and genuine positive regard. Frequent communication, open communication, and the ability to suck it up and apologise are important skills!

### **Who supported or encouraged you as you entered leadership roles?**

Gosh, I would have to go all the way back to my parents for that one! My husband and friends are also great supporters. In terms of my professional self, generally I think I have had the habit of either suggesting things that could be done differently or been enthusiastic about new ideas/innovations, so my bosses have all been keen to support that.

I appreciate the experience of others, so I will seek out people I respect and ask them to help me figure out how to approach things and where to go next.

### **What advice do you have for clinical psychologists considering moving into leadership roles?**

You have a fabulous resource in your clinical thinking skills and ability to critically analyse information. Do not think that they do not apply outside clinical work—it is just the subject matter that might be different. Psychologists can however, be a little inclined to intellectualise, so make sure you keep practical feet on the ground.

Our ability to maintain professional boundaries can also be a bit of a double-edged sword. On one hand it can help you handle difficult conversations, challenges, and facilitate well, but it can also confirm the reputation psychologists can have for being a little aloof.

One of the transitions when moving into a leadership role means moving out of a clinical role is the loss of your clinical supervisor. I really recommend finding a good mentor who can help you process some of the aspects of your new role.

### **From your experience, what are the challenges and advantages of taking on formal or informal leadership roles?**

You need to be aware that from the moment you take on a leadership role, you are no longer one of the group you were part of before. This can feel a little disorientating at first, especially if you are in an informal leadership role, so still within the same team. You will need to find a new way to relate to the people around you and it can be a really positive thing, but it takes a little time for you all to adjust.

Stepping up into a leadership role certainly proves the maxim “fake it til you make it.” There is a steep learning curve and lots of situations where there are no procedures to follow. If you are like me, there is a certain satisfaction in navigating your way through—in fact, one of the things I love about the leadership roles I have taken on, has been that from the beginning of the week to the end of the week (and sometimes day) I have learnt to do something I had not done before.

I think taking on a leadership role is hugely rewarding. You get to stretch yourself, learn constantly, think on your feet, use your psychology reasoning and communication skills to influence a wider sphere, and most importantly, make a meaningful contribution to the people who use our services and the people who provide our services.

### **What do you see as important skills/competencies of leaders?**

Communication skills are the number one I think; being comfortable facilitating a group, making a formal presentation, chairing a meeting, or talking one-on-one with anyone from the top to the bottom of the

organisation. Psychologists have the core skills for all of these.

Planning and organisation skills, with creative problem solving are really important. Leadership roles tend to be less well defined and have less precedent than many clinical roles. You probably want to ramp up your project skills too, as leading projects is pretty common to most leadership roles.

**How is your position as a leader different from a management role?**

I think that as a leader, you have to be very disciplined in constantly grounding/referencing yourself to the operational realities of your context. You are a leader of something—so you need to understand that “thing” really well and be leading in a way that is very connected to that. Your role is to optimise the “thing,” whether that is an organisation, a project, a group of people, or an idea.

However, it is also your role to stretch your thinking beyond the immediate to innovate and inspire.

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## Book Review

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**Title:** **Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome and the Diagnosis of Moral Disorder.**  
**Author:** Armstrong, E. M.  
**Publisher:** Baltimore, MD: Johns Hopkins University Press, 2008  
**Reviewer:** Peter Stanley

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In 1979 I was doing a course in clinical psychology at Victoria University of Wellington, and *Conceiving Risk, Bearing Responsibility* reminded me of a bus trip that our class made to Levin to see four residential institutions in operation. As a consequence of this field trip, I began to truly appreciate that medicine, education, psychology, and social work occupy largely irreconcilable domains (Stanley, 2006), but there was also an event on the trip that left a particular impression of the medical perspective of disability. When we visited Kimberley Hospital and Training School, the university class was given a whirlwind tour of disabling syndromes with real-life exemplars. One after another, men and women, and boys and girls were led out and a training officer pointed out the physical manifestations of their conditions. “Note the microcephaly, the protruding tongue, the square-shaped ears, the broad neck, and the space between the big and little toes.” I cannot recall whether the patients stood on

a raised platform, or if the instructor used a pointer to illustrate his observations, but neither of these props would have been out of place in this piece of medical theatre.

The relevance of the Kimberley experience is that the pathological-medical view of disability and of childhood adjustment issues is once again in the ascendancy in this country (Health Promotion Agency, 2015; Ministry of Health, 2015), and this time, it has some especially pernicious aspects and possibilities. *Conceiving Risk, Bearing Responsibility* by Elizabeth Armstrong is a detailed analysis of the intersection of alcohol consumption and pregnancy, of the ways that medical entrepreneurs have sequestered a social phenomenon, and of the costs to liberty and to constructive social action that this appropriation can entail. The author focuses on foetal alcohol syndrome (FAS) and on the social and historical contexts that resulted in the creation of a medical disorder. She argues that the

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“discovery” of FAS in 1973 was the result of a confluence of technological developments, of an historical reawakening, and of major social change. Together, these movements produced pervasive anxiety among women about the possibility of birth defects. The response of doctors was to codify compromised birth outcomes with a new diagnostic label. This gave them much greater management of pregnancy, while it also intensified the social control of women’s lives.

Two technological developments, the advent of ultrasound in 1958 and amniocentesis in 1967, effectively changed the status of the unborn and increased the mother’s responsibility for a perfect birth outcome. Now that it was possible to have a baby’s “first picture” within months of conception, foetalhood became a distinct and special part of the human lifespan. Moreover, the foetus became a person in his or her own right (“it’s a boy/girl”) and progress could be closely watched through foetal monitoring. In addition, prenatal genetic testing meant that it was possible to consider terminating the life of an imperfect foetus. These capacities brought with them several philosophical shifts, and one of these sets of ideas was that mothers are responsible for the children with disabilities that they give birth to. The changes in perceptions and in culpability also occurred at a time (in the 1960s and 1970s) when there was a preoccupation with medical risk (e.g., thalidomide and rubella), and a concern about toxic and teratogenic threats in the environment.

The linking of alcohol consumption with birth defects has a long, broken, and complicated history. It is a long history as it goes back to biblical times; it is a “broken” history because for periods of time, it was forgotten; and it is a complicated history because it has had contrasting constructions over time. In *Conceiving Risk, Bearing Responsibility*, Armstrong concludes that the ancient condemnations of alcohol were associated with symbolism and ritual, and

they were arbitrary. In contrast, in the nineteenth and early twentieth centuries alcohol was seen as degenerative force and a “fool-killer,” and dipsomania was believed to be transmitted across generations by heredity. The eugenics and temperance movements flourished in the United States, as in New Zealand, and these movements were associated with much moral fervour and condemnation. Armstrong contends that attempts by modern-day exponents of FAS to connect FAS to the different histories are inaccurate and inappropriate. Nevertheless, the moral zeal of the prohibitionists continues at least, as do the preoccupations of the early eugenicists with “quality” offspring and with individualising fault.

The author says that it was hardly coincidental that the landmark abortion decision in the United States, *Roe v. Wade*, occurred in the same year that FAS was promulgated. Relations between the sexes and motherhood were in turmoil in the 1960s and 1970s as a result of the sexual revolution and availability of the oral contraceptive pill, and demands by women for equality in relationships, jobs, education, health, and politics. Abortion was an especially divisive issue that had a particular consequence: It was seen to pit a woman’s right to control her body against the rights of a foetus to life. As in the 1880s–1930s, which was also a period when women sought emancipation, social forces struck back in later times by reemphasising women’s responsibilities to the next generation in pregnancy. Concurrently, in the second half of the twentieth century, numerous problems of living were medicalised, with FAS just one more in a long list that includes alcoholism, addictions, child abuse, and the so-called mental illnesses.

The reader of this review may feel that Armstrong’s historical and sociological analysis is obscuring some obvious points. Mothers drink alcohol, kids get FAS, and health professionals make sound clinical

judgements to assist them, right? But data show that many women do not drink alcohol at all; that most women reduce (or eliminate) alcohol use when they are pregnant; and, nobody knows for sure how ethanol (or its metabolites) exert their deleterious effects (Armstrong, 2008). Furthermore, while individual assessment and casework may be regarded as powerful and instructive experiences, studies reported by Garb and Boyle (2015) show that it is difficult to learn from clinical situations, and that the judgments of more experienced mental health workers are usually no more accurate than those made by their less experienced colleagues. Numerous cognitive and environmental influences impact on clinical decision-making and an upshot is that some practitioners may, in part, persist with pseudoscientific methods because they fail to learn that they do not work.

There is no laboratory test for FAS, and none of the peculiarities of the syndrome are specific to it. Diagnosis is inherently subjective and impressionistic, so, how is it that doctors actually make this potentially life-changing categorisation? Armstrong interviewed obstetricians, paediatricians, and family doctors, and found that some practitioners start from a clinical presentation and then ask about the mother's drinking. Other doctors know (or suspect) that the mother has used alcohol and then look for the minor, and subtle, physical symptoms of FAS. What we have here is an example of what Shermer (2011) described as "belief-dependent realism," where a belief in FAS comes first and confirmatory evidence is subsequently sought to support the conviction. Such beliefs are reinforced by coalitions of like-minded practitioners, and they can become powerful, pervasive, immune to scrutiny, and polarising.

In *Conceiving Risk, Bearing Responsibility*, Armstrong asserts that FAS is a case study of the ways, and speed, that new knowledge can move through the medical community. As a psychologist, I am also impressed (and

dismayed) by how easily and quickly our professional activities come to be dominated by new medical interpretations. This aside, it is understandable that fear of birth defects (and of FAS specifically) has become so prominent and consuming with modern women that they "are guilt ridden by whatever they do during the pregnancy" (p. 137). Armstrong talks about a woman contacting a hotline because she had eaten rum and raisin ice cream, and there have been other concerns after consuming communion wine. Popular health information and comments by family members undoubtedly add to the burden of responsibility that maternity brings. Inevitably, the life of a pregnant woman becomes less certain and less manageable, and it may be associated with feelings of acute vulnerability. It is contended that these are encouraging conditions for the acceptance of authoritative medical counsel. Equally, in the unsettled and disquieting time after the birth of a child who is different, a formal medical diagnosis might be seen as providing reassurance and an explanation.

There are numerous problems that follow from the medicalisation of alcohol use in pregnancy. For the author of this book, the principal concern would be the social control of women's behaviour that is mediated through expectations and guilt. Medical practitioners have become the "pregnancy police" who maintain order in social as well as biological domains. The expansion from FAS and "alcoholic mothers" to foetal alcohol effects and "alcohol-using mothers" has simply extended the medical mandate and increased the pressure on women. And, while disadvantaged women are less likely to change their drinking patterns during pregnancy, and are more likely to give birth to children with special needs, all women are subject to strictures about maternal behaviour, and this includes their drinking behaviours. A further irony concerning the medical approach is that doctors have, professionally, very little to offer children

who have been affected by alcohol prior to birth. As one of Armstrong's interview group concluded, there is "nothing to do about it directly, so you name it" (p. 101).

Another major concern that the author has is that our society's collective responsibility for social welfare may be progressively abandoned, and in its place we will only have alarms about other people's risk-taking behaviours and their lifestyles. FAS is disproportionately diagnosed in First Peoples in Canada and Native Americans in the United States. There is also a sharp disparity between whites and African Americans in the United States. Part of these differences are likely to be the result of ascertainment bias (when it is looked for, FAS is found), but much of it is also likely to be related to severe social disadvantage and personal suffering. Armstrong suggests that we "as a society mislocate responsibility not only for individual cases of ill health but for social ills as well" (p. 219). As a community, we need to respond to a woman's drinking before she gets pregnant, we need to consider the more pervasive social and health costs of heavy drinking by men, and we need to ensure that all children are born into families that are sufficiently resourced and supported to give them the best start in life.

*Conceiving Risk, Bearing Responsibility* is a highly topical text to review as it contributes a great deal to a critical understanding of the current preoccupation in the health and social services with foetal alcohol spectrum disorder. The sociological perspective that Armstrong brings does much to enlighten, and it sits alongside other disciplines, such as special education and disability studies, that dispute the necessity and utility of a medical diagnosis for children and adults with special needs (Stanley, 2016). The author says that FAS is effectively a victim-blaming strategy, which suits a culture where children who are less than perfect are considered "tragedies," and where such youngsters are believed to be destined to lives of endless difficulties and heartache.

At the least, as practitioners, we should give our clients and their caregivers hope and, in my experience, parental optimism can triumph over the dark side of diagnosis and biomedical beliefs. I would like to tell of another occasion when I witnessed the evaluation of a person's physical stigmata and to recount what subsequently transpired. I was accompanying a mother to a paediatric appointment, and when her son was on the examination couch the doctor identified the points of facial similarity that the boy shared with a named syndrome. I was shocked and concerned for the mother, but I need not have worried because as we were walking across the carpark after the appointment she said to me: "The thing that the doctor doesn't know is that my boy is the spitting image of his father."

#### Acknowledgement

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## Book Review: The LadyBird Book of Mindfulness—Reflections and a Review of Sorts

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**Title:** The LadyBird Book of Mindfulness  
**Authors:** Hazeley, J. A., Morris, J. P.  
**Publisher:** Loughborough, LadyBird Books, 2015  
**Reviewer:** James Hegarty

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*The Ladybird Book of Mindfulness* is part of Ladybird’s “books for grownups” series. The series includes such titles as *The Ladybird Book of the Hipster*, ...*the Hangover*, ...*the Husband*, ...*the Mid-life Crisis*, and so on. While it is possible to dismiss *The Ladybird Book of Mindfulness* as a frivolous, humorous take on the popularity of mindfulness, I found that its short vignettes reflected many of the assumptions and preoccupations that both clients and therapist bring to the practice of mindfulness.

On reflection, I came to the conclusion that if given proper attention by therapists, it will perhaps prove one of the most useful explorations of the subject for clinical psychologists. With this in mind, I offer a few of my thoughts on reading this book for grown-ups.

While mindfulness practices have become a common component of therapy, and endemic in popular culture, there can be some confusion around what mindfulness is and how best to include it as an integrated part of therapy. For example, various clinical psychologists, research scientists, and authors have described mindfulness as a relaxation technique, a visualisation practice, a cognitive strategy to develop awareness of thoughts, a strategy to control thoughts, an acceptance technique, a body based strategy, and a method to disengage from cognitions (e.g., Baer, 2014; Cook-Cottone, 2015; Gilbert & Choden, 2013; Hayes, Stroschal, & Wilson, 1999; Kristeller & Bownan, 2015;

Storshal & Robinson, 2015). Some even see “mindfulness” as a clear cognitive change strategy, such as in the generation of “compassionate thoughts” to change patterns of thinking. In addition, many clients and therapists bring their own assumptions about mindfulness, and mindfulness practice to its use in therapy. It is against this background that I discovered *The Ladybird Book of Mindfulness*, and found it an intriguing starting point for reflection on mindfulness in general, and its applications in therapy in particular.

A feature of the book is that it consists of short pithy vignettes accompanied by pictures in the style of old Ladybird books. Together they illustrate many of the popular misconceptions and assumptions around mindfulness. This combination is also generally humorous. Like all good humour, this fosters a leap of imagination, a sudden realisation of the absurdity of the situation portrayed. We side step linear symbolic thought processes and experience a brief insight into many of the common misconceptions around mindfulness.

For example, when Sophie, a frail young woman in a diaphanous gown decides to become an airian (to live only on air), we immediately see the absurdity of the situation. With a little reflection, the therapist familiar with different approaches to mindfulness can see the connection to other forms of unworldliness, idealisation, and attempts to escape reality through mindfulness that some clients come with; tendencies that are fostered by unskilful

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comments by some mindfulness “experts.” Here, I am thinking not only of confusing instructions regarding how to practice mindfulness, but the inclination of some clinicians and writers to make suggestions such as that mindfulness practice will lead to lasting happiness (e.g., Baer, 2014), or that they are involved in practicing some vague spiritual practice reflecting a “universal dharma” (Williams & Kabat-Zinn, 2011).

Many of the very short vignettes in this book reflect attempts to avoid reality and normal responsibilities through mindfulness or related practices. This is often accompanied by an artificial, idealised view of mindfulness, and of what life should be like. The episode where Thaddeus reflects that thanks to mindfulness based self-realisation, he is much happier working as an air conditioning technician than being Chancellor of the Exchequer, can reflect the dual curative fantasies that mindfulness will “make it all better” and that simple drastic life changes will result in lasting happiness. We all know that this is not necessarily so. Your problems, your personality, and your way of dealing with issues go with you. Change takes practice, and rarely, if ever, occurs overnight.

There can also be costs to such devotion to an idealised state. The episode describing Guru Bhellend highlights this to a certain extent. The text states that he “entered a state of mindfulness that lasted 35 years,” and then “wrote the answer on a grain of sand.” Ignoring the implicit assumption that mindfulness practice leads to an “answer” of some sort, the text simply goes on to state that “he never married.”

For some therapists, engaging in mindfulness-based therapies seems to elicit a range of apparently profound comments; a demand to demonstrate some greater knowledge of life, or of a spiritual wisdom. Some examples might be references to concepts such as mindfulness leading to “your inner wisdom” (Kristeller & Bownan, 2015), to mindfulness in relation to a

universal dharma (a Buddhist term for the way things are, or the Buddhist way, Williams & Kabat-Zinn, 2011), stating mindfulness leads to compassion (Gilbert & Choden, 2013, p. 48), or simply conflating mindfulness with Buddhism and spirituality as many authors appear to do (e.g., McGowan, Reibel, & Micozi, 2011). This can be counter-productive in some cases and cause a negative reaction in others. The vignette concerning Jake illustrates this. Jake was always saying things like “there is more wisdom in a waterfall than in a hundred men.” As a result of this behaviour, Jake’s “ex-wife’s sister” habitually referred to him as “Jerk.”

I was particularly taken by Clive’s story. I believe that it is worth quoting in full:

“Clive likes to practice loving kindness meditation. This is when someone thinks of a friend and sends them love.

Clive finds this easier than bothering to meet his friends, or to lend them money.”

This reflects two aspects of the use of mindfulness within psychology that are worth noting. Firstly, the pseudo Buddhaisation of mindfulness within therapy (compassion training is often seen as a Buddhist technique), something that is strangely accepted in many psychological circles yet would be condemned, or avoided if similar practices associated with Christianity were advocated. The second worrying aspect of modern mindfulness highlighted by Clive’s behaviour is not just the tendency to simply think about something and call it mindfulness, but to act as if wishful thinking, or at best cognitive rehearsal divorced from actual behaviour change will result in positive outcomes.

Of course, *The Ladybird Book of Mindfulness* was not written specifically for therapists. It was intended for the general public, therefore it does not directly address issues regarding research, how to apply mindfulness in therapy, or the differences



between different therapeutic approaches to mindfulness. It would be possible to see it simply as a cynical take on the popular mindfulness movement; or as a trifle, a series of jokes. However, I believe that to take such a stance ignores the possibilities of this intriguing little volume. It offers a rich source of reflection for those therapists interested in mindfulness and who attempt to use it as a component of therapy. It can serve as a touch stone not only for recognising the dark side of mindfulness, but for reflection regarding what mindfulness is, how it is used, and around our unspoken assumptions about mindfulness. It can also prompt us to reflect on, and guard against the hidden agendas and assumptions within various articles and books on mindfulness. Reflecting on the common themes presented in *The Ladybird Book of Mindfulness* can also foster our ability to identify our personal assumptions around mindfulness, and sources of avoidance in ourselves and in clients. In short it can help us to think critically; to think as psychologists.

I would not recommend *The Ladybird Book of Mindfulness* to most clients or to those therapists without some training in mindfulness. For those with some experience in the area it can be a useful starting point for reflection. I believe that engaging with this little volume could usefully be included as an activity in the log book of practices related to reflection and to continuing competency around mindfulness,

and perhaps as a discussion point in group supervision.

*The Ladybird Book of Mindfulness*. From LadyBird Books and mediocre bookstores near you.

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## Innovations in Behavioural Parent Training: A Visit to the University of New South Wales

Melanie Woodfield

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When the call for applications for the NZCCP travel grant came around, this time I thought—why not? I had admired the work of Professor Mark Dadds and his Child Behaviour Research Clinic at the University of New South Wales (UNSW) in

Sydney from afar for some time, and the idea of visiting was very exciting to this rather earnest psychologist. A demanding client load had meant that, like many of my colleagues, I rarely had time to devote to “big picture” professional interests. An

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increasingly modest professional development allowance had resulted in fewer opportunities to refresh and reinvigorate my practice.

The application process was simple, and I was delighted to be told that I had been awarded one of the five \$1000 grants. It was also very simple to arrange the visit itself—a few emails, and everything was arranged. I visited the UNSW in Sydney for several days in October, 2015. For the majority of the time I was hosted by the Child Behaviour Research Clinic, who research and deliver an evidence-based parent management training approach for addressing childhood conduct difficulties.

Childhood conduct difficulties have been in the spotlight in New Zealand in recent years, with the publication of several significant reports, such as the best practice report put out by the Advisory Group on Conduct Problems (2009). And rightly so—as Fergusson, Boden, and Hayne (2011, p.42, emphasis added) assert “there is no other commonly occurring childhood condition that has such far reaching and pervasive consequences for later health, development and social adjustment.”

Behavioural parent training (BPT, also known as parent management training) is one of the most effective interventions in early- and middle-childhood. The most established manualised BPT approaches are Triple P (Positive Parenting Programme, Prof Matt Sanders and colleagues, see [www.triplep.net](http://www.triplep.net)) and The Incredible Years (Prof Caroline Webster-Stratton and colleagues, see [www.incredibleyears.com](http://www.incredibleyears.com)), and both are widely available in New Zealand. Mark Dadds was one of Matt Sanders’ PhD students, and went on to create a manualised parent programme integrating family systems theory and behavioural principles. The programme is outlined in his book (with Dr David Hawes) *Integrated Family Intervention for Child Conduct Problems: A Behaviour-Attachment-Systems Intervention for Parents*. Since then, he has been

researching various applications of the programme, along with fascinating elements such as the links between eye contact in infancy and the development of empathy.

Unfortunately, Mark Dadds was unwell during the few days I was in Sydney, and we were unable to meet. His team more than made up for this, answering my endless questions and tolerating my considerable enthusiasm. The team is made up of intern psychologists, PhD students, and several experienced clinical psychologists. All deliver the manualised intervention either at the free clinic at the UNSW, at a satellite clinic, or even via Skype for rural families. They have a useful system where interns rotate through the clinic—a mutually beneficial arrangement whereby interns are able to implement an evidence-based manualised intervention (I remember the days when a manual was an effective anxiety-management strategy as a beginner therapist), and the clinic increases its capacity. Mark Dadds is very charismatic, and his YouTube clips and “Kids on Speed” documentary are well worth a watch. Whenever the documentary screens on TV in Australia, the clinic is inundated with families wanting to access the free intervention.

The team had arranged a couple of group inter-rater supervision sessions to coincide with my visit, and these were very interesting to participate in. A case would be briefly presented, then all clinicians would individually form an opinion as to the most relevant diagnosis and the severity of the child’s difficulties (on a Likert scale). These were then compared, to obtain inter-rater reliability. While this was primarily for research purposes, it was impressive to witness the precision with which cases were presented and summarised. Case summaries were precise and succinct. It put many an MDT case review to shame!

Professor Dadds and his team recently moved from the UNSW to the University of Sydney, where they will have a purpose-built

suite of rooms, and will continue to research and deliver this intervention, alongside Dr David Hawes.

While at UNSW, I also arranged to meet Dr Eva Kimonis, who is a senior lecturer interested in developmental psychopathology, including psychopathy, and early intervention to prevent the development of childhood conduct problems. One of her studies involves parent-child interaction therapy (PCIT). PCIT has been introduced to New Zealand in recent years, and is being disseminated around the country. A small group of clinical psychologists and I deliver this intervention at the Kari Centre (the Child and Adolescent Mental Health Service for Auckland District Health Board). Delivering PCIT and witnessing the profound improvements for children and families is some of the most rewarding work I have been involved with. Eva Kimonis and colleagues have designed a brief adjunct module, the CARES (Coaching and Rewarding Emotional Skills), which is designed to supplement the PCIT intervention. It involves direct teaching of skills to children (alongside their parent) according to a manualised protocol after the parent has reached mastery of the earlier PCIT phases. Early studies have shown short-term improvements in empathic responding and emotion recognition in children.

Eva Kimonis was very welcoming. We talked about PCIT over lunch and toured her stunning purpose-built PCIT rooms at the university clinic. These rooms are fitted out with state-of-the-art technology and have been carefully designed to complement the intervention. It was reassuring to see that her clinic shares some of the same difficulties as ours; for example, she

specifically requested a modest, durable chair to be used for the children's time out space, but an expensive brown leather high back armchair had arrived instead. Within weeks, it had been christened with pens by an involuntary young guest.

Eva also arranged for me to view a client session, and it was a really validating experience to observe an almost identical session to that which we would offer in our clinic. Reassuring to know that we are keeping pace with progress.

I came away from the visits to these two clinics reinvigorated. It was refreshing and encouraging to see the innovations that are being investigated within treatments for young children with conduct difficulties. The precision of the research clinic environment was inspirational, though not necessarily directly translated to the front lines of public mental health services in New Zealand.

I heartily encourage fellow clinical psychologists to apply for this generous grant in the future, and wish to express my sincere gratitude to the College for allowing me this opportunity.

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## Dyadic Developmental Psychotherapy—Level 1 With Kim Golding, Consultant Clinical Psychologist at AdoptionPlus, Milton Keynes, UK

Emma Lonsdale

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Earlier this year I was fortunate enough to be awarded a NZCCP travel grant that enabled me to travel to the UK for specific training I have been wanting to do for some time: dyadic developmental psychotherapy. Many thanks indeed for that opportunity. Few people in the antipodes have done this training and I would love to hear from anyone, especially in New Zealand, who has.

Dyadic developmental psychotherapy or practice (DDP) was developed by clinical psychologist Dan Hughes through his extensive experience working with families in the US. In particular, he works with children with early developmental trauma and the families that fostered or adopted them. DDP is an attachment-focused approach drawing on neurobiological research into early developmental trauma. It now has an evidence base as well as a wide following in the US and UK.

DDP, as I see it, relies on homing in on inter-subjective experiences between children, caregivers, and therapist live in the therapy session, and supporting emotional shift and rebalance through a technique called “affective-reflective dialogue.” The mnemonic P.A.C.E. (Playfulness, Acceptance, Curiosity, and Empathy) helps therapists remember aspects of the “dance” of therapy to guide the intention of therapeutic conversation; although not necessarily in the P.A.C.E. order—more often Acceptance, then Curiosity, and Empathy with some Playfulness thrown in!

I have been interested in DDP for about 15 years, and using it in my work for the last 3 years. What I really enjoy is that it combines many fields of knowledge and skills I already have and gives me tools and a sense of structure to work with some of the most

challenging and distressing psychological cases I believe we see. These are children who have been unloved, unwanted, and maltreated and who now seem unable to receive and engage with the affection offered to them. Training with Kim made me more aware of how to effectively proceed in sessions with P.A.C.E. as well as providing more information and skills about how best to explore the attachment history of caregivers.

The latter is a key part of DDP: children with histories of attachment difficulties often seem adept at “pressing the buttons” of their caregivers, as there tend to be key parts of the attachment history of the caregiver which are triggered by the child’s behaviour. DDP seeks to sensitively identify and explore this with caregivers so that the children and caregivers can enjoy a reciprocal relationship in the present, with less interference from the “ghosts” from the caregivers’ nursery, so to speak.

In addition to working with foster children and their families, I have successfully used this approach with families with teens with borderline personality-style presentations. The aspects of working in the present moment and radical acceptance from dialectical behaviour therapy lend themselves well to integration with DDP. I also enjoy DDP having long enjoyed working with families in therapy. DDP requires a high degree of authenticity from the therapist and fits well with my interests in compassion-focused therapy and self-compassion.

For those of you whose interest is piqued, further information is available at <http://ddpnetwork.org/> or [www.danielhughes.org](http://www.danielhughes.org). I would also highly

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recommend the DDP training: Kim Golding will be following up on her introductory days last year with Level 1 training in October/November 2016.

See <https://www.compass.ac.nz/therapy-approaches/dyadic-developmental-practice-135969511.html> for further details.

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## **NZCCP Travel Grant Report: International Conference Attendance** **Charlotte Gutenbrunner**

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My name is Charlotte Gutenbrunner and I am a current PhD (final year) and clinical psychology student at Victoria University of Wellington. Thanks to the NZCCP travel grant, I was able to attend the 6th biennial meeting of the Society for Applied Research in Memory and Cognition (SARMAC) in British Columbia, Canada in June, 2015. The grant enabled me to travel to an international conference and present my PhD findings to leading academics in the field of memory research. It was an invaluable learning experience for me, and I would like to extend my gratitude to NZCCP's National Executive and other board members who selected me as a grant recipient.

My PhD research involves the study of a phenomenon called overgeneral autobiographical memory (OGM), a memory disturbance that has been identified as a predictor of the course and recurrence of depression. This phenomenon refers to a tendency to retrieve general event memories when asked to provide memories of specific events in response to cue words. For example, an individual might recall the general event category of "having fights with people" in response to the cue word "angry," rather than a specific event example, such as "when I had a fight with my brother last Saturday."

Despite evidence identifying late childhood and early adolescence as critical times for the development of depression, limited research has investigated OGM and its covariates in youth. Furthermore, existing research has primarily been of cross-sectional nature, obviating the possibility of observing the initial depression onset.

Therefore, no evidence clearly identifies OGM as a precedent, and therefore vulnerability marker, of depression in youth.

Considering these gaps in the literature, my PhD research examined OGM and emerging psychopathology in a community sample of New Zealand adolescents across 3 years. Our study was the first to investigate the associations amongst OGM, depression, and anxiety across three data collection waves, and we obtained interesting and clinically relevant findings. That is, a tendency to retrieve overgeneral memories when asked to retrieve specific memories may indeed, under particular circumstances such as increased risk, predict symptoms of psychopathology in young people.

Several learning outcomes may be considered a direct consequence of my attendance at this conference. First, attendance enabled me to establish relationships with international academics in a relevant research community. This highlighted the nature of scientific research being conducted in New Zealand to fellow academics, and also increased the likelihood of future collaboration, including postdoctoral research opportunities. Second, by communicating my study to expert researchers in relevant academic fields, I was able to gather valuable feedback on my findings, which I have been able to incorporate into the scientific manuscripts I am preparing for publication as part of my PhD. In addition, by attending other international researchers' paper and poster presentations, I was able to expand my knowledge on a vast array of processes related to memory and cognition. Such an invaluable opportunity will permit me to

incorporate acquired knowledge not only into my own research, thereby enhancing its scientific quality and value, but also into future clinical practice. As a result, I hope to be a more valuable asset to fellow researchers and clinicians in New Zealand when I finish my Clinical Psychology Diploma in 2018.

More specifically, in terms of future clinical practice, attendance at this conference not only broadened my understanding of research related to my own academic interests, but also other clinically relevant research domains. Indeed, memory and cognition are constructs central to the practice of clinical psychology. Attending and participating in discussion of recent scientific research in these areas has had comprehensive beneficial effects on my understanding of, and ability to critically

evaluate, current psychological research—a skill central to effective clinical practice.

In summary, my research interests concern associations between autobiographical memory and emergence of depression and anxiety during a developmental period critical for the onset of psychopathology, namely adolescence. Presentation of my findings at an international conference allowed me to seek feedback on theoretical and practical implications of this research. This has informed my understanding of psychopathology in youth, allowing me to critically evaluate my findings in the context of multiple research domains. My research focuses specifically on the development of psychopathology in New Zealand youth, and I hope to translate the knowledge I have gained as a consequence of attending this conference into my own research, as well as future clinical practice in the wider New Zealand community.

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## Review: Russ Harris Online ACT Workshop

**Bruce Donaldson**

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Hi everyone. I thought I would take a few moments to review an online ACT workshop I have just completed, as I am feeling particularly inspired by it right now having just finished the course.

The course is Russ Harris's Advanced ACT workshop.

<https://imlearningact.com/product/act-advanced>. He does other workshops, including Introductory ACT and ACT for Trauma—and probably many more are on their way.

This was the first online workshop I have taken part in, and all in all, the experience has been very positive. I found there were many advantages to an online workshop. I did not have to get up at 5am to make it to the airport for an early flight. I did not have to force myself to look calm and relaxed flying into Wellington while my fingers

gripped like a vice onto the seat arms. There was no 5kg post-conference weight increase from overindulging on conference food and living on Indian takeaways for a few days. This was a totally different workshop experience, and one I would recommend.

Online workshops are about carving out a window of time in your day just for you. Sitting back in the comfort of your office. Feet up. Drinking coffee. Pausing every now and again to do a mindful stretch (which is a regular part of the course) and make a few golf putts with my office golf set (not part of the course). I could press pause, rewind, and occasionally fast-forward, while listening to Russ explaining to me how I should have been doing therapy during the last ten years. And it's all at a reasonable price. An ACT online workshop will set you back about \$550AU; however, you can knock \$100–150 off that with the early bird

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rate. And no travel expenses (to state the obvious).

The workshop has eight different modules on different areas of ACT Therapy, one module for each week of the course.

Week 1: Where we get stuck and self-compassion.

Week 2: Getting creative and in-depth case formulation.

Week 3: On target: Functional analysis and designing specific interventions.

Week 4: Mandated clients and interpersonal work.

Week 5: Starting off well, getting active, and staying on track.

Week 6: Problems with self.

Week 7: Suicidality and shame.

Week 8: Classic barriers and new directions.

Each module is supposed to take around 3 hours a week (but I would say that you need more time than that). A lot of material is covered and lot of work has gone into these workshops. The video clips are frequently interspersed with images and cartoons to help mix it up and keep you focused. Russ does his best to get a few laughs with various antics. It all comes together quite well—only occasionally did I feel lethargy

creeping in, which probably had more to do with my caffeine cycle than the workshop itself. While you cannot download the videos, for obvious reasons, you can download a number of ACT resources related to the course. The course material also stays available for 28 days after the last module.

I really liked the anonymity of the online workshop. I could ask all the most ridiculous questions online that I would probably never ask in a workshop surrounded by my peers. What is more, a whole team of people, including Russ, took my questions seriously and provided considered answers to them. So, I encourage you to give an online workshop like this a go and see what you think.

Just before I wrap up, there is one thing that is the same between an online workshop and a live workshop. You still end up with lots of pages of scribble and largely indecipherable notes afterwards that are guaranteed to compost in your office until you have no idea what conference they actually refer to any more.

Best of luck,  
Bruce.

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## Learn Basic Leadership Skills in 30 minutes

**Kris Garstang and Elena Moran**

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The College's Strategic Plan includes a goal of building the leadership capability of our members. Council members formed a Leadership Working Group for the purpose of meeting this objective.

Among other activities, the Leadership Working Group decided to explore learning opportunities in the field of leadership which are already readily available to

members.

We discovered that The Royal Australian and New Zealand College of Psychiatrists provide a free e-learning resource on management and leadership, which is available on their website (<https://www.ranzcp.org/Publications/E-learning/Communication-management-leadership.aspx>), and embarked on trialling the e-learning modules in a bid to provide

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you with some feedback on their relevance and usefulness.

The e-learning modules cover the subjects of communication, management, and leadership. So far, we have reviewed 11 modules and here is what we thought:

### **Performance feedback for positive change (two modules)**

These were very useful, particularly if you are currently managing staff. The information was helpful for improving understanding of different types of staff members and it gave ideas for different ways to manage them.

### **The role of the manager (three modules)**

These seemed less useful and were dry. However, the distinction between clinical leadership and clinical management was helpful, particularly if you are still feeling confused about the difference. It was also helpful to learn about the relationship between the roles of manager and a leader.

### **Characteristics of clinical leadership (one module)**

This was useful as it encouraged you to explore your own potential leadership style. It also contained video material, which made the module more interactive. The ideas around how clinical leaders may instigate change and promote improvements were helpful, particularly to those who might already be in a management role.

### **Leadership styles and resilience (one module)**

This was more of a self-reflective module and encouraged you to evaluate your own resilience skills. It seemed like a useful exercise for us all to do, even if you are not yet considering being a leader.

### **Leadership skills (one module)**

This seemed most relevant to those of us who are already in management and leadership roles. It explained the function of a strategic plan, and encouraged you to reflect on the organisation's plan, giving guidelines for managing change.

### **Understanding self as manager (one module)**

This module recapped the differences between management and leadership, before outlining different leadership styles and when to use each. It also included a useful look at the personal changes one needs to make to transfer into a leadership role. Less useful was material on understanding one's own values and beliefs, which comes across as superficial and only briefly covered.

### **Managing conflict (two modules)**

These modules give a brief overview of conflict at work and describe different behaviours in conflict. Module 1 suggests ways for assessing workplace conflict using a useful framework. Module 2 covers many skills already well honed by clinical psychologists, including active listening, showing empathy, analysing situations from multiple points of view, and managing stress. More useful was a stepwise process for resolving conflict between self and another or between staff members.

### **In summary**

The positive aspects of the e-learning modules were:

- no cost
- brief (each module takes about 30 min to complete)
- semi-interactive (you can test your knowledge)
- easily accessible
- simple to follow and understand
- they have a clinical rather than a business focus
- give some useful tips that you can begin to apply in your workplace
- give you a sense of confidence that as clinical psychologists, we already possess most of the skills required for effective leadership and know the basics of management.



The less positive aspects were:

- some content was a bit dry and repetitive
- some content seemed less relevant and targeted more to managers than leaders.

The overall mark out of 10 in terms of practical relevance and impact on practice was 6/10. So, well worth trying out when you have a spare 30 minutes.

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## ***Diversity in Clinical Practice: Whakahangai te tikanga mahi*** **NZCCP 27<sup>th</sup> National Conference, Wellington, 2016**

**Clare Couch**

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The 2016 Conference was held in sunny Wellington, which basked in glorious weather for the weekend. The conference was attended by 90 participants and was smaller than previous years, but well received by those attending. The opening address was given by Dr John Crawshaw (Director of Mental Health and Chief Advisor Ministry of Health) who challenged us to consider ways how, as a professional group, we could respond to health needs and this may require us to consider different ways to use our skills. The first keynote address was by John and Julie Gottman on the science of betrayal and trust, which was based on their many years of research in couples therapy and how this relates to trust in relationships. They had to rush to leave us so they could attend a TV interview, which aired on TV3's programme Story the following week.

Our second keynote was Ranka Margetic-Sosa, who led us through various vignettes of people's experiences as refugees in New Zealand. This was very touching, and a powerful way to highlight the issues for refugees. The next keynote was Russell Kolts, who talked about compassion and diversity, using a compassion framework to consider privilege and oppression in our world. Big issues to address and nicely considered in this theoretical framework. The last keynote by Jane Freeman-Brown was entitled "How to get away with murder? The legal and ethical implications when a client confesses to an undetected homicide."

Jane introduced key concepts of the law and how this can impact our profession and therapeutic work.

Between these invigorating keynotes, there was a wide array of speakers and presenters. The various streams included: psychology and leadership, therapeutic tools and styles (group, equine therapy, prolonged exposure, DBT), cultural issues, working in the rural sector, family- and children-focused work, supervision, reflective practice, and service delivery issues. Participants appeared well engaged in the workshops and the feedback we received has generally been positive.

Before the conference, we had a 2-day pre-conference workshop by John and Julie Gottman for Level 1 couples therapy. John presented findings from over 40 years of research in the area. Julie provided guidance in the therapeutic tools and techniques they use. Together, they were very engaging and professional presenters who knew their material well. Each participant received a 300-page manual, and there were also a lot of resources on sale.

Our 1-day post-conference workshop was on compassion focused therapy (CFT), and was presented by Russell Kolts. Russell not only introduced participants to the concepts but also led people through experiential exercises. Russell's examples of using CFT in prison populations were well received and the role play powerfully showed the therapy in action.

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Tawhiti Kunaiti, who was at the time in discussion with the NZCCP Executive about taking on the role of the College Kaumatua, was happy to support the conference proceedings on an interim basis and to lead the whakatau, mihi whakakapi, and karakia throughout the weekend.

Overall, the feedback for the whole event was positive. Thanks to the organising committee and a huge thank you to Caroline, without whom this would not have been possible.

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## Mindfulness and Clinical Psychology—A Reflection on a “Zen Mindfulness Retreat” with Dr Marsha Linehan

James Hegarty

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*I was fortunate to be able to attend a retreat with Dr Linehan in August 2015. It was described as Zen a mindfulness retreat for graduate students in clinical psychology and other health care providers. I believe that some feedback from this retreat may be of interest, as I found Dr Linehan’s view of mindfulness markedly different from what I commonly encounter in the literature on mindfulness (including journal articles and books), among my colleagues, and as applied in some other mindfulness-based therapies. In this brief article I briefly outline the purpose of my visit, how the retreat functioned, some key comments from Dr Linehan, and my very brief reflections on these.*

Dr Linehan is of course the primary developer of dialectical behaviour therapy (DBT). Not only has DBT been very influential in clinical psychology, but was also the first cognitive-behavioural therapy to place primacy on the use of mindfulness as a core component of therapy. Much of the modern literature on mindfulness does not reference a DBT analysis of mindfulness, and I was very keen to understand Linehan’s view of mindfulness, how it fits into therapy in general, and how she saw mindfulness as seen/used in DBT as opposed to its use in other therapies. I was also interested in her views on the applicability of mindfulness to different situations, and any instances where mindfulness would be considered unhelpful, or even counterproductive for clients.

I was also aware that Dr Linehan is a Zen practitioner and teacher, and has referenced Zen as an influence on DBT. I was interested to experience how Dr Linehan taught and integrated her experience of Zen to her work. As a Zen student myself, I never really understood the proposed relationship between Zen and DBT, and found this confusing. In addition, many well-known proponents of mindfulness in therapy make a clear link between Buddhism and Buddhist conceptualisations of mindfulness and how it is applied in therapy (e.g., Gilbert & Choden, 2013; Kabat-Zinn, McGowan, Reibel, & Micozi, 2011). At times, such comments have made me wonder about whether there was a sound scientific rationale for mindfulness in these therapies, and I was interested to see how this was resolved in DBT.

### Background to the Retreat

Dr Linehan runs one to two retreats a year. I attended the one held near Seattle. The Seattle retreat allows her graduate students to attend; however, most attendees were experienced therapists, and in at least one instance I was aware of a Zen student who was not a therapist. Dr Linehan was clear that she regarded attendance at such retreats important for gaining a greater understanding of mindfulness, and necessary for those who wished to use mindfulness in therapy. This view is consistent with both the suggested guidelines of the Mental Health Foundation

regarding training for mindfulness teachers, and the consensus of a meeting of New Zealand mindfulness teachers held last year.

### **The Place**

The event was held at the Archbishop Brunett Retreat Center in Washington State. This is about 30 miles south of Seattle and 16 miles from SeaTac International Airport. The centre is located on bluffs overlooking the sea, and surrounded by forests. While the centre was comfortable, the organisers did apologise for the fact that we were not allowed to arrange our own catering, and thus the periods of (mindful) work practice typical of such retreats.

### **Timetable and Practice**

The daily schedule Dr Linehan chose was typical of that used in the style of Zen practice in which she has been trained (the Diamond Sangha).

This consisted of 25 minute blocks of sitting, followed by periods of walking meditation. This latter usually lasted 5–7 minutes; however, due to the arrangement of the practice area and the size of the group our walking periods were a little longer. The retreat was in silence, apart from question and answer periods.

The day began at 6am, with lights out at 9pm. We had four blocks of sitting during the day, ranging from 1.5–4 hours. There were opportunities to meet privately with Dr Linehan during these periods. There was also a half-hour period of led outside walking meditation each afternoon along the paths and woods surrounding the retreat centre, and two talks each day by Dr Linehan. Questions were allowed following both talks; however, one had an extended question and answer period.

The mindfulness practice at the retreat consisted of Zen practice which can be described as primarily mindful awareness. In the traditional style of retreat, each student might be working with something different, from breath counting to koan practice and

full awareness practice. The impression I received was that most people were working with breath and awareness of body practice. Interestingly, in this retreat Dr Linehan did include koan practice for those familiar with this. This is an inquiry practice typical of certain types of Zen which is embedded in a mindful meditation practice.

Also typical of Zen practice were several opportunities each day to meet with the teacher in private. The purpose of these meetings was to discuss issues related to practice. Over the course of the retreat, Dr Linehan said that it was clear many people were interested in asking DBT-related questions during these meetings, and that she would inadvertently get diverted on to lengthy discussions of these interesting issues. As this was the case, opportunities were set up for private interviews with Randy Wolbert, a senior DBT trainer, to discuss primarily DBT-related issues. While there were over 60 participants at the retreat and interviews with both Randy and Marsha were very popular, I still found it possible to have several meetings with each of them.

Where the retreat differed from a more traditional Zen retreat was at the beginning and end of the day. Each day began with a period of brisk walking outside (around a car park) followed immediately by the pre-breakfast meditation period. Each evening ended with a slow dance. This was modelled on a European folk dance and involved slowed synchronised movement in time to music. We danced in a circle while holding hands. This was a clear example of engaging in what Dr Linehan referred to as “participation.”

### **Content**

While in her original book on DBT Linehan referred to the influence of Zen on the therapy, before attending this retreat I could only see a superficial relationship between the two. However, during my first conversation with her, Marsha (everyone called her Marsha) very quickly explained this without me bringing it up. What is

more, she did this in one or two simple sentences that were startling clear. This was also a topic that she subsequently brought up repeatedly in her talks to the group. She explained that the core of DBT was influenced by her repetitive experience in her Zen training of her teachers saying “concepts Marsha concepts.” That is, that she was stuck with concepts, and should come to experience without these constraints. As an example, she explained the function of such practices in DBT as “describing” as a way of setting aside concepts and focusing simply what is just there rather than the words or ideas we attach to things and situations. This view of mindfulness seemed consistent with one of the definitions suggested by Jon Kabat-Zinn (2003) “a non-conceptual seeing into the nature of mind and world”; also to an acceptance and commitment therapy (ACT) informed view of mindfulness as “awareness without any conceptual overlay”; as well as the effect of some mindfulness integrated cognitive behavioural therapy (MiCBT) exercises.

Participation, another DBT skill was similarly described. It was seen as complete/absolute engagement in what you are doing without conscious, conceptual self-monitoring (several examples are available in the revised DBT skills manual, Linehan, 2015). In fact, Linehan gave considerable prominence to participation and described this as the aim or culmination of mindfulness practice. To be fully engaged in those activities that make up our life. She described this as being related to the acceptance, and the allowing of experience. In this sense she was referring to participation not as a mindfulness skill, but to what for want of a better phrase might be termed a higher order, or theoretical understanding of participation as the overarching aim of mindfulness practice.

She stated that in recent years, she has “come out” regarding the strong influence of Zen in the development of DBT, in addition to being much more public about

her own significant struggles with emotional distress. In the original DBT book there were references to Zen, but these were primarily related to “acceptance” and to the holding of the dialectic. In this retreat, Dr Linehan stressed the importance of the non-conceptual nature of mindfulness practice and its influence on her and the development of DBT. I also found it interesting that she convinced the University of Washington to fund much of her early investigation of and training in Zen, such as the attendance of retreats, and training with teachers. She described this training as important in the development of her clinical work and her subsequent research. I could not help wondering how many institutions in New Zealand would fund such training.

Another point that Dr Linehan repeatedly made regarded her aim for the retreat. She said that she wanted us to bring what we learned on the retreat back to our own everyday lives, and to our work with clients. She was generally careful not to prescribe exactly what this should be, but at other times also made it clear that she was referring to the simple dropping away of the reliance on our conceptual thinking in our relationship with the world. My experience is that the process of persistent mindfulness practice over several days during a silent retreat allows one to not only more fully appreciate the difficulty of mindfulness practice, and its intricacy, but also to taste, if even only slightly and briefly, a more open relationship with experience. Linehan might call this “wise mind,” a term I still think that unnecessarily suggests something special, or other, but which many people seem to find helpful.

On the issues of whether anyone could learn mindfulness, and when it is contra indicated Dr Linehan was clear. She said that everyone could learn mindfulness. There does not seem to be clear literature on this; however, her view, based on her experience with vulnerable clients, was that only the most extremely distressed clients would find activities like mindfulness of breath practice,

or a strong focus on the body as extremely destabilising. She suggested that in these cases people should start with other practices. She was also clear that this group constituted only a very small portion of those that she saw, and that her client group were a highly selected sub-set of those most emotionally reactive to distressing trigger events. I found her comments interesting in light of comments by some colleagues and clients that they “can’t do it” with regards to practicing mindfulness.

While Dr Linehan’s view was that anyone could learn mindfulness, and that many people could “learn it from a book,” she also stressed the importance of a good grounding in mindfulness practice for therapists wishing to use it as part of their work, attendance at a silent retreat or retreats as part of this development, and again stressed the view of mindfulness as a way of stepping out of our concepts.

### **Reflections**

Going to a conference, or to a workshop conducted by those that have made undoubted contributions to the field can feel a bit voyeuristic, a bit like being a tourist. Particularly if this occurs towards the end of their career. The majority of those attending this retreat were DBT therapists and clearly were Linehan fans. Marsha is also a bit of a heroine to many psychologists outside the world of DBT trained therapists. I felt that there was an unavoidable element of this tourist-type attitude, a sense of a journey to see the famous person; however, due to the experiential nature of the event, and Marsha’s emphasis on full “participation” this was limited. Dr Linehan seems to be a no nonsense type of woman; and in spite of two daily talks, most of the time was spent in silent meditation; the practice of mindfulness.

I came to the event as a non-DBT trained therapist with an interest in mindfulness and its uses in therapy. Overall, I found the retreat interesting and useful. I gained in my

understanding of DBT, its development, and how mindfulness is seen in that therapy. I became much clearer regarding Linehan’s view of mindfulness, and through my interactions with others before and after the retreat, got a little insight into the American therapy scene and the interests of participants.

I did not learn how Dr Linehan saw the differences between mindfulness as used in DBT and its role in other therapies. I am unsure if she deliberately side stepped this question, or simply got distracted in the midst of a free ranging discussion. It is clear that the theoretical view of mindfulness from a DBT perspective is not that dissimilar from that found in ACT or MiCBT. It would have been interesting to hear Dr Linehan’s view on the differences between mindfulness as used in DBT and in other therapies such as MBSR. Unfortunately this was not possible.

During her talks, Marsha repeatedly stressed the purpose of the retreat and focus of the personal interviews was the practice of mindfulness, not an exposition of, or supervision around DBT. Nevertheless, many of the participants did ask repeated DBT-related questions, and Dr Linehan had difficulty not responding to these. She seemed to have a real passion for DBT. This was not necessarily a failing in my eyes. However, I did wish that more therapists asked mindfulness-related questions during the open sessions. In my experience, it is always interesting and enlightening hearing and discussing such questions. These questions were relatively limited though compared to those related to DBT. The impression I have gained over the years is that many therapists feel they understand mindfulness, and have a “been there done that” type of attitude towards it. Dr Linehan obviously believed that even experienced therapists would benefit from concentrated and supported practice as this is the purpose of the retreats she offers.

Having attended similar retreats both in New Zealand and overseas, I can confidentially say that to practice and to gain in depth training in mindfulness it is not necessary to go to America, or to leave the country. We have several good teachers in New Zealand who come from the same broad background in meditation training as Dr Linehan. Marsha's aim for the event, which she repeated over and over, was that participants would take away what they learned at the retreat in terms of meditation practice and make use of it both in their personal and professional lives. She saw this as a way to enrich our lives and our work with others.

### References

- Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology Science and Practice*, 10, 144–56.
- Linehan, M. M. (2015). *DBT® skills training manual*, 2nd edition. New York: Guilford.

I wish to thank ACC, my employer at the time, for funding my attendance at this retreat as part of my ongoing professional development. I believe that their support demonstrates ACCs' commitment to informed practice with the aim of benefiting all New Zealanders.

## 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/>)

### TRAINING TIMETABLE

#### NZCCP Events

LOCATION	MONTH	PRESENTER/ CONTENT
Christchurch	1 July	Three Psychotherapies - Vive la Différence!
Christchurch	9 September	Martin Dorahy/ <a href="#">When mortification knocks: An exploration of shame and its relevance to distress and therapy</a>

#### Other Events

LOCATION	MONTH	PRESENTER/ CONTENT
Auckland	21 July	<a href="#">Practising Coaching Psychology</a>
Nelson	26-27 July	Alan Fruzzetti/ <a href="#">DBT with Families workshop</a>
Nelson	July/August/March 2017	Alan Fruzzetti/ <a href="#">DBT Intensive Training</a>
Auckland	8-9 August	Robyn Walsler/ <a href="#">ACT Masterclass</a>
Auckland	9-10 August	Dr Chris Wagner/ <a href="#">Motivational Interviewing Groups</a>
Auckland	23-26 August	<a href="#">TheMHS Conference 2016</a>
Christchurch	26-27 August	<a href="#">Australian and NZ Academy of Eating Disorders Annual Conference</a>
Auckland	15-16 September	Tony Attwood & Michelle Garnett/ <a href="#">Master Class: Children and Adolescents with ASD</a>
Auckland	17 September	Professor Tony Attwood/ <a href="#">Emotion Management with Children and Teens with ASD</a>
Wellington	31 October-1 November	<a href="#">AnzaCBT Annual Conference and Workshop</a>
Auckland	27-28 October	Trish Pumell-Webb/ <a href="#">Gottman Level 1 Clinical Training</a>
Auckland	3-5 November	Trish Pumell-Webb/ <a href="#">Gottman Level 2 Clinical Training</a>
Wellington	24-26 November	<a href="#">Psychosocial Oncology New Zealand 2016 conference</a>
Nelson	2-4 March 2017	<a href="#">Annual Scientific Meeting of the New Zealand Pain Society</a>

