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The Specialist Organisation for Clinical Psychologists

**E whā ngā tapa o te whare: ko te whānau, te wairua, te hinengaro
me te tinana**

***There are four sides of a house that represents four sides of social,
intellectual, spiritual, and physical selves***

Editorial

Dear Colleagues

I hope that you are all warm and well wherever you are. I am astonished that the year is moving by so quickly!

After 11 years of editing the journal, I think I am finally ready to hand ‘my baby’ to someone and would like to invite expressions of interest in the role of editor. Being part of the journal and watching it being transformed has been so much part of my development as a clinical psychologist, and it is hard to imagine not being involved. However, with my kids so young and private practice becoming increasingly busy, I feel it is time to hand over.

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

Wishing you the very best for the rest of 2019. We hope you enjoy this journal. Please let us know what you think,

With great warmth
Kumari & Nicole

Perceptions, Skills, and Knowledge of Sleep-Related Difficulties and Their Treatment in a Cancer Psychosocial Workforce

Bronwyn M. Sweeney & Lora J. Wu

Sleep is a basic human need under the influence of and influenced by mind and body processes. Optimal sleep is critical at times of increased load, such as during growth, illness, or healing. Sleep problems among patients with cancer are strongly associated with physical and psychological distress and reduced quality of life. Patients frequently report sleep concerns from the time of diagnosis into the survivorship period. Despite this, clinicians may not have access to the knowledge, skills, and resources needed to support optimal sleep in this group. A survey was conducted with a nationwide psychosocial cancer support service comprising psychologists and social workers (52% response rate). Most participants reported having received some education about normal sleep and sleep problems, and 68% felt competent to screen for sleep difficulties. Less than half of the participants reported feeling competent, skilled, or qualified to complete sleep assessment or treatment, and few used standardised measures for assessment or outcome tracking. Almost all participants endorsed the need for more sleep-related knowledge, skills, and resources, including continuing education and patient-focused resources. The development and provision of such resources could enhance workforce capacity and positively impact the distress of cancer sufferers beyond their immediate medical prognosis and treatment.

Introduction

Sleep problems in patients with cancer have been strongly associated with increased pain and emotional distress (Sharma et al., 2012), and diminished quality of life (Fleming, Gillespie, & Espie, 2010). Analysis of data from 1,205 outpatients with cancer collected using the National Comprehensive Cancer Network's (NCCN) Distress Thermometer ranked sleep among the top five risk factors associated with patient distress (VanHoose et al., 2015). Difficulty with sleep is frequently reported as a symptom of concern by patients with cancer. Estimates suggest at least one-third of active patients with cancer and 28% of cancer survivors report sleep problems (Sharma et al., 2012). Prevalence estimates for insomnia among women affected by breast cancer are higher, with up to 70% of women reporting difficulty falling asleep, staying asleep, and reduced sleep duration (Fiorentino & Ancoli-Israel, 2006). Sleep problems in this population often appear as part of a cluster of symptoms including pain, fatigue, and emotional distress (Fiorentino, Rissling, Liu, & Ancoli-Israel, 2011). While each symptom can be linked to cancer and its treatment, the symptoms are also linked in a negative feedback loop where one symptom exacerbates another. This means that each symptom domain is a potential intervention point.

Improving sleep in patients with cancer is likely to be of great benefit. Sleep duration has been associated with survivorship in patients with advanced cancer, with both very long and very short sleep associated with increased mortality (Collins et al., 2017). It has also been shown in animal studies that changes to the timing and quantity of sleep are linked to alterations in hormones regulating the immune system, and that suppression of immune activity is related to cancer tumour growth (De Lorenzo, de Oliveira Marchioro, Greco, & Suchecki, 2015). For example, exposure to light at night (when humans are biologically evolved to be sleeping) has downstream effects on the production of melatonin (suppressing this powerful anti-oxidant and influencer of sleep timing), with flow-on impediments to its role in repressing oestrogen

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synthesis among other processes. Since elevated levels of ovarian hormones are related to the incidence of breast cancer, this pathway has robust support as a mechanism contributing to an increased risk for breast cancer in shift-working nurses (Samuelsson, Bovbjerg, Roecklein, & Hall, 2018). At the same time, a growing body of research is considering how to harness the power of the body's clock or 'circadian' system to optimise the timing of treatments such as chemotherapy, with a goal of minimising treatment toxicity and maximising efficacy; an approach known as chronotherapy (Truong, Lam, Grandner, Sassoon, & Malhotra, 2016).

Well-established and scientifically-validated non-pharmacological interventions for insomnia have existed for decades, and are now strongly recommended as first-line treatment in both primary care and oncology settings (Johnson et al., 2016; Qaseem et al., 2016). Despite this, health professionals are unlikely to be trained in these approaches (Kathol & Arnedt, 2016), leaving patients with cancer with few options (other than hypnotic medication) to cope with sleep problems such as insomnia.

New Zealand has one of the highest per capita rates of cancer in the world, with over 23,000 new cases recorded in 2015 among a population of 4.6 million (Ministry of Health, 2017; Statistics NZ, 2015). Based on these statistics, New Zealand is ranked among the Organisation for Economic Co-operation and Development member countries (Melaku et al., 2018) for its age-standardised cancer incidence rate. However, in recent years, its age-standardised incidence rate places it second only after Australia (Bray et al., in press).

Diagnosis and treatment of cancer in New Zealand is provided under universal healthcare. In general, patients with cancer do not bear the direct financial burden of diagnosis and treatment. Most of these activities occur within the publicly funded setting, although some private services exist for those with premium insurance cover or who choose and can afford to pay out-of-pocket. A 2010 national review of care available to individuals affected by cancer identified gaps in the provision of supportive care, highlighting the need for psychological and social support (Ministry of Health, 2010). Following this review, the Ministry of Health established a psychosocial support service focused on adults with cancer who also have high or complex psychosocial needs, patients from communities where services may be difficult to access, and patients with a cancer diagnosis typically associated with fewer supports or higher levels of distress.

This study aimed to assess the level of knowledge and skills related to sleep difficulties in a cancer psychosocial workforce. From this, potential opportunities may be identified for education, skill enhancement, and resource development aimed at health professionals to improve current practice and patient experiences.

Methods

This study was evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by a university human ethics committee. Participation in the survey was voluntary and implied consent was given by proceeding past an information and consent page on electronic survey.

Participants

The Cancer Psychological and Social Support Initiative is a discrete sector of the New Zealand oncology workforce, employing social workers and psychologists. Sixty employees of this service were eligible to participate in this study. All 60 employees were sent an invitation to participate.

Measures

A 31-item online survey aimed at psychosocial support providers was developed for this study. Demographic information including gender, age range, and ethnicity (New Zealand Census question) was collected, as well as professional information such as field, experience, and workload. The questionnaire investigated providers' knowledge and beliefs about the role of sleep in their clients. Additional items focused on training and skills in screening, assessing, and treating sleep issues. Questions were generated based on current literature and guidelines about sleep difficulties in oncology populations, as well as the researchers' experience working with clients affected by sleep difficulties. The questionnaire was refined following feedback from the National Lead of the service and several healthcare professional test users. Question and response formats varied throughout the survey, and included: closed response items (e.g., "I have received formal education on normal sleep/assessment of sleep difficulties/treatment of sleep difficulties"; yes/no/not applicable); open response items (e.g., "When do you refer patients on for sleep issues?"); and multi-option items (e.g., "Have you used any of these standardised sleep related screening or assessment tools in the last year?"). For the listed measures, response options were yes/no/don't know/never heard of this. The listed measures included the NCCN Distress Thermometer (National Comprehensive Cancer Network, 2019), NCCN 3 question screen (Berger, Matthews, & Kenkel, 2017), Auckland Sleep Questionnaire (Arroll, Fernando III, Falloon, Warman, & Goodyear-Smith, 2011), Insomnia Severity Index (Morin, 1993), and the Pittsburgh Sleep Quality Index, (Buysse, Reynolds, Monk, Berman, & Kupfer, 1989).

Procedure

An email inviting participation in the survey was distributed to eligible participants by the national service leader. The email contained an internet link to the questionnaire, which was completed anonymously in Qualtrics. At the end of the questionnaire, participants were asked to supply an email address (through a separate linked questionnaire) if they wished to be included in: a) a draw for one of two NZD50 prize cards, and b) a database for future research. Reminder emails were sent at weekly intervals, with the final reminder advising a 2-week extension to the survey completion closing date. Data collection lasted 4 weeks, from 21 May to 18 June 2018.

Data Management and Analyses

Data were exported to SPSS for analysis. In total, 60 practitioners were exposed to the survey, of which 31 submitted completed surveys and two submitted partially completed surveys. Only completed surveys were included in analyses. Descriptive statistics were generated.

Results

Thirty-one participants (52%) completed the online survey. The majority of participants identified as female (84%; male 16%), and of New Zealand/European ethnicity (64.5%), with 20% identifying as Māori. The median age range was 35–44 years. More than half of the participants reported general clinical experience of ≥ 10 years, with 57% reporting their experience in the oncology setting as ≤ 3 years. Professional roles were predominately psychologists (55%) or social workers (45%), with several participants holding dual discipline status (e.g., social worker/counsellor). Half of the participants worked full-time (40 hours/week) and the minimum hours worked in this setting was 8 hours/week. Participants reported seeing 2–25 clients per week (mean = 9.3, standard deviation = 5.5).

All participants reported that they had contact with patients during early and ongoing treatment stages, and 90% had contact with patients around the time of diagnosis. Patients were less involved in the service during recovery or survivorship phases (39%). It was common in this

setting for patients to have whanau attend with them for face-to-face contact (77% sometimes, 16% often).

Patients in the service commonly reported sleep problems. Participants responded that almost all patients (97%) reported sleep difficulties, with half (52%) reporting these often. Participating health professionals screened for sleep difficulties regularly, with 68% doing so often. Fewer participants completed assessment of sleep difficulties, with 45% reporting they often did so. Patients were more likely to report fatigue often (77%), with participants reporting the perception that fatigue was most likely related to both sleep and cancer difficulties (52%) or cancer difficulties alone (45%), as opposed to solely due to sleep problems.

Knowledge/training

Most participants reported that they had received at least some formal education about normal sleep (61%), assessment of sleep problems (68%), and sleep treatment (65%). For most participants, this education was ≤ 4 hours in duration (range 2–30 hours, median 5.5 hours).

Skills

In general, participants felt competent, skilled, and qualified to screen for sleep difficulties (68%), with fewer reporting the same skill level in relation to assessment (48%) and treatment (42%) of sleep difficulties in this population. No participants reported that they maintained their sleep-related knowledge and practice skills through supervision or continuing education. Participants were asked how they went about screening for sleep difficulties. Most reported that this occurred through a general question or ad hoc discussion (90%). Some information was also derived from client self-report on a patient assessment form (32%), with the least common method being use of a standardised questionnaire or set of questions (13%). Most commonly, screening covered insomnia (71%), excessive daytime sleepiness (52%), and regularity of sleep patterns (42%). Other sleep disorders, including restless legs syndrome, were infrequently screened.

The majority of participants who undertook sleep assessments reported that they did this through a clinical interview (77%) or by taking a sleep history (42%). A few used standardised sleep-related measures such as the Insomnia Severity Index (Bastien, Vallières, & Morin, 2001), Epworth Sleepiness Scale (Johns, 1991), or the Pittsburgh Sleep Quality Index (Buysse et al., 1989); 26% reported using a sleep diary of varying duration (from 3 nights to 2 weeks). Use and awareness of standardised sleep- and fatigue-related measures are shown in Figure 1.

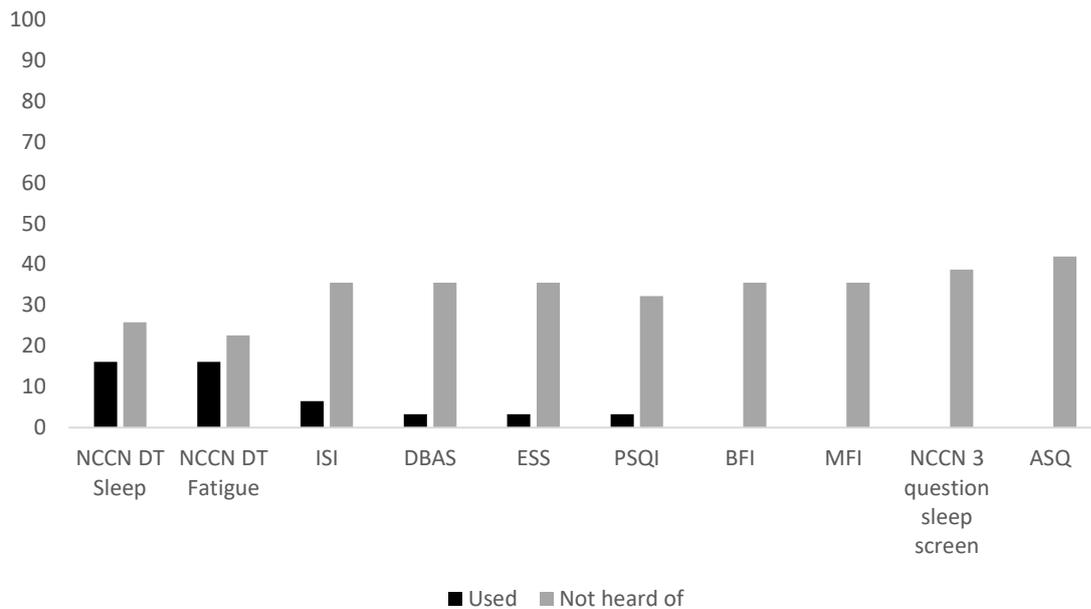


Figure 1. Percentage of participants who used or have not heard of specific sleep and fatigue screening and assessment tools.

NCCN DT: National Comprehensive Cancer Network Distress Thermometer; NCCN 3: 3 questionnaire screen from NCCN DT; DBAS: Dysfunctional Beliefs and Attitudes about Sleep Questionnaire; ESS: Epworth Sleepiness Scale; ISI: Insomnia Severity Index; PSQI: Pittsburgh Sleep Quality Index; ASQ: Auckland Sleep Questionnaire; NCCN DT Fatigue: fatigue screen from NCCN DT; BFI: Brief Fatigue Inventory; MFI: Multidimensional Fatigue Inventory.

Participants indicated which of a range of common sleep-related treatments and interventions they recommend or provided to patients, and which they felt comfortable to provide or give guidance on (Figure 2). For each approach endorsed, they were also asked to indicate what, if any, training they had received and whether this training was sufficient (Table 1).

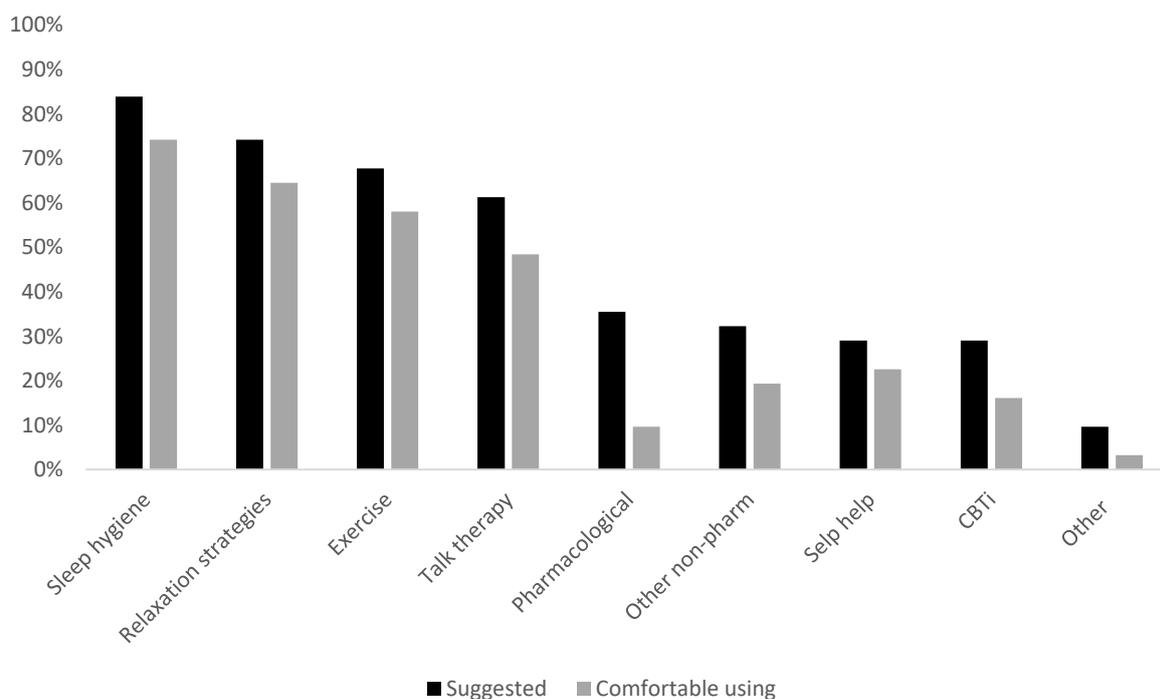


Figure 2. Percentage of respondents who suggested sleep-related treatment/interventions and those who felt comfortable to provide or give guidance on the suggested approaches.

Table 1. Number of Participants Reporting Training Received for Sleep Related Interventions or Treatments

	No formal training	Part of basic training	Self-trained course	Online	In-person training <1 day	In-person training ≥1 day	Supervised practice	Training was sufficient ^a
Sleep hygiene	4	13	12	1	5	6	4	82%
Relaxation	1	13	13	3	3	9	9	77%
Exercise	3	9	8	1	4	3	2	78%
Talk therapy ^b	3	9	5	2	1	10	8	75%
CBT-i ^c	1	1	3	1	3	3	3	71%
Self-help ^e	2	2	4	1	0	1	3	71%
Pharmacological ^f	1	3	1	0	2	1	1	38%
Non-pharmacological ^d	3	3	4	0	1	1	1	33%

Note: ^apercentage of participants who reported the training they received was sufficient; ^bfor example cognitive behavioural therapy, mindfulness-based stress reduction; ^ccognitive behavioural therapy for insomnia; ^dother non-pharmacological approaches, for example herbal or nutritional supplements; ^efor example books, online programs, mobile apps; ^fparticipants in this study were unlikely to be prescribers.

Of those who indicated they referred patients to specialist sleep services (42%), the most common referral reason was suspected obstructive sleep apnoea. Referrals were also made when there were long-standing sleep disorders, sleep did not improve despite trying strategies such as sleep hygiene, or when the sleep difficulties or support required were judged to be beyond the scope of the service. Approximately half of the participants indicated they referred patients to local sleep services, one indicated there was no such service in their area, and the remaining participants were unsure if there were local sleep services.

When asked about barriers to helping patients with sleep problems, the most common response was that patients' other clinical issues took precedence (52%), followed by insufficient experience to help patients who reported sleep difficulties (36%). Participants also selected time constraints (23%) and a lack of referral services as barriers to helping patients (16%). Only 10% selected cost as a barrier to helping patients with their sleep.

To determine the need for more sleep-related knowledge, skills, and resources, we asked participants if they thought they would benefit from provision of a range of offerings. These were: in-person training for health professionals (94% agreed, 61% strongly agreed); continuing education resources (94% agreed, 65% strongly agreed); patient-focused resources (97% agreed, 77% strongly agreed); screening tools (87% agreed, 65% strongly agreed); and assessment tools (90% agreed, 65% strongly agreed).

Discussion

In this study, members of a cancer psychosocial service workforce completed questionnaires about their knowledge and skills related to sleep difficulties for patients in that setting. Participants reported limited formal sleep education, consistent with healthcare training in New Zealand. The responses indicated that almost all patients reported sleep difficulties at some point during treatment; however, only two-thirds of participants felt sufficiently skilled to screen for sleep difficulties. Less than half of the participants reported confidence in completing a sleep assessment or providing treatment for sleep difficulties.

Participants most often referred patients for respiratory sleep disorders, such as sleep apnoea, which made sense given the clinical context. No government funding is provided for behavioural treatment of sleep disorders in New Zealand, and referral to a DHB sleep clinic for investigation of insomnia is unlikely to be accepted. Even if an individual presents with severe and/or chronic insomnia beyond the scope of the psychosocial service, there is nowhere to refer, as insomnia treatment is not provided for in public funds beyond pharmacological intervention. A 2011 economic analysis of insomnia treatment in New Zealand identified a lack of both a systematic treatment pathway and public funding to effectively treat insomnia; this situation remains unchanged (Scott, Scott, O'Keeffe, & Gander, 2011).

Previously, Sharma et al. (2012) observed that one-third of outpatient attendees with cancer reported problems with their sleep. In the same sample (2,862 outpatients), sleep problems were more prevalent among those who also reported higher levels of pain and emotional distress. Other studies have reported a mismatch between cancer healthcare providers' and patients' assessments of symptoms, with nurses and physicians underestimating the intensity of symptoms including pain, fatigue, and gastric and sleep disturbances (Laugsand et al., 2010). In the present sample, the perception of health practitioners surveyed was that almost all patients experienced sleep disturbance. This high estimation likely reflects the complex presentations of those attending the service, and may also be a function of social workers and psychologists in this setting having more time during consultations (compared with medical staff) to go beyond the most pressing clinical cancer-related symptoms, treatment plans, and side-effects.

Patients with cancer with insomnia commonly report onset around the time of diagnosis, with comorbid symptoms of fatigue and sleep difficulty intensified by active treatment; evidence indicates that these effects persist long after active treatment is finished (Fleming et al., 2010; Schieber et al., 2019; van Leeuwen et al., 2018). Our data suggested unmet needs in relation to sleep problems among patients with cancer because of other clinical problems taking precedence or health practitioners not feeling skilled to address sleep issues. Patients may be receptive to

supportive care for sleep before commencing treatment, which is a time when they are actively engaged in medical oversight and treatment (Zhou, Clark, Recklitis, Obenchain, & Loscalzo, 2018), and also a time when distress levels may be at their highest (Cuttillo et al., 2017).

Limitations of this research included canvassing the perceptions of health practitioners in a single government-funded clinical service. Further, this service was established relatively recently (2014), rolled out progressively across the nation, and is still evolving in terms of any standardisation of services and approach. Not included in this survey were oncology social workers, counsellors and psychologists working outside of the public health system, including in not-for-profit cancer-focused organisations. These organisations are more likely to work with individuals and families affected by cancer through all phases of the cancer pathway, including survivorship. They are also more likely to work with a wider range of presentations, not just individuals assessed as having complex needs in this setting. Data collected represent the perceptions and estimates of responders; the response rate was also low, resulting in a relatively small sample size. Our questionnaire was long and we relied on the goodwill of individuals to respond in an already busy context.

In contrast, this study was strengthened through the engagement of the National Lead for the service who supported the study and its aims, and facilitated face-to-face access to a meeting of Regional Leads, where one of the research team was able to explain the purpose and process of the study.

These results highlight needs for sleep support, knowledge, and skills in both patient and workforce populations. Our findings could be extended by eliciting the experiences of patients directly, as well as experiences of the wider oncology workforce including nurses, physicians, and support workers. A more pressing agenda may be the identification, development, implementation, and evaluation of specific resources to support these needs. Service users' voices should inform such work. Obtaining accurate data on the prevalence across the spectrum of sleep disorders in this population is also a gap in the current literature (Otte et al., 2015).

Conclusion

Our findings are consistent with extant literature on the experiences of patients with cancer with sleep difficulties. These findings give strength to the need for behavioural sleep support and training to be met in the oncology setting. The situation in New Zealand is not unique (Berger et al., 2017; Schieber et al., 2019; van Leeuwen et al., 2018). Sleep may be a modifiable factor in the pathway for patients with cancer. Behavioural approaches to sleep problems are not only likely to improve sleep in the short-term but also offer the individual strategies throughout treatment, recovery, and survivorship. Improvements in sleep and self-efficacy around sleep are also likely to positively impact other cancer-related distress. Psychologists, social workers, and counsellors in the oncology setting are in an ideal position to provide sleep interventions and support.

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Deconstructing Weight Stigma in Western Society and Clinical Practice

Dr Eve Hermansson-Webb

Weight stigma is pervasive in our collective culture, including in our therapy clinics. It can manifest in the physical environment, in the language we use, in the assumptions we make, and in the treatments we deliver. This paper details some of the barriers faced by individuals with larger bodies and how clinicians might acknowledge and address these at both the individual and wider societal levels.

Among the core competencies a clinical psychologist is required to demonstrate is an ‘understanding of the concepts of stigma, discrimination and social exclusion applied to diverse client groups, including the consequences of these factors on the practise of psychology’ (The New Zealand Psychologists Board, 2018, p.21). Individuals who are marginalised in our culture on the basis of their race, class, gender, sexuality, religion, disability, or mental health diagnosis should be able to trust that they will receive exemplary care from a clinician who will endeavour to be non-prejudicial and affirming in their stance. They should also be able to trust that their clinician is exploring through clinical supervision any implicit or explicit biases they may have that could interfere with treatment. One marginalised group against whom prejudice is widespread and relatively unchallenged within our culture—and for whom established and stereotyped narratives prevent the uptake of new scientific knowledge, including by clinicians—comprises individuals with higher body weights.

Terminology

With over half of the New Zealand population being categorised as ‘overweight’ or ‘obese’, it stands that some of our clients will be fat (Ministry of Health, 2017). The use of the word ‘fat’ is based on the recommendations of the National Association to Advance Fat Acceptance (NAAFA), who are committed to reappropriating this word as a neutral descriptor, similar to how we might describe someone as tall or brunette. A precedent for this can be seen in the reappropriation of the term ‘queer’. Various individuals have started to self-identify as fat,

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including fat activists. One would not, however, describe a client as fat unless they used this word themselves first, and made it clear that they were intending it non-pejoratively. Deep into treatment, a mutual decision between the client and the therapist may be made to use this word following a considered discussion of the political history of the word, after addressing any traumatic experiences the client has had involving fatphobic slurs, and only if the client believes they may find it liberating or empowering to do so. ‘Overweight’, ‘obese’, and ‘morbidly obese’ are medicalised terms that are not preferred by individuals with larger bodies (Lozano-Sufrategui, Sparkes, & McKenna, 2016). Furthermore, these labels can inadvertently result in negative psychological consequences (Essayli, Murakami, Wilson, & Latner, 2017). In this article, these terms will be presented with quotation marks, and used solely in reference to extant studies that have used these labels to preserve the original intent of the authors of such studies.

To validate the experiences of people who are fat in a respectful and informed way, clinicians need to have an understanding of weight stigma as it occurs in Western culture and the ways in which it can manifest in clinical practice. When supporting women in particular, it can also be helpful to have some knowledge of feminist theory and of cultural beauty standards, including the thin ideal. Note that weight stigma hurts people across the weight spectrum; however, this article specifically considers the experience of people with *objectively* larger bodies.

Locating the Author

As a clinician with a body type that is not subjected to societal stigma, I cannot profess to speak on behalf of individuals with larger bodies, but as an ally I am committed to adding my voice to theirs. Fatphobia—my own and that of others—contributed to my historical development of an eating disorder. This was an illness that perhaps could have been avoided or ameliorated if society were more tolerant of all bodies. In my field of specialism (eating disorder treatment) I am privileged to support various individuals with higher body weights. It saddens me to hear them speak with shame about their physical appearance, to hear them describe the punishments they have inflicted on themselves, and to detect the anti-fat attitudes they have internalised. In this article, I hope to share some of the knowledge I have attained from working in the field of eating disorders, where discussions about bodies are relatively commonplace, and I have read widely about body positivity, the fat acceptance movement, and weight inclusive treatment in an effort to better support my clients. Of course, not all people who are fat have eating disorders, and not all people with eating disorders are fat. Regardless, it is important for *all* clinicians to be educated about weight stigma, as with any other source of stigma, to avoid potential harm to clients.

Microaggressions

Ideally, we would treat all clients with dignity and respect, irrespective of personal features of their body or background. However, discrimination and stigma are so entrenched in our social system that we may unknowingly perpetuate unhelpful beliefs and stereotypes (Puhl & Brownell, 2012). Discrimination against people with larger bodies is so endemic that many of us are not aware of it. Microaggressions, or ‘verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership’ (Sue, 2010), occur on a daily basis. In general society, people with larger bodies may have the experience of being called pejorative names, being judged for the contents of their supermarket trolley, and of not seeing themselves represented in entertainment media unless as a joke or a stereotype. They may have family members impose food rules upon them, need to shop at specialist clothing stores, feel uncomfortable in spaces designed for smaller bodies, and have people make erroneous assumptions about their behaviours, intelligence, health, and character simply based on their external appearance. Problematically, these microaggressions do not stop outside the doctor’s or

therapist's door; in fact, there is greater potential for harm to occur as the professional is often a respected and qualified individual imbued with authority, but who may have no specialist training in the metabolic, nutritional, psychological, and socioeconomic determinants of body weight and who may simply be imparting their own opinions, formed in popular diet culture.

The clinic environment can prove unaccommodating; recommendations are that these environments should feature sturdy armless chairs or couches, adequate air conditioning, wide doors, spacious restrooms, and body positive publications (Davis-Coehlo, Waltz, & Davis-Coelho, 2000). However, just as unaccommodating may be the attitudes of the professionals themselves. In a study of primary care physicians, over half of the sample reported that they considered 'obese' patients to be awkward, unattractive, and noncompliant, and many endorsed beliefs that people with larger bodies are weak-willed, sloppy, and lazy (Foster et al., 2003). Doctors report less desire to help 'obese' patients, devote less time to their care, and are less empathic and warm towards them (Hebl & Xu, 2001; Gudzone, Beach, Roter, & Cooper, 2013).

The body mass index (BMI) scale, which is used by many health professionals, is not an accurate tool for assessing individual health, and there is evidence that its categories were arrived at arbitrarily; however, some physicians insist on weighing clients and using the results to make clinical decisions with little rationale (Buckingham, 2008; Tomiyama, Hunger, Nguyen-Cuu, & Wells, 2016). Individuals with higher body weights are more likely to receive unsolicited (and non-evidence-based, non-individualised) weight loss advice from doctors, dietitians, psychotherapists, family members, friends, and colleagues (Diversi, Hughes, & Burke, 2016; Kinavey, 2019; Mann, 2015). While physicians may argue that they have a duty to inform their patients of potential health concerns, the evidence indicates that weight stigmatisation does not elicit weight loss, but rather triggers physiological and behavioural responses that lead to weight *gain* (Tomiyama et al., 2018; Major et al. 2014). There is also the risk that genuine physical health concerns may be wrongly attributed to or overlooked because of a patient's weight, resulting in misdiagnosis and unnecessary suffering (Kolata, 2016).

Similar to physical health professionals, mental health professionals have also been found to judge higher-weight clients negatively (Agell & Rothblum, 1991; Young & Powell, 1985). One study showed that clients' weight can negatively affect psychologists' diagnostic considerations and proposed treatment goals (Davis-Coehlo, Waltz, & Davis-Coehlo, 2000). In eating disorder treatment, professionals with anti-fat bias are more likely to attribute weight to behavioural causes, express negative attitudes about treating 'obese' clients, and perceive poorer treatment outcomes for these clients (Puhl, Latner, King, & Luedicke, 2014). For clients with higher body weights, therapists are more likely to assume that their weight is relevant to their presenting psychopathology (Schafer, 2014). One example is a woman who attended counselling to discuss her grief over the death of a family member, only to have the counsellor say, 'when are we going to talk about how you use food to cope with your feelings?' This was reportedly inaccurate and invalidating, and the client never returned for further sessions (M.S., personal communication, October 13, 2018).

Weight need not be discussed with every client who walks through the door. In fact, it is not advisable to raise the subject unless the client themselves initiates and directs the conversation and conveys that it is relevant to their presentation for treatment (Akoury, Schafer, & Warren, 2019). It is inappropriate for a therapist to recommend weight loss. So then, what do we do if the client *does* raise the subject and states that the reason they have presented for therapy is for help to lose weight?

Therapy for Weight Loss?

Some may suggest this poses an ethical dilemma. However, from another perspective, the ethics are clear. It is categorically *unethical* to target weight loss in treatment given the dearth of evidence supporting the long-term effectiveness of dieting for weight loss, and the significant evidence that shows dieting leads to weight cycling and associated negative health consequences, plus increased risk for developing a clinical eating disorder; issues that may pose greater risk to a person's health and mortality than higher body weight (Bacon, 2008; Golden, Schneider, & Wood, 2016). Various reviews suggest that weight loss leads to weight gain (Ayyad & Andersen, 2000; Mann et al. 2007), while others suggest a modest weight loss of 3%–6% of one's body weight is all that may be sustainable long-term (Franz et al., 2007). The Australian Medical Health & Research Council has found A-grade evidence to support the statement:

Weight loss following lifestyle intervention is maximal at 6–12 months. Regardless of the degree of initial weight loss, most weight is regained within a 2-year period and by 5 years the majority of people are at their pre-intervention weight. (National Health & Medical Research Council, 2013, p. 161)

It is a widely-held assumption that body size and weight is a result of individual control, and therein lies stigma. The inability to lose weight and keep it off is not simply attributable to psychological factors such as willpower and self-control; critical factors that are often ignored are physiology and social inequality; factors that are out of one's individual conscious control. In terms of physiology, there is evidence that several genes determine adult weight and also contribute to weight gain, such that our 'obesogenic' environment affects some individuals more than others (Bacon, 2008; Dubois et al., 2012). Another factor is the body's response to weight loss efforts: slowed metabolism, preoccupation with food, physical fatigue, and intense hunger. In a fascinating study conducted using ex-contestants of the reality television show *The Biggest Loser*, Fothergill and colleagues (2016) found that weight loss resulted in enduring suppression of the subjects' metabolic rates, such that weight regain was inevitable. A study published in the *American Journal of Public Health* found that women with a BMI of 30–35 kg/m² had a 0.8% chance of reaching a BMI under 25 kg/m², while women with a BMI over 40 kg/m² had a 0.15% chance. Men with a BMI of 30–35 kg/m² had a 0.48% chance, and men with a BMI over 40 kg/m² had a 0.08% chance (Fildes et al., 2015).

Recommendations focused on supporting people to engage in health-enhancing behaviours, such as increasing enjoyable physical activity, learning to prepare more home cooked meals, or diversifying their nutritional intake are advised; taking into account that there will be barriers to achieving these targets that we may not initially perceive because of our social privilege. Engagement in health-enhancing behaviours has demonstrated benefits for physical and mental health regardless of whether there is a resultant change in weight (Bacon, 2008). Instead of recommending weight loss to improve clients' self-esteem, a focus on self-acceptance, self-advocacy, and personal values would be more useful and effective. As Hawkes and Gast (2000) stated, 'body size may be less important for holistic health than activity level, diet composition, social ties, spiritual wellbeing or emotional health' (p. 25).

If a client wants to lose weight and comes to a psychologist for help, it is important to validate the person's desire to lose weight given the current social climate, ask what they are hoping to achieve through weight loss, discuss the literature, and consider other ways the client could achieve their goals. If a client's relationship with food is clearly disordered (based on their self-report of their behaviours, not on assumptions), structured eating using a meal plan may be beneficial, but only so long as this plan is not restrictive, as any form of restriction will risk initiating the body's weight regulatory systems. Psychoeducation about this subject is one of the most important components early on in any eating disorder treatment (see Box 1).

Box 1. The body's weight regulatory system

Our bodies each have a genetically determined weight range wherein they function optimally. This is called our 'set point' weight. If you restrict your food intake, your body will initially draw from its own energy stores, leading to weight loss below the set point. However, once your body realises that this famine is likely to endure, it activates various mechanisms to try and restore weight, including: feeling tired so you are less likely to burn energy, becoming preoccupied with food, slowed metabolism, amenorrhoea, and vulnerability to binge eating. The more intensely one diets, the harder the body works to restore to the set point, and over time, this can ultimately lead to weight gain rather than weight loss.

Note that binge eating is one of the ways that your body tries to recover weight and make up for restriction; however, it is often undermined by subsequent compensatory behaviours such as further restriction, exercise, or self-induced vomiting. To avoid an endless fight against our biology, we need to learn to accept our set point weight and respond to our bodies' physiological and psychological needs.

Information adapted from the Department of Health, Western Australia, 2018.

Acknowledging Privilege

While there are many things that the therapist can keep private about themselves, body weight and shape is not one of them. Transference dynamics regarding weight can emerge upon the first face-to-face meeting between the client and the therapist (or even earlier if the client has looked up an image of the therapist online). No matter where the therapist's weight falls on the spectrum, there is the potential for judgments and assumptions to be made by the client that could interfere with the therapeutic relationship and with treatment.

As a clinician with a genetically slender build working in eating disorder treatment, there are times when it is important for me to acknowledge my 'thin privilege' in the therapy room so that the client and I can openly discuss if and how this impacts on treatment. When the client is in a body with less societal privilege, a discussion of the clinician's privilege and of the advantages unfairly afforded to some bodies over others in our society can allow for greater self- and other-bidirectional awareness within the therapy relationship. Furthermore, this discussion of 'thin privilege' can help to communicate that the clinician does not ascribe to society's idealisation of thin bodies, even if their own body type is one that is idealised. Although I have often felt uncomfortable raising this topic, clients have so far responded appreciatively and it has led to useful discussions that seem to enhance rather than undermine the therapeutic alliance. It is important to convey to clients that all bodies are acceptable bodies, and that weight does not determine worth; ours or theirs.

Social change

As clinical psychologists, we have both a platform and a responsibility to incite change that addresses social inequalities. This can occur at a macro level (e.g., by conducting research, educating the public, urging for policy change) or at a micro level in our individual one-to-one communications, not only with clients but in every relationship. Routine conversations about such topics as diets, exercise, summer bodies, 'feeling fat', pregnancy weight anxieties, or guilt over having a second slice of cake may seem relatively benign, but in actuality they perpetuate a focus on bodies and the notion that there is a social hierarchy of physical weight, with thin

bodies being idealised. The moralising language we use around food, bodies, and behaviour can also be stigmatising; for example, ‘good’ and ‘bad’ food, ‘clean’ food, ‘healthy’ and ‘unhealthy’ food/behaviour/weight, ‘lazy’, ‘greedy’, and ‘naughty’. While it may sound pedantic to monitor our language, letting go of judgments around food and bodies may help us be less condemning of ourselves and others, and reduce the occurrence of clinical and sub-clinical eating disorders and unwarranted guilt and shame.

At a macro level, there is a significant change that many others in the field of eating disorder treatment would like to see. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM; American Psychiatric Association, 2013), despite having undergone some improvements between the fourth and fifth editions, continues to require that individuals meeting the criteria for a diagnosis of anorexia nervosa have a significantly low body weight. In clinics internationally there is an increasing trend of people with higher body weights being referred for restrictive eating behaviours and experiencing medical instability at these higher weights. Many of them may have come from a higher body weight and lost a significant percentage of weight, but as they do not appear physically emaciated they are diagnosed with having atypical anorexia nervosa (AAN), a subtype of other specified food or eating disorder (previously known as eating disorder not otherwise specified). However, ‘atypical’ anorexia is a misnomer, given the condition indicated has been found to have a lifetime prevalence by age 20 years among 2.8% of females, compared with 0.8% with [standard] anorexia nervosa (Stice, Marti, & Rohde, 2013).

Medical instability and malnutrition in AAN can be just as severe as for anorexia nervosa (Peebles et al., 2010; Sawyer et al., 2016). Unfortunately, eating disorders among people with higher body weights are often misdiagnosed and treatment can be delayed (Conason, 2018); a serious issue given that we know the longer the illness goes untreated the poorer the prognosis (Gumz et al., 2014). Individuals themselves may not consider themselves to be ‘sick enough’ for treatment, as they do not match the common stereotype of restrictive eating disorders and may have even been advised to lose weight ‘to improve their health’ in the past. Problematically, medical and mental health professionals risk colluding with the idea that the client is not sick enough, or that pursuing weight loss is desirable. It is imperative that we look beyond body weight when diagnosing eating disorders (no other mental health problem requires a physical indicator), and the hope is that future editions of the DSM may facilitate this by excising the weight criterion.

Health at Every Size® (HAES)

Fortunately, a set of established principles exists to help guide practice in a manner that is inclusive and respectful of body diversity (see Box 2). HAES (trademarked by the Association for Size Diversity and Health; ASDAH) is a weight inclusive approach that champions the following values: weight inclusivity, holistic health enhancement, respectful care, eating for wellbeing, and life-enhancing movement (ASDAH, 2019). ASDAH (2019) described the HAES approach as shifting the focus away from weight and towards ‘acknowledging and respecting an individual’s circumstances, and work[ing] to investigate and support options that are available to him or her to help make choices that benefit his/her health and well-being’, regardless of body size. The HAES approach has been found to be effective in improving various physical health indicators for individuals, and also mental health symptomatology (Bacon & Aphramor, 2011; Bacon, Stern, Van Loan, & Keim, 2005; Bacon et al., 2002).

Box 2. The Health At Every Size® principles

- **Weight Inclusivity:** Accept and respect the inherent diversity of body shapes and sizes and reject the idealizing or pathologising of specific weights.
- **Health Enhancement:** Support health policies that improve and equalise access to information and services, and personal practices that improve human wellbeing, including attention to individual physical, economic, social, spiritual, emotional, and other needs.
- **Respectful Care:** Acknowledge our biases, and work to end weight discrimination, weight stigma, and weight bias. Provide information and services from an understanding that socioeconomic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.
- **Eating for Wellbeing:** Promote flexible, individualised eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control.
- **Life-Enhancing Movement:** Support physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement, to the degree that they choose.

Association for Size Diversity and Health (2019)

Further, based on the literature and clinical experience, I have offered some key assumptions that can serve as guidelines for treatment when undertaking work with individuals with larger bodies (see Box 3).

Box 3. Key assumptions to guide practice

- 1) All humans and all bodies have innate worth.
- 2) Body weight is not a reflection of behaviours, personal choices or character traits, but rather of complex biopsychosocial factors.
- 3) The presence or absence of health-enhancing behaviours is a product of reinforcement and punishment contingencies; more barriers = less accessible reinforcement and therefore less likelihood of behaviour emerging.
- 4) Clinical psychologists have a social responsibility to speak out against weight stigma and adopt a weight inclusive approach to treatment. There are ethical issues associated with offering 'weight loss' treatment.
- 5) Disordered eating behaviours can occur in any person of any body weight. This includes the presence of anorexic behaviours (and risk of medical instability) in individuals with higher body weights.
- 6) Not all bodies can lose weight in a manner that is healthy or sustainable, but all people have the potential to learn to accept their bodies and to work with rather than against their biology, given the right tools.

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Conclusion

The topic of weight/size inclusivity is multifaceted and cannot be adequately detailed in one article. Subtopics that warrant attention include: the body positivity movement, intersectionality, the ethics of surgery for weight loss, and ‘healthism’, and the social determinants of health. This paper is an introduction and a prompt for further reading. Recommended texts include: *Health at Every Size* (2008) by Linda Bacon; *Secrets from the Eating Lab* (2015) by Traci Mann; and *Body Respect* (2014) by Linda Bacon and Lucy Aphramor. Some therapists may feel uneasy incorporating this knowledge into practice; note that it seems evident that clients appreciate the ‘bravery of...therapists who [are] willing (however imperfectly) to frankly discuss issues related to weight, fatness, and weight-based discrimination’ (Harrop, 2019). As divulged to me in the preparation of this paper: ‘One of the most compassionate helpful things a therapist did for me was [to] acknowledge the pain and discrimination I had faced in a larger body’ (B.N., personal communication, April 23, 2019). ‘My therapist told me that I did not have to hate my fat body. At the time [that] was very different from anything I had ever heard about my body’ (E.O., personal communication, April 29, 2019).

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Experiences of Countertransference When Working With Children and Families

Danielle Hay, Claire Cartwright, & Kerry Gibson

The term countertransference most commonly refers to therapists' cognitive-affective reactions to clients in therapy contexts. Research has revealed that countertransference in individual therapy with adults is associated with increased negative therapy outcomes, whereas understanding and managing countertransference can enhance therapy outcomes. Despite the importance of countertransference, there has been almost no research on countertransference experiences when working with children and families. The present exploratory study was an online study conducted with psychologists and trainee psychologists working with children and families in New Zealand. Twelve psychologists and 10 trainee psychologists participated in the study, and provided descriptions of countertransference reactions in child and family work. A thematic analysis of the data revealed four main types of countertransference reactions. These included feeling protective towards child/ren and critical of parent/s; feeling helpless or frustrated with challenging families; feeling worried or afraid for a client or the self; and positive reactions. In making sense of their experiences, participants sometimes reflected that their countertransference reactions were connected to their own family-of-origin experiences. The results of this study suggest that countertransference is relevant for psychologists working with children and families in New Zealand and an important area of focus for skill development in trainees.

Experiences of Countertransference (CT) When Working With Children and Families

CT is most commonly used to refer to the therapist's cognitive-affective reactions to clients in therapy. A meta-analysis suggested that CT negatively impacts the therapeutic relationship and therapy outcomes, whereas understanding and managing CT can enhance outcomes (Hayes, Gelso, & Hummel, 2011). Research also suggests that experiences of CT are common among therapists from different therapeutic approaches, including experienced therapists and those who do not believe in CT (e.g., Betan, Heim, Zittel-Conklin, & Westen, 2005). This paper presents the results of an exploratory study that examines the relevance of the concept of CT for psychologists and trainee psychologists working with children and families in New Zealand.

The concept of CT was first introduced by Freud, and has developed mainly within psychodynamic paradigms and adult psychotherapy theory and practice. Initially, Freud viewed CT as a potential impediment to therapy. This perspective was dominant until the 1950s, when several psychotherapists began writing about the potential benefits of therapists attending to their total emotional responses to clients (e.g., Heimann, 1950; Winnicott, 1947). Winnicott also introduced the notion of different aspects of CT, which he labelled objective and subjective. Objective CT, as it is currently understood, refers to the CT reactions of the therapist that are evoked by clients' challenging behaviours or ways of relating; subjective CT reactions emanate from the unresolved issues of the therapist (e.g., Shafranske & Falender, 2008; Cartwright, 2011).

Although there is increasing evidence of the impact of CT on therapy processes (Hayes et al., 2011), there is little or no research into psychologists' CT in child and family therapy (Friedlander, Escudero, & Heatherington, 2006; Gehlert, Pinke, & Segal, 2014). Hayes et al.'s (2011) meta-analysis of CT research did not include any research with children and families. Despite this, some psychodynamic family therapists (e.g., Gehlert et al., 2014) argued that CT has special significance in working with children and families because of the increased points of CT

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activation relative to individual therapy. Others (e.g., Nichols, 2013) suggested that CT in child and family therapy may be more complex and challenging because of the multiple relationships and alliances that need to be maintained in an environment that can be characterised by conflict and vulnerability (Rober, 2010). CT may also be more impactful in child and family therapy where the family drama is played out in vivo, in contrast to individual therapy where the client reports on family experiences (Nichols, 2013).

In contrast to the lack of attention on therapists' CT, Bochner (2000), a psychodynamic family therapist, argued that therapists' emotional reactions (CT) in family therapy are inevitable and that CT can be used either intentionally or acted upon unintentionally. He argued that emotions aroused in the therapist when working with a troubled family can offer insight into the 'shared current of feeling' among family members (p. 10). In this way, the therapist's emotional reactions (CT) and use of self are vital tools in family therapy, as the therapist's CT is representative of the therapist's part in the system.

In adult psychotherapy, as discussed previously, some therapists emphasised the importance of considering objective and subjective CT (Cartwright, 2011; Shafranske & Falender, 2008). Gehlert et al. (2014) proposed a theoretical model of CT in child and family therapy. According to this model, 'activating' (or objective) CT arises when a therapist reacts to an aspect of the client family and is drawn into the family's dysfunctional interactional patterns. This aspect of CT can provide information or understanding about the family's experience in therapy. In contrast, 'interfering' (or subjective) CT arises when a therapist is triggered by an experience in therapy that is reminiscent of personal or family-of-origin issues. Family-of-origin issues can lead to an over-identification with one or more family members. Hence, it is important that therapists working with children and families are aware of their own personal sensitivities and unresolved issues that may lead to CT behaviours.

Managing CT

As yet, little is known about the ways in which therapists manage their CT reactions in either adult or child and family therapy. There is some evidence that awareness of CT and the ability to conceptualise CT may enhance its management (Latts & Gelso, 1995). Five therapist qualities thought to promote CT management that are characteristic of reputedly expert therapists have also been defined and researched (Gelso & Hayes, 2007; Hayes, Gelso, Van Wagoner, & Diemer, 1991). These are self-insight, self-integration, empathy, anxiety management, and conceptualising ability.

Although there is acknowledgement of the personal challenges that therapists face when working in child and family therapy, no research has focused on understanding therapists' CT responses in this therapy work. The present exploratory study examined the experiences of CT for psychologists and trainee clinical psychologists working in child and family therapy in Aotearoa New Zealand. This may be important as historically, there has been a lack of emphasis on understanding and managing CT in clinical psychology training (Cartwright, 2011). However, more recently, a national study of CT training offered to clinical psychology students suggested positive benefits of such training (Cartwright, Barber, Cowie, & Thompson, 2018).

This study aimed to gain insight into the CT experiences of psychologists and trainee psychologists (referred to as therapists) working with children and families in New Zealand, and examine the strategies they used to manage their CT reactions. The research questions guiding the study were:

1. To what extent do therapists experience CT when working with children and families?
2. What types of CT reactions do therapists experience?

3. What strategies do therapists use to manage their CT?

Methods

Participants

Following ethics approval from the University of Auckland Human Participants Research Committee, an advertisement with a link to the online study was sent to members and student members of the NZCCP via its email lists. Twenty-two participants participated in this study; 12 clinical psychologists and 10 trainee clinical psychologists. The age of participants ranged from 24–66 years and 72% were female. The psychologists' professional experience ranged from 4–45 years ($M=15$ years) and their experience in child and family therapy ranged from 2–35 years ($M=13$ years). Trainee clinical psychologists had, on average, worked with eight children, adolescents, and/or their families.

Measures

An online questionnaire was developed using Qualtrics. The questionnaire provided a general definition of CT as: 'Psychologists and therapists talk about countertransference. They are referring to the emotional responses that therapists and trainees have towards their clients. Countertransference includes feelings and also thoughts (for example, thoughts about the client, the therapy and about yourself as therapist). Countertransference reactions can also influence how we behave'. Participants were asked to write one or two written report(s) of a CT reaction experienced recently during a child and family therapy session. They were asked to describe what was happening in therapy, the CT they experienced, and any behaviours in which they engaged. They were also asked to write about their understanding of their CT reaction, how they managed it, and how they generally manage CT. They were asked to rate how often they experienced CT in their child and family work on a scale of 1 (not at all) to 5 (very often).

Data Analysis

Sixteen participants provided one CT description and six provided two, resulting in 28 reports in total. Participants' responses added up to 9,524 words, but varied in length from 137–757 words ($M_{\text{words}}=433$). Qualitative data were analysed using thematic analysis as described by Braun and Clarke (2006) to identify, analyse, and report patterns (themes) within the data. The data related to types of CT reactions were examined independently by the first two authors and coded according to the content and meaning of individual phrases or sentences. Initial codes were thereby generated for the types of CT responses described by participants. Data on the types of triggering situations, behavioural responses, and participants' reflections were also coded. When the initial coding was completed, the codes were examined and initial themes related to CT types were proposed and agreed on. The next stage involved the same method of thematic analysis of the data relating to strategies for managing CT. The third author then reviewed the thematic analyses, and confirmed that the themes were a valid representation of the data. The results of the thematic analyses are presented below. Quotes from participants are used for illustration.

Results

All participants reported experiencing CT in child and family therapy, and the majority (59%) said they experienced it often. The results from the thematic analyses of the qualitative data and the rating scales are presented below.

Types of CT

Four main themes emerged from the process of thematic analysis regarding the types of CT participants reported (Table 1).

Table 1.
Four Types of Countertransference

Types of countertransference	<i>n</i>
1 Feeling empathetic or protective of the child/adolescent and critical of the parent/s	11
2 Feeling frustrated or helpless with challenging clients/therapy situations	10
3 Feeling worried or afraid for client or self	3
4 Positive countertransference	4

Feeling empathetic or protective of the child/adolescent and critical of the parent/s. In this theme, participants described feelings of anger or frustration and judgmental or critical thoughts towards parent/s in the family. Conversely they felt empathic and often protective towards the child/ren. In some cases, therapists reported the urge to protect the child/adolescent. This was the most common theme for trainees, who provided six of the reports.

One participant who worked with an adolescent and his parents perceived that the son's 'identified illness' had developed because the son 'was meeting the mother's emotional needs' and this had led to 'triangulation against the father'. The participant wrote that they felt angry at the mother for her lack of understanding of the impact of her behaviour and felt like they 'had to protect the son from the mother'. The participant also felt pressured at times by the mother to take a parental role with the son. The participant reflected that they tried to contain these feelings and remain empathic in the session. However, they reported that:

At times there was a power struggle between me and the mother. Then other times I was expected to take all the power in the family. I went straight to anger and frustration because I felt undermined. (P.13)

Another participant described working with a boy with behavioural problems and his parents who had a conflictual relationship. The participant described feelings of anger towards the parents and sadness for the boy.

The boy was unlikely to change his behaviour because the parents were too fixated on blaming each other and not willing to be challenged on that. I felt angry that the parents were screwing up this boy's life. (P.5)

On reflection, that participant commented that as a result of this CT, they had avoided contacting the parents, which resulted in sessions occurring less often than they should have. Similarly, another participant described working with a family with conflictual relationships, particularly between the mother and adolescent daughter. The participant described feeling angry and having critical thoughts about the mother whom they perceived had been 'parenting with a style that induced guilt'. The participant identified with the daughter and struggled to empathise with the mother. Afterwards, they realised that this response had negatively impacted on the therapeutic relationship with the mother and wrote,

In the intervention, I spoke more as an advocate for the [adolescent] than as a neutral therapist. ... I did not handle the mother well – turned out she was very angry with me after the session. (P.17)

On reflection, the participant was aware that this mother reminded them of their own mother, who was 'the dominant parental figure in my upbringing' and commented that, 'it was a short step from the client to my mother'. Some other responses from participants in this theme also linked their CT reactions in part to family-of-origin issues. For example, a therapist who had grown up in a stepfamily was involved as an observer with a stepfamily in therapy, and strongly

identified with the children and felt anger/blame towards the stepfather. Participants' comments under this theme suggested that their CT was triggered by witnessing parents engaging in behaviours that were detrimental to the child/adolescent. This appeared to evoke empathy and a desire to protect the child/adolescent and a critical response to the parent/s. Some thought that the therapeutic situation also triggered family-of-origin issues for them.

Feeling frustrated or helpless with challenging clients/therapy situations. Ten CT reports, seven of which were provided by psychologists, described reactions characterised by feelings of frustration, irritation, or helplessness and also dissatisfaction with the therapeutic situation. Some also described self-doubt. These reactions appeared to be triggered by therapeutic situations where the children/adolescents and/or parents were perceived to be behaving in ways that were confrontational, destructive, or disengaged, and where progress was slow or had come to a halt.

Several participants described working with family members who exhibited behaviour they perceived as very challenging. For example, one participant described an adolescent who was engaging in a 'grandiose and demeaning style of interaction' and insulting his parents and the therapist. The participant perceived that the adolescent was 'baiting' and wrote, 'I was irritated and desired to put him in his place' (P.11). However, the participant reported trying to maintain composure to let the adolescent's feelings surface.

Another participant described working with an adolescent who was uncommunicative and hostile. The participant described feelings of anger towards the client and doubted their competency, 'I lack the skills...I need to work harder (even though I know that is almost always counter-productive)' (P.12). The participant reported recognising their own vulnerability to 'fall into old patterns of self-attack', and resisted the urge to work harder. They wrote,

I like to succeed and to be liked and well thought of...I am better at this now and recognise the traps and circumnavigate them more competently than in earlier days. (P.12)

Another participant described a situation where they drew a skateboard metaphor with a family in session and they laughed at the drawing. The situation triggered childhood feelings of rejection for the participant who described feeling sad, inadequate, and frustrated, with thoughts of 'I'm not cool' (P.19). The participant described continuing with the metaphor, and through a sense of insecurity, engaged in the laughter, which they believed 'kept the session at a superficial level'; however, on reflection they wondered if the clients themselves also 'felt uncool' (P.19).

In this theme, participants' feelings were triggered by difficulties maintaining the therapeutic alliance and moving forward in therapy. Some participants internalised this, experiencing feelings of inadequacy. Some described the urge to react and intervene in ways that would have been problematic to the therapy.

Feeling worried or afraid of clients or worried for them. Three CT reports, two of which were provided by psychologists, described participants' worry or fear. Participants described being triggered by situations they perceived to be threatening or intimidating, or when they felt worried about the client's disapproval or anger. As an example, one participant described working with the parents of a toddler who presented with anxiety and behavioural difficulties. The mother, who was also anxious, was worried that she had caused her son's problems. The participant described sensing the mother's defensiveness when asking standard questions. This in turn led them to feeling anxious and wanting to avoid asking these questions. Their thoughts included, 'She's going to think that I think she did cause her son's difficulties. She might not come back and I'm going to make her anxiety worse'. On reflection, the participant wrote,

I realised the anxiety I was feeling was a reflection of the anxiety the mother was feeling and the underlying fears she had, which we were later able to discuss—at the time it felt like there was a big elephant in the room and we were all trying to avoid it and it felt awkward and uncomfortable. (P.4)

Another participant described working with a family in which the father was verbally aggressive and disruptive. The participant described feeling intimidated, undermined, and afraid of the father. During the session, the participant reported wanting to withdraw but resisted this urge.

I was wanting to leave the room and I was thinking he might do something and I don't trust him not to be unpredictable. I felt strong dislike towards him. (P.15)

Participants in this group described feelings of fear regarding their own sense of safety or the safety within the therapeutic system. This appeared to be triggered by the client's anger or fear of the client's reaction. These participants described an urge to avoid or withdraw although they did not do this.

Positive CT. Four CT reports, half from psychologists and half from trainees, described positive CT towards the client family or child/adolescent. These participants described feeling compassionate, affectionate, or strong identification with the client/s. These feelings seemed to be triggered in situations where there were strong, collaborative therapeutic relationships and participants felt mutual affirmation, rewarded by the connection and identification. Three of the reports described therapeutic situations where the participant was working alone with a child/adolescent.

One participant described working with an adolescent with whom they identified. The participant described good rapport and being 'struck by' their similarities. They wrote, 'I felt like I was down in my child-self at the same age, and felt my own memories rushing back'. This elicited 'feelings of fondness' and the participant felt 'very close and connected' to the adolescent. The participant reflected later that these feelings strengthened rapport but also recognised the potentially negative impact of the positive CT as they assumed similarities that 'clouded the assessment' and prevented me from drawing out the adolescent's experiences' (P.14).

Managing CT

Participants were asked to write about how they managed the feelings they had described in the CT reports. All participants responded to this question. Most responses were brief and some described a number of strategies. An overview of these is presented below along with illustrative quotes and listed in Table 2.

Table 2.

Managing Countertransference

Themes	<i>n</i>
Identifying my reaction	11
Calming or centring myself	20
Using CT as a source of understanding	10
Strengthening the therapeutic relationship	7
Reflections and supervision	11

The first theme, *Identify my reaction*, included comments about recognising, noting, being aware of, and acknowledging the CT reaction. As one participant who described a CT reaction related to childhood issues said, 'I noticed my feelings, tuned into the thoughts that went with them, observed these, and recognised my child-self speaking'. The second theme, *Calming or centring myself*, referred to participants' attempts to manage their emotional states and to calm down. Strategies included pausing, taking breaths, 'trying to let go' of difficult feelings, consciously attempting to move into a more balanced emotional state, and presenting a 'calm demeanour'.

The third theme, *Using CT as a source of understanding*, related to participants' attempts to take a 'curious' stance towards their emotional responses, and focus on understanding the clients' experiences or perspectives as well. One participant described their approach, using both a calming and then a refocusing approach.

I imagined myself as a warm rock and refocused my attention on the child/parents to review their mental and emotional states and worked at understanding their behaviour. (P.16)

In the fourth theme, *Strengthening the therapeutic relationship*, some of participants talked about using their CT or their understanding of it as a basis for their responses back to the family. This included sharing their feelings, such as 'sadness' for them, if this seemed 'appropriate'; demonstrating empathy for them; and showing a strong interest in their perspectives.

Finally, in the fifth theme, *Reflections and supervision*, participants talked about reflecting on their reactions after the session and talking about this and the family with colleagues, and importantly, in supervision. Sometimes this led to new formulations. As one psychologist who identified with and had strong empathic responses to the children in a family said, 'I later noted my reflections about the possible dilemmas facing the children to my supervisor and we used this to formulate some of the underlying and unspoken dilemmas that the family may be facing'.

Discussion

All participating psychologists and trainees reported experiencing CT. The most common CT reaction reported was feeling critical or judgmental towards the parent/s and empathic or protective towards the child/adolescent. These reactions have been observed previously and represent what family therapists describe as a loss of neutrality (Minuchin & Fishman, 1982), over-identification with the child (Friedlander et al., 2006), and in some cases an urge to rescue (Carr, 1989). As Flaskas (2005) noted, immediate resonances and identifications with some family members and not others are common in therapy with children and families. Some family therapists suggest it is easier to empathise with children/adolescents than with parent/s, particularly if therapists are dealing with their own family-of-origin issues, or are not parents themselves (e.g., Heatherington, Friedlander, & Diamond, 2014). Consistent with these reports, the majority of trainee clinical psychologists in this study reported this type of CT.

Other CT reactions included feelings of frustration or helplessness triggered by challenging behaviours of family member/s and also associated with therapy that was viewed as stuck or stagnating. Some psychologists and trainees also reported feelings of worry, fear, or concerns for safety, which tended to be triggered by threatening or intimidating therapeutic situations, or perceptions that the therapeutic relationship was at risk. Friedlander et al. (2006) suggested that these types of CT, such as feeling frustrated or feeling threatened, may be a cue to the therapist to attend to family members' experiences. Therapists can also consider if these reactions fit with what is referred to as objective (Shafranske & Falender, 2008) or activating CT (Gehlert et al., 2014), in which the therapist's feelings of frustration or fear reflect the family or family members'

experiences of frustration or lack of safety within the family or the therapy situation. In this way, the CT reaction can be seen as a potential source of information about the family's experience, as argued by Bochner (2000). Consistent with this perspective, several participants perceived, on reflection, that their feelings may have mirrored their clients' feelings and some described being able to use this knowledge to better engage with their clients.

Although therapists in this study appeared to be aware of their CT reactions and the potential problems of acting on these reactions, only a small number actually described engaging in CT behaviours. This may reflect discomfort in sharing such material, or perhaps therapists and trainees are less likely to engage in CT behaviours when they are aware of their CT, as reported previously (Latts & Gelso, 1995). Some participants also reflected on what Gehlert et al. (2014) referred to as interfering CT that arises when a therapist is triggered by an experience in family therapy that is reminiscent of personal or family-of-origin issues. This included: identifying with children who were observed to be experiencing similar family dynamics to those experienced by the therapist in childhood; having negative feelings towards parents that appear to share similar characteristics to one's own parent; and wanting to be liked by clients and feeling anxious about the possibility of clients' criticising or rejecting them.

Little is known about the strategies therapists use to manage CT (Hayes et al., 2011). However, most psychologists and trainees in this study reported attempting to manage their CT. Strategies included being aware of their CT reactions, attempting to stay calm, thinking about what the CT meant, and reflecting on CT later or in supervision. Psychologists and trainees appeared to be aware of the importance of not acting on their CT. For example, those who found themselves identifying with the child appeared to engage in what Flaskas (2005) referred to as empathic balancing. These all appeared to be constructive strategies and were consistent with research that suggests therapists being aware of CT and understanding their CT reaction may be helpful in managing CT (Latts & Gelso, 1995; Cartwright et al., 2018).

Limitations

This small-scale exploratory study had several limitations. First, the number of participants was small. This sample cannot be seen as representative of psychologists and trainee psychologists generally. It is also possible that those who participated were relatively more interested in CT and had a greater awareness of their own CT than non-participants. Participants may also have reported on experiences of CT that were successfully managed. Additionally, the reports were sometimes quite brief. This is a limitation of an online study as opposed to an interview study, which could probe for more in-depth understanding. Finally, the study included both experienced psychologists and trainees. It is possible that trainees' experiences differed somewhat from those of more experienced therapists. Despite these limitations, several common themes emerged across the data, and the study is useful as an initial exploratory study given the lack of empirical research in this area.

Conclusions

Overall, this study suggests that psychologists and trainees working with children and families in New Zealand experience a range of CT reactions and employ a number of strategies to manage these responses. However, at times, they struggle to understand, manage, and make use of their CT. The results of this study suggest that specific training in understanding and managing CT in work with children and families is important.

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Opinion: How Relationships Affect Your Health

Karen Faisandier

'Supportive relationships protect health. But some have a more powerful effect on health than others. These are our attachment relationships.'

Hunter & Maunder (2015). Love, fear and health.

Supportive relationships protect health, but some relationships have a more powerful effect on health than others. These are called our *attachment relationships*, and we experience the first of these with our parents/caregivers, then our close peers, romantic partners, and significant mentors or health professionals (Cassidy & Shaver, 2016). Survival favours caregivers being close by to care for their children until they become independent. Our species (and other mammals) needed a system that ensures the first few years of life go according to plan—a reliable way of staying close to the caregivers who keep you safe and alive (Maunder & Hunter, 2016). Enter the attachment system.

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Attachment serves the evolutionary goal of helping offspring survive, and enables individuals of any age who feel threatened to re-establish physical and emotional security through contact and comfort (Maunder & Hunter, 2016). There are four attachment styles found in the literature, including secure attachment and three insecure attachment templates: preoccupied, dismissing, and disorganised (Cassidy & Shaver, 2016). Our default template occurs through our repeated relationship experiences, which although are most significant in infancy and childhood, can also be altered by relationships across the lifespan (Sroufe, 2005). We naturally develop adaptive strategies to cope with inconsistent, unavailable, or abusive attachment relationships. To summarise the attachment styles in a nutshell, secure attachment is characterised by these nice experiences:

1. Feeling worthy of care and love
2. Being (generally) trusting of others to care for us
3. Gaining mentalising skills (i.e., imagining the mental/emotional perspective of others, which is related to empathy skills)
4. Gaining the ability to self-soothe when in distress or pain
5. Forming the ability to delay gratification.

In contrast, insecure attachment is characterised by some less easy experiences, such as:

- Reduced self-regulation of stress/emotions
- Difficulty seeking effective social support
- Amplifying and/or minimising techniques (see below)
- Effects on the gut-brain-axis and a less calm autonomic nervous system ('jumpy' vagus nerve, over or under-activated hypothalamic pituitary adrenal (HPA) axis, and effects on the gut such as dysbiosis/intestinal permeability/impaired digestion and absorption).

Preoccupied Attachment (Amplification)

- Relationships have been inconsistent or mis-attuned
- Connection has been unreliable/vulnerable
- Protective mechanisms are to amplify behaviour that seeks closeness (e.g., seeking approval/reassurance and to heighten distress signals)
- May struggle with anxiety and distress and with calming down
- Heightened protest at separation from loved ones
- May seek health provider support at increased rates

Dismissing Attachment (Minimisation)

- Relationships have been unavailable/rejecting
- Connection has been unavailable/disconnected
- Protective mechanisms are to become independent (i.e., 'I don't need others')
- Tend to deny closeness needs, avoid relationships (to avoid rejection/hurt), under-report symptoms/distress
- May seek external forms of avoiding feelings/self-soothing (sex, alcohol, food, gambling, work)
- Avoid healthcare providers when unwell, compulsive independence

There is a further insecure pattern (disorganised) that fluctuates between preoccupied and dismissing behaviours, which is generally associated with relationships that have been abusive or dangerous but this won't be focused on here.

Whichever way it develops, your attachment system is a complex 'meta-system' (Maunder & Hunter, 2016). This implicates multiple physiological systems, hormones, and neurotransmitters

when it is activated, ranging from oxytocin and vasopressin (bonding and commitment hormones), adrenalin and cortisol (stress and threat hormones), and those implicated in reward (dopamine and endogenous opiates; endorphins), relaxation (GABA), and contentment (serotonin) (Mauder & Hunter, 2016). Illness, pain, separation, loss, and distress all activate this meta-system, and trigger default attachment behaviour - whichever template you developed (Mauder & Hunter, 2016).

In the literature, insecure attachment is associated with diabetes, cardiovascular issues, inflammatory diseases, medically unexplained symptoms, psychological concerns, and can drive chronic stress. Chronic stress is associated with raised inflammatory cytokines (Interleukin IL-1 and IL-6, and tumour necrosis factor) and less anti-inflammatory cytokines that terminate the inflammatory response. This relates to the cytokine theory of mental health concerns, whereby a combination of chronic psychological, dietary, lifestyle, and interpersonal stressors contribute to an inflammatory response and mental health symptoms like anxiety or depression (Dean, & Keshavan, 2017; Greenblatt & Brogan, 2016).

Long-term exposure to stress can also result in desensitised glucocorticoid receptors to cortisol (cortisol resistance), chronic low-grade inflammation with a reduced immune response, and changes to brain-derived neurotrophic factor, which aids brain growth and plasticity, insulin sensitivity, and parasympathetic/relaxation system tone (Cirulli, 2014; Greenblatt & Brogan, 2016). Long-term exposure to stress can also churn through vital nutrients needed for optimal functioning, and can adversely impact on the gut lining via impaired digestion/stomach acid production, contributing to gut permeability (Greenblatt & Brogan, 2016). This places the individual at risk for nutritional deficiencies that further worsen the original insults and cause more symptoms, as the physical foundations are compromised. In addition, when chronically stressed, we are more likely to use health detracting behaviour to numb, avoid, or change how we feel (e.g., alcohol, smoking, caffeine, poor nutritional choices, avoiding meaningful social connection) and reduce our health helping behaviours, like getting quality sleep, nutritious food, and movement (Hunter & Mauder, 2016).

There are various interesting studies looking at attachment and immune functioning that I find fascinating. Chronic social stress has been found to impair vaccine responses, delay wound healing speed, and dysregulate cellular immunity (Mauder & Hunter, 2016). Epstein-Barr virus (glandular fever) latency has been found to be higher in those with preoccupied attachment (but not dismissing attachment) (Fagundes, 2014). Those with preoccupied attachment had delayed or impaired recovery from glandular fever compared with those with other attachment styles (Fagundes, 2014). Gut microbiota disruption during critical developmental windows has also been found to occur, with effects on the modulation of the immune system and changes in hormones and neurotrophins (proteins that determine neuronal outcomes) (Greenblatt & Brogan, 2016). There are also epigenetic changes found. For example, some genes relating to health outcomes seem to be “socially sensitive” and may switch on or off depending on social experiences (Brown et al., 2019). Those with preoccupied attachment experience significantly greater number of physical symptoms compared to other patients (Ciechanowski, Walker, Katon, & Russo, 2002). This makes sense. With preoccupied attachment the HPA axis is jumpy (feel more stressed/anxious), vagal tone is poor (it's harder to calm down), and the gut is impacted by chronic relational stress and all the things going on above. Over time immune functioning can be impaired causing further health issues, especially chronic types such as autoimmunity (Mauder & Hunter, 2016).

Those with chronic health issues or chronic symptoms without a diagnosis, or with hard to understand conditions, often get classed as ‘psychosomatic’ by nature (e.g., chronic fatigue syndrome, fibromyalgia, chronic pelvic pain, irritable bowel syndrome, non-cardiac chest pain, tension headache, multiple chemical sensitivities, autoimmune conditions, chronic anxiety/depression, and cases entitled ‘forme frusta’ or below threshold for diagnosis). The label ‘psychosomatic’ inappropriately emphasises psychological factors and attributions in the cause of these difficulties (i.e., ‘It’s all in your head’). People experiencing such health symptoms have usually had repeated invalidation by health professionals who have not found a cause (and others in their life who struggle to understand their experience), and this can cause epistemic distrust that the medical profession or others will not adequately believe or care about them (Mauder & Hunter, 2016). These people are not ‘difficult to treat’, but can be difficult to reach because of this repeated invalidation (whether intentional or not) when help seeking (Mauder & Hunter, 2015). As well as this, they often experience trauma from their body, with symptoms that seem often frightening and out of their control. This kind of diagnosis also reinforces insecure attachment. In my opinion and experience, these individuals are the most in need integrative approaches of physical health/nutrition/gut health and attachment and stress work.

The Good News

According to Mauder and Hunter (2015; 2016), when illness or injury activates the attachment system through distress and vulnerability, relationally appropriate responses by health professionals can be healing, with the following benefits seen.

- Responsive attuned care = corrective attachment experience
- Offsets the stress response (can reduce cortisol)
- Promotes healing (can reduce inflammation)
- Reduction in anxiety and distress
- Maximises treatment adherence
- Is correlated with patient satisfaction
- Improves health outcomes

Healthcare providers have a powerful intervention available to them at any moment in their relational responsiveness to their clients/patients. We have probably all had an experience of going along to talk to someone about our health concern and being not felt heard, understood, believed, or cared about. Yet, one study found that the duration of the common cold was reduced by one whole day, simply by the doctor providing an empathic response to their patient (Rakel et al., 2009)! If this had been a new medication, it would be all over the news. In practice, relational responsiveness includes building rapport; being predictable, attentive, and supportive. To be soothing of distress and anxiety through facial expressions, voice tone, and body language. To listen compassionately, believe the experience, and to focus on distress rather than content (initially). Consider the full spectrum of gut-brain axis solutions that can help from body-work practitioners; for example, yoga/mindfulness/relaxation, nutrition, and talk therapy alongside traditional psychological and medical interventions.

Dualistic models in health just do not work. We are not just a mind or a body, or even a mind-body, we are a *mind-body-other*. We are not a gut or a brain, or a gut-brain, but a *gut-brain-other*. As we focus more and more on nutrition and gut health, lifestyle and stress, and epigenetics, let us not forget that these aspects of a human are always in the context of their relationships, especially their attachment relationships—and do not forget that if you are a health provider you may be one of these.

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NZCCP Travel Grant Report: Bringing Evidenced-Based Yoga to Trauma Therapy: Trauma Centred Trauma-Sensitive Yoga

Jane Thurlow

Intention

I have written this piece to introduce an adjunctive evidence-based intervention for complex trauma, childhood trauma and treatment resistant-chronic post-traumatic stress disorder (PTSD) to the New Zealand clinical psychology community. Many of us have heard about, and use, prolonged exposure or eye movement desensitization and reprocessing to support our clients on their path to overcoming trauma. We have all likely heard of, and use, the three-stage model of treatment for complex trauma (Herman, 2015). However, it is likely that not many have heard about yoga based adjunctive treatment: Trauma Center Trauma-Sensitive Yoga (TCT-SY). Below, I invite you along on my journey of discovering TCT-SY and completing the 300-hour certificate training. I will summarise the underpinning theory of TCT-SY, the practice, and provide an initial overview of the evidence base. This is not a general piece discussing the benefits of yoga or meditation for mental health, but is specific to TCT-SY as an adjunctive evidence-based psychological intervention.

Disclaimer: This is not an exhaustive description of TCT-SY practice or every aspect of the theory or process of facilitating the practice with a client. Only after you have undertaken formal training can you incorporate this practice into your therapy or yoga.

My Journey towards Trauma Center Trauma-Sensitive Yoga (TCT-SY)

I commenced my own yoga journey during my clinical training. My motivation to start yoga was a focus on the potential physical benefits, and the hope that one day I could do the splits (a childhood dream). What I quickly noticed, and what has kept me practicing ever since, was the psychological and wellbeing benefits that outweighed the flexibility and strength I gained. I

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began to experience greater mental clarity and concentration, reduced mental traffic, and enhanced equanimity. Yoga at its heart is a moving meditation and as a result, many of the benefits can mirror regular meditation/mindfulness practice. Yoga is a comprehensive system of practice that involves postures (asana), breathing (pranayama), and meditation/concentration (dhyana/dharana). There is now a large body of research supporting the significant benefits yoga can bring, including arousal regulation. Yoga has also been shown to be helpful for those with depression, anxiety, schizophrenia, chronic pain, and other physical illness including arthritis (Meyer et al., 2012, as cited in Clark et al., 2014). For me, the sense of wellbeing and stress reduction I gained from just a single practice a week was immensely beneficial during my clinical training. So, each week I went to yoga.

I qualified as a clinical psychologist in 2010, and promptly moved to Australia and then London, where I practiced as a clinical psychologist in adult mental health and continued to build my yoga practice. On my travels home to New Zealand in 2014, I detoured through India to complete my initial 200-hour yoga teacher training. I wanted a deeper appreciation of yoga philosophy and greater confidence in my personal practice. Undertaking my training provided me with both of these aspects, alongside the ability to offer yoga to my community.

In 2017, I became part of a mental health pilot offered in New Zealand prisons. I began working 5 days a week inside the wire. I was confronted by what felt like a bottomless pit of human suffering and childhood trauma. Even through the suffering, what quickly became evident was the men's and women's eagerness to tell me that they liked yoga and found it beneficial. This offered me a nice pathway to combine the use of evidenced-based psychological therapy with yoga in service of my clients' aims. I had believed for some time that facilitating mindfulness and breath practice via yoga forms could be a beneficial way for some people to connect more readily with their body and the regulating quality of breath. However, I also believe in the importance of offering evidence-based interventions to facilitate therapeutic goals. Just because my clients and I like yoga and had noted our own empirical benefits, it did not qualify it as a mental health intervention. I felt I required evidence, alongside intentionality, for the use of yoga in the therapy room.

Serendipity: Stumbling Across Trauma Sensitive Yoga (TSY)

Fortunately, in this moment of seeking some Western evidence to inform my use of Eastern yoga, I came across Kirsten Pringle. Kirsten is the Founder and Director of the Mindful Movement Center and the Victorian Director of TCT-SY in Australia. Kirsten was coming to New Zealand to offer a 20-hour, 2.5 day foundation workshop in TSY. The goal of the workshop for health professionals was to bring the body into the therapy room through the use of some of the TCT-SY principles and exercises, with the overarching intention of being trauma informed (Sensitive Yoga Workshop Slides, 2017).

TSY is based on three theoretical underpinnings: trauma theory, neuroscience, and attachment theory. Part of the trauma theory that informs TSY is an understanding of the impact of socio-political and cultural movements that have played a significant role in the evolution of trauma theory and intervention. The inclusion of attachment theory is based on the knowledge that when we discuss complex or developmental trauma, and at times post-traumatic stress disorder (PTSD), we are talking about relationships. Hence the need to appreciate the role of attachment for health and wellbeing, as well as for traumatic adaption to prolonged interpersonal violation.

Besides understanding the neuroscience underpinning trauma response, the main neuroscientific process on which TSY and TCT-SY is predicated is interoception. 'Interoception has [...] come to refer to a multimodal integration not restricted to any sensory channel, not restricted to mere sensations, but also relying on learned associations, memories, and emotions and integrating

these in the total experience which is the subjective representation of the body state' (Ceunen, Vlaeyen, & Diest, 2016, p. 13). Interoception informs one's ability to feel the physical body in contact with one's external and internal world. For those who have experienced significant trauma, their ability to interocept effectively can become severely undermined, often in favour of the adaption to exterocept. To support survivors to reclaim their interoceptive abilities, TSY offers the invitation to notice sensations in one's body. For example, if someone is engaging in shoulder rolls, the cue 'you may notice some sensation in the tops of your shoulders' could be offered. The level of forms, number of choices, nature of invitational language, and number of interoceptive cues are titrated to match the individual's tolerance, as with any psychological intervention.

The practice of ahimsa (non-violence) is also a cornerstone in TSY that arises from yoga, and is fundamental to the trauma principle of non-coercion. This has informed the use of invitational language in TSY, rather than the traditional commands offered in yoga. Ahimsa also speaks to honouring the person's own journey; as such, TSY practitioners are referred to as facilitators rather than teachers. Therefore, invitational language is used to offer yoga forms that survivors can choose to engage with or not. TSY aims to be a fully inclusive practice, with all people welcome. Some individuals may believe that their body limits their ability to engage. A chair option is always offered in TSY, and finding forms with which anyone can engage is central to the practice.

This initial TSY training provided me with an understanding and appreciation of how yoga can be adapted for those who have experienced trauma. For anyone interested in bringing yoga more formally into their therapy, this training is a great starting point. Both yoga teachers and therapists can attend the training. You do not have to be a yoga instructor to incorporate TSY in the therapy room.

TCT-SY 300-Hour Certificate Programme

For me, TSY was a step towards undertaking the 300-hour, 7-month certificate programme in TCT-SY, which I have now completed. The TCT-SY training is substantially more in-depth than TSY and the TCT-SY practice is the evidenced-based version of the yoga. As part of the certificate programme, we had to submit fortnightly reflection pieces on the theory/core principles of the practice based on assigned readings and weekly webinars. In addition, we had to submit several video recordings of us offering the practice, and specifically gaining competence in the difference aspects and titration of the practice. A final 5,000 word essay was also completed, focusing on expanding beyond to course content to explore an aspect of theory or practice. I wrote my paper on connecting with a compassionate motivation to enhance self-care and trauma stewardship for TCT-SY facilitators that in turn could support practice fidelity.

The brief history of the development of TSY and refinement to TCT-SY is that in 2002, David Emerson walked into Dr Bessel van der Kolk's office at the Trauma Center in the USA Justice Resource Institute with the hope to offer yoga at the Center and commence research. Over the next several years, with many other collaborators (namely Jenn Turner), TCT-SY was practiced, researched, and refined to what it is today. TCT-SY, as a full protocol, has qualified as an evidenced-based adjunctive treatment that was listed on the Substance Abuse and Mental Health Services Administration–National Register of Evidence-based Programmes and Practices (SAMHSA-NREPP, 2016) for traumatic stress, PTSD, complex trauma, or other related behavioural and emotional conditions. It is important to note that in 2018, SAMHSA suspended the NREPP format and are currently reviewing their processes for reporting evidence-based programmes and practices to the public.

If you are a trained yoga instructor and undertake the certificate training you can offer hour-long TCT-SY yoga classes. If you are a therapist or health professional with no yoga qualifications, you are able to offer up to 20 minutes of TCT-SY practice within a normal therapy session. Scope of practice and competencies are outlined in the certificate programme and ongoing professional development and supervision is required to maintain good standing as a TCT-SY facilitator. David Emerson is now the head of the Center for Trauma and Embodiment at the Justice Resource Institute, where TCT-SY is the lead programme.

Key Reflections From my TCT-SY Certificate Journey

As part of orienting to the 300-hour course, certificate students are asked to read Judith Herman's book *Trauma and Recovery* (2015). I found Judith's book to be a powerful grounding in the politics, social movements, and evolution of our understanding of trauma and intervention. I would highly recommend this book to anyone who is working with survivors. A quote from Judith around which David centres his ethos and repeatedly grounded us in was 'no intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest' (p. 205). From this statement arise the five core principles of TCT-SY.

The five core principles of TCT-SY are: 1) interoception or present moment experience, noticing arising physical sensations; 2) invitational language rather than the traditional commands found in yoga; 3) non-coercion arising from ahimsa (non-violence); 4) shared authentic experience; and 5) choice making. Ultimately, our role as a TCT-SY facilitator is to provide a safe place people can enter, and when they are ready they can choose to begin the process of reconnecting to their body in ways that feel right for them. The individual is at all times in full control to begin making choices about how they would like to be.

It is known now that when people experience trauma, especially prolonged and relational trauma, the ability to interocept, feel one's own body, can become compromised (Emerson, 2015). Once this element of human awareness is compromised, our sense of safety, self, and assuredly in the world alongside our agency becomes compromised (Emerson, 2015). It is also important to understand that when a survivor is triggered or asked to discuss traumatic events there is reduced activation in Broca's area. This can literally hinder the person's ability to effectively articulate their experience. Providing a body-based effective trauma intervention that bypasses Broca's area while enhancing interoceptive ability can be very supportive of survivors' recovery. The combination of being unable to accurately experience one's body in the present moment and having reduced ability to articulate one's experience can in itself be profoundly distressing and isolating for people. This often renders a person's own body a traumatic trigger. As a result, our fundamental ability to regulate our emotions, actions, and self is diminished, as is our ability to make fully informed choices and discernments regarding safety (Rhodes, 2015). TCT-SY was intentionally designed to provide survivors opportunity to feel their body at their discretion, offering purely invitational language that allows a space for survivors to begin to move with intention and without coercion. An individual can begin to discover that they can reclaim their body as a refuge, rather than it being a reminder of trauma. This begins to allow true re-embodiment to take place, or for some their first experience of safe embodiment.

There are three levels of dosage in TCT-SY that relate to reclaiming one's body. The first is the ability to simply notice one's body; this is done by offering the cue of 'notice' and simple two option choices of action. The second is befriending one's body; this is done by changing the invitational language from the simple cue of 'notice' to other words such as 'curious', 'if you are interested', or 'explore', while providing an increase in choices. The third is reclaiming one's body as a resource (self regulation) helping individual's notice that when they do things with their

body this can change their interoceptive experience (Sensitive Yoga Workshop Slides, 2017). The intention here is to begin supporting survivors to be able to live in the present moment, without feeling or behaving in line with irrelevant response demands belonging to the past (Dr van der Kolk, as recorded in Sensitive Yoga Workshop Slides, 2017).

At first as I commenced the course, the use of invitational language felt clunky and uncomfortable, especially as a trained yoga teacher fluent in the use of commands. For example, instead of offering the command ‘take your left leg in front, moving your back foot to a forty-five-degree angle’, you would offer the invitation ‘when you are ready, you could step one of your legs forward’. Throughout the course, the profound difference and reason for offering invitation became obvious from a trauma theory perspective, the fundamental element of trauma is coercion or the removal of choice, and from my own experience of the practice. Another explicit aspect of TCT-SY that differs from traditional yoga is that no one is ever offered hands-on assist. For those who have practiced yoga, you may have had the experience of the teacher providing you with adjustments to your asana. For some of us, this can be an enjoyed and desired part of a class. For others, including those who have experienced trauma, this can be incredibly fraught. In the development of TCT-SY, hands on assists were initially used and viewed as a positive aspect that yoga could offer towards healing. However, the feedback offered by participants was that hands-on assists were experienced as coercive; indicating to the person they were doing something wrong and effectively removing their choice or any invitation. It was also reported to disrupt the person’s interoceptive experience by replacing it with exteroception, and trigger shame based self-concepts (i.e., am I not good enough to be adjusted, do you not want to touch me).

From undertaking the TCT-SY certificate I learned and absorbed so much information related to trauma, attachment, neuroscience, yoga, and social justice. Of these aspects, opening up to a much boarder idea of social justice and oppression was most important to my personal and professional growth. Learning that oppression itself can lead to trauma (Treleaven, 2018) was eye-opening and allowed me to view my clients’ struggles through an added lens. I am at the beginning of my journey in developing a greater understanding of oppression and intersectionality, but I now believe that understanding oppression is central to trauma sensitive and culturally responsive practice. Another central aspect of TCT-SY is self-care; as such, the book *The Trauma Stewardship* (Van Dernoot Lipsky & Burk, 2009) was assigned as core reading. From reading this text I began to appreciate how oppression within the New Zealand context, and for myself within a prison, collided with my own and my clients’ wellness or subsequent experience of a trauma exposure response. The true meaning of self-care, especially the reality of personal responsibility, within services defined by service rationing and oppressive power structures was made stark. As with Judith Herman’s book, I recommend *The Trauma Stewardship*.

Overall, I highly recommend the certificate training to anyone who is interested in expanding their tool kit for helping clients presenting with trauma symptomatology. But be forewarned, it is a significant commitment of your time and money, but well worth it.

TCT-SY: Brief Overview of the Evidence Base to Date

David started bringing yoga to the Trauma Center in 2002. From 2003–2006, two pilot studies were undertaken, which led the Center to gain a National Institute of Health grant. The subsequent research undertaken with the funding was published in 2014. Various research articles examining TCT-SY have now been published. Below, I summarise some of these, but it is not an extensive review.

As a baseline comparison to reflect on when considering the following evidence base for TCT-SY, lets briefly consider this statement regarding the state of PTSD interventions made during TCT-SY's early invention: 'The Institute of Medicine found that the [...] available scientific evidence for the treatment for PTSD does not reach the level of certainty that would be desired for such a common and serious condition' (Zayfert et al., 2005, as cited in van der Kolk et al., 2014 p. 1). In addition, following a large clinical trial of prolonged exposure, 59% of participants still had PTSD symptoms after 12 weeks of intervention, and 78% were still symptomatic at the 6 month follow up (Michelson et al., 1998). Therefore, the ongoing exploration and research of good interventions for those suffering from trauma is paramount, with TCT-SY being one such intervention. A required aspect of effective PTSD treatment is an individual's ability to remain present while managing powerful emotions and impulsive reactions that arise in response to traumatic reminders; this then supports the process of deconditioning the autonomic reaction to trauma stimuli (Rhodes, Spinazzola, & van der Kolk, 2016). TCT-SY supports people's ability to remain present and has shown positive outcomes for survivors, as discussed below.

A feasibility study was undertaken in 2014 (Clark et al., 2016) with women who were attending group psychotherapy for intimate partner violence. Seventeen women were attending group psychotherapy and were experiencing varying levels of depression, anxiety and PTSD. TCT-SY was offered as an adjunctive treatment that occurred alongside group therapy for eight of the 17 women. The results indicated that the yoga intervention was feasible in the setting and was well accepted by participants, with a 25% drop-out rate (lower than that for group therapy alone).

As a result of the positive outcome from the feasibility study, a randomised control trial was then conducted by van der Kolk et al. (2014). That study examined the efficacy of TCT-SY to increase affect tolerance and reduce PTSD symptomatology. Sixty-four women with chronic, treatment resistant PTSD were randomly assigned to TCT-SY (1 hour a week for 10 weeks) or supportive women's health education. The results showed that 16 of the 31 women assigned to the yoga intervention no longer met criteria for PTSD compared with six of the 29 who completed the control protocol. Both groups showed statistically significant reductions in PTSD symptomatology, with the yoga group showing a larger effect size. The yoga group maintained their gains over time, while the control group unfortunately experienced relapse following the initial improvement. The effect size for the yoga was comparable with well-researched psychotherapeutic and psychopharmacological approaches. The women in the yoga group also showed greater decreases in symptoms of depression, dissociation, and the use of negative tension-reducing behaviour (i.e., self harm). Seven women in the control condition elected to enrol in TCT-SY classes following study completion.

In 2016, a long term follow up study (Rhodes, Spinazzola & van der Kolk) was undertaken with the participants from the above study. The follow-up period was 18 months, with 49 of the original 60 participants taking part. The follow-up study looked at the hypothesis that frequency of yoga practice following the initial 10 weeks would significantly influence long-term outcomes. It was found that following the initial 10 weeks of yoga, 39 women continued independent yoga practice. Interestingly, this reduced the study's ability to distinguish initial benefit from the original study and the benefits the women obtained from continued practice. Overall, while the original group assignment was not significantly associated with long-term outcomes, greater frequency of yoga practice following the study was significantly associated with loss of PTSD diagnosis and reduced depression severity. It was also noted that depressive and PTSD symptoms improved, but dissociation and engagement in tension reducing activities did not change. The overall conclusion was that having an adjunctive yoga practice alongside traditional psychotherapeutic intervention was beneficial for survivors of prolonged interpersonal violence.

However, all in all, more research with larger sample sizes and the addressing of limitations was required.

In 2015, Rhodes conducted a randomised control trial to understand experience of practicing TCT-SY (1 hour a week over 10 weeks) among 39 women who were identified as having complex trauma. In that study, the core element of healing identified by the women through the practice of yoga was *reclaiming of peaceful embodiment*. This was defined as an ‘ongoing process occurring on a continuum whereby women experienced improved connections with and sense of ownership and control over their bodies, emotions and thoughts, and a greater sense of well-being, calmness, and wholeness in their bodies and minds’ (p. 247). What this meant for the women was that they no longer felt defined by their trauma. They were able to maintain a sense of self-efficacy alongside present moment experience without being drawn into their past. Aspects that were described as supporting the process of peaceful embodiment were a new, present-oriented, positive embodied experience, interoceptive exposure, desensitisation, taking effective action, and yoga as a tool to cope with stress and trauma triggers. New capacities identified by the women following yoga included practicing pause and grounded response, hope initiating change, priority and capacity for self-care, and capacity for emotional and physical intimacy. Aspects of the practice that the women identified as supporting their journey to embodiment were the gentle approach, sense of safeness with the teacher, and regular practice. That study noted that what the women described through their yoga journey was more than symptom reduction, and actually mirrored a post-traumatic growth process.

A small-scale, non-randomised treatment feasibility study was undertaken in 2017 by Price et al. with nine participants to examine if greater length of intervention, specifically 20 weeks, of TCT-SY would show greater benefit than the 10-week protocol. The main finding was that greater practice, including additional home practice, led to greater improvement in PTSD and dissociative symptomatology than in the 10-week course. It was found that 83% of survivors no longer met criteria for PTSD 1 week post intervention compared with 52% in the 10-week course. The overall sample showed a 51% reduction in PTSD symptoms compared with 33%. At the 2-month follow-up, 64% of women showed a reduction in PTSD, suggesting ongoing reduction post conclusion of the core component of the study. This finding was reported as being consistent with other studies of yoga that indicate longer practice yields greater benefit.

The general conclusions from the research to date is that yoga may improve the functioning of traumatised individuals by helping them to tolerate physical and sensory experiences associated with fear and helplessness and to increase emotional awareness and affect tolerance. TCT-SY is an effective form of yoga that supports trauma survivors to experience symptom alleviation and is well accepted and tolerated by survivors. Furthermore, when practice is maintained over time, greater improvements are generally found. This improvement can even include post-traumatic growth. As with all research, more research of greater rigor is required with more diverse populations and participants. Studies with other populations have been undertaken; the above is a summary of the core research that established the efficacy of TCT-SY as an adjunctive evidence-based treatment for trauma.

Body-Based Interventions

There are numerous body-based interventions for psychological difficulties, including other mental health clinicians creating and researching their own yoga interventions (i.e., Deiredre Fay). TC-TSY differs from other body-based psychotherapies, such as sensorimotor psychotherapy by Pat Ogden and somatic experiencing by Peter Levine, in that TCT-SY does not engage in any cognitive meaning making. For TCT-SY, the focus is solely interoception, not interpretation. Importantly, TCT-SY is an adjunctive treatment, so it is generally offered

alongside traditional therapy (at least initially) and clients may therefore choose to discuss their experience and make meaning from their practice with their therapist.

Where to From Here for TCT-SY in New Zealand?

Presently, there are four of us in New Zealand who have now completed the TCT-SY certificate. We are spread through the country from Dunedin to Northland. I am one of two who are both a therapist and yoga teacher. This means I can offer TCT-SY both within individual therapy and as a full yoga class/course. I am the only practitioner based in Wellington with the full TCT-SY qualification, although you will likely have noticed growing advertising for TSY classes, which is different from TCT-SY. My hope for us as a community is to have access to many more fully-trained TCT-SY facilitators. I believe being able to offer survivors access to all available evidence-based interventions is fundamental to survivors' ability to choose and guide their own recovery. Having the ability for yoga teachers to complete this course to support those traumatised could be an effective means for expanding our mental health workforce; something we really need, although bearing in mind that TCT-SY and TSY is not for everyone.

For myself as a psychologist, I believe in continued innovation and forward thinking. I hold the value of remaining at the forefront of evidence-based interventions. I think we as a profession are being offered a great opportunity during this exciting time, a time in my mind of the fourth wave; moving beyond behaviour and cognition to embodiment, true integration. To that end, my intention as I move forward with my TCT-SY qualification is to begin offering classes and individual TCT-SY to the Wellington community. I also hope to be able to undertake the further study required to begin offering the initial TSY training in New Zealand.

If you are interested in learning more, another avenue for dipping your toe into TSY I have not referenced above is to attend a class yourself or read David Emerson's book *Trauma-Sensitive Yoga in Therapy* (2015). It is a short, easy-to-read book that outlines the underpinning theories, five core elements, and some yoga forms. David also has several published studies regarding TCT-SY that are listed on the following webpage:

http://www.traumacenter.org/clients/yoga_articles.php.

You are also welcome to contact me if you have any more questions or would like to know more (thurlow.jane@gmail.com).

Thank you to NZCCP

Finally, I would like to thank the NZCCP for honouring me with the 2018 travel grant to attend the opening weekend of the TCT-SY certificate training in Melbourne. I appreciate your support and open mindedness towards yoga as a therapeutic intervention.

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NZCCP Travel Grant Report: Attachment in Clinical Practice: A Seminar with David J. Wallen

Jenny Wilson

I appreciated attending David Wallen’s 2 day seminar in Wellington in March 2019. Day 1 was an overview of attachment theory and research, and day 2 was mainly focused on the implications for clinical practice. I will describe a couple of highlights, a low point, and some reflections on the process of this seminar to convey some of my experience of it.

Highs and Lows

Highlight

One of the most memorable pieces of information presented by David Wallen was video and discussion of the still face experiments (Tronick, 1975). These images were new to me. Although I knew in theory that a depressed or traumatised mother would have an impact on her infant, the 2 minute video (<https://www.youtube.com/watch?v=apzXGEbZht0>) gave me a visceral learning experience that I will not forget in a hurry. We saw a baby happy cooing and engaged with its mother. When the mother made her face blank for 2 minutes we saw baby increase efforts to engage—initially smiling and pointing but within moments, fragmenting into high pitched squealing, distressed body movements, and crying. It was a powerful reminder that the ‘child must attach’ and will do whatever it needs to do to manage its connection with the caregiver. The imperative to attach explains the patterns people develop in childhood, particularly with emotionally inconsistent, emotionally unavailable, or abusive parents. These relational patterns are then carried (I am thinking as schema) into adult relationships, including the client’s relationship with the therapist, and potentially the therapist’s relationship with the client.

Jenny Wilson is a Clinical Psychologist in private practice in Christchurch. She works with a variety of adult clients. She is particularly interested in the thoughtful integration of therapy modalities including CBT, Schema Therapy, Compassion Focused therapy and the action methods of Psychodrama.

Low Point

David Wallen suggested that our own attachment style is likely to have influenced our choice of therapy modality. Various therapies were hypothesised to fit with particular attachment styles. I found this an intriguing idea worth considering. However, imagining myself to be one of only a handful of cognitive behavioural therapy (CBT) therapists attending, I had a cringing moment of intense embarrassment when ‘CBT’ was illustrated by a dismissing and avoidant Albert Ellis in one of the *Gloria* videos. Surely there must be some warmer, kinder CBT videos available! I sought refuge with some psychodrama peers and pondered the meaning of my own diverse choice of therapy methods.

Highlight

Anna Flemming, an invited speaker on day 2, gave an eloquent presentation on attachment from a Māori perspective. Anna is psychotherapist with links to Ngāpuhi, Tūhoe, and England; she uses indigenous models of practice alongside Western concepts, and has completed her master’s research exploring the nature of cultural attachments for Māori. After so much attention to the parent–child dyad and Western views on attachment, it was refreshing to consider a broader view including attachment to whenua, whanau, and hapu. Anna’s explanations about multiple definitions of relevant Māori words (e.g., Whanau as ‘family group’ and also ‘to be born’) were fascinating. She provided glimpses of overlapping and layered meanings related to attachment, woven into Māori language.

Process

Arriving in NZ just 1 week after the Christchurch mosque shootings, David Wallen had a difficult job. There was a great deal of tension in the room on day 1 (not helped by the thump of loud music playing outside the venue!). He presented information didactically in a lecture format, and there were some in the audience who wanted a more interactive experiential process. He handled this graciously but firmly; he could not facilitate an experiential workshop with 300 people.

David referred to therapists, including himself, as ‘wounded healers’, believing that many (most?) come to work as therapists because of our own attachment patterns. He talked openly about his own experiences as a client in therapy. He normalised his and our responses to relational situations, including the experience of being challenged as a presenter. I appreciated his compassion, self disclosure, and clarity of thinking.

I came away from this seminar with an increased awareness of attachment patterns (both in myself and in clients) and a heightened sense of how I may consider and make use of this, particularly with clients in long-term therapy. This included key questions I might ask myself, such as ‘what is the implicit relational meaning of what I am doing with this client in this moment?’

David Wallin, PhD, is a clinical psychologist in private practice in Albany, California. A magna cum laude graduate of Harvard, he received his doctorate from the Wright Institute in Berkeley, and has been practicing, teaching, and writing about psychotherapy for more than three decades. His most recent book (2015) is *Attachment in Psychotherapy*. The 2-day seminar was hosted in Wellington by the New Zealand Association of Psychotherapists. My costs for this seminar were generously covered by an NZCCP Travel Grant.

Report on the 3rd Global Adolescent and Young Adult Cancer Congress

Nicole Cameron

To begin with, I would like to thank the Selection Panel and the NZCCP wholeheartedly for the Travel Grant awarded to me to attend the 3rd Global Adolescent and Young Adult Cancer Congress in Sydney. There were three purposes to my attendance: first, to learn more about the current knowledge on adolescent and young adult (AYA) patients with cancer and survivors from a multidisciplinary approach; second, to network with professionals from around the world and enhance alliances between New Zealand and other countries that may lead to research collaborations; and third, to present the qualitative portion of my doctoral thesis.

There were over 400 attendees at this year's conference, representing an impressive 23 countries. The Congress offered delegates the opportunity to hear from and meet with oncologists and other medical doctors, psychologists, researchers, nurses, social workers, and advocates from around the world, including America, Canada, the UK, Europe, Australia, and Japan. The main theme for the Congress was 'Navigating the road through AYA cancer' with the 3 days divided into life before cancer, life with cancer, and life beyond cancer. There appeared to be consensus from all presenters that there is not enough currently being done—medically, scientifically and psychosocially—to support AYAs globally.

The gaps in the services surrounding AYAs were highlighted and innovative ways to address the gaps were discussed. The gaps identified varied among countries and states. For example, Canada is currently implementing a national framework for AYA cancer care based on the Australian Youth Cancer Framework. Previously, Canada had not approached AYA cancer from a national perspective; rather individual states conducted their own frameworks. Other nations such as the UK, America, and Australia are leaders in the field of AYA cancer management. However, there is still room for improvement internationally, and Dr Lorna Fern from the UK presented the findings of a recent BRIGHTLIGHT study that examined the diagnostic intervals of over 800 young people with cancer. These findings showed that young people presented with a range of non-specific symptoms in combination before diagnosis in frequencies substantially greater than those previously reported. This means there can be delays in diagnosis as GPs may find it difficult to distinguish between potentially cancerous and other symptoms; for example, distinguishing growing pains versus the early signs of bone cancers. Therefore, even among world leaders in AYA cancer care, there are still gaps in services and required steps to improve healthcare for this population.

The importance of respecting culture was addressed from a number of countries, including New Zealand (presented by Heidi Watson; discussed in more detail below), Australia (presented by Kyran Dixon, an advocate for young Aboriginal people), Japan (addressed by Yumiko Shirai), and India (addressed by Prakash Chitalkar). There were a number of presentations from New Zealanders, some of which included discussing the importance of respecting culture when treating AYAs (Heidi Watson), improving access to clinical trials for young adults (Tracey Vincent), and a new treatment programme from CanTeen called Reset (a lifestyle intervention programme for AYAs presented by Georgina Lincoln).

Nicole Cameron is an Intern Psychologist currently working for the Massey University Psychology Clinic in Palmerston North. Nicole works with clients referred to the clinic under the MidCentral DHB's Health Conditions and Cancer Psychology pathways. Nicole recently submitted her doctoral thesis on the psychosocial impact on adolescents and young adults (aged 16–25 years) with cancer. Her interest in improving care for this population stems from her personal experience with cancer as an adolescent.

Heidi Watson, New Zealand's National Clinical Lead for the AYA Cancer Network, delivered a particularly poignant presentation. Heidi presented a moving video incorporating the lived experiences of a group of young Māori and Pacific people diagnosed with cancer and provided examples of the actions highlighting the commitment to reducing current disparities. This video included young people discussing how these disparities affected their cancer experience; for example, the lack of understanding by health professionals about the logistical impracticalities of travelling to and from appointments, and young people being unable to take time off work for treatment because of the financial implications of supporting whanau. This really highlighted the fundamental importance of considering each young person's unique needs, and making the health system work for AYAs, not the other way around. Heidi's presentation was met by a standing ovation.

Of particular interest to me were the creative ways that health professionals were involving young people in their health journeys. For example, a social worker in a Brisbane hospital founded the concept of 'memory making', which is a creative way for AYAs in palliative care to record memories for family and friends to keep after the young person has passed away. Personal highlights included the numerous AYA survivor presentations throughout the Congress (e.g., by Kyran Dixon, Kathryn Woodward, and Mette de Fine Lecht) and the international survivor panel on the final day. The panel was represented by AYAs from Australia, Denmark, Japan, the UK, and America. It was astounding hearing the ways that young people have overcome enormous challenges in their lives, and their efforts to advocate and support those young people who will face cancer in the future. For example, Mette de Fine Licht survived Ewing's Sarcoma at the age of 16 years, which resulted in an internal prosthesis in her leg. She went on to write 10 books, including a memoir about her cancer journey, and was awarded Fighter of the Year in Denmark in 2012. Another highlight was attending the gala dinner, where the guest speaker, Chris Bond, spoke of his experience with leukaemia at 19 years old and his subsequent amputations as a result of contracting a bacterial infection. Chris went on to be a two-time Paralympian gold medalist in wheelchair rugby for Australia.

A number of psychologists also spoke at the conference. Professor Nick Hulbert Williams discussed how he is currently undertaking research on how acceptance and commitment therapy (ACT) could be an effective treatment modality for patients with cancer. He also delivered a workshop on using ACT with clients with cancer in a range of healthcare settings, particularly focused on understanding that psychological suffering and distress in this situation is not necessarily able to be fixed. Unfortunately, I was unable to attend this workshop, but did enjoy his presentation on the second day of the conference. In addition, clinical psychologist Dr Ursula Sansom-Daly presented an evaluation of an advanced-care planning tool, and on understanding and addressing training needs of clinicians to improve end-of-life care for AYAs worldwide. The latter study is an international collaboration that establishes global end-of-life communication practices, and uses this information to develop a training model for the future.

I was fortunate to present the qualitative findings of my doctoral thesis, entitled *The psychosocial interactions of adolescents and young adults (AYA) and the possible relationship with their development*. This study, conducted with my supervisors Dr Don Baken, Dr Kirsty Ross, and Dr David Bimler, has recently been accepted for publication in *Cancer Nursing*. This research explored the psychosocial interactions of AYAs through interviews in 2015 and follow-up interviews in 2016, providing a rare longitudinal perspective on both the interactions young people experienced and the developmental impact of cancer. The findings showed that social interactions differed at the two time points (as there were fewer cancer-related interactions at follow-up), and the developmental impact that cancer had reduced in the follow-up interviews. Particularly important to note was the different effects on adolescents (aged 16–19 years) compared with young adults (20–25

years). Adolescents reported a much larger impact on their social interactions and development (especially on identity formation) than their older peers, which the authors purported may be attributable to the slightly more advanced development of young adults. I felt privileged to be presenting in the company of many inspiring speakers, including a number of researchers who I have cited in my thesis. Not only is this experience beneficial for improving my public speaking skills, but it is also an invaluable opportunity to disseminate my findings to potential employers and collaborators.

My overall experience at the Congress gives me hope that young people in the future who are diagnosed with cancer will have an experience that is as positive as it can possibly be, and that their lives will be changed for the better as a result, just as mine has been. Once again, I thank you sincerely for the opportunity to attend the Congress in Sydney.

Book Review

Title: Trauma and the Struggle to Open Up: From Avoidance to Recovery and Growth
Author: Muller, R.
Publisher: W. W. Norton and Company, 2018
Reviewer: Tara Clark

To psychologically survive trauma, many clients have rightfully avoided feelings, memories, situations, thoughts, and images connected to the traumatic events. While this ‘phobia’ helps clients survive, it does not help them with recovery. Therapists need to understand this avoidance and find ingenious ways to safely help the client open up these feared experiences. Using a relational framework, Dr Robert Muller has pulled together research, contemporary understanding of trauma, his own deep clinical experience, and the opinions of other experts in the field to talk about methods of achieving this with traumatised clients. He clearly shows how there is a link between opening up to a safe person and the reduction in post-traumatic stress disorder symptoms. Full of descriptions of frustrating, difficult, poignant, slow therapeutic moments, this book illustrates the sometimes counter-intuitive and unpredictable process of therapy with avoidant clients who push us away and pull us in. It challenges us to hold the therapeutic frame so that we do not end up avoiding these clients, this work or our own emotional experience. Like Robert Muller’s first book (*Trauma and the Avoidant Client*), this book is beautifully written and a pleasure to read. I especially liked the chapter on ‘strained apologies and the rush to forgive’ and how we can unwittingly collude in avoiding difficult material by premature forgiveness.

https://www.amazon.com/dp/0393712265/ref=pe_1098610_137716200_cm_rv_eml_rv0_dp

Tara Clark (Registered Clinical Psychologist) has been a member of the NZ College of Clinical Psychologists since 1996. She has over twenty years' clinical experience and specialises in working with adults with a history of abuse and trauma. Tara started her career working in various multi-disciplinary teams in acute psychiatry and then moved into private practice in 2000. Tara is Managing Director of Psychology Associates - a large private practice of 10 clinical psychologists which has been providing clinical psychology services to people in Dunedin for over 30 years.

Book Review

Title: When Trust Goes Missing: A Clinical Guide
Authors: Chris Skellett
Publisher: KDP Publishing: Amazon
Reviewer: Liesje Donkin

When Trust Goes Missing: A Clinical Guide is an easily accessible book that explores the role of trust in our day-to-day lives, and the impact on how we function when trust is lost or negatively impacted. From the start, this book reminds you of the importance of trust, highlighting how frequently we talk about trust and by equating trust to oxygen in that it is vital 'for survival'. Trust is an important part of all our interactions, whether it be in our relationships with loved ones, whānau and friends, or in the clinical work that we do. We trust those that we interact with to be honest, open, and receptive to us, all of which involves a level of trust from us in return. More recently, this may have begun to waver because of increasing reports of violent crime, high profile infidelities, and an increase of cybercrime and identity theft. On a more community level, the recent Christchurch terror attacks are likely to have impacted our trust in some way, therefore making the timing of this review seem particularly serendipitous.

The book provides a framework that proposes three domains of trust (trust in self, trust in others, and trust in the world), and outlines the changes we experience in our world when these domains are threatened or aversively impacted. These threats of trust are also mapped onto common clinical presentations such as: low self-esteem/depression; alcohol and substance abuse; anger; infidelity; domestic violence; and parenting and professional misconduct. This further helps explore the role of trust in a clear and concise manner.

The layout of the book follows a logical progression of defining trust, clinical problems related to trust, and then how the reader can strengthen and rebuild trust. Throughout the book are self-reflective exercises (called Trust Bites); examples from clinical work, research, and historical scenarios; and several activities such as a quiz to establish your own personal trust profile, a trust questionnaire, and a trust audit. The inclusion of these activities helps to consolidate the message in the book and the application of the content from paper into everyday life. I would imagine that readers would enjoy doing these activities as a means of self-reflection and that the questions could be useful to help generate conversations around trust (it could be an interesting exercise for a couple to complete these activities and use their answers to explore their differences in trust and what this could mean for their behaviour in the relationship).

I found this book easy to read and it could easily be read in one sitting. However, I believe that doing so would limit the benefit of the reflective exercises and activities in the book. Instead, I would foresee this book as being a useful clinical companion that clients could work through alongside therapy relating to trauma or relationship issues, or that the book could be read as a standalone guide to support someone in treatment. Regardless of whether the book is used as treatment companion or by itself, it is likely that the best way to use to the book is to work through a section at a time, giving space and time to reflect on learnings and how these might be applied to day-to-day life before progressing to the next relevant chapter.

Liesje Donkin is a clinical psychologist working in private practice working with people with eating disorders and trauma, delivers training in supervision and suicide prevention, and is a research fellow at the University of Auckland in the Department of Psychological Medicine.

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

TRAINING TIMETABLE

NZCCP Events

LOCATION	MONTH	PRESENTER/ CONTENT
Nelson	12&13 August	NZCCP Nelson branch workshop: Laying the Foundations for a Successful Psychotherapy
Christchurch	27 September	NZCCP Canterbury branch workshop: Radically Open Dialectical Behaviour Therapy

Other Events

LOCATION	MONTH	PRESENTER/ CONTENT
Auckland	26&27 July	Elation Institute Workshop offerings
Wellington	5-6 August	Sharpen Your Skills: Intermediate ACT Workshop
Christchurch	17 August	MMPI-2-RF workshop
Napier	22 August	Introduction to CBASP - Treating Chronic Depression with the Cognitive Behavioural Analysis System of Psychotherapy
Napier	23-24 August	Complex Cases: Treatment of Chronic and Recurrent Mental Health Problems by Personality Functioning Informed Therapy
Wellington	26-27 August	Accredited Gottman Marital Therapy Training
Nelson	18-20 September	The Royal Australian and New Zealand College of Psychiatrists 2019 NZ Conference
Dunedin	23-24 September	The Snow White Model: Working with complex and developmental trauma
Christchurch	17&18 October	2019 ANZACBT Conference and Workshop

