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The Specialist Organisation for Clinical Psychologists

Kia mau ki ngā kupu a ō mātua.
Heed the words of your elders.

Editorial

Dear Colleagues,

This issue is starting a bit differently, as it is the first in a very long time without Kumari introducing it. So, I would like to begin this journal by thanking her for her amazing work and dedication over the years, steering the journal to where it is today.

Although this journey for her now ends, it signifies the start of another for Liesje and I, who will be co-editors. We are hoping that we can continue to grow the journal while honouring all of the work everyone has put into it thus far, and are looking forward to see where this takes us.

The theme of this journal and that of #39 is 'what I wish we had been taught', which might bring some reflections for us all, it certainly did for me. I would encourage everyone to notice these and then find a way to incorporate these musings back into your practice and lives, as it is important to take time to reflect on where we are now and what we have gone through to become the clinicians and people we are today.

We wish everyone the best for the rest of 2019, and can't wait to see what 2020 holds.

With kind regards,
Wade & Liesje

The Problem of Psychology and Aiming for Integration

Mark Ottley

Psychology suffers from fragmentation and a lack of integration. No overarching conceptual framework guides the relationships of prominent ideas to each other, or to related domains of enquiry like biology and the social sciences. It has been said that theories in psychology come and go because of baffled boredom as much as anything else, with an absence of the cumulative character that impresses in more established sciences. Psychological phenomena are repeatedly rediscovered and renamed. Psychotherapy schools compete for attention and acolytes. Diagnostic systems are released and rejected by leading professional bodies. There is tension between the descriptive versus prescriptive mission of psychology. All of this makes teaching students, treating clients, researching and communicating with each other more haphazard and difficult than it should be. It is time to 'look bigger', and examine how the pieces of the puzzle could fit together into a more coherent whole. This will be the focus of the NZCCP Annual Conference in March 2020.

What is 'grit'? As popularised in recent years, grit is a powerful psychological phenomenon and 'the secret to outstanding achievement' (Duckworth, 2016). However, as an independent research review judged, once you factor out conscientiousness, grit explains very little and is an aspect of conscientiousness of which we are already aware (Schmidt, Nagy, Fleckenstein, Möller, & Retelsdorf, 2018). This incident appears to be a recent example of a repetitive problem in psychology, where a 'new finding' and nomenclature is operationalised and heavily promoted—and then revealed as rediscovery and confirmation of an existing finding, as was suspected by those familiar with that original finding all along.

What incentives drive this particular problem in psychology? A publishing model that has historically rewarded positive novel findings over carefully researched null findings or replication is a clear contributor (Open Science Collaboration, 2015). This publishing model has led to a bewildering plethora of theories and empirical publications (many of dubious quality), and a comparative paucity of deeper efforts at integrating findings into a coherent bigger picture.

In aspects of academic psychology where connection to human suffering and its alleviation may be less obvious, this phenomenon may be personally frustrating for researchers and those seeking to understand the world. But in clinical psychology, the impact on people's lives and wellbeing has potential to be far more damaging. At best the most substantive bodies of knowledge in psychology (e.g. personality) are often neglected (Garb, 2005), despite this being one of the most extensive and reliable bodies of knowledge in psychology (Soto, 2019). At worst, clients are deprived of an appropriately comprehensive understanding of their difficulties, and offered instead whatever branded therapy approach their healthcare provider favours. Even over-attachment to traditional one-to-one therapy has problems, such as scaling these interventions to meet need or neglect of important factors extrinsic to the individual such as poverty or injustice (Kazdin & Blase, 2011). The descriptive versus prescriptive mission of psychology, which is both a science and a profession focused on clinical intervention, complicates matters further.

For nearly 70 years, the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) system of psychopathology has reigned supreme in psychiatry and clinical psychology. This posits largely discrete syndromes or disorders (e.g. 'depression' or 'generalised anxiety'), characterised by clusters of particular symptoms. The DSM/ICD system has been challenged by multiple critics since its inception. However, in recent

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years, leading professional bodies have also postulated and operationalised dramatically different approaches.

Perhaps the most important challenge to existing traditions of categorisation and understanding has been the Research Domain Criteria (RDoC) project. This has been promoted as a research and conceptual framework for understanding normative function and dysfunction (Cuthbert, 2014). The American National Institute of Mental Health, which is the largest funder of mental health research in the world, announced they would no longer fund research based on DSM categories (Insel, 2013). Instead, they fund research based on transdiagnostic neuroevolutionary categories, with broad divisions such as negative affect systems, positive affect systems, social attachment systems, executive function and arousal systems, and general cognitive, reasoning and perceptual systems. Normality is a species typical adaptive variation in function of these systems, and dysfunction is taken to be broadly transculturally applicable and recognisable.

Another approach to understanding mental disorders is the Hierarchical Taxonomy of Psychopathology (HiTOP) (Kotov, Krueger, & Watson, 2018), which groups disorders according to phenotypic expressions rather than etiological mechanisms or neurobiological substrate like the RDoC. The consortium of scientists advocating this approach (numbering 69 at the time of the previously mentioned paper) advocates organising systems of psychopathology according to statistical modelling, similar to that used in psycholexical personality research. Such research is seen as complementary to the RDoC project.

Coming from a different perspective, the British Psychological Association last year released their Power Threat Meaning framework (PTM) (Johnstone et al., 2018). In contrast to the RDoC and ICD/DSM, this system places great emphasis on ecological situatedness, particularly social ecology (e.g. socioeconomic status, race, gender, identity). This is seen as vital to understanding 'patterns of emotional distress, unusual experiences, and troubled or troubling behaviours'. With phrases such as '...there are not, and cannot be, universal categories of emotional distress' (Johnstone et al., 2018, p. 6), a strong degree of cultural relativism in problem conceptualisation is suggested at times. This contrasts with the RDoC emphasis that, for example, an acute fear or reward reaction is not just a transcultural universal, but even a trans-species universal recognisable in species as distant from us as zebra fish because of conservation of anatomical structures across evolutionary time (Cuthbert, 2014).

The DSM-5/ICD-11, RDoC, HITOP and PTM; for qualified psychologists—let alone trainee psychologists and the clients we help—this variety of explanatory conceptual systems and their underlying justification systems, and thus treatment implications, can be an Olympian challenge to navigate. These four systems have very different conceptual foundations, language and philosophical assumptions (Zachar & Kendler, 2017). And that is to say nothing of the innumerable psychotherapies offered as treatment.

Optimistically, one might view these different systems as related expositions with different emphases. There are practical benefits of remaining with the established (if flawed) DSM/ICD system, grouping phenotypically (HITOP), establishing the fundamental neuroanatomical systems underlying thought and behaviour (RDoC) and sociological influences on expression (PTM). Ideally, these should be conceptually overlapping systems (and to a degree they are) that offer complementary perspectives.

A visual aid to understanding this potential for complementarity is shown in Figure 1. This 'Tree of Knowledge' meta-theoretical structure illustrates the relationship of different levels of complexity and emergence from physics to culture, and also the relationship of different

scientific disciplines to their subject matter (Henriques, 2003). The place of psychology as a discipline becomes clearer. For example, RDoC focuses attention on the level of fundamental neuroanatomical substrates and their relationship to 'behavioural investments' of energy and actions, whereas PTM focuses more deeply on 'justification systems' of meaning making and culture.

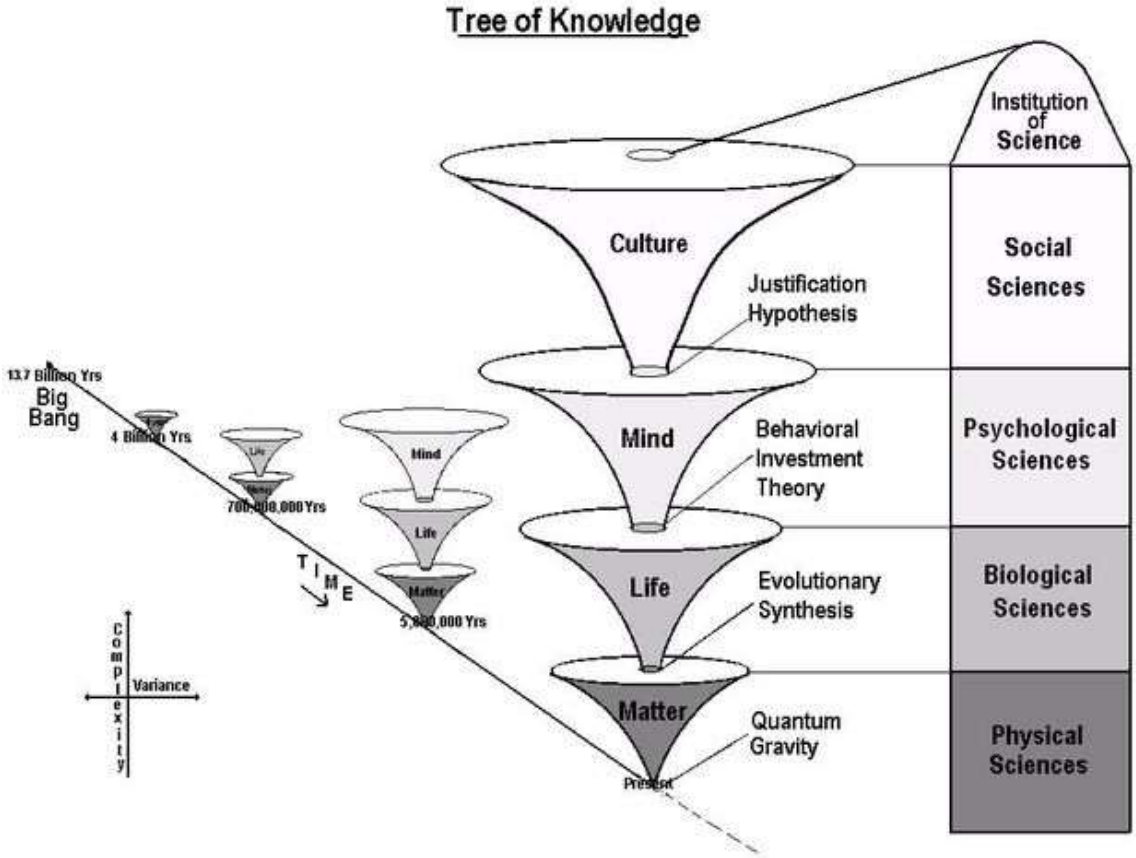
As a discipline, psychology is the joint point between biology and the social sciences; this creates significant challenges in defining its scope, focus, language and enterprise (Henriques, 2003). As part of the human cultural institution of science, psychology seeks truth. However, a fundamental challenge is that this joint point encompasses descriptive facts as well as prescriptive values, and this is especially so for clinical practitioners.

The distinction between facts and values is not as clear as some psychologists and philosophers may suggest. Claiming something as a fact is an implicit act of valuation, and psychology is arguably always a 'moral' science, dependent on implicit or explicit conceptions of normativity (Brinkmann, 2011). This is a challenge that has been directed at 'healthcare' more generally; that is, who gets to even say what 'health' is (Metzl & Kirkland, 2010), especially when it comes to issues such as obesity, nutrition, drug use or other contentious issues. However, this challenge is particularly salient for clinical psychology given the enormous range of thoughts and behaviours under its purview. It is instructive to understand the normative assumptions underlying existing mental illness classifications. If one reverses the 'should not have' lists of diagnostic criteria, a list of 'shoulds' and imperatives about how life should be lived is revealed (Leising, Rogers, & Ostner, 2009). On what scientific and philosophical grounds can these decisions about values be justified?

Coherent theoretical foundations and deeper integration should facilitate a more informed and less haphazard application of psychological knowledge to both clinical research and practice. It should lessen the proliferation of terminological duplication, with consequent benefits for comprehension and communication. Linkages and implications of research and clinical findings should be located more accurately and easily thanks to a comprehensive model, and phenomena more appropriately valenced when it comes to weighting in case formulation. Wide cultural variation should be accommodated and inform conceptualisation without abandoning scientific realism.

In March 2020, the NZCCP annual conference in Christchurch will focus on the above themes and related topics. As the abstract leading this piece notes, we aim to 'look bigger', and examine how the pieces of the puzzle could fit together into a more coherent whole, both at the level of psychology as a discipline and field and from the perspective of everyday clinical psychological practice. Our keynote speaker will be Professor Gregg Henriques (Henriques, 2011). We look forward to seeing you there.

Figure 1. Tree of Knowledge System (Henriques, 2003).



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Kai and Hauora Hinengaro

Taryn Hale (Ngāti Koata, Ngāti Pākehā)

I am currently doing my Master of Science research at *Te Puna Toiora – The Mental Health and Nutrition Research Group* at Te Whare Wananga o Waitaha, University of Canterbury. Our rangahau (research) aspires to reduce the burden of mental health on communities, and is currently focused on the important link between our tinana (physical body) and our hinengaro (mind), through our taioranga (nutrition). This concept fits well with the Māori wellbeing model, Te Whare Tapa Whā (literally the House of Four Parts). Dr Mason Durie proposed this model in the 1980s as a result of many marae-based discussions regarding the approach to healthcare for Māori in Aotearoa New Zealand. The model conceptualises wellbeing as four taha or dimensions that support the wellness of the whole person using the metaphor that four parts of the house are needed to make the building strong. Therefore, a whole-person approach to health was advocated. Te taha tinana (physical wellbeing) is the aspect most often considered in Western medical models, whereas te taha hinengaro refers to the mental processes such as cognitions and feelings that are typically the domain of psychiatrists and psychologists. The model also includes te taha whānau (the social wellbeing dimension) and te taha wairua, which is the dimension of spiritual connection that includes connection to identity, whakapapa, ancestry and the natural environment. The model suggests then that when we work to obtain wellness, we consider the interplay of all four taha (Durie, 1985). Nutrition, mostly obtained through kai (food), can be seen as central to all four taha.

In Māori culture, kai was gathered from the bush, sea and rivers. Access to traditional kai gathering sites (mahinga) is immensely important and loss of these as a result of colonisation was a central part of the iwi (tribe) Ngāi Tahu's Waitangi Tribunal claim (McKerchar & Heta, 2009). Kai is considered to come from the atua (gods) and there are many spiritual components to the processes of gathering and preparing kai. Kai is used to lift tapu (sacredness) in many rituals, and manaakitanga (hospitality) is demonstrated at hui (gatherings) by providing lavish kai. The process of growing, gathering and sharing kai connects whanau and brings pride and joy (Pickering, Heitia, Heitia, Karapu, & Meek, 2015). And as anyone who has prepared a hāngī (or food cooked in the earth) will know, it can also be hard work but made easier with whanau, family and friends to help out. Along with the benefits to our wairua (spiritual wellbeing), our whanau connections and our connections with ngā atua (the gods) and the natural environment, kai is the way in which we provide our tinana (body) and hinengaro (mind) with the nutrients it needs to perform at its best.

Research from around the world has established that healthy diets, particularly the Mediterranean diet, are associated with better mental wellbeing, with the opposite also true as highly processed or Westernised diets (including takeaways and sugary drinks) are associated with poorer mental wellbeing (Jacka et al., 2010). The Mediterranean diet is rich in plant-based foods (e.g. fruits, vegetables, legumes, nuts and olive oils) and fish, with limited red meat, poultry, dairy and alcohol consumption (Lassale et al., 2019), this is also consistent with many international healthy

Taryn Hale is originally from Te Tau Ihu, the top of the South Island, and her whanau whakapapa to Ngāti Koata. She worked as a rehabilitation programme facilitator with Ara Poutama o Aotearoa, Department of Corrections for twelve years prior to starting her clinical psychology training at Te Whare Wānanga o Waitaha, University of Canterbury this year. Her time at Corrections gave her a wide range of experience in working alongside people making changes and developed her confidence in using concepts and principles from te ao Māori in her therapeutic work. She is conducting her Master of Science research with Te Puna Toiora – The Mental Health and Nutrition Research Group at Canterbury University, looking at the effectiveness of a micronutrient formula for people experiencing traumatic stress. Her study is a part of a randomised control trial looking at a micronutrient intervention for anxiety and depression. She is also working to build relationships with the research lab and community organisations including whānau whanui Māori in their rohe, area, to ensure their rangahau, research, is relevant.

eating guidelines. Two studies of adolescent diet and mental wellbeing in Aotearoa New Zealand found similar patterns, with the young people eating the healthiest diets having the lowest rate of depressive symptoms and those with the least healthy diets having the highest rates of mental health problems (Kulkarni, Swinburn, & Utter, 2015; Puloka, Utter, Denny, & Fleming, 2017). The idea that what we eat affects our mental wellbeing is not new and most of our great grandparents would probably not be surprised by this finding.

Also of interest is a reference in the literature to 'traditional diets' as associated with better mental health. This has largely come to mean diets that are not highly processed and consist largely of whole foods, meat, fruit and vegetables (Jacka et al., 2010), similar to the Mediterranean diet but perhaps more reflective of the part of the world in which you live and the kai to which you have access. A Japanese study found that people who adhered more strictly to a traditional Japanese diet experienced lower rates of depression than those who did not, and observed a difference in eating patterns based on a person's marital status (Nanri et al., 2010). This highlights the important social aspect of food preparation and consumption, and how our te taha whanau (family dimension) can influence our diet. These findings seem relevant to the Aotearoa New Zealand context given the impacts of colonisation on access to traditional kai through environmental impacts on mahinga (kai gathering sites) and migration of Māori away from ancestral whenua (land).

The beautifully named study, 'Korero te kai o te Rangatira: Nutritional wellbeing of Māori at the pinnacle of life' spoke to older Māori about their dietary practices and the significance of these to their health and wellbeing. The kaumatua (elders) reported that traditional Māori kai was important to them, and those who had access to Māori kai had lower nutritional risk; that is, they ate well. They reported that their access to Māori kai was often facilitated by whanau (family) bringing kai to them, eating kai at gatherings on the marae (meeting house) or that they were able to get the food themselves (Wham, Maxted, Dyall, Teh, & Kerse, 2012). Food insecurity increases the risk of depression and anxiety, possibly through the effect poor quality food has on vulnerability to illness (Pickering et al., 2015).

What we eat provides us with vitamins and minerals or taiora moroiti (micronutrients). Many micronutrients are essential factors in neurotransmission, which is the process of sending signals around our brain to give us our thoughts, feelings and physical responses. Our brain uses up a massive percentage of the energy and nutrients we consume each day, so it is important we eat sufficiently to provide our brain with what we need to achieve optimal functioning and mental health.

Traditional Māori kai includes huawhenua (vegetables), ika me ngā kaimoana (fish and shellfish), miti (meat), paraoa (bread) and miro berries, although many meats we eat today arrived with European settlers, along with bread. In pre-European times, birds would have provided the main source of meat. Kumara is a well-known Māori vegetable, brought to Aotearoa by Māori who then had to establish ways to cultivate the tuber in colder climates. The kumara is high in carbohydrates and fibre, and provides taiora moroiti. Kumara is typically high in pre-vitamin A or beta-carotene, which is great for youthful skin, organ regeneration and night vision, and is a known anti-oxidant. You might have heard about anti-oxidants being 'anti-aging', and in terms of our brains, anti-oxidants can help prevent our brains deteriorating over time or in older age. Kumara also has a decent amount of vitamin C, famous to many for its important role in warding off scurvy, but which is also an anti-oxidant that is required for the absorption of iron and works to support the body in stress. Kumara also contains B vitamins, which are important for our bodies' stress response; these vitamins are usually well-represented in over-the-counter stress management supplements. Other plants such as puha (sow thistle), kōwhitiwhiti (water

cress), mouku (hen and chicken fern) and tī kouka (cabbage tree) also provide all the taiora moroiti (goodness) of leafy green vegetables and are known for their anti-inflammatory properties, which can in turn improve mental health.

Ika (fish) was a traditionally accessible Māori food, similar to the Mediterranean and Japanese diets found to benefit mental wellbeing. It has been found fairly consistently that essential fatty acids from fish are associated with a reduced risk for depression and post-partum depression, and improved mental wellbeing generally; we should aim to eat this two to three times per week. Tuna, the te reo Māori word for eel, is a really good source of omega-3 fatty acids, with its healthy fatty acid content being about the same as sardines, which is a regarded as a great source. It is also suggested that tītī or muttonbird, traditionally harvested around Rakiura (Stewart Island) contain high levels of polyunsaturated fatty acids because of their largely seafood diet. The seeds or berries from plants such as harakeke (flax), miro, rengarenga and kohia also provided good sources of essential fatty acids.

Kai not only provides us with our nutritional needs, but plays a role in our connections to whanau, family, culture and our relationship with the natural environment. These connections in turn impact our sense of wellbeing. Access to traditional kai is a taonga (treasure) and needs protecting. Dr Durie called for the prevention of poor health in a holistic way, and nutrition and access to culturally significant kai is an important step in this direction.

> *Nā tō rourou, nā taku rourou, ka ora ai te iwi.*
> *With your food basket (your contribution) and my food basket (my contribution), the people will be healthy.*

As part of my thesis, I am involved in two randomised controlled trials being run through Te Puna Toiora – Mental Health and Nutrition Research Group, recruiting adults and pregnant women with symptoms of āwangawanga (anxiety) and/or pōuritanga (depression). We are investigating the efficacy of taiora moroiti (micronutrients) in improving pōuritanga and āwangawanga. These studies will be completed in 2021. If you want to know more about this rangahau (research), follow our lab on Facebook (https://www.facebook.com/pg/mentalhealthandnutrition/posts/) or email for more information (mentalhealthnutrition@canterbury.ac.nz).

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What I Wish we had Been Taught: Biosphere II, Trees, Stress and Resilience

Amanda Baird

Our clinical training was a time of stress, and ours is a challenging and at times stressful occupation. In that we are not alone, as research has demonstrated increased levels of stress and burnout in a range of helping professions, from nurses and doctors to social workers to paramedics (O'Dowd, 2018). There is growing interest in understanding how stress is experienced by staff and its relationship with burnout, resilience and coping (O'Dowd, 2018). Alongside this, there is interest in how we can promote resilience, coping and maybe even thriving in the face of stress (Masten, 2015). Understanding this link would be beneficial for us as individuals, for us as a profession and of course, for our clients.

Perhaps there were processes at play during our training aimed at helping us to develop this resilience. These processes were not (but could be) made explicit to help students identify how to cope with stress. This could lead to a more resilient clinical psychology workforce. I recently came across a story about what makes for a strong and healthy tree, which seems applicable as a metaphor for this situation.

Biosphere II is a research facility in Arizona, USA, built in the 1980s (Biosphere 2, n.d.). The goal of Biosphere II was to develop a completely enclosed environment capable of supporting human life. The technology developed inside Biosphere II could be used if one day Biosphere 1—the earth—became uninhabitable. Or perhaps relatedly, humans tried to colonise another planet. Through the 1980s and 1990s, researchers continued in their attempts to replicate the earth's environment; however, many unanticipated challenges occurred. One of these challenges involved vegetation. A wide range of vegetation was planted inside Biosphere II. Typically, trees and plants grew more quickly than in the outside world, but would then die off and collapse. After some investigation, it was thought that the weather patterns inside Biosphere II were important. Biosphere II could produce a gentle breeze but could not generate more extreme wind, rain or storms. It was thought that winds and storms are necessary to a young tree's development. During such weather, trees stretch and bend and develop a structure called 'stress wood'. This provides strength and allows for further bending and stretching, which it seems, is vital for a tree's healthy growth and development.

This story got me thinking about what happens in the garden. Initially when a seed is planted it is kept in a hot house in a propagator tray. It is watered daily and possibly given specific nutrients. As the seed begins to grow, the seedling is moved to progressively larger pots, giving it the room while keeping it inside the hothouse. As the seedling turns into a sapling it may be placed outside for some time each day to 'harden off' or get used to the elements outside the hothouse. When the tree is ready, it is planted in its permanent position. At this stage, wise gardeners place two stakes on either side of the young tree and tether the tree to it. This will provide some protection

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as the young tree experiences its first winter storms and spring gales. Eventually those stakes in the ground will rot and fall away, leaving a healthy strong tree that can withstand all but the most extreme weather events.

The story of the trees inside Biosphere II could serve as a metaphor for explaining the role of stressors in developing resilience for clinical psychology students. Our training and in fact post-graduate study generally, is a stressful thing to undertake. Students are constantly managing competing demands from work, home and family. There are frequent deadlines and assessments. There is a multitude of feedback, not all of it complimentary. It is 3 years (or more!) of hard work. Through training, students can be supported in the manner of a seed developing into a healthy strong tree, while inevitably being exposed to 'stormy weather'. In their daily work, qualified clinical psychologists hear about, witness and walk beside life's storms in all their catastrophic glory, while managing their own personal stormy weather. Our training prepares us for this in more ways than teaching diagnostic criteria, therapeutic models and the questions to ask when assessing risk for suicide. Those deadlines, multiple demands and difficult feedback sessions can also assist us to develop resilience.

The use of the Biosphere trees metaphor could lead to discussion about identifying the stressors facing the individual and how the individual could manage stress. Factors like the individual's internal resources for coping, such as being flexible, persistent and patient, or using humour can be identified. Skills for managing stress, such as prioritising workloads and setting boundaries between work and personal life can be made explicit. In addition to this skills identification, discussion could also focus on the potential benefits of successfully managing stressors, particularly so that the individual will learn skills they can use repeatedly in the future. The metaphor and resulting discussion would normalise and validate the individual's experience of stress, while also providing motivation for managing the stressor successfully. This metaphor is applicable to the experience of clinical psychology students, but could also be used for a range of other people and situations, including during therapy.

In summary, the story of the Biosphere trees is proposed as a metaphor explaining the role of stressors in the development of resilience. If this process of building resilience is an intentional part of our training programmes, I wish that we had been taught this. Discussion of this metaphor could normalise and validate the experience of stress, while also providing motivation to successfully manage stressors. Consideration of this metaphor may also encourage teachers in clinical programmes to be even more mindful of their role in safely ensuring exposure to increasing but manageable challenges (stormy weather) and provision of the supports (stakes in the ground) that allow students to 'harden off' without irreparable harm.

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Opinion: Student Loan Limit Perpetuating Inequalities in Education and Mental Health

Anonymous NZCCP Student Member

The recently unveiled Wellbeing Budget (Treasury New Zealand, 2019) has underscored our urgent need to train more clinical psychologists. Yet the government's own policy—the student loan borrowing limit—may undermine its own objectives. Put simply, the borrowing limit stops some students from accessing a student loan in their final year(s) of clinical training. If they cannot self-fund tuition costs, they cannot finish their training, and cannot register and work as clinical psychologists. Surely this apparent barrier to education that discriminates against students from disadvantaged backgrounds does not fit well with our Prime Minister's Wellbeing Budget message of equal opportunities to train or retrain?

'Equality' and 'Wellbeing', which lie at the heart of the Budget's kōrero[1], are the very hopes threatened by the student loan limit. While at first glance it only affects a handful of students, the limit's negative consequences for the clinical psychology workforce, our tāngata whaiora[2], and even the government itself are far-reaching.

Background

Studylink's 7-EFTS[3] lifetime limit stops students who have borrowed roughly 7-years-worth of fees since 2010 from accessing further student loans. Becoming a registered clinical psychologist takes a minimum of 6–7 years. Many students complete additional qualifications before entering training, meaning they may need 8+ years of student loan. This makes clinical psychology students the perfect prey for the student loan limit scheme. Without financial support from whānau, some students may have to withdraw from training in their final year(s) simply because they cannot afford the fees. That is hardly a cost-effective solution from the perspectives of the universities and the government, whose own investments are wasted along with those students' 7+ years of blood, sweat and tears. Financial pressure to cover basic living expenses on $0 per week[4] does not make life much easier for students who do manage to scrape up $10,000+ for annual fees. Working part-time alongside the infamous more-than-full-time workload of clinical training and research is bound to compromise students' ability to make the most of their training, and does not bode well for their wellbeing. Do we really want our future clinical psychologists to be burnt-out before they even start their working careers?

Clinical Psychology Workforce

The student loan limit is a systemic financial barrier to education, which prevents the development of a sociodemographically and culturally diverse clinical psychology workforce and undermines the profession's long-standing aim. This barrier may not only stop existing students from finishing their training, but may deter potential students without access to financial support from entering training in the first place, as the financial uncertainty of the final year(s) might render clinical psychology an unfeasible career path. As such, the student loan limit contributes to inequalities in education by disproportionately disadvantaging those from lower socioeconomic backgrounds. If only financially privileged students can become clinical psychologists, how do we grow a clinical psychology workforce that mirrors (Scarf et al., 2019) the sociodemographic and cultural makeup of our society?

Equal Opportunities

We need a representative clinical psychology workforce to meet the unique needs of our diverse populations, because we must challenge our inequalities in mental health outcomes. Māori and Pasifika are over-represented in negative mental health statistics (Oakley Browne, Wells, & Scott, 2006), yet severely under-represented in our existing clinical workforce and clinical psychology training programmes (Scarf et al., 2019). To effectively treat our most vulnerable tāngata whaiora—and, indeed, to honour our Treaty of Waitangi obligations—we need to train more Māori and Pasifika clinical psychologists, psychologists who are better able to relate to and engage clients through shared lived experiences. But how do we do that with financial barriers in place that exclude lower income groups—who are more likely to be Māori or Pasifika (Treasury New Zealand, 2019)—from entering the profession? By limiting opportunities of Māori and Pasifika to train as clinical psychologists, the student loan limit jeopardises mental health treatment and outcomes for Māori and Pasifika, and in doing so perpetuates inequalities in education AND mental health.

Costs to Society

If the goal of the student loan limit is to minimise government expenditure, then its very purpose is misguided and short-sighted. In reality, this policy increases rather than minimises costs to our society. Any financial savings are short-term and minimal relative to the long-term financial and wellbeing burdens these 'savings' create by undermining effective and accessible treatment for our tāngata whaiora. Every clinical psychology student affected by the loan limit is a missing psychologist in Aotearoa, and this loss is especially critical when it is one less Māori or Pasifika psychologist. Ultimately, this limit costs the wellbeing of those who desperately need these psychologists—our people suffering from psychological distress. If the government is serious about meeting the needs of our tāngata whaiora and training more clinical psychologists, inevitably, it will need to address barriers affecting clinical psychology *students*.

A Simple Solution

The government's action to extend loan limits for medical and other healthcare degrees in 2018[4] showed that it does recognise the importance of training health professionals and addressing education and health inequalities. *So why has clinical psychology been overlooked?* It probably does not help that numbers of clinical psychology students are very small (Scarf et al., 2019), so their voices are easily muffled. But just because something affects a small number of people, does not mean it is not a big problem with wider repercussions, as this article has humbly hoped to illustrate. However, the good news is that small numbers of students mean small costs of implementing change, coupled with big and far-reaching benefits.

Extending, or better yet, *removing* the limit would support the wellbeing of clinical psychology students by minimising their burnout and dropout, and enable them to support the wellbeing of our communities. Critically, it would also chip away at the barriers blocking equal access to clinical psychology training for students from underprivileged backgrounds. In the long run, a more diverse and representative workforce would be better equipped to provide our tāngata whaiora with responsive treatment they deserve and to challenge the inequalities in our mental health outcomes. Ultimately, removing the student loan limit is not a cost, but an investment into our clinical students, our clinical workforce and our community wellbeing. It is the government's perfect opportunity to show their commitment to equality and wellbeing and deliver on their proud Wellbeing Budget promises.

1. **Footnotes**Kōrero (noun) translates to speech, narrative, story, news, account, discussion, conversation, discourse, statement, information. Retrieved from https://maoridictionary.co.nz/search?keywords=korero
2. Tāngata whaiora (noun) literally translates to 'people seeking wellness'. This term is generally used in preference to 'service users' and 'consumers'. Term defined in (2018) *He Ara Oranga: Report of the Government Inquiry into*

Mental Health and Addiction. Wellington: Ministry of Health. Retrieved from *https://www.mentalh*ealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/

3. (Acronym) Equivalent full-time student points. Every university paper holds a certain number of EFTS points, designed to reflect the workload required to complete that paper. The more papers a student takes each year, the more points they will use up. This means that 7 EFTS points might only cover 6 years worth of papers for some students (e.g. those who completed a double degree). Additionally, clinical psychology students completing concurrent training and research do not qualify for Studylink's 1 EFTS point extension, because their combined course of study is beyond 1 EFTS point in a single year (e.g., 1.25 EFTS). Retrieved from https://www.studylink.govt.nz/
4. Introduced in 2010, Studylink's 7-EFTS point lifetime limit leads to no Student Loan entitlement for students who have used more than 7 EFTS points since 2010. This means no Student Loan to cover tuition fees and no weekly Student Loan Living Costs. Since clinical training requires a minimum of 3 years of postgraduate study, clinical psychology students do not qualify for a student allowance due to the 2013 cuts to postgraduate student allowances. Since these students are studying full-time, they are 'not available to work full-time', and therefore do not qualify for Work and Income assistance. Without paid employment, their weekly income is $0. Retrieved from https://www.studylink.**g**ovt.nz/ and https://www.workandincome.govt.nz/

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What we Wish we had Been Taught

Thought Collage From NZCCP Students

In the spirit of the theme of this issue of the NZCCP Journal, 'What we wish we had been taught', *we thought it would be appropriate to include an anonymous collaboration of collected comments to this effect from our student members. They were invited to complete an anonymous one-question survey. Some definite themes arose from the unanimously poignant and at times touching responses received.*

The overwhelming majority reported struggling with the application of knowledge and skills they had been taught in the real world. They wished for more about 'how to do therapy'. They said the focus was on assessment, rather than treatment and while they had theoretical knowledge of treatment, applying that remained a mystery for them. This arose particularly in regard to treatment planning for individual clients and use therapy skills in a non-structured and flexible way. There was a collective wish for more instruction on attachment, how to work with grief and trauma, and how to hold a feedback session.

It was noted that clients will not always fit into specific formulation models; therefore as practitioners, they need to adjust accordingly and learn that there is no one correct way to conduct therapy and as a clinician you will find a way that is most correct for you. This included a wish that they had been taught about how to handle the complexity of cases they will see, and how to sit in the discomfort of not knowing where to start or what to do. This extrapolated out to a wish to have been taught how much the learning curve continues, even after qualifying and people's expectation 'that you know what you're doing'.

Not unrelated to this was an expressed desire that they had been taught more about the diversity of positions available concerning mental disorder as a concept. In other words, are mental

disorders natural phenomena, social constructs, pragmatic labels, brain disorders, behavioural phenotypes that are not adaptive in modern society, mental injuries or just something else entirely? It was noted that the answer to this question seems fundamental to how one approaches practice as individuals, and how one considers the ethical standing of our profession moving into the future.

There was regret that there had not been more emphasis on cultural awareness not just of Māori/Pasifika, including more practical cultural safety (e.g. learning and practising karakia), but also working with gender and sexual minorities, and other diverse populations within New Zealand.

Another common theme was that it is okay to be a service user, and that there could have been more information on how to share and discuss their own mental health difficulties with their supervisors. The dual relationship the student/intern has with their supervisor (i.e. supervision, but also assessment) made this a really confusing and difficult space to share, and it would have been great if they had been taught about how to do this appropriately. Along similar lines, there was a wish expressed for more tuition on how to actually look after themselves, particularly with the toll the profession can take (not only the client work but also the caseloads and other pressures).

Financial literacy was also mentioned, including the principles of not getting into debt (or only for appreciating assets such as education and property), saving, spending, investing and creating an inheritance for your children's children (not just one generation). The responses were broadly encapsulated in one rather poetic if plaintive response:

> *It's a tricky question because the amount of knowledge I would like to have is endless! Especially in terms of content knowledge. I wish we had been taught more about how to formulate clients experience as this is a tricky skill to develop. I wish we had been taught more about how to plan therapy sessions specifically...not just generic treatment models...not just 'it will fall out of the formulation', I mean shall I give my report a good shake? We did do some of this, but it is such a critical part of our work it makes sense to me for it to be more central in training. It would also be great if there was some advice around how to manage when your own past experiences (e.g. trauma, pathology) are the presentations your working with. And given the uni and our supervisors are grading us it's hard to know where the appropriate space is to take those thoughts/experiences...I have found myself across my internship piecing together a formulation of my own life experiences and ways of being in the world. On occasion, I have wanted to use ideas from my own personal therapy with clients (not self disclosure, just ways of understanding family systems, or ideas/metaphors I had discussed with my own therapist) and have had to really consider if this was A) evidence-based and B) if I was straying from their formulation to my own. And although I could say 'yes' I was evidence based, and 'no' I hadn't strayed from my clients experience, it's an interesting experience to hold those two spaces at the same time. Maybe some training around transference? and how our lives impact our work would have been helpful??*

Short Story: Dyslinksia

Peter Stanley

'The thing that gets me about golf is that I never get any better'.

Simon said this to his three best friends at the course café after another pitiful round.

'My age or something should work to my benefit. But nothing does, and I still get more pleasure from finding lost balls than from the game itself'.
'Have you ever wondered whether you could suffer from Dyslinksia?' Anton asked gently. 'It's big in America. It has also been identified amongst squash players, and it's a real career killer if you're born with it'.

'Don't be silly', replied Simon. 'I've never had lessons and I've got third-rate gear. What's more, I don't play often enough, and I'm probably not suited to the game. That's more than enough to explain it'.

'Please yourself, Simon. But if I was you, I'd see a specialist'. Anton leaned further forward: 'What if you are not really responsible for the way you play, and there is actually nothing that you can do about it?'

Jason was also now interested in what was being said. 'Frankly, I think our Simon could be a trailblazer for golfers who can never get a handicap because they are disabled'.

Johnny finally joined the conversation. 'If it's okay for women to have their own shorter tees why shouldn't the course cater for a person with a recognised disability as well? It's only fair'.
Suddenly, Simon saw all the burdens of his inadequacy slipping away. There were many possibilities ahead of him: distinctive clothes and clubs, special awards, disability payments, support groups and even medication. But then a caution occurred to him.

'Hey, but wouldn't you guys think less of a player with Dyslinksia?'

'Simon, you are yourself. We love you, buddy. And you'd still be playing alongside real golfers'.

Peter Stanley PhD, FNZPsS, is a retired counselling psychologist who also worked as a police constable and probation officer, primary and secondary school teacher, and guidance counsellor and university lecturer.

NZCCP Travel Grant Report: Attendance of the 22nd Annual Cognitive Remediation Therapy in Psychiatry Conference and a Visit to the Lieber Rehabilitation and Recovery Clinic in New York

Dr Melodie Barr

Thank you to NZCCP for the Travel Grant, which partially supported my attendance at these two wonderful learning opportunities.

Background

Cognitive deficits are well recognised in the major psychiatric disorders. Although research into cognitive dysfunction has lagged behind other symptom domains such as psychotic and mood symptoms, there is now considerable evidence that cognitive dysfunction is significant and highly prevalent across many different psychiatric diagnoses, and that it can have a major impact on prognosis and functional outcomes.

Despite this recognition of the prevalence of cognitive difficulties in specific psychiatric disorders, no research currently exists regarding the prevalence of cognitive deficits in adults requiring treatment at secondary community mental health centres (CMHCs). This has hindered the development of appropriate treatment programmes. In 2017, somewhat frustrated by a lack of clinical attention on the cognitive difficulties experienced by people with major mental illness, I conducted an observational research study at the South Auckland CMHC where I work (Barr et al., submitted). That study administered the Neuropsychiatry Unit Cognitive Assessment Tool (NUCOG) (Walterfang et al., 2006) cognitive screen to a random sample of 81 patients. The results indicated that the average total NUCOG score of the psychiatric group was almost 4 standard deviations below that of the control group. Compared with age-matched controls, 87.6% of the psychiatric group performed in the significantly impaired range, 9.9% in the moderately impaired range and 2.5% in the normal range. Results were non-significant for ethnicity, but patients without psychotic symptoms were more likely to be in the normal range. It was concluded that the rates and severity of impairment in our sample were likely to reflect the level of severity and disability of service users under the CMHC generally, more so than the specificity of their psychiatric presentation. These results were presented to Counties Manukau District Health Board (CMDHB) Mental Health Management. Useful conversations were had around the implications of the results for the optimal provision of routine mental health care, as well as the need for specific treatments to improve cognition and consequently functional outcomes for service users. One of the outcomes of these conversations was that CMDHB approved three colleagues and I to attend a 2-day cognitive remediation therapy (CRT) training in April 2018 with Dr Matteo Cella from Kings College London, organised by the Waikato DHB. We subsequently ran a pilot CRT programme in August 2018 with a small number of service user participants, who all achieved positive outcomes (thank you to Katrina Wallis and others from Waitemata DHB for their support in starting this programme). The plan for 2019 was to take the learnings from the pilot, and roll out a more comprehensive CRT programme. CMDHB supported this plan through their endorsement of my attendance at the above conference and centre visit.

CRT

CRT is a short-term, intensive therapy that improves targeted areas of cognitive functioning (e.g. attention, memory, planning) through the repeated use of computerised and/or pen-and-paper tasks. The effectiveness of CRT has been well-substantiated in various meta-analyses (see Wykes et al., 2011). It helps people to develop the underlying cognitive skills that can make them better

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able to function in daily tasks, including school, work, social interactions and independent living, and is recommended by Royal Australian and New Zealand College of Psychiatrists as part of treatment for schizophrenia. It must be stressed that CRT is a 'therapy' and not just 'brain training'; the therapist's input is crucial in supporting the person to develop metacognitive awareness and regulation so that they can apply what they have learned to everyday functional goals. CRT is a collaborative process whereby the individual's profile of cognitive strengths and weaknesses—and their personal 'CogSMART' goals—drive the treatment. In order to generalise the cognitive improvements into everyday life, CRT also needs to be provided in a context that provides support and adequate opportunities for this to occur. This might include support from a community support worker, an employment consultant, or attendance at a social skills group (as some individuals may have difficulties in this area that create an additional barrier to the achievement of their goals). Family/whānau involvement in goal development and implementation is also encouraged.

Lieber Rehabilitation and Recovery Clinic Visit

Dr Alice Medalia is an international expert in CRT and has authored many important research studies and treatment manuals in the area (see References below). She is currently the Director of Cognitive Health Services for New York State and is a Professor of Psychology at Columbia University. She is also the Director of the Lieber Clinic and kindly organised my visit while I was in New York. During the visit to the clinic I observed a CRT group in addition to a recently-developed executive functioning group, which targets the barriers to people achieving goals and making changes (e.g. difficulties with motivation, negative self-talk, time management). I also spoke with Dr Medalia and other therapists at the clinic and came away with many practical ideas for improving our programme, as well as building useful networks with experienced CRT clinicians.

22nd Annual Cognitive Remediation Therapy in Psychiatry Conference

Unfortunately the conference was only 1 day in length, and thus many difficult choices had to be made about which of the many presentation streams and workshops to attend. Following the keynote speakers, I chose to attend workshops rather than research presentations, following the logic that the research would be published and therefore easily accessible in journals. The first workshop, 'Selecting cognitive software for programs and individuals', was facilitated by Tiffany Herlands, a clinician from the Lieber Clinic. As the CMDHB programme is currently exploring this issue, it was a useful workshop to be able to learn from and ask questions of a very experienced practitioner. The second workshop was 'Behavioural treatment to enhance executive functioning in psychiatric outpatients' (discussing the above executive functioning group), and was also facilitated by a clinician (Sharon Fader) from the Lieber Clinic. Again, the opportunity to explore the potential barriers to improvement and strategies to overcome these was useful so that we can optimise the uptake of our programme in New Zealand.

Where to?

For a long time, cognitive difficulties have unfortunately fallen into the 'too-hard basket', and have either not been assessed or we have not had effective treatments to help with these symptoms. It is exciting to be able to offer an evidence-based treatment to support service users to work towards individually-tailored functional goals that have meaning for them.

On returning to New Zealand, I focused on translating my learnings into the next cycle of our CMDHB CRT programme, beginning in August 2019. Through the work of the National CRT Steering Group (which at this stage is composed of clinicians from CMDHB, Waikato DHB and Waitemata DHB), we have delivered CRT training to additional staff from our three DHBs; CMDHB now has eight clinicians trained (psychologists and occupational therapists). We are

moving from a 1:1 delivery of the CRT programme to a group-based programme (4–6 service users in a group) to allow more service users to access the intervention, and also to allow more group-based support and learning. We are now involving non-governmental organisation staff (community support workers) in the delivery of the programme. We have not yet started an executive functioning group for two main reasons: 1) staffing resource, and 2) the group I observed in New York was with very high-functioning (mostly university-educated participants), which is less applicable to the service users with whom we are working. We have incorporated elements of the executive functioning group into our CRT programme and will continue to review the priorities for inclusion in the programme.

If other clinicians around New Zealand are practicing CRT, the National CRT Steering Group would like to know about the work they are doing. We are also here to support other services that would be interested in developing programmes. Please feel free to get in touch with me at: melodie.barr@middlemore.co.nz

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NZCCP Travel Grant Review: Dialectical Behaviour Therapy 'Trainer-in-Training' Meeting

Reviewed by Shelly Hindle & Tessa Brudevold-Iversen

In May this year we travelled to Seattle, Washington, USA, to attend a dialectical behaviour therapy (DBT) 'trainer-in-training' meeting and subsequent trainers' meeting. We attended these meetings as part of DBTNZ (https://www.dbtnz.co.nz/), who deliver training and conduct research, evaluation and dissemination of clinically relevant information in the treatment of people with complex and severe mental health difficulties. The training offered us opportunity to improve our skills as trainers, and we also received updates on the latest behavioural research pertaining to treating suicidal people with multi-diagnostic problems—a priority concern in New Zealand.

About our Work

We are the developers and coordinators of Australasia's first comprehensive DBT programme for eating disorders, and also work clinically within both the eating disorder and child and

Shelly Hindle, M.A (ClinPsy), PGDipClinPsy, MNZCCP, works as a Clinical Psychologist in both private practice and public sectors (has worked predominantly in CAMHS and Eating Disorder Services within the public domain). Shelly was the lead developer of a comprehensive DBT programme for complex eating disorder presentations, both within CAMHS and Adult services. She is also part of the training team for DBTNZ and provides supervision and consultation to individual clinicians and teams.

Tessa Brudevold-Iversen, DClinPsych, FNZCCP, DBT-Linehan Board of Certification, Certified Clinician™, is a Clinical Psychologist working in both private practice and public sectors (Kari Centre CAMHS and Tupu Ora Regional Eating Disorder Services). She is also part of the training team for DBTNZ and provides supervision and consultation to individual clinicians and teams.

adolescent mental health services (CAMHS) fields. Shelly drove development and coordination of a comprehensive DBT programme at Tupu Ora Regional Eating Disorder Service (Auckland District Health Board [DHB]). During the programme development, Shelly consulted with Dr Lucene Wisniewski, the leading international expert in DBT for eating disorders. Dr Wisniewski then travelled to New Zealand for the final stage of an intensive training programme for the DBT team at Tupu Ora, and has been providing subsequent supervision for our team in programme implementation and delivery. The programme has been running for nearly 2 years, and is currently coordinated by Tessa. Tessa also works as both a treatment provider and coordinator of ADHB's CAMHS DBT programme at the Kari Centre.

DBT is delivered in all Auckland DHBs with varying levels of implementation. Some DBT programmes (e.g. Counties Manakau and Waitemata DHBs) have also worked hard to implement the DBT STEPS-A 'DBT in Schools' programme (http://www.mazzaconsulting.com/dbt-steps-a), which brings DBT skills to both general and targeted school populations. DBTNZ have hosted a number of internationally acclaimed DBT experts to provide training on enhancing DBT therapists' skills. Lastly, following Melanie Harned's visit to New Zealand in 2018, many clinicians have begun implementing the DBT protocol for prolonged exposure for trauma in their work.

The Events

The week-long events covered the following topics.

- As trainers-in-training, we presented on topics and got feedback from expert trainers, such as Dr Vibh Forsyth and Dr Christine Dunkley.
- We also learned about other topics, including:
    - Engaging reluctant participants
    - Managing difficult feedback
    - Embodying the principles of DBT as a trainer
    - Use of stories and metaphors
- We saw some inspiring teaching examplars, which also (reassuringly) mimicked much of what we do here in New Zealand. These included teachings on:
    - Opposite action
    - Validation
- Various workgroups gave updates from their findings:
    - Suicide workgroup
    - Eating disorders workgroup
- Research updates were also presented:
    - Updates on exposure therapy in DBT by Dr Sarah Schmidt
    - DBT-prolonged exposure (PE) (Dr Melanie Harned) and DBT- posttraumatic stress disorder (PTSD) (Martin Bohus, Prof. MD)
    - Dr Alexander Chapman's 'faster DBT' study https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-018-1802-z
    - DBT for employment by Dr Janet Feigenbaum https://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780198758723.001.0001/oxfordhb-9780198758723-e-23
- Panel discussions included:
    - Cross-cultural application of DBT
    - Advanced case formulation
    - Priorities and emphases in training
    - Sustainability and implementation of treatment programmes

Points of Interest

At the Trainers' Meeting, we heard that epidemiological studies suggest at any point in one lifetime, 136 million people globally will suffer to the point of contemplating suicide. A Cochrane review (2012) cited DBT as the only evidence-based treatment for borderline personality disorder. While DBT has very strong evidence for treating suicidality, it also has growing evidence for effective for treating a range of challenges (e.g. eating disorders, alcohol and other drugs, PTSD).

We learned of the encouraging Norwegian study on long-term outcomes for DBT for adolescents. At the 3 year follow-up, patients who had completed DBT-A had fewer incidents of deliberate self-harm and less hopelessness than patients who had received enhanced usual care. They also noted that receiving more than 3 months of follow-up care following the programme was associated with further enhanced outcomes (Mehlum et al., 2019).

Dr Kirsten Davis from DBTNZ participated in a panel discussion on cross cultural issues and DBT. She spoke engagingly and with a depth of knowledge about how we are starting to approach this in New Zealand. For example, how DBT principles translate within Māori Tikanga and how these already established ways of being, doing and understanding the world can inform how the DBT is both taught and implemented.

Dr Melanie Harned presented on her recent study on the implementation of DBT-PE (for PTSD) in a community mental health setting. She noted that one of the biggest barriers to positive outcomes was high therapist attrition due to turnover of staff, commenting that therapist burnout was often cited as the reason for turnover. She also noted the pressure within the services for therapists to see other clients, leaving less time to continue the PTSD treatment work within DBT (e.g. therapist's leaving DBT teams due to work pressures). We saw similarities between her findings and our observations of DBT teams within New Zealand and the difficulties therapists face in providing treatment in a DHB setting where pressure to see more clients is high.

There was a panel discussion with small group participation on implementation and sustainability of DBT programmes, an ongoing issue for any DBT team including in New Zealand. We identified which of the key areas of implementation pose the most difficulties for the DBT teams and how these problems have flow on effects for both service and client outcomes (e.g., service outcomes: efficiency, safety, effectiveness, equity, patient-centredness and timeliness; client outcomes: satisfaction, function and symptom reduction). We made note of ideas generated by the larger group to address some of these issues.

Dr Larry Katz and Dr Lizz Dexter-Mazza presented on some of the findings from the suicide workgroup. They discussed the differences between training people receive in DBT foundational training versus the suicide risk assessment and management training. In particular, they emphasised the crucial step of removing access to means of suicide, as the timeline from ideation to action generally occurs within the span of an hour. They also discussed the language we use when discussing suicide, preferring the term 'died by suicide' versus 'committed suicide'. Lastly, they discussed the benefit of understanding the process of moving from suicide ideation to acting on urges through an ideation to action framework.

Dr Alexander Chapman spoke about the study he co-authored with Shelley McMain and associates (McMain et al., 2018), in which they examined 6- versus 12-month treatment programmes. He noted that it was very important to assess the population for whom different treatment intensities and durations were effective.

While in Seattle, we had the pleasure of attending Dr Marsha Linehan's Professor Emeritus event, which included two lectures (by Dr Michaela Swales and Dr Kate Comtois) on the legacy of Dr Linehan and DBT. It was a humbling experience to attend the celebration of the career of one of the current great minds of psychology, who has made an incredible difference to the lives of so many clients who have received her treatment.

We had an extremely busy week with a great deal of learning. The trainers and speakers were inspiring; their expertise and the high calibre of the research presented was evident. It was a privilege to attend and we are grateful for the support from NZCCP to do so. We are eager to begin implementing our learning through various DBT trainings we are involved with, and through our own DBT programmes in which we work.

More information on DBT training in New Zealand is available at: https://www.dbtnz.co.nz/

Review of the Third Wellbeing and Public Policy Conference

Mark Ottley

The 'Wellbeing Budget' of the present New Zealand government is much in the news these days. One might be forgiven for imagining the terminology and constructs are owned by this particular government. However, much research and work on wellbeing frameworks has proceeded in a non-partisan, international and largely theoretical way for decades before this.

The Third Wellbeing and Public Policy Conference, jointly hosted by the New Zealand Treasury, Victoria University and the International Journal of Wellbeing, was held in Wellington from 5–7 September 2018. I had attended the first conference in 2012 and reviewed it for this journal at the time (Ottley, 2013). I have followed this work over the years because the concept of 'wellbeing' and its policy implementation is of central importance to us as psychologists. The conference has grown in size and scope since the first conference, with 300 delegates in attendance representing diverse academic, political, governmental and community organisations. In addition to keynote speakers at the Beehive each morning, there were nine paper streams each afternoon at Victoria University.

In selecting streams, I chose to focus on New Zealand policy framework development, which has matured in terms of the theoretical basis and implementation readiness since the previous conference. I also attended as many of the cultural streams as I could, curious as to what systems may enable us to successfully navigate potential value conflicts. I share some impressions from these perspectives in this article.

Wellbeing, Government Policy and Societal Success

What is the purpose of societal institutions and government? To enable citizens to develop the freedom to pursue lives they have reason to value. Briefly stated, this is the philosophy of Economist and Philosopher Amartya Sen (Sen, 2001), which has been the guiding principle behind the development of New Zealand Treasury's Living Standards Framework (LSF), (New Zealand Treasury, 2018)[1]. For several decades now, theoretical and empirical enquiry has focused

[1] Sen argues for an important distinction between 'human capital' approaches and 'capabilities' approaches. He suggests the first often involves technocratic top-down extractive economic or utility maximisation (such as maximising financial or productivity measures), whereas the latter prioritises individual wellbeing and freedom and is to be preferred.

on the generation of more comprehensive accounts of societal prosperity, by which public policy can be evaluated before and after implementation. From this process, New Zealand national metrics have been developed that share a great deal of conceptual space when compared internationally, and in many cases, also have identical operationalisation. These new wellbeing metrics are multidimensional. They include material conditions such as income, wealth, jobs and housing, but also matters such as health, work-life balance, education and skills, social connections, civic engagement and governance, environmental quality, personal security and subjective wellbeing.

This LSF is 'apolitical' in that different political parties may choose to prioritise certain metrics over others. However, a collection of empirical data is available to inform policy decisions about likely and actual outcomes and trade-offs. Statistics New Zealand collects data, which the LSF then aims to transform into useful information. The objective is to enhance decision making by citizens in electing their representatives and by politicians about government policy (e.g. national budgets).

In an opening talk at the Beehive current Minister of Finance, Grant Robertson, described how his government will be using the LSF to guide policy decisions around the 2019 budget. As one example of how the LSF informs policy, he described the choice between replacing a dilapidated prison with a large prison with a cheaper price per bed, or replacing it with a smaller prison with an attached mental health unit and transitional housing. The first option may look attractive initially, but also fuels the current unsustainable situation where expenditure on imprisonment has grown three times faster than gross domestic product (GDP) over the past decade. The second and favoured option facilitates rehabilitation, reintegration and the gradual lowering of the prison population, especially if this is combined with other early intervention policies.

Professor Ed Diener, a well-known psychologist with over 100,000 citations, was the first keynote speaker. He gave a broad overview of findings from his research career illustrating the positive effect of subjective wellbeing on multiple life outcomes, including health, risk behaviours, education, social connection and economic status (e.g. Diener et al., 2016). He also illustrated the problems associated with focusing on too narrow determinants of policy success, such as GDP or education. I described the difficulties with focusing on GDP in my review of the first wellbeing conference (Ottley, 2013); namely, that it is a narrow economic measure that discounts many valued aspects of existence (e.g. volunteer work[2], recreation) and counts negative aspects of society as positives (e.g. tobacco industry).

Professor Diener also discussed the problem of focusing on educational outcomes as a measure of success may not be immediately obvious but was illustrated by the example of some American schools recently trying to match the educational attainment of Asian countries by replicating their schooling practices (e.g. long school days with no recess except 20 minutes for lunch, plus 3 hours of homework a night). In South Korea, this pattern of hyper-competition and punishing schedules extends into work careers and seems likely to be associated with alarming mental health statistics and the highest suicide rate among Organisation for Economic Co-operation and Development countries. A school regimen such as this creates some exceptional results in a narrow range of cognitive skills (e.g. calculus), but socio-emotional skills are comparatively neglected. Diener spoke of the positive effects of schooling where socioemotional skills are given greater priority in the curriculum, including community volunteering, psychology classes and parenting classes in secondary schools. He is supportive of a shift away from schooling that

[2] Volunteer work is also not an unambiguous good, as it may represent under-funding of services that should be better provisioned.

focuses upon a narrow range of cognitive and technical skills to a much greater focus on supporting the development of citizens with the knowledge and skills to achieve long term sustainable wellbeing.

Professor Diener also described other dilemmas for policy makers to consider, encouraging a greater analysis of wellbeing gain per dollar spent. For example, he described the relatively poor return on investment from breast cancer screening services as compared with the benefit from mental health service funding. I am uncertain how similar the cost benefit ratio of these services is in New Zealand, but the chronic underfunding of mental health services in comparison with 'physical' health services is a familiar problem. More objective measures about wellbeing outcomes may see changes so that funding has greater proportionality to overall benefits. Diener also described the significant benefits to wellbeing of such seemingly mundane matters as multi-use zoning (e.g. having residential areas close to facilities such as shopping centres and work). Progressive tax policies were also strongly endorsed. Positive experimental results from an 'Enhance' phone app were also related, which provides a 12-week course in a range of evidence-based psychological skills, making use of the functionality of mobile phones to prompt the user to learn and implement these. The potential for such technological assistance with large scale public psychological health issues is an area for further exploration.

Another research finding of much interest was that a negative shift in average population wellbeing of one standard deviation equates to an 8.4% vote swing against the incumbent politician; such swings were evident in the 2016 American elections (Herrin et al., 2018). Such findings should motivate politicians to pay greater attention to wellbeing measures.

Overall in this public policy section, I was struck by the progress and transfer of theory to practice, not least by the fact that three government ministers (representing finance, health and statistics) addressed this conference at the Beehive. New Zealand is leading the way in attempting to operationalise some of this theory, with comprehensive and internationally comparable outcome measures available to help judge the success of the exercise.

Wellbeing and Culture

Professor Carla Houkama was the second keynote speaker. She discussed Māori wellbeing, emphasising that recognising a diversity of pathways to wellbeing for Māori is important. She noted that present policy approaches often essentialise one particular and often narrow view. Efforts to ensure Māori voices are heard and leaders willing to present 'the' Māori perspective can lead to oversimplified policy capture. As one example of diversity, Houkama commented on the role of spirituality in Māori perspectives on wellbeing and posited self-determination theory as one that serves well for many Māori, whereby spirituality is meaning and purpose in life, rather than anything more traditionally 'religious' or supernatural in character. Houkama and a co-researcher developed the Multi-dimensional Model of Māori Identity and Cultural Engagement (Houkama & Sibley, 2015), which is a useful tool for researchers to investigate links between diverse aspects of Māori culture, identity, self-identification and wellbeing.

Presenter Jez Tavita provided an insight into Pasifika perspectives on wellbeing and how the 'Fonofale' model of Pasifika wellbeing maps onto the LSF. The Fonofale model uses Bronfenbrenner's ecological model as a theoretical basis for the embeddedness of Pasifika wellbeing (Ministry of Health, 2008). She illustrated how traditional Pasifika systems consist of the individual, surrounded by ever enlarging circles of family, village, district and country. For the first waves of immigrants to New Zealand, the church replaced the village as the centre of community cohesion and connection. She noted a shift in more recent years to other support systems that have taken the place of the village and church; for example, peers, sports

organisations and even gangs. Novel challenges have also arisen, such as easily available but high interest loans, which have often fuelled significant financial insecurity when combined with traditional patterns of obligations to family members or tithing demands from Pasifika churches. Building new institutional structures and a culture supportive of wellbeing that are well matched to a globalised context is a specific challenge among other more general challenges for Pasifika peoples.

Yoshiaki Takashi discussed his research examining ideal happiness as a cultural setpoint (Takahashi, 2014). Subjective wellbeing surveys indicate Asian countries tend to have lower scores than European and Latin American countries, despite comparable or greater incomes. This raises the obvious question: Are these Asian populations really less satisfied and happy with their lives or is there another explanation? Takashi's research found that cultural expectations tended to influence these scores, in particular views of what an ideal setpoint on such a scale should be at different time points. For example, Asian cultures tended to suggest that the ideal point should be lower earlier in life but higher later, as you work hard when younger to make a good life for yourself later. In contrast, Western and Latin American cultures tend to set an expectation for a more consistently higher setpoint. When this discrepancy score is compared, it seems that levels of wellbeing are similar between most Asian and Western countries. For culturally informed clinical practice in gauging wellbeing, this suggests the discrepancy between a person's ideal rating and actual rating is a more important measure to assess than the raw rating.

I had also talked with Takashi 6 years ago regarding suicide, which was at a very high level in Japan at that time. He described that Japan has since introduced government-funded anonymised mental health screening in both businesses and unemployment assistance offices. Those who score very low on wellbeing measures (1–2/10 on a scale where 10 represents highest wellbeing and 1 the lowest) are offered referral for further mental health support such as counselling. Japan's suicide rate has dropped from 25.9 per 100,000 people in 2009, to 16.8 per 100,000 in 2017[3]. This seems promising, although the peak suicide rate in Japan also coincided with an economic recession, so it is uncertain to what extent the government programmes impacted, and I understand that lack of regulation in Japanese mental health services remains a significant problem.

Another interesting theme was debate about the cultural specificity versus universality of wellbeing concepts. For example, PhD student Wei Zhang noted there is no word for 'wellbeing' in Chinese, and so similar concepts like 'harmony' must be used to convey the meaning in interviewing. As I discussed with her over a lunch break, an interesting point here is that 'wellbeing' is also a relatively new term in English, and it is not just people from non-English speaking cultures who are unfamiliar with this term and what it might usefully mean (e.g. the academic understanding discussed at this conference). As a clinician, promoting wellbeing involves collaborative education and exploration of the concept, and of practical evidence-based personal strategies for achieving enduring, rather than more transient, states of wellbeing. Such strategies can also only be realised in a society that enables capability and freedom of action to enact them, so conducive societal conditions must be created and maintained to this end.

Reviewing different cultural perspectives on wellbeing also offers the opportunity to examine what various cultures may miss or get right. For example, common 'Western' understandings of wellbeing may neglect the importance of social connectedness (e.g. Triandis, 1996). A scientific transcultural understanding of wellbeing should include the best possibilities from traditional

[3] In comparison, New Zealand's suicide rate for 2017–2018 was 13.7 per 100,000 people (Coronial Services of New Zealand, 2018).

understandings, avoid the pitfalls of any one particular enculturated view and represent our best understanding of human psychology and other sciences. Not all pathways are equal in benefit or even possibility, and research will help avoid the pitfalls of both cultural imperialism/colonialism and cultural relativism.

Evidence suggests everyone needs a sense of competence, belonging and self-determination (Deci & Ryan, 2000), but there are many possible cultural expressions of those needs. We need to ensure that superficial details representing a specific cultural expression of needs that have arisen over a few hundred years are not confused with or prioritised over deeper cross-cultural universal human needs that underlie and drive these expressions. Such universal needs serve as a truly uniting principle for humanity and policy designed to serve us, including mental health diagnostic systems.

Concluding Thoughts

New Zealand is leading the way in implementing a comprehensive and far reaching wellbeing approach to public policy. There are limitations to this including the continuing underfunding of the psychology workforce in District Health Boards. In addition, while many aspects appear positive, the larger global public policy environment is fractured and troubling and we are not immune to these trends. There are increasing tensions between parochial and cosmopolitan value systems. Loss of economic means, partly attributable to geographic shifts in manufacturing and technological obsolescence, has fuelled large and angry constituencies with a ready ear for charismatic demagogues. There are increasing conflicts between experts and non-experts, and between diverse identity groupings. Equality of access to information distribution via the Internet means both negative and positive social movements can flourish. New Zealand is part of this larger world environment, and how to successfully navigate this global wellbeing and public policy space while avoiding perverse or catastrophic outcomes is by no means straightforward.

There is an urgent need for leaders able to articulate a clear, aesthetically appealing, coherent and reality grounded message about achieving a good life, and a good society. The science behind this cannot be superficial; it requires deep conceptual and empirical knowledge and theoretical integration. As experts in wellbeing, clinical psychologists have an opportunity to get their professional house in order, to help shape and amplify this message in a more effective manner. Potential challenges to doing just this as a profession, and potential solutions, will be examined at the NZCCP Annual Conference in March 2020: ***'Tui, tui, tui, tuia' 'Bind, join, be united as one' Psychology: Foundations and Integration***.

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NZCCP President's Award Report: Introductory Acceptance and Commitment Therapy Workshop

Reviewed by Jenny Jeffrey

As the recipient of the NZCCP President's award, earlier this year I was able to attend a 2 day introductory workshop on acceptance and commitment therapy (ACT) presented by Dr Russ Harris. I am currently a clinical psychology doctoral student, and cognitive behavioural therapy is the modality in which we are primarily trained. However, given the array of therapies used by practicing clinicians across different settings, I was eager to attend an ACT training workshop to broaden my knowledge base; putting me in good stead for my internship year as well as my future career as a whole. Dr Harris is an internationally renowned ACT trainer who has written extensively on ACT principles. He is known for his 'jargon free' teaching, clear explanations and practical skills-focused workshops. It therefore seemed obvious that this would be a great place to jump start my ACT learning.

I certainly was not disappointed! The workshop was packed full of useful information, practical examples and thought provoking discussions. The room was full, with well over 100 people in attendance. Unsurprisingly, most attendees were psychologists, although there were large numbers of other allied health professionals, such as counsellors, social workers and occupational therapists. I happened to sit between an occupational therapist working in a specialist pain service and another postgraduate student training to become a school counsellor. This added to my positive experience, as during our discussions their different perspectives from their disciplines gave me further insight and learning. As promised, there were several group and pair activities scattered throughout the workshop, giving us a break from just listening and allowing us the space to digest, discuss and practice the content we were learning. Even though I was keen to practice new skills and activities, the thought of role playing with people who were not only strangers, but also much more experienced than I, was anxiety provoking. Russ addressed this elephant in the room and challenged us all to use the workshop itself as a way to practice acceptance of uncomfortable thoughts and feelings and to make room for our anxiety about role playing. This was a good reminder to me that I was not the only one feeling discomfort towards role playing; learning and practicing new skills can also be challenging for even the most experienced.

The workshop gave a broad overview on the process of ACT, taking the audience through key parts at the start of therapy, such as informed consent, teamwork and clients' freedom to say no. The majority of the workshop was spent discussing the six core principles of psychological flexibility: acceptance, present moment, values, defusion, self-as-context and committed action. The audience was introduced to multiple techniques and activities to help explore each of the six principles with clients.

Jenny completed her BSc and MSc in Psychology at Victoria University of Wellington. Since her graduation, she has worked in a variety of research settings, both in New Zealand and the U.K. Jenny has a passion for applied psychological research working with children, youth and families. She is about to start her internship in 2020 as part of the Doctor of Clinical Psychology programme (DClinPsych) at Massey University.

My Take Home Messages

Use Simple Practical Activities to Illustrate More Complex Therapeutic Processes

Russ introduced us to several key concepts and processes in ACT to work on with our clients. These concepts (such as workability, cognitive fusion or self-as-context) can be difficult to explain to clients in a simple and accessible way, especially for therapists new to ACT. For every concept we learnt about, multiple practical activities were provided to concretely explain these complex ideas to clients. For example, I found the 'Hands as Thoughts and Feelings Exercise' a really clear way to demonstrate cognitive fusion or 'getting hooked' by thoughts and feelings. This exercise asks the client to slowly raise their open palms up towards their face, eventually covering their eyes. The hands represent the client's thoughts and feelings; highlighting that when their palms are close to or covering their eyes, they are 'hooked' or fused and it can be difficult to focus our attention on everything else in life. Becoming unhooked (lowering their hands back down) can help us to be fully present in what we are trying to do. Yet it is important to emphasise that even when the client's hands are lowered, their hands are still there. Therefore, their difficult thoughts and feelings may still be present, but it is how they choose to pay attention to them that is important.

Broad use of Mindfulness

The workshop approached mindfulness in a simple and accessible way, defining it as 'a set of psychological skills for effective living, that involve paying attention with openness, curiosity and flexibility' (Harris, 2019, p. 40). It was discussed as a toolbox or Swiss army knife that can serve several different functions, including but not limited to: engaging, defusion, self-compassion, acceptance, grounding/centring, observing thoughts, broadening or narrowing focus as well as noticing and acknowledging what is present. The versatility of ACT is such that practicing mindfulness to bring clients' focus to the present moment can be as simple as stating 'Notice X'. 'X' can be anything from a thought, feeling, body sensation, memory or urge. Alternatively, more involved and detailed techniques such as 'Dropping Anchor' or 'The Curious Child' may also be used. When using a mindfulness technique with a client, we were reminded to be clear about its function. What is the purpose? How will it help the client achieve their therapy goals? Whether it is helping the client to increase their acceptance or their ability to unhook from their thoughts and feelings, it is important to always refer back to its function.

It is Ok to Sometimes get it Wrong

Throughout the workshop it was made very clear to the audience that simply attending the workshop or reading a textbook on ACT was not going to give us all the skills we need to be effective ACT therapists. The necessity of practicing was continuously emphasised, with the frequent role play activities viewed as the first of many practices to come. We also watched multiple video clips of Russ using specific techniques with clients. I found this insightful and helpful for a number of reasons:

1) It was an opportunity to consolidate and reflect on the content.
2) Gave great examples of how to approach techniques with a client in session.
3) Reassuring to see that things do not always go as planned, even for very experienced therapists like Russ.
4) Able see how to navigate and recover when techniques do not work as expected.

When answering audience questions about the video clips, Russ was open and reflective about his own experience when sessions do not go as expected. He was realistic about the likelihood that as new ACT practitioners, we were likely to get it wrong in session with clients, regardless of how much we practice beforehand. His reassurance was validating to know that it is OK, and almost expected, to get it wrong sometimes.

Conclusion

I thoroughly enjoyed this workshop. It was the perfect opportunity to extend my understanding of the six core principles of ACT and learn how to effectively incorporate mindfulness techniques into therapy. What I had not anticipated was the sheer amount of additional resources (such as numerous mindfulness audio MP3s, worksheets and handouts for clients) and continued online learning (an 8-week e-course) we would have access to after the workshop. Not only did this make the workshop great value for money, it also helped consolidate all that I had learnt. As discussed above, the workshop gave a broad overview and brilliant introduction to ACT. At times I found myself questioning how to apply it for clients with complex clinical presentations. Russ addressed similar questions from the audience, stating his advanced ACT training explored these issues in depth. This introductory course provided enough incentive to attend advanced training.

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Book Review

Title:	**Handbook of self-regulation: Research, theory, and applications (3rd ed.)**
Author:	Vohs, K. D., & Baumeister, R. F.
Publisher:	Guildford, New York. 2018
Reviewer:	Peter Stanley

It is challenging to review an edited text that represents multiple perspectives and opinions, and particularly when it is 640 pages in length and has supplementary chapters online (available for purchasers of the book). Moreover, this volume is packed with research and theoretical models, as well as carefully argued positions, and it took me about 100 hours to read and reflect on it. My interest in self-regulation began a decade ago when I read a couple of lines in an academic paper (now mislaid) which suggested that self-regulation was the best candidate for understanding the link between the environment and how people behave. In other words, self-regulation may be *the* explanation of behaviour that accounts for individual success and failure, and for human adaptation and maladaptation. This is a very good reason for trying to understand this subject despite its significant intellectual breadth and complexity.

The *Handbook of Self-Regulation: Research, Theory, and Applications (3rd ed.)* (Vohs & Baumeister, 2018) is divided into six sections: Part 1, Basic regulatory processes; Part 2, Cognitive, physiological and neurological dimensions of self-regulation; Part 3, Social, organisational, and cultural dimensions of self-regulation; Part 4, Personality and self-regulation, Part 5, Development and self-regulation; and Part 6, Self-regulation challenges. This review follows the book's structure and discusses themes and specific topics in self-regulation under the designated section headings. At the end of this review, there is a conclusion where I offer some personal speculations in relation to self-regulation. This is a lengthy book review, and it is offered in the spirit of the text itself to provide accessibility to a rapidly developing field.

Basic Regulatory Processes

Self-regulation means many things and definitional issues abound. However, a simple way of understanding it is to see it as the pursuit of goals despite distractions. At the outset, it is important to acknowledge the potency of diversions; the present text contains a useful chapter on desire. Contributors Hofmann and Vohs contend that each of us spends about 50% of the

time that we are awake yearning for things and notably, 40% of deaths in the US each year are the consequences of poor diets, drug use, violence and other 'more troubling aspects of the jungle of human desires' (p. 89). Nevertheless, for me, the most powerful representation of human craving comes from Greek mythology, where Odysseus put wax in his sailors' ears and had them tie him to the mask to avoid the seductive song of the Sirens that would have led to shipwreck. The interaction of desire and cognitions is an interesting aspect here because it is dynamic and progressive. An environmental stimulus may spark intrusive thoughts and fantasises, which if dwelt upon, intensify desire. The increasing longing and urges can then consume more and more cognitive space and they may ultimately crowd out self-regulatory representations. Nonetheless, according to the text, humans are generally very good at the regulation of desires.

In terms of self-regulation, people are the goals that they pursue. Typically, we are shifting across multiple goals with a particular concern predominating at any one time. In the beginning may be the behaviour, but we make adjustments in what we do in response to the emotions and other consequences that we experience. According to Scholer and Higgins (in an online supplementary chapter) people utilise either promotion or prevention strategies depending on the situation, who they are, and their regulatory state. Promotion is about making good things happen, whereas prevention requires vigilance to keep bad things from occurring. Yet whether self-regulation is an aspiration or a duty, it is task-limited when vigorously deployed. According to the strength model of self-control, self-regulation is a finite, domain-general, resource. This means that if we use it for one thing we may not have it for something else. Equally, however, we can strengthen the 'muscle' of self-regulatory capacity by training in one domain and then reaping the benefits of this preparation with a different sort of challenge. A model like this integrates a lot of data in the field. It also tells us why diets and exercise are abandoned when we are under pressure, and explains how going to the gym can actually help a student to complete his or her assignments.

Another central theme and controversy in the self-regulation field is the relative contributions of conscious processes and habitual responding to what people do. To act deliberatively and with awareness reflects rationality, whereas habits are acquired through associative learning and operate outside of conscious understanding. However, both systems can contribute to either regulation or dysregulation depending on individual differences and situational influences. It is highly probable that self-knowledge (and self-efficacy) affect the adaptive goals that we pursue. Similarly, the exercise of 'good' habits facilitates constructive personal outcomes. As significant is the reality that reasoning processes can justify indulgence; just as surely as 'bad' habits can lead to a life of dissolution. Conscious and effortful control may be given primacy in explanations of self-regulation because of its presumed capacity to override a strong reflexive tendency. And it is a fact that people with higher levels of self-efficacy are likely to have superior self-regulation; not least because it makes sense that their perceptions of capability are factored into what they do. But then again, there is the possibility that the thoughts that people have in their minds about agency and control actually follow rather than precede the activation of habits and nonconscious goals.

The Neurology and Physiology of Self-Regulation

The importance of the prefrontal cortex to effortful control can be dramatically demonstrated in people who have sustained damage to this part of the brain. The early case of Phineas Gage has appeared in many textbooks and tells of a man who was serious and hardworking but who became irresponsible and thoughtless of others after a tampering rod was blown through the front of his head. Nevertheless, in the absence of such extreme traumatic events, self-regulation and behaviour actually have multiple physiological and experiential inputs. And even at the level of a single entity, such as the prefrontal cortex, there is significant complexity; as the executive

functioning operations that it hosts include attentional selection, response inhibition, working memory, decision making and planning.

The present text reports that self-regulation has its own distinctive physiological profile involving changes in the immune system, heart and liver. Contributor Blair goes further and provides a psychobiological model that suggests bidirectional relationships among different parts of the brain ('top-down' and 'bottom-up'), environmental stimulation and stress hormones. Blair's research-based thesis incorporates the work of Yerkes and Dodson (1908), and the understanding that executive functioning has a restricted operating range. When arousal is low or high, nonconscious attentional and affective processes predominate in behaviour. Cortisol is hypothesised as a primary means by which experience affects self-regulation. When fully elucidated, this thesis has important implications for parenting and education. Actually, it also represents a serious challenge to simplistic explanations of child and adolescent behaviour that invoke unsubstantiated damage to or underdevelopment of the prefrontal cortex.

Personal distress may lead to eating unhealthy foods, impulsive decision making, reduced task persistence and aggressive behaviour towards others. These consequences, which might sometimes be attributed to negative states like anxiety and depression, can also arise solely from insufficient sleep. Effectively, without enough sleep, many of us are in danger of becoming 'tall 2-year-olds' (Jensen, quoted by Krizan & Hisler, p. 182). Sleep loss impacts cognitions, affect and behaviour; within each of these domains, it can have some unexpected effects. For example, lack of sleep negatively impacts on planning and memory, but it also has particularly adverse outcomes for divergent thinking. Poor sleep increases negative affect, decreases positive affect and makes it more difficult for us to understand other people's emotions. The behavioural consequences of bad nights include deficient inhibition, as in inappropriate humour and laughter, and actions like taking shortcuts and cyberloafing at work. Another interesting aspect about insufficient sleep is that people know that it negatively affects their self-control and this awareness may also explain the desultory way that they conduct themselves the next day.

Relationships and Self-Regulation

When some beginners think about the psychology of self-regulation it could be that they start with laboratory work and with children and delay-of-gratification experiments. Almost certainly, it will be about individual human behaviour and only rarely may it extend to the pursuit of goals with other people. Nonetheless, the practical significance of self-regulation is in real-life settings. In particular, it is concerned with what we do in the context of our relationships with partners and families, friends, strangers, and work and recreational colleagues. The critical component that self-regulation can contribute to relationships is a sense of trust; this is pivotal because it reduces unpredictability and risk. Trust (and interdependence) arises when it is perceived that there is a mutual beneficence that will translate into actions. Effectively, an individual's trustworthiness increases with the signs of self-control that they display; although other people have to be capable of reading these signs if they wish to benefit from them. Meanwhile, people with high self-control can often feel burdened by the demands of others in their personal and professional lives.

A hill does not appear to be a steep when we are with a friend, and the longer the friendship, the less steep that the hill seems. Correspondingly, the chances of becoming obese increase by almost 40% if a spouse becomes seriously overweight. These and other studies cited in the relationship chapters in Vohs and Baumeister (2018) point to the fact that progressively and imperceptibly, relationship partners can become a single self-regulating system. This is not to say that each of the partners will desist from attempting to sculpt the other so that they more completely conform to the ideal image that they have for them. The success of the Michelangelo

phenomenon (known in some church circles as 'aisle, altar, hymn') depends on positive and direct forms of influence that avoid producing negative self-evaluations and relationship dissatisfaction. Of course, such an approach does demand that the partner who is so engaged has sufficient self-regulation to see his or her change project through.

Self-regulation is typically in relation to normative standards of behaviour and as we know, such standards change over time. Increasingly, workplace roles seem to be associated with emotional display rules, and this commercialisation of feelings can have significant personal costs. However, there are likely to be differential affects by occupation, as there are by personality, gender and culture. Presumably, some work roles are more protected than others by the nature of what they do, by their status and authority, and by organisational dictates. Nevertheless, as the present text makes clear, there has been a general moment for workers to perform emotional labour for money. It is probable that few of these transactions are likely to be fair as they are dependent on investments of emotional self-regulation, and because they can provoke a confrontation with the private self.

Personality and Self-Regulation

Self-control is implicated in many personality models and traits, and it is also represented in more specific preferences and propensities that are assumed to vary between people. The present discussion is restricted to two individual differences (impulsivity and grit) that are opposites in important respects. Impulsive action is evocatively described by T. S Eliot in *The Waste Land*, and an abridged version of his statement is, 'The awful daring of a moment's surrender/Which an age of prudence can never retract'. Little wonder then that impulsivity is second only to subjective distress as a diagnostic criterion in the DSM, and that it is associated with a catalogue of self-control failures such as overeating, overspending, excessive drinking, excessive gambling, risky sexual behaviour and risky behaviour of many other sorts. Interestingly, impulsivity that is used to alleviate personal distress is more likely to predict negative outcomes. This said, rash actions can also arise from heightened and dysregulated positive emotions. Note: impulsivity can be distinguished from sensation seeking. People who seek out novel and exciting experiences do not necessarily abandon premeditation, risk management and perseverance.

Like impulsivity, grit is complex and needs to have long-term stability to be considered a trait. Actually, without a long-term commitment, grit has no meaning at all as it is defined as 'sustained self-regulation in the service of superordinate goals' (Eskreis-Winkler, Gross, & Duckworth, p. 380). Grit demands grunt, but it also requires quality effort that is focused and deliberative. The individuals who show this special sort of determination believe that they create their own destiny, and are motivated by engagement and meaning. Understandably, grit is associated with achievement and wellbeing. Significantly, it is not consistently coupled with talent. Grit contrasts with self-regulation in being staunchly devoted to a single overarching goal. In contrast, self-regulated individuals may change the goals that they pursue depending on the consequences that they receive. Although gritty individuals function exceptionally well in contexts where dropout is commonplace, conventional self-regulation may be more adaptive in everyday situations which contain many demands and multiple distractions.

Development and Self-Regulation

How does early childhood experience, and more specifically disadvantage and maltreatment, get 'under the skin' and influence the development of self-regulation? Mention has already been made of Blair's psychobiological model, which hypothesises that stressors stimulate additional hormone production which canalise neural responses to match chaotic environmental demands. In resource-rich and predictable settings, stress hormone levels are more moderate and conducive to executive functioning and effortful self-regulation. Having said this, all new-borns

clearly bring biologically-based dispositions to the care-giving circumstances in which they find themselves; the tendencies that they come with can affect the nature of the parenting that they receive. Significantly, intervention studies show that highly emotional and reactive young people can become effective self-regulators when they receive high levels of sensitivity and parenting skills from caregivers who possess exceptional degrees of emotional regulation. These data confirm the psychobiological model, and also accord with much correlational research, which indicates the importance of self-regulation to the development of positive emotionality, empathy and conscience, and social competence and adjustment in children and young people.

Self-regulation can also be a central issue in old age, and deficits may manifest as verbosity and making socially inappropriate remarks, gambling and obesity. With ageing, there is often atrophy of the frontal and temporal lobes of the brain and there is increasing difficulty in recognising emotions such as anger, fear and sadness. The inability to interpret the facial expressions of others is likely to be a problem in social situations, although it may be compensated by a greater tendency to pay attention to positive information. There are other regulatory processes to balance cognitive decline in older people and these include self-conscious emotions and self-efficacy perceptions. Pride, guilt, shame and embarrassment are self-conscious emotions that can promote good self-care and relevant social behaviour. Older people can also be aided by having enhanced self-efficacy perceptions on everyday problems that matter to them.

As individuals, we can increase our self-regulatory capacities by training. A really easy and economic way to do this is by learning to use implementation interventions. These are 'if-then' self-statements, and can be especially effective when these are combined with mental contrasting, which is the anticipation of obstacles and difficulties. Nevertheless, when most people are talking about self-regulation training, they are usually referring to the technique where exercises in one modality are expected to transfer to controlled performance in another. According to Berkman in Vohs and Baumeister (2018), there is moderate support for this approach, but a problem with it is that it does not specify its mechanism of action. Berkman asks, 'if, in the resource model, self-regulation is the speed of the car and the resource is the amount of gas in the tank, then what is the engine?' (p. 451). Lack of specificity about mechanisms is a problem more generally for training models, but in a simple practical sense, it may not be especially important. Beliefs about self-regulation can have significant power, and it could even be that placebo-based interventions that are generalisable and durable are capable of being disseminated at population levels.

Self-Regulation Challenges

The final part of Vohs and Baumeister (2018) addresses six self-regulation challenges. The section begins with a chapter on the psychiatric diagnosis of attention-deficit/hyperactivity disorder (AD/HD). The contributor here asserts that AD/HD is an executive function deficit disorder, despite the fact that few participants who have this assortment of issues actually have difficulties with executive functioning on laboratory tests. Nevertheless, in keeping with contributor Barkley's presumed brain dysfunction perspective, medication is proposed as the only really hopeful treatment for children diagnosed with AD/HD. Tobacco addiction is also the topic of a chapter, and with this habit behaviour the environment clearly has the key role as cue, means, maintainer and explanation. The writers of the addiction chapter make the suggestion that smokers should attempt to give up when other self-control demands in their lives are minimal. This recommendation reflects the resource and strength and model of self-regulation, and it is undoubtedly a good caution when enacting New Year resolutions and going on holidays with friends and relatives as well.

'Whenever I want something I just visualise myself having it and then I back myself to win'. Comments like this may indeed characterise the age in which we live, but, according to chapter writers Oettingen and Cachia, such sentiments are often unhelpful. People daydream about many things; from writing a novel to resolving climate change and everything in between. However, unless persistent positive fantasises are coupled with a close consideration of the impediments that are likely to be encountered, the dreaming can sap the energy to actually do the job. In a related chapter, entitled *Deciding to Curtail Persistence*, contributors McGuire and Kable contend that it is okay for people to revise their goals and to change course when they run into the realities of what they have undertaken. Desistance does not necessarily represent a self-control failure. Rather, it may arise from a careful cost-benefit analysis and a refusal to chase sunken costs.

There is a separate chapter on self-control and criminal offending, which is a review of Gottfredson and Hirschi's general theory of crime. This is a prominent and substantiated model of offending, which interestingly, provides an explanation of victimisation as a problem of self-regulation as well. It is probable that individuals who are assaulted and battered more often stray into harm's way. In this chapter, cross-cultural evidence is explicitly presented, and it could be that this is the only time that this occurs in the text. International studies are cited by the chapter contributors and these support self-control problems as an invariant cause of crime and delinquency. The last chapter in the book discusses the challenges to self-regulation in achieving financial wellbeing and, in particular, the extraordinary ease with which we can now spend our money in a cashless society. Another issue is saving for retirement as this requires us to empathise with ourselves as a different person in a distant time. And then there is the 'what the hell' effect (p. 595), which can occur with both spending and dieting; and it is when we step out wildly after making a first transgression against an irksome goal.

Conclusion

Fundamentally, it could be that self-regulation and self-control represent a contest between our impulsive natures and our more sensible selves. This is a view largely taken by Carnevale and Fujita in a creative and instructive chapter in Vohs and Baumeister (2018), which has the abridged title of *Consensus versus Anarchy in the Senate of the Mind*. Utilising an extended analogy, these authors propose that self-control operates like a well-ordered democracy. In this familiar form of government, conduct is rule-governed and goal-directed; it is informed by policy and priorities. As well, it characteristically represents the will of the majority of its constituent influences. Moreover, this within-person parliamentary process is dependent for its inputs on high-level construals. And these cognitive mechanisms can attend to larger meanings rather than be taken over by the immediacy of facts and feelings, and petitions and protests. In contrast, self-control failings are chaos and anarchy. Due process has been hijacked by low-level construals. Sensory and perceptual capacities predominate, and minority interests replace governance by consensus.

The thing is, however, that impulsivity is implicated in many of the most important things that we do, and it can also be a great deal of fun. Without it, there would be far fewer proposals of marriage, fewer babies conceived, fewer tries scored in rugby, fewer emergency medical interventions and much less therapeutic shopping. If we can return to Eliot's *The Waste Land*, the lines that follow that eminently quotable 'awful daring' couplet have actually much more to say about impulsivity: 'By this, and this only, we have existed/Which is not to be found in our obituaries/Or in memories draped by the beneficent spider/Or under seals broken by the lean solicitor/In our empty rooms' (*Selected Poems*, pp. 66–67). The other thing is that pure compulsion is probably a rare phenomenon. In a vast array of circumstances there is some contemplation before action, even if it is just a decision to throw caution to the wind.

Surprisingly, perhaps, conscious self-control and high-level construals are not inherently high-minded; this is in addition to the fact that they may be our habits that are talking to us about the actions that they have just taken. Returning to Odysseus, what we have here is a mythical man who dealt with personal temptation with some mental contrasting and precommitments, and who might subsequently have also savoured the seductresses' song.

Finally, the major advantage of a mega interpretation like self-regulation is that it can generate conversations on many topics. One of these dialogues might concern the relationship of intelligence and self-regulation, and the relative importance of these overarching outlooks as the most useful explanation of human conduct. What may be even more interesting is a discussion about the normative nature of self-regulation and the effects of changing social mores on its application. Previous generations can tell us that they were defined by collective commitments and by individual prudence, dignity and decorum. If this were the case, then there is some contrast with the present social media driven age where the personal seems to have a special priority, where feelings can be facts, and where overt expressions of emotion are encouraged. Self-regulation and self-control have much to teach us, and it is hoped that this review has accurately represented some of the more important themes and issues in this area as these are contained in the present text.

NZCCP

National Education Training Timetable

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

TRAINING TIMETABLE

NZCCP Events

LOCATION	MONTH	PRESENTER/ CONTENT
Christchurch	26-29 March	NZCCP 31st National Conference "Tui, tui, tui, tuia"

Other Events

LOCATION	MONTH	PRESENTER/ CONTENT
Auckland	19-21 February	Level 1 Schema Therapy Training
Wellington	21 February	Clinical Practice Issues in the FASD Field
Auckland	24 February	Māori suicide prevention: Research, policy and practice
Various	Feb, Apr, May	Emotionally Focused Therapy (EFT) Training
Auckland	10 March	Working with the impact of Developmental Trauma on Sexuality and Intimacy
Auckland	13 March	Treating the effects of childhood abuse and neglect on young adults
Bay of Islands	18-21 March	New Zealand Pain Society 2020 Conference
Wellington	23 March	The Call Of Darkness: Managing Suicidality In Clinical Practice
Auckland	26-27 March	Introduction to Compassion Focus Therapy
Wellington	Mar, Jun, Sep	ACT workshops
Wellington/Christchurch/ Auckland	June	The Snow White Model: Working with complex and developmental trauma
Auckland	17-23 October	MTI NZ Intensive
Auckland	7-10 November	ANZ ACBS conference 2020