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“Ka tō te rā, ka ara anō te rā”
The sun sets, but always rises again. Though darkness descends,
the shine of light surpasses it.
Today is a new day to overcome tribulations.

Editorial

Dear friends,

Welcome to this special issue on trauma. While this is a relatively slim issue compared with some of our recent issues, I hope you will enjoy the creativity, thought-provoking insights, and knowledge that our contributors have been kind enough to share. On that note, I would like to thank all of our authors, without whom we would not have a journal, as well as our reviewers who generously give their time, effort, and skill. Birthing this Journal into peer reviewed status has been a labour of love, and this is only possible because people are willing to review material. I am very aware that the same group of people frequently say yes (or, at least, do not say no!), and I would urge you to let us know if you are interested in becoming a reviewer for the Journal. Being a reviewer involves reading an article (or two) and providing your comments about the content and/or style. In addition to Caroline Greig’s extremely able stewardship of the Journal, we are fortunate to have the talented Audrey Holmes proofreading/copyediting our Journal and making sure we are consistent with APA style (6th Edition).

This special issue addresses a topic dear to my heart, and a topic that is at the heart of what we, as clinicians, frequently deal with. These days, most of my work is with people who have experienced sexual abuse. It has been humbling to see how resilient people are in the face of adversity. Many of you will be aware of the small area of research that is “post traumatic growth” in contrast to post traumatic stress. While writing this editorial, I searched online for post traumatic growth, and came across a post written by an (anonymous) author from the University of North Carolina Charlotte, about the five domains in which there might be growth subsequent to trauma. The first is seeing possibilities that were not present before; the second is in the area of (possibly deeper, more connected) relationships; the third in a sense of one’s strength; the fourth in appreciation of life in general; and the fifth reflects spiritual growth (<https://ptgi.uncc.edu/what-is-ptg/>). Do these domains map onto what you have seen with your clients who are overcoming adversity? Please write a letter to the Editor and let me know what you think.

The topic for our upcoming journal is “Proactive Change,” and we look forward to your articles, poems, book reviews, and more. On the topic of being proactive with changes, Caroline and I hope you are able to come to the NZCCP Conference 29–30 of July in picturesque Queenstown. The theme for this conference is “Working with Complexity, Clinical Psychology in the Digital Age, *Te tikanga mātai hinengaro i te ao hangarau.*”

I hope you enjoy this edition of the Journal, now moving steadily into digital production. Warmest regards, Kumari.

Follow Kumari’s blog about psychology at www.TheConsciousAdventurer.com. Kumari also has a radio show by the same name. The NZCCP Journal is also on Facebook—please like our page!

Letters to the Editor

Dear Editor

Trauma-informed practice: Are we all talking about the same thing, and if not, what are we going to do about that?

I work in the trauma area and so when invited (along with all NZCCP members) to contribute to a Shrink Rap special edition on trauma, I did what any right-minded clinician does...I quickly discounted anything I could offer and looked forward to reading the thoughts and research of others!

I then heard myself talking to a group of parents who were feeling at a loss about how to firmly and clearly deal with their children's anxious behaviours...as they did not want to "traumatise" them. I then had a meeting with a parent whose child had been sleeping in the parental bed since the earthquake as the child was too "traumatised" to sleep in their own room. I was then part of a meeting where representatives of a government department were talking about their "trauma-informed" policies and procedures, which in practice did not seem to reflect any model of trauma in which I had been trained.

This got me thinking. The word "trauma" and the related concept of "trauma-informed practice" are in common use (even fashionable, some might say), and like many such concepts, the assumption is that we are all talking about the same thing. However, my suspicion is that this is not the case. As in terms such as "culturally sensitive" or "strengths-based practice," people are operating under different principles, knowledge levels, and agendas, which can create confusion when these differences are not made explicit. Do not get me wrong, I think it is great that trauma and its impacts are more visible, as for too long those suffering its effects have been pathologised, seen as somehow "less than," and not well supported within traditional systems of care. However, a potential difficulty with this increased "press" is that people can start to see trauma everywhere and as a result, over react or become "stuck" in the face of normal human reactions.

Professionals can also operate under trauma-informed policies and procedures without a true understanding of what informs them, and without funding packages that truly allow the underlying aspirations to be realised. This can result in clients waiting a long time for services; potentially not being able to access evidence-based interventions for as long as they need them; being treated in isolation from their living context; getting their different problems parcelled off to be managed by different services (each requiring a different assessment); and when the pain of addressing painful experiences leads to inconsistent attendance or creates other problems such as drug and alcohol abuse, they get discharged from services as they are too difficult to manage.

In highlighting this issue, I am not suggesting that there is a simple answer to how we define, understand, and work with trauma; and even if there was, would we all agree about what these are? What I am wondering about "out loud" is whether psychologists should take on a bigger role in influencing this trauma-informed landscape, because as a discipline, this is something we know quite a bit about. This is not to say that other disciplines are not highly informed, because many are. The point I am making is that outside of the therapy room, how vocal are psychologists in taking what we know and influencing social policy, workplace policy and procedures, community knowledge, and public opinion?

I get that speaking out may not be everybody's cup of tea, and that the therapeutic work done by my colleagues throughout NZ has great worth. I just want us to get a bit braver and put our

knowledge out there in settings that allow for greater access and debate about this information. Recently, I was approached to talk on the radio, and if I had not just been lecturing (or should I say “appropriately encouraging”) my son to take up a new challenge at school, I would have easily said “no.” Before the interview, I had all the normal nerves about speaking in public. The fact that I was in my living room made this experience even more surreal, as I knew thousands were listening. I also experienced anxiety about how my colleagues...you know the ones that know far more about this than me...would accept what I had to say. I hope I’m not alone in my natural fear of being caught out as an “imposter,” in fact I know I am not. As a professional group, I think we are a cautious bunch and this has its absolute place, as we do not want to foreclose too early or rush our clients to a place they are not ready to explore. Half of us probably have a toe, if not an entire foot, in the genetic pool of anxiety; for how else would we achieve the demands set during the clinical programme or have the sensitivity to respond appropriately to clients and establish sound therapeutic alliances where meaningful change can occur. All of these factors make it hard for us to put our heads above the parapet, especially if we throw in a bit of “tall poppy” anxiety reinforced in NZ culture.

So, this challenge is not an easy one, but like any good psychologist, how do we break it down into manageable chunks? One way is to take a small risk and see how it goes. Why not accept an interview, talk at that public meeting, join in on a panel discussion, step into that leadership role, or even write that article☺. In doing this, we have the opportunity to take our hard-won knowledge and the skills that make us excellent communicators and make a difference to more than the person sitting opposite us in therapy. We then have a chance to influence how **truly** informed our trauma-informed social and professional networks become. Worth the risk I would say. Who knows, you might even get to enjoy it!

Yours sincerely,
Catherine Gallagher

Processing Trauma: Is it Ever Complete?

Quintin Leith Chrystal

Part I: The Song

HARDLY A TRICKLE
(Hipnottick Erra, 2016)

It’s hardly a trickle
Just a drop of blood
But it’s the pain
That I’ve been thinking of

It’s hardly a grizzle
Just a tiny sigh
There’s no one to help us
It’s just you and I

How can you
Sit so passive
In your rocking chair?

Empty cans
And broken bottles
Around us everywhere

How can you
Sit so passive
In your rocking chair?
Empty dreams
And broken promise
Around us everywhere

We've got to find a portal
Out of this place
We've got to find some kindness
In a human face
We've got to find a portal
Out of this place
We've got to find some kindness
In the human race

Part II: The Story

The Pre-Story

At around 6 years of age I was severely beaten by a middle-aged woman. She only hit me twice, but it was with a thick stick. I vividly recall her taking the cane off the wall and bending it into a full circle before straightening it again and instructing me to bend over. I also vividly recall looking deeply into her eyes while she was demonstrating her weapon of choice. I will never forget those eyes. They contained the cold rage of a sadist.

I have always remembered the initial pain as a white, searing burn that simply would not go away. I had never experienced anything like this before. I could not sit comfortably for at least a week and I was deeply shocked to see the awful marks left on my body. I remember exactly where I was and which way I was facing when I first saw them. Over the following few days, they gradually changed from red and white to purple, green and blue as the blood vessels healed. I told no-one about this vicious assault, mainly because it was clearly my fault. I had broken the rules. I had talked in class.

An early musical burn. At around 10 years of age, two of my favourite girl-friends at school overheard me singing *New York Mining Disaster 1941* by the Bee Gees. In good faith, they dragged me off to our music teacher for a potentially proud public performance of my nascent vocal skills. The teacher listened briefly, rolled her eyes, mimicked me with a few flat notes and sent us all packing back to the playground.

After that brief, but effective “social degradation ceremony,” I never sang in company again. I also struggled to talk out loud. I developed a form of “vocal anorexia” characterised by intense feelings of shame, anxiety, sadness, and emotional pain associated with the sound of my own voice.

It was around this time that I started experiencing increasingly serious doubts about mainstream

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education on the one hand and other people in general on the other.

A ray of hope. At around 13 years of age, I had the good fortune of attending a talent contest at my new high school. I vividly recall two bands made up of senior students: “Satan’s Harvest,” a tight, punchy, rock band, and “Benedict Arnold,” a slick, jazzy outfit delivering edgy renditions of classics such as *Summertime* that I had personally never heard before. I remember being so excited I could barely stay seated in my chair. At that stage, I knew nothing about attention-deficit/hyperactivity disorder.

It was around this time that I knew I also wanted to play on that stage one day. I knew I had to confront those internal demons that had clipped my musical wings. There were two big problems facing me at that stage: firstly, I could not play a musical instrument and, secondly, I still really hated the sound of my own voice.

With the aid of a steady stream of primarily well-channelled, angry, antisocial energy, I managed to purchase a cheap electric guitar and amplifier, learn some basic chords, and forge some links with a range of other misfit musicians who have since either died early or gone on to achieve great things in the international arena.

Curiously enough, I eventually landed up playing on various stages with most of the members of the two bands that had originally inspired me. It remained an ongoing form of torture for me, however, and I never sang a note on stage for at least another decade or more.

The Background Story

Meanwhile, at home, both of my parents were dying from different, nasty, irreversible, degenerative diseases. I learnt first-hand about the traumatic effects of helplessly witnessing parental death courtesy of chronic illness. I also learned about iatrogenic effects of pharmacotherapy, the impotence of modern medicine, the shame and anxiety associated with poverty, and the darkness of adolescent depression.

Miraculously, I continued performing at the top of the academic food chain, achieving various largely meaningless accolades and awards along the way.

Fast-forward. Many years later, as a young clinical psychologist, it dawned on me that I had been writing songs since around 11 years of age. I had a brief, somewhat pretentious spell of writing poetry in my teenage years, but there was nothing contrived about the songs that kept emerging from me. I seemed to be acting as a conduit for underlying, archetypal, unconscious material that was being spawned from the dark recesses of my mind.

I recall reading Ronald Laing’s autobiography at one stage. He noted his preference for singing over speech. He referred to the latter as “singing that had gone flat, rotten, and dead,” or something similar. I could probably dredge out an appropriate academic reference, but that would almost certainly activate an awful form of academic pedanticism, characterised by a paucity of creativity, slavish attention to essentially arbitrary sets of rules, and the growing inability to recognise any real value in my own thoughts and experiences.

Hipnottick Erra

Out of this background emerged the concept-band, “Hipnottick Erra.” This vehicle has remained a psychotherapeutic container for me since the 1980s. In summary, I am a song-writer and Hipnottick Erra is the band that provides the vehicle for delivering this material to larger audiences.

Hardly a Trickle. *Hardly a Trickle* is a song I wrote in January 2016. Without the music, the lyrics are likely to lose their evocative power, but I have long since stopped worrying about these things. I also make absolutely no claims to musical or lyrical greatness. On the contrary, I need to be clear that I cannot read a note of music and my singing remains frankly marginal and occasionally awful to this day. As Michael White once said, “This is not intended as an exemplar.”

I found myself frankly tearful when I wrote this song, mainly because it reconnected me with many of the traumatic threads that are inherent in my own personal history, as well as the histories of many people I have worked with over the past 35 years or more.

As John Briere would say, “No pain, no gain.” Again, I could chase a reference here, but I am aware of the risks associated with taking this step closer to more florid obsessive-compulsive symptomatology. I certainly have the urge to acknowledge the source of wisdom where possible, but I no longer have the obsessive need to tie my thoughts tightly to what has been said or written before. All ideas are derivative. I make no claims to originality. I acknowledge and honour everything that has brought me to this moment.

Hardly a Trickle contains seeds from multiple arenas. Perhaps the searing pain of that initial assault at the hands of my school principal more than 50 years ago is still struggling to find a voice. Curiously, I recall how to spell the word “principal,” as distinct from “principle,” because it contains the word “pal”: “Always remember that your principal is your pal.” This was drummed into me as a child. The irony of this memory trick has never been lost on me.

Over the years, I have heard many stories of children cowering under beds and behind furniture whilst their drunken parents fight. I have repeatedly heard references to “broken parental promises,” and I have personally witnessed the deleterious impact this has had on many developing minds.

I recall with considerable discomfort the overwhelming emotional pain of a young girl who had been left alone in the care her grandmother. Tragically, her grandmother died in her rocking chair, leaving the child to discover death in a way that no child should ever have to experience. Finally, I have deeply engrained traumatic memories of the increasing passivity associated with the steady deterioration of my own parents’ health before their relatively early deaths. I also deeply understand the phenomenological concept of “sense of foreshortened future.”

The Resolution

Most importantly, songs and musical arrangements need to “resolve.” We need to be brought back to a root note, a familiar chord and a place of hope and comfort.

There is always “a portal out of this place.” Faith in the human race begins with faith in a human face.

As a clinical psychologist, I remain forever grateful for the opportunity to keep working on my own journey towards greater mental wellness and wholeness, while simultaneously assisting others in their journeys through life. Curiously, my mission as a songwriter is not very different. We are all works in progress, of course, and I will never be at risk for becoming complacent or smug. In a sense, the processing of trauma is endless, limited perhaps by death alone, or for Jean-Paul Sartre, human “facticity.”

For clinical psychologists working with clients in a psychotherapeutic capacity, the processing of trauma is invariably bi-directional. If we remain connected and attuned, we have the capacity to facilitate each other's healing processes. You may ask why I have chosen to spend Easter Friday consolidating these ideas for possible publication. Is this primarily a narcissistic, self-aggrandising pursuit, or is it more about seizing another opportunity to engage in a creative process that facilitates my own healing, while simultaneously potentially benefiting others? I would opt firmly for the latter, but maybe that is just because it is a more palatable narrative.

Trauma-Informed Care: Upholding the Core Principles in Individual and Organisational Practice

Debra Olson-Morrison

Abstract

Trauma-informed care is a term that encapsulates how services should be delivered to victims of trauma, and encompasses trauma theory, models of care, and guidelines for assessment, engagement, and evaluation. Clinicians may understand basic tenets behind trauma-informed care, yet often struggle to operationalise and enact the core principles rooted in this framework. This article discusses how to integrate basic yet foundational trauma-informed care principles into programming. The five core principles in trauma-informed care are discussed, and the author provides recommendations on how to implement each principle into individual and organisational practice.

The last 20 years have witnessed a profound shift in our understanding of trauma and the impact of traumatic events in people's lives. Instrumental in supporting this shift, advancements in research in interpersonal neurobiology have increased our understanding of how trauma affects the brain and body, and emphasises the use of holistic, safe, and responsible treatment practices. As clinicians, the general strengthening of trauma theory and treatment (see Courtois & Ford, 2015; Herman, 1992, 1998, 2015; van der Kolk, 2014) enables us to understand subsequent behaviours and mental health impairments resulting from traumatic life experiences. Judith Herman's seminal text (1992, 1998, 2015) highlighted the enduring effects of complex relational trauma, and articulated a phase-based model for working with victims that emphasises physical/emotional safety and empowerment. This phase-based model is now considered the gold standard in trauma treatment (Courtois & Ford, 2015). Our combined understanding of trauma's effect on the brain, as well as how to provide safe and effective treatment, form the underlying principles around what is referred to as trauma-informed care (TIC).

TIC principles have been embraced by individuals and organisations working in mental health care, and have transformed the dynamic of interaction between client and provider from one that enacts treatment based on the question "What is wrong with you?" to supporting healing and recovery rooted in the question "What happened to you?" (Fallot & Harris, 2001, 2009). While this transition seems simple enough, changing the way clinicians approach clients using mental health services has the capacity to shift the contextual understanding around the impact of trauma on all domains of human functioning. For example, some treatment organisations may focus on the behaviours that bring the individual into treatment as a central (and possibly only) focus of the treatment plan (What is wrong with you?), rather than inquiring about history of trauma and using a trauma framework for treatment (What happened to you?). Further, as clinicians and service providers begin to grasp the neurobiological consequences of trauma and the resulting injury to the brain and nervous system, the importance of supporting TIC programming based in client safety becomes compelling.

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TIC

The TIC model aims to provide a framework for safe, effective, strengths-based treatment. Hopper, Bassuk, and Olivet (2010) stated:

Trauma-informed care is a strengths-based framework that is grounded in an understanding and responsiveness to the impact of trauma; it emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities to rebuild a sense of control and empowerment. (p. 82)

Undertaking a trauma-informed approach means organisations “respond by fully integrating knowledge about trauma into policies, procedures, and practices, and seek to actively resist retraumatisation” (SAMSHA, 2014, p. 9). Widely considered as leaders in the trauma informed care movement, FalLOT and Harris (2009) developed five core principles essential to TIC: safety, trustworthiness, choice, collaboration, and empowerment. TIC programming embraces these five core principles, and intentionally promotes and enacts them on all levels of individual and agency operations (Kezelman & Stavropoulis, 2012).

While many resources exist for understanding TIC (e.g., Kezelman & Stavropoulis, 2012; SAMSHA, 2014), clinicians and service providers often fail to consider all the nuances of each core principle, and how these principles fit into the bigger picture of successful TIC treatment. The following sections highlight how an understanding of trauma theory and neurobiology translate into everyday interactions, to create a safe trauma-informed space for our clients. Even in organisations that have yet to embrace TIC, individual clinicians may enact small changes in their practice that reflect sensitivity to TIC principles. In the following section, the author highlights the core principles and outlines simple steps for clinicians to create a more trauma-informed culture in their individual and organisational practice space.

Neurobiology of Triggers

TIC protocols stress the importance of understanding the neurobiology of trauma. While it is beyond the scope of this paper to go into a lengthy discussion about trauma’s effect on the brain and nervous system, an elementary overview is necessary to understand how to create a trauma-informed climate. How our clients receive and process information from the environment informs why safety is emphasised, and essentially makes or breaks a client’s ability to engage in treatment.

External or environmental input is processed in the brain on an unconscious level, and our brain sends signals to the body before thoughts occur, affecting bodily responses, feelings, and behaviours. External input usually consists of sensory stimuli (sounds, smells, tastes, touches, and visual input) rooted in non-verbal environmental cues. For example, one might experience headaches, muscle tightness, and general feelings of repulsion or anxiety on walking into a brightly fluorescent-lit crowded waiting room with a television playing in the background. Many trauma clients may not realise sensory stimuli as contributors to the resulting physiological changes in their body, and therefore may behave in ways that could be viewed as treatment resistant (not wanting to come to sessions anymore, not engaging in therapeutic interventions). This experience and the resulting behaviours illustrate the unconscious, neurobiological response to external stimuli.

Sensory cues may also trigger memories of past events. For example, most of us find the sounds of a dog barking rather benign, but for a person who experienced a dog bite, the sound may set off a series of unconscious processes in the brain and body, leaving the victim responding in a way the rest of us have trouble relating to (e.g., fleeing, crying, or even engaging in physically violent behaviours). The triggered response is rooted in survival, and is therefore usually beyond the control of conscious processes (however, the behaviour following the response can *sometimes*

be controlled). Further, the work of Steven Porges (2011) illustrates how neurobiological (subconscious) reactions also occur in response to interpersonal interactions in the form of non-verbal behaviours such as body posture, tone of voice, facial expression, speech prosody, and even gait.

Considerations on Enacting the Core Principles of TIC

Safety. Most individuals have a low and manageable baseline level of response functioning due to perceiving people and the environment as relatively safe. However, a nervous system injured by trauma has a heightened reactivity threshold more easily triggered into survival mode responses. A victim of trauma may display erratic, unhealthy, and dysfunctional behaviours in response to external or internal triggers outside the clinician's understanding. Because trauma survivors have a hyper-aroused stress response system, the first principle of trauma-informed care is safety. This principle includes environmental, sensory, and interpersonal safety.

Although clinicians and service providers should always be “checking in” with their clients to ensure they are on board with safety practices, sometimes office or agency settings fail to consider all facets of ensuring a safe environment. The following bullet points provide general universal guidelines for providing the environmental, sensory, and interpersonal safety supported by TIC:

- Keep lighting pleasant; avoid fluorescent or very bright lights. Windows that infuse the room with natural lightening are often preferred by clients.
- Avoid strong smells in the therapy setting. Artificial smells, such as strongly scented candles, can be off-putting and cause irritability. Ask clients about their smell preferences before using any natural aromatherapy products, even lavender.
- Avoid loud or distracting music in the waiting area. Avoid television programmes on news channels. Even loud fans can put clients on edge.
- Avoid wall clutter: walls overcrowded with artwork, quotes or wordy wall-hangings, or other various decorations. A few nice prints are pleasing to the eye and the sensory system.
- In the treatment area/room, make sure clients and staff have free and open access to doors. Many clients feel more comfortable if they can see the door from where they sit. Further, clinicians should be careful not to sit between the client and the door.
- Educate all personnel who have contact with clients on the importance of tone of voice, posture, facial expression, and vocal prosody when talking with clients. Males should be particularly conscientious of their posture, facial expression, and tone of voice if they are working with victims.
- Clinicians should always follow the phase-based protocol of establishing safety and self-agency/regulatory skills *before* processing traumatic events (Courtois & Ford, 2015). Avoid unintentionally triggering a client by processing too soon, even if the client verbalises a need to process. To keep the spirit of choice and control, the clinician should explain why processing might overwhelm the brain and nervous system if done too early in treatment.

This list is by no means inclusive, but the points provide starting places for establishing safety. The clinician should remain sensitive to cues that the client has been triggered, and then work to discover the origins of that trigger in hopes of removing it from the treatment environment.

Trustworthiness. The second core principle, trustworthiness, is accomplished by the clinician's ability to be upfront about treatment, and provide psychoeducation about why certain techniques and methods are used. The trauma-informed therapist should have a solid understanding of interpersonal neurobiology so they can discuss brain processes with their clients. Lastly, the therapist should maintain appropriate and safe boundaries. The nature of trauma suggests that

the victim has endured boundary violations, and therefore may have developed unhealthy perceptions around boundaries. Clients with experience of boundary violations may find personal information given out by a clinician, such as personal emails and cell phone numbers, confusing and potentially triggering. TIC guidelines recommend that policies are put in place around use of personal information in professional practice.

Choice and collaboration. The third and fourth principles, choice and collaboration, both aim to provide ongoing opportunities for clients to be active members in their treatment process. Perpetrators take away choice when they victimise, therefore the survivor may lose the ability to make healthy choices in their own lives. The clinician should therefore strive to create strengths-based opportunities that reinforce choice and control. From the very first point of contact, the clinician should ensure that the client is aware they have a choice in treatment providers, and that it is acceptable to choose another clinician if they perceive a poor fit after that first meeting. During treatment planning, the clinician collaborates with the client rather than making decisions about their treatment for them. Before every session, the therapist can offer choices for interventions and treatment: “I know we were completing the timeline last week. Would you like to continue doing this or did you have something else in mind for our time together today?” When offering materials for the client to review, rather than “I’d like you to read this,” the clinician may phrase the request differently by saying “I invite you to read this.”

Empowerment. By being an active participant in their treatment, clients begin to feel empowered and in control. The last core principle emphasises the overarching importance of empowerment. Service providers strive to facilitate feelings of efficacy and pride in their clients by offering choices and then supporting them. The clinician proposes and teaches skills for the client to practice and build internal capacity for regulation and healing. The clinician recognises that the client is the expert in their own life, and honours their internal strengths and naturally occurring external resources. Empowerment happens through the clinician’s implicit and demonstrated belief that the client can develop skills to live according to their own potential. The clinician’s verbal validation and non-verbal communication affirms empowerment principles. In the organisation, these strategies for developing relationships transfer to every member of the treatment team; holding to the truth undermining a client’s potential for growth by being overly protective, removing options for care, or taking on an inappropriately parental-type role is inherently disempowering.

Conclusion

Working with victims of trauma requires expertise and experience. Yet, all those working with victims, including those untrained in psychology and counselling, can help to create and support the healing environment. A basic understanding of how the brain and body respond to stress, triggers, and external cues helps decrease the possibility of triggering a traumatised client, and increases the potential for healing. When clinicians, agencies, and communities embrace and enact the five core principles of trauma-informed care, they are providing an opportunity and atmosphere for lasting, holistic change, growth, and healing to victims of trauma.

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Memory Grafting versus Memory Transmutation: A Cognitive Behavioural Therapist explores Eye- Movement Desensitisation and Processing

MaryAnn Stevens



Cognitive behavioural therapy (CBT)-based therapies and eye movement desensitisation and processing (EMDR) have been running neck to neck in outcome studies for trauma therapy, but does EMDR really add something new?

On a daily basis over the last 4 years, EMDR has become my preferred mode of transport for working with traumatised people. It not only achieves equivalent outcome results to CBT modalities (Davidson & Parker, 2001) but also adds significant new value and hope for trauma survivors. This article is not a literature review or academic paper. The aim is to share my reflections, as a therapist with 20 years of CBT experience in working with trauma, about my transition to practicing EMDR. I discuss the differences I have seen between CBT and EMDR for both the client and therapist, and ponder on the potentially different mechanisms of change. I hope to inspire others to train, study research, and experience the value that I believe EMDR adds to trauma recovery.

Does EMDR Add Anything to Trauma Therapy?

John Briere’s “self trauma model” (Briere, 2002) integrated many aspects of trauma theory and proposed four key ameliorative components to post-traumatic stress disorder (PTSD) recovery: (a) exposure (to the memory), (b) activation (cognitive and emotional responses), (c) disparity (between past and present reality), and (d) processing (extinction of conditioned emotional responses to the memory, and restructuring of meaning).

EMDR and its underlying adaptive information processing (AIP) model add something new to this mix (Solomon & Shapiro, 2008). CBT has had good empirical outcomes and is a research gold standard, but it also has had its real-world challenges. In practice, CBT modalities such as trauma-focused CBT (TFCBT) and prolonged exposure (PE) require superior rapport, collaboration skills, emotional stability, self assurance, and confidence in a therapist to win people over to feel safe doing something they experience as extremely painful. When able to maintain a consistent therapeutic window, I have found it an effective therapy. However, for

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people with an early attachment trauma history, progress has been limited using CBT-based trauma therapies. For most, the safety of avoidance far outweighs the prospect of graded exposure to memories that trigger terror, self loathing, and anger. The therapeutic window is often just too small for some people for healing to occur. The relational safety that other clients may feel in therapy to allow stability is not always accessible when people are so physically, emotionally, and behaviourally activated. TFEBT and PE are not often quick, and often require repeated exposure sessions and a lot of out of session work that is difficult to monitor. As John Briere (2002) stated at the end of his article: “the inescapable implication of abuse-focused therapy (and any other exposure-based treatment) is that in order to reduce post traumatic pain and fear, both must be repeatedly confronted and experienced.”

About 4 years ago I trained in EMDR and completed the Institute Basic Training and Master Class. I have since used EMDR several times a day. The majority of my work is with survivors of sexual trauma. My clinical experience has so far been that processing memories using EMDR is more effective than when using TFEBT and PE. I have found that EMDR is easier to provide, is quicker, less painful for clients, and there is a lower dropout rate. In my experience, bilateral stimulation (BLS) of the brain, either by eye movements or some other method, appears to widen the therapeutic window and make things less painful, therefore speeding up the process of recovery. My experience appears to be supported by current research. At least seven randomised controlled trials reported EMDR therapy to be “more rapid and/or more effective than trauma-focused CBT”. (Shapiro, 2014). Such studies support that therapy is easier and quicker, experienced by survivors as less painful, effective, and has a lower dropout rate (Jaberghaderi, Greenwald, Rugin, Dolatabadim, & Zand, 2004; Ironson, Freund, Strauss, & Williams, 2002; Edmond, Sloan, & McCarty, 2004). There are also studies indicating greater gains at follow-up and better results for intrusion symptoms and general recovery (Lee, Gavriel, Drummond, Richards, & Greenwald, 2002; Power et al., 2002).

Is the Role of the Therapist Different With EMDR?

From collaborative software developer to project manager. With CBT-based approaches, collaboration with the client to build something new is the key. I am a software developer consulting with the client. The current system is seen to be ineffective, and we are working together to build or improve the cognitive, behavioural, and relational software system. The client and I experiment with ways to reduce their distress to be able to gradually expose to the distressing memories at a tolerable level so processing of the disparity and thus extinction can occur. I find this a more intellectually and relationally taxing role. There is joint pressure to find the right input to help the client calm their system. Maintaining collaboration can be very difficult.

With EMDR, encouraging the client to collaborate with their own brain is the key. I am less involved in doing the actual technical work and more like a project manager. The client already has an effective memory processing software system that they can access and service. It does not need fixing. I explain the project brief is to use their own system to process old memories (the AIP model) and then facilitate them to restart it with BLS. Their job is to do data entry by noticing their own emotions, thoughts, feelings, and sensations while moving their eyes to follow my fingers. This eye movement appears to help keep them present. I watch as they skilfully feed new data into their memory processing software where it integrates with their old memory data. I see them making links, associations, connecting with thoughts, sensations, and emotions, and building adaptive networks before my eyes. I sometimes intervene when required to help them restart the system if there is distress or dissociation or blocking beliefs. Like CBT, I am a necessary presence to maintain a sense of safety and awareness of disparity, and I might need to cognitively intervene to draw their attention to new data they do not know about or have lost

sight of. As with CBT, I am certainly not the expert about their system, but with EMDR I have found that I am less intellectually influential, feel less pressure to come up with ideas, and more grounded and emotionally and physiologically in tune. I do not know what links will be made within the clients system, what information needs to be integrated, and how long it will take to reach adaptive resolution. The client and I are often surprised about what the system comes up with. The brain and body communicate to complete the puzzle.

Are the Models and Mechanisms of Memory Processing Different?

From CBT to AIP and memory grafting to transmutation. In my career so far, I have been able to accommodate the theoretical models I have come across, either into or alongside a CBT framework. I saw them as rooms of the same house, each adding useful additions, extensions, and perspectives. But doing EMDR requires formulating using the underlying AIP model, and I have needed a whole new house for this one.

Memory processing is about learning. Learning occurs through integrating new information, whether it is cognitive, emotional, or sensory information. CBT facilitates processing in cognitive appraisal by accommodating or strengthening new corrective cognitive and behavioural information alongside the old. The helpful belief then becomes more dominant, reducing distress caused by the dysfunctional belief. This is perhaps like grafting root stock to grow a different fruit onto a tree. For example, as a client sits in your office experiencing physiological distress about a past rape, they feel shame and distress connected to the old protective belief “It was my fault.” This is the old root stock. Then, they realise that they were only 3 years old and the perpetrator was a “big grown up.” They begin to graft onto their old belief root stock their new current adult beliefs, “I was a child,” “they were bigger,” and “it could not be my fault.” With CBT-oriented approaches, the process of exposure to the memory, activation of the old reaction, and awareness of the present must be achieved over and over to achieve a reduction in physiological arousal. I have frequently seen the effectiveness of this process. However, I have often not been convinced that the new growth has been sufficient to permanently override the old root stock “It was my fault.” Relapse prevention strategies have been needed to prepare for times where a client may be vulnerable to a flare-up by the old root stock.

In my experience so far, EMDR seems to have a quicker and more permanent processing effect. I have wondered if EMDR creates a whole new memory tree rather than grafting onto the old one. Instead of grafting a kiwifruit belief on to an old banana rootstock, perhaps with EMDR, we can create a true hybrid kiwiana belief?

Following is a summary of some of my reading about the AIP model and a theory of what may be going on in EMDR that is different to exposure-based memory processing. Of course, there is extensive research and many other theories about the mechanisms of change in EMDR that I do not go into here.

EMDR is reported to facilitate the brain’s intrinsic information processing system to process what is stuck. The AIP model suggests that as humans, we have an innate, natural information processing system that receives new information, makes connections with all existing information, and associates, assimilates, and reconsolidates the memory networks to integrate the new information. Any current distress is caused by this process getting blocked or frozen. Old distressing sensory information has become isolated from the larger memory network and is stored “live”! It may then be re-experienced again and again in its original state, causing further distress. The aim of EMDR is to unblock the natural AIP processing system and allow the distressing sensory information to be integrated into the network.

In 2014, Roger Solomon and Francine Shapiro wrote a very useful article, *The Potential Mechanisms of Change*, which has taken me time to adaptively process. They used the term “transmutation” to describe the process of AIP. Transmutation, a term from chemistry, means that two elements transform into a new one. Their article discussed the potential mechanisms of change in EMDR compared with an effective CBT-oriented therapy (PE). They purported that CBT therapies add new information to help defuse a distressing memory, whereas EMDR actually breaks down the memory and merges it with other memories.

Below is a chart I have put together to clarify for myself some differences proposed in the article. I suggest you read the article above, as these are just my reflections and I would like to hear yours, especially those who are also training in EMDR with experience in CBT-oriented trauma therapy.

	PE	EMDR
Source of distress	Inaccurate cognitive appraisal of past event Emotional reaction to past event Conditioned responses	Physiological perceptions stored in isolation from other memory networks (e.g., images, thoughts, beliefs, sensations, emotions, smells)
Treatment process	Activate/expose to feared memory Fear is experienced in conflicting safe environment Fear is extinguished and only memory remains	Access unprocessed perceptions Stimulate innate processor through BLS Facilitate links to adaptive networks
Mechanisms of change	Extinction Accommodation	Information integrates with other memory networks Associates Assimilates Consolidates
Outcome	Addition or new information to memory The memory is grafted with other information.	Transmutation of memory The memory becomes part of a new hybrid

What is EMDR Like for the CBT Therapist?

In terms of happiness in the workplace, I encourage any therapist, from any modality, to start the EMDR Institute Basic Training. It has been an easy transition and has renewed my passion and hope for clients, which makes my work more enjoyable.

As a clinical psychologist in New Zealand since the 90s I have trained in a range of therapies, including CBT, dialectical behaviour therapy, and acceptance and commitment therapy, and have found my previous skills and strategies are still valuable when using EMDR. I do think that someone needs to write a book entitled “EMDR for CBT Practitioners.” It would be helpful to have training oriented to the view of the CBT practitioner. This may help CBT-oriented clinicians to more easily know which skills and concepts are transferable and which are not. I have found some challenges in transition. I have had to learn to hold my tongue and let the person use their own software/AIP system, rather than use socratic enquiry. Often, what appeared irrelevant turns out to have a meaning that I would not have predicted. At other times, I have found old skills and experience very helpful when required for cognitive interweave

strategies when the client is stuck, and for teaching behavioural skills for emotional regulation resources to stay in the therapeutic window.

Another challenge was that with EMDR, I have become more emotionally and physiologically impacted by the client's processing. Perhaps the cognitive focus of CBT-oriented trauma work had previously protected me from over empathising. With EMDR, I have needed to work harder to be more present in my body and learn some physiological grounding strategies that are not too obvious. Babbette Rothschild (2006) outlined a technique of "un-mirroring," which I have found very effective. Essentially, it is a physical grounding technique which means that I can cue my body into physiologically skiing down Mt Ruapehu whilst working with a client, and hopefully they are unaware!

Conclusion

EMDR now has a strong evidence base as an effective treatment for PTSD, and a growing evidence base as a complete psychotherapy for all mental health and some physical health conditions. Given results in the research and those from my clinical experience, I can no longer justify providing only CBT-based interventions for PTSD and trauma-based psychopathology.

From my clinical experience so far, I am seeing that EMDR adds something new and beneficial for my trauma therapy clients. I have found it to be quicker and less distressing than CBT-based therapies, and thus more effective as people can tolerate it. I have also observed that the processing that occurs through EMDR seems more effective and enduring. I look forward to the ongoing development of the psychotherapy of EMDR in New Zealand, and exploring whatever new rooms are added to this modality.



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Proliferation, Memory, and Dissociation: Warnings From Research About Some Practices Associated With Eye Movement Desensitisation and Reprocessing

Gauranga Jeram Patel

Eye movement desensitisation and reprocessing (EMDR) was developed by Shapiro (1989) as a therapy for post-traumatic stress disorder (PTSD). Although EMDR has since been developed into an 8-phase therapy (Shapiro, 2001), the primary difference between EMDR and trauma-focused cognitive behavioural therapy (CBT) approaches is the use of bilateral stimulation, which typically involves the client tracking the therapist’s moving fingers with their eyes while recalling memories. Research has found that EMDR is as effective as trauma-focused CBT in the treatment of PTSD (e.g., Benish, Imel, & Wampold, 2008). Along with trauma-focused CBT, EMDR has been accepted into many treatment guidelines for PTSD (Forbes et al., 2010).

EMDR has become popular in New Zealand, with hundreds of psychologists and other clinicians undertaking training. I myself have conducted research evaluating the eye movement component of EMDR, and have completed EMDR practice training at Weekend One and Two (introductory) and Master Class (more advanced training incorporating dissociation) levels. However, through almost a decade of research and practice in EMDR (a limited time compared with some) I have noticed a number of practices associated with EMDR that may need to be approached with caution. My purpose in writing this article is to present some of the arguments against these pre-existing practices that are presented in EMDR lore without reference to the cautions that we may glean from research and literature.

Proliferation

After finding that EMDR was effective for PTSD, Shapiro (2001) developed the adaptive information processing (AIP) model to explain this effectiveness. According to the AIP model, humans have “...a neurological balance in a distinct physiological system that allows information to be processed to an ‘adaptive resolution.’” (Shapiro, 2001, p. 30). It is thought that any distressing event can disrupt this information processing system, leaving dysfunctional memories that result in the thoughts, sensations, emotions, and behaviours of most mental disorders. The eye movements in EMDR somehow activate the information processing system and remove the negative potency of the memories. The broad acceptance of the AIP model has contributed to EMDR literature suggesting that EMDR can also be used for “depression, anxiety, panic reactions, interpersonal problems...” and many other disorders (Shapiro, 2013, p. 13).

The AIP model has received criticism that its assumptions are flawed, untested, unnecessary, and damaging to EMDR (Greenwald & Shapiro, 2010). The AIP model has led to over-simplified formulations where all problems are caused by memories, despite the standard approach that “...case formulations for patients who meet criteria for PTSD differ from those who do not, even if both have experienced trauma” (Zayfert & Becker, 2008, p. 23). The AIP model has also encouraged the practice of using EMDR for disorders where the evidence is severely lacking (Herbert et al., 2000; Muris & Merckelbach, 1999). The acceptance of the AIP model in EMDR

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lore has also precluded research to test the model's assumptions, with even the primary assumption that all disorder is caused by memories remaining untested (Lipke, 2009).

Research into the effectiveness of EMDR outside of PTSD is very limited, as I discovered while conducting a review of this research for a recent EMDR study day (Jeram Patel, 2016). With some disorders, EMDR shows promise compared with waitlist; for others, research is limited to case studies or results that indicate lower efficacy for EMDR than other established therapies. Using depression as an example, a recent review found that EMDR "...cannot currently be described as an evidence-based treatment for depression" (Wood & Ricketts, 2013, p. 225). Those authors found no randomised controlled trials (RCT), two uncontrolled trials, and six case studies. In my review, I found no significant new contributions and noted that the results of the RCT conducted to evaluate this have not been published, despite a completion date over 3 years ago. Although a review for each individual disorder is well outside the scope of this article, it is important to note that EMDR is included in treatment guidelines (e.g., NICE) for PTSD only (Forbes et al., 2010).

Given the limited quantity and weak outcomes of EMDR research for disorders other than PTSD, it is essential to reflect on the importance of evidence-based practice (Lilienfeld, 2007). Other examples from the history of psychology illustrate the risk of harm from practising therapies that have yet to be evaluated in structured research. A relevant example is the finding that some critical incident stress debriefing (CISD) practices may paradoxically increase distress and disorder in participants (for review see Devilly, Gist, & Cotton, 2006). Unfortunately, the problems associated with CISD were discovered only after therapists had been using these practices for some time in the belief that they were effective despite the lack of sufficiently controlled research (which eventually highlighted the risks).

It is important to note here that formulating problems in terms of distressing memories and exposing clients to these memories (as required in EMDR) is unlikely to be an inert process. The EMDR therapy process is arguably very demanding for clients and often results in significant distress. This approach should not be undertaken lightly, particularly when there is little research to show effectiveness, and when evidence-based therapies and formulations already exist and do not require such distressing practices (see Beck & Bredemeier, 2016, for the depression example). To continue the example, it would be highly unusual to use trauma-focused CBT to treat depression when other evidence-based approaches (e.g., behavioural activation and restructuring unhelpful thoughts) are available. At the very least, it is part of our role as clinical psychologists to understand the research informing our work and to include this in our discussions with clients (Seymour, 2007).

Memory

Another outcome of AIP-informed EMDR practice is the importance placed on memories of distressing events. EMDR assessment focuses on identifying the most salient and earliest distressing memories (Shapiro, 2001). Techniques used to identify early memories include standard interviewing along with the floatback technique, which typically involves holding thoughts and emotions that are currently problematic in mind while attempting to find "matching" autobiographical memories. In EMDR treatment, memories are thought to sometimes block the processing of other memories (Shapiro, 2013). So, if a client is not progressing through therapy they are prompted to identify earlier memories that may need to be targeted first. It is important to note here that these additional techniques are not normally included in EMDR research protocols for PTSD and so have not been systematically studied.

These memory practices associated with EMDR are arguably a significant departure from

assessment procedures that typically stress the importance of open questioning and less-directive exploration. In contrast, these memory practices are specifically aimed at finding distressing memories and indicating to clients that their problems are being caused by these memories. Given that these practices are not included in research protocols, there is no evidence of adverse events. However, these memory practices arguably create a clinical climate high in suggestion, expectancy, and demand characteristics. Researchers have found that these clinical aspects have the potential to cause problems.

The recovered memory controversy developed in the 1980s, when researchers systematically explored the fallibility of memory. In short, expectations, suggestions, and demand characteristics can change the perception of existing memories and result in fabricated memories of events that did not happen (Lynn, Loftus, Lilienfeld, & Lock, 2003). This research and the critiquing of associated practices was more than an academic exercise, as many clients, their families, and clinicians were embroiled in disputes and legal battles due to “false” recovered memories. Although it is important to note that effect sizes in the research were small (see Brewin & Andrews, 2017, for a recent review) and controlled studies of clinical practice are non-existent (due to obvious ethical issues), the risks are still present.

While memories can spontaneously be recalled after long periods of forgetting (Geraerts, Raymaekers, & Merckelbach, 2008), that some “suggestive therapeutic practices can foster false memories in some clients appears indisputable.” (Lynn et al., 2003, p. 46). Suggestive practices include guided imagery (arguably similar to the floatback technique), direct suggestion (that there must be memories underlying problems), and searching for earlier and earlier memories (Lynn et al., 2003). Therefore, it is arguable that some practices associated with EMDR risk creating false or elaborated memories, particularly when they are combined. In addition, these practices are not essential for effective interviewing or therapy and have not been part of EMDR protocols in research for PTSD.

Dissociation

From the beginning of basic EMDR training, clinicians are socialised to consider clients as being on a dissociative continuum including hypo- and hyper-arousal, depersonalisation, derealisation, and/or dissociative identities. Some EMDR literature claims that all clients have separate “self-states or identities that are not integrated into a unified sense of self” (Knipe, 2015, p. 7). Clinicians are taught to discover “dissociative parts” by asking parts to attend an imagined meeting place. In the Master Class, clinicians are taught to discuss parts with clients who experience any level of dissociation, formulate problems using parts, and encourage clients to work with parts and the memories they hold out of awareness (for the rationale see Nijenhuis, van der Hart, & Steele, 2010). Such techniques (herein referred to as parts work) are not included in standard protocols for research into EMDR for PTSD.

Parts work is infused in EMDR lore with a confidence that belies the literature. Although this area is contentious, some researchers claim that while dissociation (depersonalisation and derealisation) is relatively common, dissociative disorders and identities are largely caused by therapist cuing (interviewing suggesting “alters” or parts exist), media influences, and sociocultural expectations (Lynn et al., 2014; for counter arguments see Dalenberg et al., 2012). This is not to say that dissociative identities do not exist, but that well-meaning therapists may inadvertently create or exacerbate them.

It is hard to see how explaining to clients that their problems are caused by “parts,” and that they must find and work with these parts to recover, does not go some way to creating these parts even if just metaphorically (Merckelbach, Deville, & Rassin, 2002). These discussions suggest

that parts work might actually create problems for clients, whose dissociation develops only after being encouraged by therapists. Indeed, unlike with any other mental health problems, research shows most dissociative disorders are “discovered” during therapy rather than being a presenting problem (Lynn et al., 2014). However, this concern is countered by the argument that these parts are found because they already exist in all clients (Knipe, 2015).

There are further risks associated with parts work, not the least of which is the lack of controlled research showing that such techniques are effective (Lynn et al., 2014). There are warnings from uncontrolled research that parts work may result in poor diagnosis and treatment of other problems as well as increased suicidality and hospitalisations for clients (Fetkewicz, Sharma, & Merskey, 2000). Clinicians using parts work may also assume that dissociative parts exist to hide memories, thereby straying into arguably problematic memory recovery techniques (Lynn et al., 2003).

Conclusion

The risks are likely to be magnified when these practices, which are unnecessary for fidelity to researched EMDR protocols, are combined. For example, combining non-PTSD EMDR with suggestive memory techniques and parts work might create an unhelpful clinical environment that increases the risks of a number of troublesome outcomes. I have attempted to cover three large and contentious topics in brief, and I hope that the review articles I have cited can help the interested reader in further exploring both sides of these complex issues. My aim in writing this article was to raise concerns from literature about some practices, which are not addressed in EMDR lore. My aim was not to criticise the well-meaning and highly skilled clinicians that sometimes use these practices. However, I hope that the warnings from literature will help us avoid the risks posed to clients, therapists, and the profession of clinical psychology by practices associated with, but not essential to, EMDR.

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A Personal Imperfect Reflection On Trauma

David Miller

Trauma (trō.mã). 1693. *Path.* A wound, or external bodily injury in general; also, the condition caused by this. **b.** *Psychoanalysis.* A disturbing experience which affects the mind or nerves of a person so as to induce hysteria or ‘psychic’ conditions; a mental shock 1916. (The Shorter Oxford English Dictionary. Oxford: OUP, 1973)

All of my best early work is dead.

I saw the first AIDS patients in London. I was a recently-qualified clinical psychologist from Auckland doing locum jobs in England while I looked for opportunities to become a journalist as an inspired child of the Watergate era.

My first patient was named Adrian—a “rent boy,” as we called male sex workers then, diagnosed by infectious diseases specialists as suffering from *pneumocystis carinii* pneumonia, one of the major diagnostic indicators of GRID (gay-related immune disorder) or AIDS (acquired immune deficiency syndrome), as it was called by the knowing few in Europe in the early 1980s. The referring consultant explained, “We need someone to talk to him about the fact he’s going to die.” At that time, discussion of death was not in the medical school curriculum, and few clinicians described any degree of comfort in such talk with patients. I had no training in what to say in such circumstances.

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So I went to talk with Adrian. Before meeting him I asked the Registrar on the Infectious Diseases ward what I should do for infection control. At that time (September 1982), the cause of AIDS was unknown, vectors for transmission were a mystery, treatments were essentially palliative, death was inevitable, and the stigma associated with diagnosis was total. The Registrar suggested that for the protection of the patient and myself, I should wear: a full-length plastic apron, a hair net, a face mask, eye protection, full arm-length gloves, and shoe covers.

Adrian was wearing an oxygen face mask and seemed weak. He hardly moved in his bed. We were both wearing masks; meaningful communication was impossible. So I took mine off. He did the same. We talked about the obvious, how he was feeling (like death), what he needed (gin), any family (none), and what he was thinking (get me out of here). He was a nice guy. He died three days later. I assumed for the next year that he had given me his disease by our having talked without barriers in the same room.

It is impossible now to relate to the intensity and drama of the early AIDS years. Margaret Thatcher, the UK Prime Minister, seemed hostile to any public discussion of the disease (and would stop school-based education that ran the apparent risk of “promoting” homosexuality), senior police officers in the UK described AIDS “victims” as “swirling in a cesspool of their own making,” the clergy were basically silent, and those diagnosed with AIDS had the social status of infectious lepers. At the same time, the AIDS wave was breaking; hundreds of new cases were diagnosed weekly, deaths were rising, the tabloid media were looking for sensationalist stories to publish, and the sense of fear was very significant.

Our teaching hospital, St. Mary’s, joined with the Hammersmith and Fulham, the Chelsea and Westminster, Bart’s, Guy’s, St. Thomas’s, and the Royal Free in my first experience of grand rounds and case conferences. We held weekly case conferences by telephone with “experienced” AIDS physicians in California and New York to discuss what to do in the face of the latest horrific manifestations of immune destruction. The internet did not exist at that time, and the first computers were just coming into offices (1 MB beauties with the original floppy disks). Email was not available just yet. I wondered if I should start keeping a journal about this terrifying new health issue? After all, I was in the centre of it. No, I was assured by my medical chums, it would all be over in a couple of years.

The senior immunologist of our treatment team called. “You’re giving a talk on psychological interventions at the next grand round” he told me. “What? What the hell should I say?” “Just tell them what you know—no-one else knows anything.” Using overhead slides and coloured pens, I wrote the lecture I would give in one form or another for the next 22 years in medical schools and in conferences all over England, Europe, North America, Africa, Asia, Australasia, and the Middle East. Versions of this talk were also given to community groups, health seminars, occupational and trades union meetings, religious symposia, board rooms, and schools. In its first outing, I described what we had observed in the first 30 patients, the psychological elements, and increasingly concerningly, some possible neurological indications suggesting brain involvement linked to immunosuppression. With a crude synthesis of Kubler-Ross and the DSM-III, with received and observed experience, and perhaps hope, I described what my patients, whom I considered my teachers, taught me. My teachers were always consulted before a meeting of any significance. “What do you want my audience to hear?” I would ask, “What do they need to be told?”

Traumatic wounds show what we are made of—the blood, guts, and gristle. They also show what makes us, the determination, fear, pain, driving intent, tenderness, rage, humour, forgiveness, curiosity, brilliance, hope, and love. My teachers showed what made them in the

worst imaginable situations. They had personal messages for the tabloid press journalists who donned white coats and stethoscopes and patrolled hospital corridors looking for famous “AIDS victims” (and those who sat in Somerset House trolling through death certificates, identifying and publishing those with AIDS-related symptoms written as cause of death). They had personal messages, too, for the bigoted politicians and public “servants” whose response to this mushrooming public health emergency was to propose transportation, segregation, and a withdrawal of treatment (such as it was) because anyone with AIDS “deserved it.” They had messages for people of God who asserted their faith by denying compassion to those most in need. They had messages for health workers about being allowed to die in dignity. Every presentation I made as a clinician carried my teachers’ messages. I feel sure that when the content of my talks was long forgotten, the content of their contributions was well remembered.

The human T-lymphotropic virus type III was isolated in 1983, and basic epidemiology revealed what was needed to be known and communicated about transmission vectors and efficacy at that time. My teachers’ messages became increasingly about processes of diagnosis and management. While the virus could not yet be managed in those infected, symptomatic management of AIDS-related illnesses improved. I was the senior editor of a medical text grandly entitled *The Management of AIDS Patients*, 202 pages of what we knew in 1986. We still did not know much at that stage; for example, we were not yet fully aware of the unfolding tragedy of AIDS in Africa, Asia, and Eastern Europe, and the complicating added challenges of health beliefs, gender disparities, poverty, education, and health access, and religions across cultural, linguistic, and geographical boundaries. What we did see, however, was the continual deaths of our patients.

Although AIDS in the early–mid 1980s became a *1001 Nights*-like revelation of pain and prurience for the public at large, there seemed to be the persistence of otherness in the way some of my friends and colleagues reacted. I have a distinct memory of leaning against a wall at a party while peers were drinking, laughing, dancing, and carousing, and thinking to myself “Don’t they realise there’s a war going on?” I was a regular media presence exhorting listeners/viewers/readers to what now seems a rather Presbyterian diet of solemn, fun-less observance of the grim inevitability of tortured death. And condoms, “dry kissing,” obsessively protected penetration, and mutual masturbation.

Our ignorance about retroviral dynamics led us down many false paths. I had been asked by a patient about the longer-term prospects of having HIV infection, “How long before I become sick?” We took our clues in the 1980s from known retrovirology (the first human retroviruses were identified in humans in the late 1970s). Accordingly, the advice was to say “If you are symptom free in 5 years, you’re in the clear.” My patient did call back 5 years later; our conversation was unhappy.

AIDS completely dominated my life within 6 months of meeting Adrian. Initially, days became focused on dealing with the clinical demands of growing patient numbers, then things changed. Because of the otherness of known risk groups, because of their dominance in my clinical life and in life after hours spent in public advocacy, health promotion, lecture preparation and delivery, and increasingly in writing (first papers then books), because of the grim intensity and experience that only my patients and my clinical colleagues seemed to understand and identify with, my life increasingly became a choice to focus on work. I could not describe or explain the experience of daily death and drama to my friends, parents, or colleagues outside that realm. Despite my growing celebrity, I found it became more isolating. My friends were increasingly only those I worked with; they did not need explanations or clarifications. We worked together; we were all we needed. Possibly tricky subjects such as assisted death or suicide advice came easily. As a dear friend and colleague noted, it was normal to discuss anal sex over breakfast.

Yet still, all my patients died. I stopped going to funerals. The isolation of my cause, the isolating intensity of its consequences, the determined stigma linked to living or working with those directly affected, the constant loss and the determinedly stifled grief of that loss, the inevitable, profoundly consequential link of intimacy with decay and death, the public opprobrium towards those most affected, the increasing personal rage towards social leaders who refused to show or demonstrate responsible leadership, understanding or compassion towards those most affected, the failure of my first marriage because of my allowing the domination of work, and the welcoming gratitude and support shown by those I worked with and for, drove me away from a balanced life and into a world where the virus ruled. I lost trust in the motivations of those who lived elsewhere. AIDS was all that mattered, and the only realm in which I was understood. To paraphrase a true ally from that earlier time, death had to be consequential. The death of life outside of AIDS *was* consequential; it led me to a life in the whole world in which millions could be saved. What could be more consequential than that?

For decades I could not be distracted. The mission was too important. Oh, there were many good times and wonderful companions, but the anger never really left. My own insecurities and vulnerabilities magnified the shock of that early time, somehow morphing an already unsure and nervous junior clinician into a clear advocate for the insecurities and vulnerabilities of others, sometimes very visibly. I am still mistrustful of most politicians, and will always remain wary of the politics of public service. But many things also helped those of us on the front line to live with the unremitting intensity and horrifying normality of inevitable loss. This was a shared disaster, clinicians and advocates shared it with those directly affected and the communities from whence they came. We were in it together. There was a bond there that led to collaboration without questions. The AIDS Quilt Project was a great example of this. In weaving and embroidering our testaments of love and loss, we wove our history, our shared story, our beautiful daughters and sons in tapestries *above* torment, celebrating and saying “we have loved.”

Also important was the honest acknowledgement that we were making it up as we paved our own roads. It was a little about becoming superficial virologists, immunologists, internists, and infectious disease and palliative care colleagues. But it was more about the humility of accepting what we could not do. I was among a team of clinicians who somehow acknowledged that we did not know everything, and that we were bound to fail in some things, although not in being the best clinicians we could be. We were honest with ourselves and our patients without letting go of hope. And, where hope ran low, we were honest about that too. We learned how to navigate conversations about quality of life and quality of death without being afraid.

Recognition also helped. For a 5-year purple patch I was regularly in the media, my books making the television and radio news and printed media. Many of my colleagues were similarly sought after as reliable media commentators when new AIDS-related issues emerged. Sometimes this media presence helped clinically, too. One of my patients was a television star who was about to be “outed” by a national newspaper. A quick phone call to the editor led to the story being pulled on compassionate grounds (a rare instance). Industries and organisations in which many of our patients worked often showed gratitude to clinicians by giving free air tickets to conferences, and similar such considerations that were very much appreciated. For some, awards indicated a recognition beyond the clinical cohorts that was enriching and, to some degree, sustaining.

Having a growing pride in our work was a huge contributor to our growing resilience as a clinician cohort. As symptomatic care became more sophisticated, as clinical treatment predictability grew, as communities at risk became firm allies in advocacy, as our count of books and papers published increased, and as AIDS became a cultural conversation, courtesy of some

very public contributions from the highest levels in society, we found ourselves as our own authorities, seen and respected as such by a broader community.

Recognition also came in the form of authority in grant applications. Much later, when recognising my own burnout and deciding to learn more by researching it, clinical authority was given and questions were helpfully advanced in support, resulting in funding for two national multi-centre studies on the subject. (Seeing the similar consequences of this work at this time in many others was I am sorry to admit, massively reassuring.) Also reassuring and indispensable was psychological supervision and support. In the pre-treatment AIDS era, psychological supervision was not yet mandatory in England. Nevertheless, I sought it out. It was a vital support and selected colleagues gave so generously of their time and humanity. I think they saved me professionally, through the disciplined observance of clinical practice, by listening, and by accompanying a young psychologist in uncharted territory.

Despite the help and distractions of intervening years, the trauma of the death of all my best early work still has the capacity to sneak up and surprise me on occasion. Even writing about this now is still an effort, largely because of what I am leaving out about that time. Shall we talk about the numerous, intentional discussions of the best ways for patients to commit suicide, or the countless reported assisted deaths in the face of suffering indignity, or the deaths averted through heroic intervention by surprising intermediaries, or the global talents, life-enrichers, and anonymous millions who have died in the face of genocidal ideology or indifference about health, human rights, gender, sexuality, and shame?

An additional trauma of AIDS in the pre-treatment era was that each individual death became somehow anonymised by fear of association or by the statistics of association, and yet there were so many! I closely observed so many and am so very sorry for their deaths and for the ways they died. Are those lost lives consequential? My clinical friends and I insisted that they should be. Our patients were teaching us so much! Their lessons ranged widely and included how we could find the best in ourselves to overcome the worst in others, how to teach those who followed, how to better conduct clinical treatment trials, how to better treat, how to work with communities rather than on or against them, how to prevent and protect (New Zealand colleagues have been especially good at this), and how to live with loss.

Our work as clinical psychologists confers great privilege upon us, and great responsibility. We are privileged observers, confidants, actors, we are “the keepers of the tears” and occasionally of the joys, we are facilitators of understanding and control, we are the askers of questions and the interpreters of answers, the givers of news and companions of consequences. Our work as psychologists is relevant to every facet of life and every life on the planet can be touched by our work with one.

Accordingly, our responsibilities become very obvious and have informed my clinical practice ever since. We must be honest, especially with ourselves. We must acknowledge our limits and strive to challenge them with humility and determination. We must be clear with ourselves and particularly with others about what we do and how we do it. We have a responsibility to describe and characterise our work responsibly to as many people as we can, in my opinion. Our patients are our teachers and we should never fail in acknowledging this fact. We must ensure we use our support structures well for self-care and our professional integrity. And a solid lesson from the pre-treatment era is that if a promise is made it must be kept and, if it cannot, be clear about why as soon as possible. These lessons—and so many others—have come at a huge cost; a cost not worth paying, and yet millions have done just that. Would that we could have learned more from our fallen.

Looking back now, I see a different world. We live now in a global culture of immediacy. Happily, the “sins” of the past are now largely lost through legislation and social progress, although assaults on such advances remain disturbingly visible in many societies. Of course, what has really changed is our ability to reliably diagnose and treat HIV disease. Back then, in the pre-treatment era no one could have possibly imagined the extraordinary advances in a treatment landscape that now mean a young person in the West diagnosed with HIV today will likely die of old age. Such is the ubiquity of good health with HIV in our society that the consuming intensity of that earlier era is now actually hard to conjure or sustain. I imagine health workers familiar with containment and management of Ebola today might relate to this dissonance, although I might well be wrong. We still have our AIDS heroes, of course, they work and live amongst us every day on this and on sexual health in its broadest senses, clinically, socially, and politically.

But many things have not changed, or have not changed enough across our world. Development of rights-based communities has not kept up with community growth; gender relations are still evolving too slowly, poverty is receding but still crippling for billions, reliable access to health services remains a dream for too many, stigma remains powerful and fatally obstructive in many settings, reproductive rights, sexuality, and sexual health are still determined for too many people by ideologues in opposition to science and human rights.

I worry that in the final analysis we have not learned much about ourselves as a species. We do not want to change behaviour that gives us pleasure. Oftentimes I have thought that, at the end of the AIDS pandemic, perhaps all we will have really learned, the *main* consequential lesson, is simply how to make a new pill.

Is that why they died? Is that really the best we can do?

Preliminary Research Report

Madeleine Stapleton

Review of Results

Earlier this year I completed my thesis, which investigated the negative and positive psychological consequences experienced by clinical psychologists who work with traumatised clients in New Zealand.

In the literature, negative psychological consequences have been described as secondary traumatic stress (STS) and positive psychological consequences as vicarious posttraumatic growth (VPTG). These phenomena result from vicarious exposure to trauma or being indirectly exposed to a traumatic event; for example, listening to the aversive details of another’s traumatic experience. In my study, STS referred to the presence of posttraumatic stress disorder (PTSD) symptoms resultant from vicarious exposure to trauma, such as intrusion, avoidance of internal and/or external reminders of the traumatic event, marked changes in arousal and reactivity, and negative changes to cognitions and mood. VPTG referred to the positive cognitive, emotional, spiritual, and relational changes resultant from vicarious exposure to trauma.

The purpose of the study was to determine factors related to STS and VPTG. Determining such factors is important to help identify clinical psychologists who are more likely to experience STS and VPTG, and determine ways in which STS can be prevented and VPTG facilitated. The study focused on factors that were related to the level of vicarious exposure to trauma, including the number of years working as a clinical psychologist, the number of hours per week working with

traumatised clients, and the percentage of traumatised clients on one's caseload. Traumatised clients were defined as clients who had an emotional response to a terrible event and who typically experienced shock and denial after the traumatic event, as well as other reactions such as unpredictable emotions, flashbacks, strained relationships, and physical symptoms. The study also focused on other factors, including one's posttraumatic cognitions, level of secondary trauma self-efficacy (STSE; perceived ability to cope with the challenging demands that result from work with traumatised clients and perceived ability to deal with secondary traumatic stress symptoms), perceived social support, and engagement in self-care activities. Correlations between these factors and STS and VPTG were analysed.

Two hypotheses were supported in the study. A positive correlation was found between posttraumatic cognitions about the self, others, and the world, and STS. This finding suggests that monitoring clinicians' posttraumatic cognitions following treatment with traumatised clients may be important to prioritise. A positive correlation was also found between self-care and VPTG. Therefore, encouraging clinical psychologists to engage in self-care activities, both in and out of the workplace, may also be beneficial.

As posttraumatic cognitions correlated significantly with STS and self-care correlated significantly with VPTG, relationships between these two variables and the other studied variables were examined. A positive correlation was found between the number of hours per week working with traumatised clients and posttraumatic cognitions. Working fewer hours per week with traumatised clients may be beneficial for clinical psychologists. A negative correlation was found between STSE and posttraumatic cognitions. It is possible that clinical psychologists who believe that they are better able to deal with trauma-related demands are also less likely to experience negative cognitions and thus, STS. Fostering STSE in clinical psychologists following vicarious exposure to client trauma may be important. A negative correlation was found between perceived social support and posttraumatic cognitions, meaning it is important to ensure that clinical psychologists feel supported by their significant other, as well as their friends and family. Additionally, self-care was found to correlate negatively with posttraumatic cognitions, which suggests that engaging in self-care activities may help clinical psychologists to cope with the negative cognitions resultant from vicarious exposure to trauma. Moreover, a positive correlation was found between self-care and perceived social support from friends and family, which provides further support for ensuring that clinical psychologists feel socially supported.

If you have any questions regarding the results of the study please do not hesitate to contact with me via the email address below.

Email: maddiestapleton@windowslive.com

Thank you to all NZCCP members who took the time out of their busy schedules to complete my survey last year, I really appreciate it.

Note from the Editor: We hope that Madeleine will be able to tell us more in future.

Psychologists as Leaders: Insights

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

As part of this, insights from NZCCP members who have moved into leadership roles will be regularly featured in NZCCP publications as a way of sharing information about pathways into leadership. The following are from Tina Earl and Matthew Leaver.

Tina Earl

What leadership roles do you currently hold?

Clinical Services Manager with ProCare PHO (primary health organisation). This role encompasses delivery of clinical services (related to psychological and social services) to support GP practice in primary care. It also involves leading initiatives such as developing and implementing new models of healthcare; and managing business as usual in the organisation. ProCare is the biggest PHO in NZ, and caters to a population of over 800,000 people.

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

The main branches to the path were to have a sound and senior knowledge of clinical psychology that could be brought to bear in a number of situations, such as professional and management forums. Other branches include: stepping up and taking initiatives and opportunities to put yourself forward to engage in projects, development, strategy, delivery of services, and so on; taking an interest in current issues (e.g., poor access to mental health services) at local, regional, and national levels; and communicating and working with teams, colleagues, and stakeholders such as other professions, managers, and community agencies. This had two main effects. It gave me good experience of leading smaller projects and teams, and demonstrated to others what I was capable of. When leadership roles or positions then become available one is in a good position to apply and to be able to bring the knowledge and skills to the position, with a demonstrated a track record of being able to lead.

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

Leadership courses were good to give an understanding and knowledge of what it entailed. But the actual “doing” provided the hands on learning and experience. It is helpful to gain a wealth of experience in a number of situations, so as to gain the competence and confidence to apply knowledge and skills. And to work with people, teams and services towards a goal. To have good mentors and supervisors that you can go to for advice and to sound things out, and to not be afraid to have your work constructively reviewed and critiqued by peers, service users, and those senior. Good learnings!

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

Yes. In one project, although I knew the work well and what needed to be done, I needed to work much more with the teams and bring them along with me! I did not put enough importance on this. The relationships you have with the people involved! This takes a lot of time, to engage the people who are critical to the success of a project, to listen and respect their voices, to socialise the concepts with them, to foster a collaborative approach, and have good “people” systems and feedback loops, and the ability to take on board and work with that. The

actual project information and direction remained valid and the way to go but the need to get everyone on board was equally important and as such it was a good learning experience.

Who supported or encouraged you as you entered leadership roles?

Often my peers. Unlike some other professions, psychologists are not trained and enculturated into leadership roles, and so it is about stepping up and taking the initiative. But having the support of like-minded colleagues is valuable, especially the leadership group “Future of Psychology” here in Auckland. Plus indirect support of other professions and colleagues you meet along the way.

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

Do not be shy. Engage with issues. Engage with people. Take initiatives as they arise. Attend leadership training. Value your expertise. Get out of the clinic room. Team work. Gain resilience skills. Being a leader means being strategic and political in the wider arena. Consult and network with others at all levels. Have a good mentor and supervisor.

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

Advantages are that you get to have a voice in creating change around important issues. You get to have a role in shaping direction and support for important issues (such as access to mental health services), and vulnerable groups (quintile 5). You might even get to have some good outcomes for people’s wellbeing! It also promotes the profession of psychology and recognition of the huge value we bring to these issues, and of the vast knowledge and skills regarding clinical intervention, systems perspective, and change management.

The challenges are that it can be tough and tiring. It requires good personal skills such as resilience and perseverance, and interpersonal skills such as tact, ability to listen well, people management, team skills, and strategic communication. Effecting influence on change takes time and although there can be some “quick wins,” good leadership is often about the big picture and the long haul.

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

Māori value and give attention to the relationship with a person long before they decide to do “business” with them. This can also be said of leadership roles. People need to trust and respect you (and it helps if they like you as well, ha ha) to come on board with any leadership initiatives. Paying attention to interpersonal relationships and the skills related to this is important if you want to understand, respect, and take people along with you to achieve the goal. Good communication (and at the emotional intelligence level), collaboration, and negotiation skills to help keep everyone in the loop and motivate them to travel the path that you want.

Not only skills, but *values* such as integrity, honesty, prudence, and the ability to keep to your word where possible are important. And although you may be a leader, humility is so important if you want a loyal and dedicated team.

Having said that, a leader needs to lead, set direction, take risks, make hard decisions, have a “customer focus,” gather resources, and work with their group to bring about effective outcomes! The actual hands-on work of project leadership and management can be implemented and carried if the ground work is prepared. And of course, you need to know what you are doing, so knowledge and skills in your area of expertise.

If yours is a management role, to what extent does it require leadership skills or tasks?

In healthcare numerous iterations of leadership and management roles abound. Currently the mantra is “clinically led and management supported.” This “new” approach means that clinicians are employed as both leads and managers of a service/organisation. This is the case for mine (Clinical Service Manager). These roles are promoting leadership and direction, but with the backing of the decision making capability that a manager has.

The operational back room functions are often done by a support role, releasing the leader/manager to oversee the big picture. It is an interesting role in that it requires the ability to discern what the clinical/professional issues are, lead on them, and delegate roles and tasks accordingly. So you are not just managing business as usual, you are also very much forging, promoting new clinical initiatives, and implementing them. Exciting.

Matthew Leaver

What leadership roles do you currently hold?

I am currently the Senior Learning and Development Advisor responsible for leadership development at my DHB.

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

I am interested in how larger health systems work and this was an opportunity to work in that context.

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

I attended a number of leadership programmes and have also been coached by others.

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

Learning that you will not make all people happy all the time was a hard lesson for me. Realising that my course of action was still the right thing to do was comforting.

Who supported or encouraged you as you entered leadership roles?

My manager at the time.

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

Your clinical skills are a transferrable, and you probably already have some of the prerequisite people skills. Upskill yourself in project management and service improvement, as our training often does not cover this.

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

Challenges include leading colleagues who were once “on the same level.” Advantages include showcasing psychology in a different setting.

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

Interpersonal skills, project management, planning, communication, and managing conflict.

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

Leaders are those who are positions of influence. You do not have to sign leave forms or hire people to show leadership.

Book Review

Title: Listening, Learning, Caring and Counselling
Author: Dr Cate Howell OAM, CSM, PhD (Med.).
Publisher: Exisle Publishing: Wollombi, NSW, Australia (2016)
Reviewer: Fran Vertue PhD, Dip Clin Psych, FNZCCP
Review date: 12 May 2017

Short description: This book is almost a compendium of therapy strategies for those in the healthcare professions who work with adults. The author presents a number of therapeutic approaches and intervention techniques or tools for a range of life issues and problem areas. She situates these sometimes disparate, and sometimes competing, ideas within a category that she calls “technical integration.” She names her model the listening, learning, caring, and counselling (LLCC) approach, as reflected in the title of the book. She describes this approach as comprising the best treatment techniques chosen for a particular individual or particular problem, with priority given to the common factors of a trusting therapeutic relationship, effective communication, and paying attention to one’s clinical intuition. One of the difficulties with taking an eclectic approach like this is that there is no overarching theoretical framework that could provide an orienting reference point or a common explanatory context, for the psychological problems that people suffer and the techniques and tools used to assist the people to overcome, or at least, manage those problems.

In the first chapter, the author acknowledges the influences on her work of a wide range of psychotherapeutic philosophies and approaches, including humanistic psychology, person-centred therapy, existentialism, attachment theory, multimodal therapy, mindfulness, positive psychology, and motivational interviewing. The range of therapies that have been incorporated in the LLCC approach include: solution-focused therapy; cognitive behavioural therapy; mindfulness-based cognitive therapy; acceptance and commitment therapy; interpersonal therapy; narrative therapy; hypnotherapy; expressive therapies; positive therapy; bibliotherapy; and e-mental health. The author has developed a model representing six key “pie slices” or elements of the client’s life, with the person and the therapeutic relationship together at the centre of the pie. She then goes on to show how each key element is addressed in therapy by drawing on a number of therapeutic approaches. Finally, she provides a potted account, in a few paragraphs, of each of the therapies incorporated into LLCC.

Chapters 4–13 cover a range of life issues and problem areas including sleep, stress and anxiety, depression, anger, guilt and shame, change and transition, loss and grief, trauma, relationships, and self-belief. Each chapter begins with a short case study, some background information about the particular problem, key areas in the LMCC approach for that problem, and then a series of tools and techniques from the different therapies that the author suggests will be most useful for that problem. The two final chapters cover crisis intervention and self care.

One of the things the author does well is cover a range of assessment and therapy strategies.

Fran Vertue is a Canterbury-trained clinical psychologist who has worked with the DHB in the Child and Family Mental Health Service, as a lecturer in Child and Adolescent Development at the University of Canterbury, in private practice covering a range of child, adolescent, and Family Court issues, and is now with the Department of Corrections.

However, the downside is that this range, in the absence of an orienting framework, makes the whole feel a bit incoherent. The author has presented a wide range of therapy techniques and tools, but there is not the space to go into any depth about each. Rather, the author points to other sources for the therapist to access for more detail. The author has described her personal approach to therapy within her experiences as a medical doctor, an occupational therapist, and a counsellor.

For this reviewer, the book does not add to the clinical psychologist's compendium of necessary literature, apart from a drive-by glimpse of what might work in therapy. However, students may find it useful as a general reference work for a brief bite of a wide range of therapy strategies.

Book Review

Title: It's All in Your Head: True Stories of Imaginary Illness
Authors: Dr Suzanne O'Sullivan
Publisher: Chatto & Windus (2015)
Reviewer: Holly Wilkins

A compassionate and knowledgeable approach is taken to exploring psychosomatic illness in *It's All in Your Head* by consultant neurologist, Dr Suzanne O'Sullivan. First off, the multitude of labels used to define physical symptoms that occur for psychological reasons is addressed. A range of case studies are woven throughout the book discussing those whose stress was expressing itself in extreme forms of paralysis or convulsions. The theme of these fascinating stories was around accepting the power of the mind over the body, and figuring out the purpose the illness is serving. These included a case study where Dr O'Sullivan was proven wrong; malingering, where someone was convinced they had an illness such as multiple sclerosis, chronic fatigue syndrome, blindness, or seizures, without a physical cause and where the pattern of symptoms suggested it was psychological. Woven through these case studies is the science and history of our understanding of the origins of health problems and what we choose to pay attention to and what we hide from ourselves. Positive results in cases were seen as symptoms may still be present but patients being able to respond to them differently.

It was intriguing to see these presentations through the eyes of someone in physical health. Dr O'Sullivan stated that in an average day approximately one-third of presentations to general practitioners have symptoms deemed medically unexplained, whether due to these being transient, disease that "stretches the limits of scientific knowledge," or psychosomatic. She sees psychosomatic presentations, the most common being fatigue and pain, as often the domain of psychology and psychiatry, yet the very nature of the physical presentation of the symptoms means that most see specialists (sometimes a multitude of specialists) and are left without answers. There is a great deal of empathy for the patient's perspective around the difficulty understanding, let alone accepting, a psychological explanation and why many choose a relentless drive for a medical explanation. Dr O'Sullivan calls for a societal change to the way symptoms like these are regarded as somehow less real than those associated with other health problems and the ongoing stigma around psychiatric illness. The only critique I can make is the focus on psychiatrists as those who Dr O'Sullivan was championing for patients to see, with no mention of the role other mental health professionals, such as clinical psychologists, can play.

Holly Wilkins is a consultant clinical psychologist, Early Intervention Service, CCDHB

Book Review

Title: Reflection in CBT
Authors: Beverly Haarhoff and Richard Thwaites
Publisher: Sage Publications Ltd (2016)
Reviewer: Melanie Lake

Bev Haarhoff and Richard Thwaites pose the question, “Why should therapists reflect?” in their book, *Reflection in CBT*. Their aim is to examine what reflection means and identify the important roles it can play for cognitive behavioural therapists. Other psychological therapies, notably the psychoanalytically-oriented approaches, have a long history of requiring own therapy and using approach-consistent strategies for personal and professional improvement. Haarhoff and Thwaites remind us that self-reflection (SR) and self-practice (SP) are not foreign or new to CBT, and go on to examine the advantages of this meta-competence across a range of practitioner and client settings.

The foreword for *Reflection in CBT* is written by Professor James Bennett-Levy of the University of Sydney. He is a leading researcher in the field of self-reflection in CBT, and has promoted the value of reflection in psychological therapy training and practice from as early as 2002. Bennett-Levy’s authority on the topic adds weight to his clear endorsement of this book as a much-needed addition to the literature, likely to improve our understanding of how clinicians become more helpful to their clients.

Haarhoff and Thwaites bring in five contributors, also experienced CBT practitioners, supervisors, trainers, and researchers, with mental health backgrounds across a range of the “step levels” in talking therapy as well as medicine and nursing. Their writing contributes perspectives on reflection in CBT training, low intensity CBT, and incorporating client feedback into more effective practice. The authors introduce a theoretical framework, the declarative procedural reflective (DPR) model of therapist skill acquisition. This model serves as a guide to map out the products of reflection as our enhanced ability to say (know) and do in therapy. A therapist using DPR is guided to discover understandings and rationales to use skills, making it both a learning and a supervision process. Clinical and practical examples clearly illustrate the practice of reflection in action, making the book well suited for training.

Across the 10 chapters, the authors discuss reflection from the stage of training through to experienced practitioners, emphasising its relevance as an ongoing development tool. Clinicians are encouraged to raise their socio-cultural sensitivity, and systematically collect client feedback and outcome information, with guidance on how to integrate these into more effective practice. Key chapters focus on how to get the most out of reflection in supervision and shape it into self-supervision. The personal and professional gains of trying CBT for oneself are discussed, and the final chapter looks at the use of reflection as an important self-care practice in our challenging work.

Haarhoff and Thwaites have collaborated before, and there is a naturally collegial and positive tone to their chapters. Both are clinical psychologists and CBT practitioners, with significant therapy, supervision, and training experience. Based in New Zealand and the UK, they continue to research SP/SR as an important tool for skill development in training and practice. Haarhoff and Thwaites were co-authors of the first published SP/SR manual, *Experiencing CBT from the*

Dr Melanie Lake is a senior clinical psychologist in Auckland, sharing her work time between public and private practice. The primary focus of her practice is psychological and/or cognitive assessment that lead to CBT interventions or other treatment plans for adults.

Inside Out: A Self-Practice/Self-Reflection Workbook for Therapists (2015). This is a workbook for cognitive behavioural therapists, encouraging them to try CBT self-practice and reflect on the process for personal and professional growth.

Reflection in CBT logically fits into place alongside the manual and could be read before it, or as a standalone text. The international authors and contributors have drawn on lessons learned from their practice, supervision, and training and put together this more conceptual and comprehensive text. *Reflection in CBT* expands on the introductory chapters of the manual, notably with current evidence for reflection. The empirical literature is still relatively limited, but Haarhoff and Thwaites link to models and research that supports its efficacy and value. The role of reflection in adult learning is a clear example here.

The book practices what it preaches in the “Taking it forward” section of each chapter, inviting the reader to digest the material and reflect upon integrating it into clinical practice. It recognises that reflecting therapists probably have a deeper understanding of CBT, more empathy in the therapy experience, and consistency between what they offer clients and how they live. It comes as no surprise that reflection is an integral part of the ongoing learning and professional competence for health professionals. Reflection is challenging, but this book helps to balance this out with greater awareness of its advantages and an accessible, encouraging approach.

Book Review

Title: Self-Help for Trauma Therapist—A Practitioners Guide
Authors: Dr Margaret Pack, Associate Professor of Social Work, Australian Catholic University, Sydney, Australia
Publisher: Routledge (2017)
Reviewer: Scott Percy

The aim of this book is to provide a self-care guide for practitioners of various disciplines who engage empathically with abuse survivors on a regular basis, and therefore risk themselves becoming impacted by the nature of trauma-related contact. It also aims to assist trauma therapists to develop an understanding of vicarious traumatisation with implications for self-care. The book details how to address this through assisting trauma therapists develop awareness and resources to remain resilient in the face of such difficult work. The author highlights that awareness can be difficult to develop when dealing with clients’ strong feelings while trying to manage one’s own emotions and responses as we attune empathically to clients.

Dr Pack suggests the reader approach this book “chapter by chapter, reading only as little or much as they feel helpful to illuminating their own process and themes.” The reviewer found each chapter to be densely packed with information; hence, reading small amounts at a time helped to process the information provided. The book includes questions for self-reflection activities and a range of resources such as web links and reference lists. Case studies are also referred to that give emphasis to specific issues or themes. Psychological effects of stress and potential secondary traumatisation or burnout are detailed as part of a literature review. It is interesting to learn how the concepts of vicarious traumatisation, compassion fatigue, and burnout overlap and to explore their distinguishing differences. As part of detailing “what works” in trauma-focused work, the author includes classic trauma theorists work such as van

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der Kolk, Briere, Herman, and others. She also includes more recent trauma frameworks and literature to indicate the development of new directions in theory building about the impact of trauma work and what mitigates it. Dr Pack includes descriptions of her own qualitative research on the impact of working with chronic trauma. This research includes New Zealand practitioners of various disciplines as subjects. It was also interesting to read of therapists' partner's views and their experience of how working with trauma clients affected their spouse. One theme of her research findings was the importance of therapists coming to terms with their own traumatic experiences. Specific mention of therapists working in a New Zealand context is most interesting, and the challenges of working in the current ACC framework are discussed and accented through results from qualitative research conducted by the author.

Dr Pack provides therapists from a variety of disciplines and theoretical orientations a resource of great importance, and one that will assist us all in our work with clients and relationships in general. She offers a road map to developing resilience, and inspiration toward taking the approach of being an eternal student with learning that will bear the fruit of a deeper connection to self, others, and a rich meaningful life.

Book Review

Title: Professional Practice of Psychology in Aotearoa New Zealand (3rd edition)
Authors: Waitoki, W. W., Feather, J. S., Robertson, N. R., & Rucklidge, J. J (Eds.).
Publisher: Wellington, New Zealand: The New Zealand Psychological Society (2016)
Reviewer: Paul Carlyon, clinical psychologist, private practice, Kapiti Coast

Now three editions deep, *Professional Practice of Psychology in Aotearoa New Zealand* brings its usual heft and utility to the student, researcher, practitioner, and consumer. This third edition updates the 2007 second edition, and builds on nearly a decade of research, progress, and societal change. Reviewing the work of leading and sometimes distinguished practitioners, shepherded by four pre-eminent and aspirational editors, seems a hiding to nothing; 580 pages, 34 chapters, 73 contributing writers, and a host of reviewers bringing rigour and a useful glossary, carefully crafted in the structure of our four ethical principles. This was a big piece of work to bite off for the contributors and editors, and it took its fair share of chewing as a reader.

Psychology in Aotearoa is broad, brings unique issues of shared whenua to the forefront, and this volume takes a necessarily aspirational and explicitly local approach to psychology. It is better for it too; psychology reference books are a dime a dozen but this one is for *us*. The responsibility for practitioners to reflect upon, as well as maintain and expand, their expertise and skills for the betterment of all who live in Aotearoa is a point made again and again. It is refreshing to be reminded of why we do what we do, and that the stones we cast create far-reaching ripples for all.

Chapters span the breadth of our work, as well as the work of practitioners sharing our profession but seemingly in far off distant realities from that of our own usual day at the office. Among others, this sees, for instance: an exploration of assessment of change and outcomes in mental health settings; the proposal of a model of self-reflective practice; an examination of He Waka Eke Noa – Māori and indigenous suicide prevention; a literature review relating to supervision; issues arising in cross-cultural neuropsychology; and an examination of Pakeha

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culture and psychology. Woven through all chapters, is reference to our Ethical Code and responsibility to understand and practice in the cultural context of Aotearoa.

I liked the differing approach of each chapter. Some provided a “how-to,” whereas others drove a more reflective, esoteric perspective. You are unlikely to read this book cover-to-cover, and good luck in your recovery if you do it in a single sitting. However, when you dip and dive in the search for details, and to test how your hypotheses stack up against the literature reviews and data contained therein, you will note the changes in style as you flit between chapters and be grateful for the shifts in tone and pace and focus.

A reference book such as this brings big promises. Prior editions have been scoured by eager students, practitioners preparing to meet new challenges, and I am sure, lay people seeking a glimpse of a profession that, despite all best efforts, still sees us routinely asked about whether we can read minds. I recall the first edition standing by, well thumbed, as I sweated through my own clinical training, and this new edition will be right there for the next generation of emerging practitioners making use of it as a required reference.

Professional Practice of Psychology in Aotearoa New Zealand concludes in a way that sums up those preceding chapters. There is a reflection on the challenges for humanity, hope for our natural world, shared work and play, diversity and strength and a sustainable future. In the middle of that, it is said, is the contribution of psychologists. This seems grandiose and self-important at first glance, but I will embrace that because our efforts are sometimes grand and, more often, at least important. We are required to maintain our competence, to reflect on our work, strengths, and weaknesses, and give thought and action to our practice in Aotearoa. There will not be a practitioner in this place we call home that will not find, never mind nuggets, but whole chapters of professional and personal interest in *Professional Practice of Psychology in Aotearoa New Zealand*. Buy it or borrow it, read it and bring it to life in your practice. We will all be the better for it.

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](http://www.nzccp.co.nz/events/event-calendar/) for further information and links (<http://www.nzccp.co.nz/events/event-calendar/>)

NZCCP Events

LOCATION	MONTH	PRESENTER/ CONTENT
Queenstown	27-28 July	NZCCP 2017 Pre-Conference workshop with Matthew Berry
Queenstown	29-30 July	NZCCP 2017 Conference

Other Events

LOCATION	MONTH	PRESENTER/ CONTENT
Hamilton	26-28 July	Level 1 Schema Therapy Workshop
Palmerston North	3-5 August	The Health Psychology Un-Conference 2017
Wellington	14 August	The Assessment and Treatment of Adult Firesetters
Auckland	17 August	Managing Medication Issues that Matter – Clinical Pharmacology for Clinical Psychologists
Auckland	22 August	Improving Access to Psychological Therapies
Wellington	28 August-1 September	Vida Law and University of Otago Health Systems Law intensive course
Auckland	31 August	NZPOPs 2017 workshop
Auckland	21 September	CBT for Substance Use
Christchurch	21-23 September	Brainspotting Training
Christchurch	22 September	1-day Intermediate Motivational Interviewing Workshop
Wellington	10 October	How to do Family Therapy Really, Really Well
Christchurch	6-8 November	NZ Early Intervention in Psychosis Conference
Wellington	13-14 November	An Introduction to Coanitive Analytic Therapy
Christchurch	23-25 November	AnzaCBT Conference

