# ShrinkRAP

**Newsletter of the New Zealand College of Clinical Psychologists**
**THE SPECIALIST ORGANISATION FOR CLINICAL PSYCHOLOGISTS**

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**E Ruaumoko, puritia, tawhia, kia u,kia itaita!**
*O, Ruaumoko, hold on, hold back, be firm, be secure!*

## To the people of Canterbury

The College of Clinical Psychologists sends deepest sympathies and support to the people of Canterbury for the continuing trauma, loss and distress you are all enduring.

What follows are two extremely useful poster/flyers, **Taking care of yourself** and **Little Steps**, which were been developed and widely distributed by a small group of Canterbury based College members, including Fran Vertue, Janet Carter, Eileen Britt and Bronwyn Trewin, in the days immediately after the February earthquake.

Later in the newsletter we've included a proposal developed by members of the NZCCP Canterbury Branch, including Martin Dorahy, Eileen Britt, Graeme Clark, Janet Carter, Deborah Snell and Juliet Thomson, for the Ministry of Social Development as a guideline for handling the psychological sequelae of the earthquakes in Christchurch.

# Christchurch Earthquake
## Taking care of yourself

### Routines *'Familiarity is comforting'*
Keep up normal activities
Treasure familiar things

### Stay connected *'We need each other'*
Stay in touch with family and friends
Take moments to give others your full attention
Listen and answer children's questions simply
Be brave for each other
Ask for and accept help

### Save your energy *'Keep it for important things'*
Lower expectations of yourself and others
Take breaks and lighten your workload
Be tolerant of yourself and others
Lots of things can wait
Children may act younger – that's ok for a while

### Lifestyle *'Balance is healthy'*
Stay active e.g. go for a walk
Relax - take a break
Limit alcohol
Try to get enough sleep
Try to eat well
Do something nice for yourself

### Safety *'Protect yourself in every way'*
Limit exposure to earthquake news e.g. TV
You are not helpless – remember the things you do well
Take care of your spiritual and emotional health
It is ok to be emotional

For extra support contact your GP, or phone 0800 777 846, or go to www.canterburyearthquake.org.nz

New Zealand College of Clinical Psychologists (NZCCP)

# Small Steps Forward To Get Back Into Everyday Life After The Earthquake

It is normal to feel scared and nervous about everyday things after an earthquake, but gradually returning to old places and activities is important.

Here are 10 small steps that can help:

- Pick one place or activity you want to get back to
- Break down the job of getting back into small steps
- Take one step at a time and be patient with yourself
- Breathe slowly on each step
- Stay on the same step until it is easier
- Go back a step if its too hard
- It is important to take a step often
- Ask others for support to take steps
- Notice how far you have come
- Give yourself a pat on the back!

Here are small steps that could be taken over a number of days to go back into a building

*Go to the building car park*
*Walk to the building door*
*Go into the building entrance*
*Stay on the same level and go further into the building*
*Gradually go to parts of the building you find more challenging*


New Zealand College of Clinical Psychologists (NZCCP)

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**College News**
Just to remind you all that the Medical Protection Society offers free counselling support service to Clinical Psychologists, a service that has been available since December 2008. They also invite any Clinical Psychologist, who works in private practice and who wishes to be included in the list of practitioners providing the service, to contact MPS.

Those who want to access counselling support can ring the MPS 0800 number - *0800 CallMPS (0800 2255677)* - at any time. MPS guarantee that, as is currently the case, all calls to this number are kept in the strictest confidence. Your call will be answered by one of the medico-legal consultants (as it is now) who will start the process.

If you feel that you or a colleague who is under stress would benefit by such a service then we suggest you call *0800 CallMPS* (0800 2255677) as soon as possible. You may use the same number for general information about this service.

**Membership News**
At the National Executive meetings since the December ShrinkRAP the following people have been approved and accepted as
**Full Members** of the College:
Emma Bosworth, Christchurch
Holly Coombes, Wairarapa
Joseph Melser, Hastings
Simon Seal, Tauranga
Regan Wisnewski, Auckland
As a Full Member each may now use the acronym MNZCCP.

The following people have been approved as **Associate Members** of the College:
Sarah Calvert, Auckland
Ruth Gammon, Wellington
Brigette Gorman, Dunedin
Laura Howard, Palmerston North
Sarah Roberts, Wellington
Mieke Sachsenweger, Auckland
Shelley Taylor, Dunedin
Leanne Taylor- Miller, Auckland

**NZCCP Fellowship Certificates** were presented by Nigel Fairley, President of the College at the 22nd AGM, on 19 March, 2011, to:
**Elliot Bell** (Wellington)
**Luci Falconer** (Auckland)
**Jennifer Jordan** (Canterbury)
**Rachel Moriarty** (Wellington)
**John F. Smith** (Auckland)

**NZCCP Life membership** was awarded to**:**
**Barbara Chisholm** (Otago)

The National Executive wishes to congratulate these people on attaining their new membership status.

**College Awards**

NZCCP is delighted to announce the following award recipients:

The **Research/Study Award** goes to **Jennifer Jordan.**

The **Travel Grants** were awarded to **Dieter Dvorak**, **Laura Howard, Leena St Martin, Malcolm Robertson** and **Roger Shave.**

The **NZCCP President's Award** was given to **Kirsty Furness**, a Massey University clinical student at the Albany Campus, Auckland.

The College heartily congratulates all award recipients.

**CONFERENCE 2012**

***Homespun Wisdom: A Student's Perspective***

*Saul Gibney*

I went along to the 2011 NZCCP conference with a great deal of excitement and a little bit of trepidation. This was the first conference I had ever attended. But not only that, it was my first experience of a large gathering of people who made up the profession I hope to eventually join, a case for excitement and nerves if there ever was one! So with all this in mind I turned up at the pre-conference drinks not really sure what to expect. I need not have worried. Right from my arrival I was made to feel welcome, both by the committee of the NZCCP and my first encounters with other clinicians and students at the drinks. I felt this set the tone for what was to be a great weekend.

The workshops I attended throughout the weekend were fantastic. From a student perspective I was worried that I may struggle to follow the content of some of the

workshops. However, I found that the material in all the workshops I attended was easy to understand and, perhaps most surprisingly, immediately relevant, even to someone in the beginning stages of their training. I received similar reflections from other students at the conference. Many of us were pleasantly surprised by just how much we took away from the workshops we went to. I understand that this is the first year NZCCP has used the theme 'Homespun Wisdom' and focused entirely on the work of New Zealand clinicians. I think in some ways this is what made this conference so unique and special. The content of the conference was directly relevant to so many because it was presented by New Zealand clinicians on issues relevant to New Zealand practice. I definitely hope this theme is reused again in the future. If nothing else, it speaks well of the future of clinical psychology in New Zealand that the NZCCP can put together a conference of such high quality drawing solely from New Zealand clinicians.

I found the Quality Hotel Barrycourt a great venue and very much enjoyed the fantastic lunches and conference dinner, which was a most enjoyable evening set along the backdrop of the Auckland city skyline. I opted to stay at the Barrycourt during the conference and have definitely become a fan of staying on site, particularly if you are going to attend the 7am Mindfulness practice!

The thing that surprised me most was the sense of community that seemed to pervade the atmosphere at the conference. Coming from Christchurch this was especially noticeable in the genuine concern expressed by those I met with regards to the wellbeing of those of us from the region. I was also struck by how approachable everyone was. Whether it was a workshop presenter, another student or someone you happened to meet in the coffee queue, everyone was very willing to chat and get to know you.

I left the conference having learned a lot and met many interesting people. That in itself would indicate the success of the conference, but, I think more importantly, I left gaining a sense that this indeed was the profession I wanted to be in and excited in particular about beginning my career in New Zealand. I am looking forward to the 2012 conference in Wellington!

**ACC report**

*ACC meeting with the Psychological Society and the College.*

Representatives from the NZPsS and the NZCCP met with Dr Peter Jansen, ACC Senior Medical Adviser and Dr Kris Fernando, ACC National Psychology Adviser, in February as part of the regular meetings scheduled through the year to discuss ACC issues.

*Supervision Arrangements for Branch Advisory Psychologists*

ACC requested that the Board, the Society and the College comment on the proposed supervision arrangements for Branch Advisory Psychologists (BAPs). The following suggestions were made:

- Although BAPs should have access to regular one to one supervision with a supervisor external to ACC, people from outside ACC often are not in a position to appreciate the unique situation the BAPs are in.
- Attendance at the ACC Clinical Advisors' two day annual conference does not count as supervision, instead it is considered to be professional development.
- The monthly peer consultation teleconferences for up to 11 participants will be focused on general issues.

BAPs also engage in peer consultation on a fortnightly to monthly basis to discuss clinical issues and peer review the advice they are providing.

ACC appreciated the feedback and emphasized that the professional associations' responses would help support their colleagues who are faced with a number of clinical issues within ACC.

*Criteria for mental injury assessments*

Following the review there were some suggestions made as to changes that ACC could make to improve the assessment process, which included using alternatives to the DSM-IV, as discussed below, but also reviewing the range of professions that can perform the mental injury assessments which at this point is limited to psychiatrists and psychologists along with some psychotherapists.

*Alternatives to DSM-IV- what other methods of classification are appropriate to determine mental injury?*
There has been discussion about which psychometric tests can be used, along with interview and collateral information to identify a clinically significant dysfunction and, depending on which are recommended, this could potentially alter the criteria around who can conduct these assessments. ACC made it clear that criteria are needed to ensure that those who are interpreting results from psychometric measures have the training and qualifications to do so.. This will be consulted on further and more formally, and ACC will be circulating a draft document to the College and Society for comment.

*Non-compliance letters*
The non-compliance letters designed to encourage clients to attend are almost always sent without consulting the psychologist involved, which can lead to a loss of rapport and significant anger towards either the clinician or the case manager sending them. ACC acknowledged this and agreed that it would be ideal that the service provider is informed at least at the same time, if not before, the non-compliance letter is sent. It was also noted that in most cases the case manager talks to the client first and the non compliance letter is sent only after the reason is ascertained. Talking the the psychologist as well may be indicated to ascertain his/her opinion as to the attendance barriers.

*ACC slow to receive clinical notes*
The time taken for ACC to request and for the DHB to release clinical notes relevant to clients' claims is often not less than 3-4 months. This has often resulted in GPs, clients, and therapists trying to track down where in the system the hold-up is. This is particularly unhelpful for sensitive claims which cannot be approved whilst ACC is waiting for relevant information. ACC agreed that this was completely unacceptable and are attempting to be more client focused. It was also noted that some DHBs are slower than others and that sometimes the client is asked to request the notes themselves to pass on to ACC, especially with respect to GP's notes.
*Clients' requests to see their reports*
The College and Society noted that ideally each client should have the chance to see their draft report before it is sent to ACC, to ascertain that the writer has accurately reported historical details. It was agreed however there is potential for the client to become upset by the content. As they may need support when they read the report, the counsellor also needs to be aware of when the report is coming to the client so as to be prepared for this. It was also suggested that it would be better that the ACC triage psychologist sees the report first. It was also agreed that some reports shouldn't go to the client and should in fact be withheld. It was suggested that perhaps potentially upsetting reports could be strategically flagged, possibly with the use of acronyms. It was also noted that some of the interventions proposed in some reports can't be provided by ACC.

On a related matter, an ACC request for clinical notes does not breach the Privacy Act and, while the client has the option to deny access to these, this can impact on cover and entitlement decisions for the client.

*Sector Liaison Groups*
All of the 30 plus ACC sector liaison group meetings have been suspended pending a review of their purpose and their terms of reference. ACC are reevaluating priorities and ascertaining which among these groups are important. It was acknowledged that some of these groups have been valuable, particularly in terms of the professional development between the professions, with special mention of the Mental Health Sector Liaison Group which had produced some very constructive outcomes. The College and Society have been asked to formally note our support for continuation of the Mental Health, Rehabilitation, Pain and Sensitive Claims Liaison and Advisory Groups.

<u>Summary of Pain Focus Group meeting</u>

*Jane Lennan*

ACC met with the Pain Focus Group (an external liaison group) in Wellington on Tuesday 14th December 2010.

***Feedback from NZ practitioners***

Overall referral numbers for pain services remain lower than 2009 reflecting the overall low claim numbers. Providers are aware that ACC's Vocational Services Review may also have an impact on some pain service providers.

Several provider representatives noted stronger influence from case managers on planning of rehabilitation. Providers are aware of a growing need from case managers to understand the indications for selecting

specific programmes or determining the duration of a programme.

***Pain Management messages for the wider Population***

The group discussed messages and vehicles for getting information to the general public on the healthy management of pain after an injury. Population based messages were felt to have an advantage over approaches which are triggered by attending general practitioner and ACC has been given some ideas to follow up on how basic pain management messages could be conveyed to the public.

***Piloting a case manager tool to assist referral for pain management***

The Pain Service Review (2009) identified pain related disability factors are not being recognised early enough and many ACC clients receive multiple or inappropriate pain services. The review recommended the development of a screening tool which could be administered by ACC staff to help stream clients into groups of low, moderate or high risk of developing pain related disability. If this can be identified and addressed early, the likelihood of a claim developing into a long term claim can be avoided and rehabilitation outcomes improved.

A three month pilot study is starting in February 2011 to identify an easy to use validated pain screening questionnaire that can be administered by case managers at their first face to face meeting with a client. Three different questionnaires will be trialled in the Tauranga, Henderson and Wellington branches. The questionnaire will allow for early identification of psychosocial flags and be used alongside a decision guide that helps case managers take into account all relevant client information ACC has ie: case notes, clinical reports and conversations with the client, their whanau, employer and primary care provider.

It is anticipated the pilot will successfully identify an acceptable questionnaire and validate the decision guide for early identification of pain related disability to support the case managers' decision making in referring clients to the appropriate pain services if indicated.

***The Pain Focus Group discussed feedback on the range of ACC pain services***.

The Pain Focus Group discussed ways in which the ***Comprehensive Pain Assessment*** service could be enhanced in 2011. ACC is still committed to the three discipline integrated approach which sets a high standard for understanding a client's experience of pain, and the functional, medical and psychological components remain the best format. The psychological report provides a valued diagnostic formulation and pivotal input into the team discussion; teasing out the causes of pain, modulators, influences and barriers to rehabilitation. The power of an integrated assessment is the influence of team members' perspective on each other's findings, to produce well reasoned recommendations for rehabilitation. A well coordinated team function with a key member as facilitator is considered vital for a successful CPA assessment and integrated report.

The ***Activity Focused Programme*** continues to provide an interdisciplinary approach to more severely affected clients with pain. The pain focus group discussed the advantages of flexibility within the contract and the paramount importance of psychological involvement in developing and guiding a client's programme. The original models for AFP place strong emphasis on the real integration of medical, functional and psychological perspectives in the programme. The group has begun the discussion of how these principles might be reinforced in the service schedule and how to link the service with vocational rehabilitation.

ACC provides ***Interventional Pain Management*** (IPM) services under a specific contract. A forum is planned for 2011 to discuss ongoing development of this service and review how the interventional approach supports rehabilitation for injured clients.

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**News in Brief from the Psychologists Board:**

The Ministry of Health is currently consulting on a range of proposals to amalgamate the Boards and/or secretariats of all 16 HPCAA regulatory authorities. None of the Boards are in favour of these proposals, as a thorough analysis shows that the significant risks to the public and to practitioners' connection to their regulator would not be

offset by any savings or efficiencies that could not be achieved via other, less damaging means. The Board believes that the psychology profession has a very real interest in defining and maintaining (self) regulation at predictable and minimised cost, and in preserving professional identification and standards. We do not believe that a large, multi-profession regulator could provide anything like the consistent, high-quality, profession-specific service currently in place. We note that similar amalgamations have driven psychologists' annual fees up in Australia (average 243%) and the UK (300%). Please watch the Board's website for updates on the consultation process.

The Board, the College, and the Psychological Society have agreed on a process to have the Code of Ethics translated into te reo Maori. A 'Request for Proposal' has gone out seeking contractors interested in the work, and it is hoped the final version will be published later this year.

All psychologists are encouraged to review the Board's newest best practice guideline - "**What to do when you have Concerns about another Psychologist" – which** can be viewed on the Board's new website (www.psychologistsboard.org.nz).

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**CONTINUING COMPETENCE REPORT**

*John S Williams*

In brief, I continually and assiduously took stock of the various domains of my clinical practice, as well as emerging domains within the field, adhering to scientific, pedagogical and organic best practice that was aligned with the shared values, vision and mission of the profession, as expected, expressed and implied by the College, the Society and the Board, in order to integrate systematically and strategically the aspirations of the discipline with the need for implementing the competencies and challenges of the varied domains of clinical practice, underpinned by stewardship and adherence of the highest order, both morally and ethically, to the tenets, principles, precepts and expectations and standards of the Code of Ethics, Code of Patient Rights, United Nations Declaration of the Rights of the Child and other lofty documents, taking particular cognisance and mindfulness of the Treaty of Waitangi (Te Tiriti o Waitangi), with its implications for the mana of iwi, hapu and whanau, their whakapapa and relations to whenua, whilst in no way neglecting other peoples who are immigrants to New Zealand, with their distinct attitudes, beliefs, mores, values and expectations, all emanating from evidence based interventions, procedures and practice promulgated through scientific, relevant, peer reviewed journals of international quality published by reputable presses, organizations and societies, as well as learning though regular, productive, helpful and studied peer supervision and taking advantage of the teachings offered through psychologically respected and reputable academics, researchers and clinicians at courses and conferences, all of which, looking back on self reflection, enables me to carry out the daunting task of providing an inspirational, professional service with integrity, flexibility, cognitive clarity and mindfulness to the varied clientele who must have confidence in my scientific and clinical judgement and competence, in the knowledge that my consolidated personal development and my focussed critical self reflection counteracts any distortion or refraction of less than ideal practice so that, at the end of the day, through scaffolding and concretising my learnings, I can provide a refreshed service with integrity, flexibility, diversity and positive outcomes going forward.

Footnote: In the interests of open-ness, fairness, correctness and transparency, I showed my competency evaluation to the few clients that I could see within the confines of work hours that were left to me after carrying out this time consuming task and both of them told me, with certain expletives, to get a life and asked to be referred to a real clinical psychologist. I now remain a competent, but destitute, clinician. J.W.

# NZCCP Proposal for the Ministry of Social Development

What follows is a proposal developed by members of the NZCCP Canterbury Branch for the Ministry of Social Development (MSD) as a guideline for handling the psychological sequelae of the earthquakes in Christchurch.

Currently this is at the planning stage and we have sent this to the MSD with a view to engaging with them in the next few days about implementing the framework in the best interests of those who suffer on-going stress and anxiety symptoms as a result of the quakes.

This is to be used in conjunction with a brief screening tool specifically developed to assess the effect of the Canterbury earthquake and aftershocks, which most of you have already received by email. This tool is already being adopted widely by services in the region including the Canterbury DHB and the PHOs and will also be useful for those from Canterbury who've moved to other regions.

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## Proposal: A framework for psychological services for those traumatised by the Christchurch Earthquake

Written by Martin Dorahy, Janet Carter, Debbie Snell, Graeme Clarke, Juliet Thomson, and Eileen Britt on behalf of the New Zealand College Clinical Psychologists (NZCCP)

As a result of the 22 February earthquake in Christchurch an elevated number of people in the city are experiencing a range of posttraumatic responses. While for most people the symptoms of acute stress will remit as they pick up their lives again with renewed resolve, for a small proportion they will persist. The problems this latter group experience will include Post Traumatic Stress Disorder (PTSD) and related difficulties (e.g., depression and anxiety symptoms). This proposal seeks to fill an important gap in service provision. Currently, those who were at work during the earthquake and who have experienced mental or physical injury are covered by EAP and ACC services. Individuals not at work during the quake or those unemployed who are experiencing distress are currently not eligible for services outside those offered by primary and secondary care within the Canterbury DHB. This will bring a large number of people into the health service who actually need for the best outcome more immediate psychosocial support within a 'health' rather than 'illness' service framework. In addition, an influx of earthquake-related problems on Health Services already experiencing considerable strain on their resource, will mean that many people will have reduced or no access to care.

A Canterbury District Health Board (CDHB) initiative is attempting to fill some of the gap in provisions for those with more complex and chronic problems, but this will not address the population more broadly. Our conservative estimates based on 1) Census data, 2) large scale trauma statistics in other parts of the world and 3) current service provision suggest in excess of 2000 adults and children will likely have ongoing PTSD and related post earthquake psychological issues, and will be unable to gain funding or therapeutic support via ACC, EAP or the CHDB.[1]

[1] According to NZ Census data in 2006 Christchurch City had a population of 348, 435. In relation to the potential workforce who may have access to EAP or ACC, 282,765 of these

NZCCP members in Christchurch have developed a framework, based on the best international evidence, for the management and treatment of individuals presenting with stress symptoms as a result of exposure to the Christchurch quake and subsequent aftershocks, and those whose symptoms persist and become problematic. The treatment of individuals experiencing a wide-range of posttraumatic responses has become a pressing and urgent issue following this earthquake. The framework involves the use of a screening measure which can be applied by frontline professionals and NGOs where stress symptoms are persisting with people for 4 or more weeks. The screening measure indicates the level of risk the person is at and provides a threshold for when it is important to refer to Mental Health Services and Mental Health Professionals. It also provides a clear indication of the seriousness of the referral which will aide early and appropriate intervention. An explanation of the total framework, including the 'watchful waiting' period, the screening measure, an indication of the types of treatment, a summary of evidence and a proposed Flow Chart are all set out below.

A considerable number of people will experience the symptoms of acute stress disorders (e.g., dissociative, re-experiencing, avoidance and arousal symptoms) following the earthquake. Over time these symptoms would be expected to naturally remit in a significant number of these individuals[2]. Yet, in a small proportion of others these symptoms will persist and give rise to posttraumatic stress disorder and related difficulties (e.g., depression and anxiety symptoms). Efficient early interventions, and effective later treatment for a smaller number in need of such work, will significantly reduce 1) the psychological cost for those affected by the earthquake and 2) the financial cost for health and social services.

Financial savings resulting from efficient and effective interventions will come from having less people requiring more intensive treatment, and intensive treatments being focused and circumscribed. For example, early detection and intervention for 59 earthquake survivors in Turkey led to a significant reduction in those who had persistent symptoms and developed chronic problems[3]. With early and brief intervention 49% of people affected by the earthquake showed a marked improvement at 6 weeks and this jumped to 83% at 1-2 year

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were over fifteen years of age and potentially able to work. Of that number 63% were in either full time or part time employment. This leaves 37% or 104, 623 of the adult Christchurch population over 15 unable to access EAP or ACC support. Disregarding population growth since 2006, it can be conservatively estimated that 75% of this group will be exposed to the earthquake in a way that puts them at risk for PTSD (i.e. 75,467). Trauma researchers Bryant and Harvey (2000) suggest that 5% of this group may develop PTSD if untreated (i.e., 3923). If the CDHB planned initiative provides support for approximately half of these, and those at the more chronic and complex end, then near 2000 are left without provision of services. In Christchurch there are 61 Clinical Psychologists in Private Practice. There are also Psychologists, Psychotherapists and Counsellors able to do this work. Given a treatment package for each individual is likely to cost up to $2000, a conservative $400,0000 allows access for treatment for a large number of the population who will currently 'fall through the gap'. Consideration must also be made for those who have left Christchurch since the quake. The appointment of a Psychological advisor (se below) to coordinate any funding made available to this group would be an efficient use of the resource. The funding for this post would be added to those costs outlined above.

[2] Bryant & Harvey, 2000

[3] Basoglu, Salcioglu, Livanou, Kalender, & Acar, 2005

follow-up. Early detection and brief intervention, while monitoring progress, significantly reduces the number who need more resources and cost intensive interventions. As the authors' concluded, brief, early treatments have "promise as cost effective interventions for disaster survivors" (p. 1). Moreover, early detection and intervention reduces the number who develop more chronic heath and mental health difficulties, and therefore reduce the number of people drawing on considerable resources over an extended period.

The proposed framework outlined below is based on current available best evidence for the management and treatment of individuals exposed to disasters. The proposed model is intended for adult populations. Empirical and clinic evidence has shown that in traumatic situations the adaptation and mental health of children is often directly determined by the psychological well being of the parents[4]. Further and careful consideration is recommended regarding the special needs of children affected by the earthquake.

In recent years guidelines for the treatment of those exposed to disasters, terrorist attacks and other potentially traumatising events have been published around the world[5]. In addition, systematic reviews (including statistically-driven Cochrane reviews in the UK) regarding the treatment of acute and chronic stress reactions to traumatic events have been conducted[6]. These guidelines and reviews for intervention with adults consistently indicate several conclusions which for ease of communication are shown in bullet point:

- For those mildly to moderately affected by a traumatic event such as an earthquake, a period of 'watchful waiting' should ensue in the initial month or two following the event. During this period, individuals should be offered support and strategies for managing, but systematic, wide-spread trauma focused interventions should be avoided (unless the person/s want to speak directly about their experience). During this period of 'watchful waiting' it may be helpful to offer psycho-education about typical reactions to traumatic events, reassurance that these reactions are not unusual and affect regulation strategies (e.g., grounding techniques, relaxation training) to help the person manage distressing feelings and thoughts.
- For individuals identified with more severe problems in this initial phase, more intensive psychological therapy should be initiated.
- Following the period of 'watchful waiting' (which may last around 6 weeks and a little beyond), those showing no sign of symptom reduction should be offered trauma-focused interventions in order to treat posttraumatic symptoms. Guidelines and reviews of interventions for trauma indicate that trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitization and reprocessing (EMDR) are the most effective treatments based on the research studies that have been currently conducted. Reviews have typically found that in those with

[4] Leiberman & Van Horn (2004)

[5] E.g., UK, National Institute Clinical Excellence [NICE], 2005; Australia, Australian Centre for Posttraumatic Mental Health [ACPMH], 2007; Europe, European Multidisciplinary Guideline [EMG], 2008

[6] E.g., Bisson, Ehlers, Matthews, Pilling, Richards, & Turner, 2007; Foa, Keane, Friedman & Cohen, 2008; Roberts, Kitchiner, Kenardy, Bisson, 2009; Rose, Bisson, Churchill, Wessely, 2002

posttraumatic symptoms there is no difference in the efficacy and effectiveness of TF-CBT and EMDR[7].

- Screening tools to identify those in need of more intensive trauma-focused work have been developed.
- Finally, it is important to recognize that posttraumatic symptoms are not the only psychological problems arising following a potentially traumatizing event. Other difficulties include depression, anxiety, alcohol and drug use, adjustment problems, dissociation, and in more extreme cases conversion, psychotic and severe dissociative symptoms. In the case of the Christchurch earthquake it would also be expected that specific phobias about travel to, or in, the City Centre would be prevalent.

Based on these recommendations we outline below in a flow chart what we believe the most efficient and effective treatment pathway for those affected by the earthquake would be (see flow chart below).

**Flow chart box 1**. GPs, EAP workers and other primary care and front-line professionals screen individuals to identify those in need of 'watchful waiting' (i.e., those at heightened risk of developing posttraumatic problems). A 21 item screening measure based on the most up-to-date research has been developed for this task.

**Flow chart box 2**. Individuals identified by this initial screening as 'at risk' should be referred to designated providers (e.g. Pegasus and primary mental health teams, individuals practitioners) for a limited number of 'watchful waiting' sessions. During this 'watchful waiting' period, individuals will have contact with a mental health professional on approximately 3 occasions over about 4 weeks, who will engage in psycho-education and affect regulation strategies. The 'watchful wait' approach has been developed to reduce the likelihood of people developing more sustained and chronic problems.–Following this 'watchful waiting' period the screening instrument will be given again by the 'watchful waiting' provider and those in need of more intensive psychological interventions will be identified. The provider should make recommendations at this point and shift to more intensive interventions-or referral to another provider for this intensive intervention.

**Flow chart box 3.** Individuals in need of more intensive intervention will then be offered a more thorough assessment in order to ensure that relevant comorbid conditions are identified and for differential diagnosis (e.g. complicated grief vs depression vs PTSD or other anxiety disorders and so on). Following assessment and as clinically appropriate, evidence based interventions such as TF-CBT or EMDR would then be provided. The literature suggests that this work will last approximately 12 sessions, with many being discharged well before that, and some needing a little longer[8]. For example, following the London Tube Bombings in July 2005, the mean times needed for treatment using TF-CBT or EMDR was 11.9 sessions[9].

**Flow chart box 4.** At the completion of the intensive intervention, the screening measure will be given again as a means of quantifying change and examining outcomes.

[7] E.g., ACPMH, 2007; Bisson et al., 2007

[8] E.g., NICE, 2005

[9] Brewin et al., 2010

Supervision for those offering the initial interventions and then the more intensive treatment could be provided by clinical psychologists and other trained mental health professionals to ensure the interventions were remaining focused.

It is also recommended that a dedicated Psychology Advisor be appointed to liaise with Providers and coordinate referrals. The appointment would be seen as time limited e.g., twelve to eighteen months, to cover the predicted high-density referral phase.

The role would also include coordination with Providers throughout New Zealand given the considerable number of traumatized individuals who have and will leave Christchurch.

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## PROPOSED FLOW CHART FOR PSYCHOLOGICAL SERVICES FOLLOWING CHCH EARTHQUAKE

**BOX 1:**

-SCREEN #1 **BY GP, EAP, MENTAL HEALTH SERVICES, HEALTH AND REHABILITATION PROVIDERS OTHER SOCIAL SUPPORT AGENCIES**

-Conducted for those people who have persistent (4 or more weeks) symptoms.

-If screener indicates persistent mild to moderate symptoms then referred to Mental Health Professional (MHP) + costing sheet sent to MSD Psyc Advisor for approval

Severe

Opportunity for Supervision by clinical psychologists or other trained mental health professional

MSD Psychology Advisor

BOX 2:

*Mental Health Professional*

-"WATCHFUL WAIT" (AS PER NICE GUIDELINES) 3 SESSIONS OVER 4 WEEKS (INCLUDES SCREEN #2)

-**Screen #2** by MHP - depending upon score, discharge or specialist intervention (referral at any time if significant symptoms/deterioration).

-Specialist intervention conducted by MHP or refer as appropriate (via MSD Psyc Advisor)

*BOX 3:*

ACC CONTRACTED SPECIALIST MHP

-Conduct more thorough clinical assessment

-Complete template report with diagnosis and recommendation to MSD Psych Advisor

BOX 4:

-**Screen #3** at end of intervention

-Report to MSD Psych Advisor

# EMOTION FOCUSED THERAPY & COMPLEX TRAUMA

## Dr Sandra Paivio

## Monday 4th & 5th April 2011
## Auckland Convention Centre
## The Edge, Aotea Centre

### DR SANDRA PAIVIO

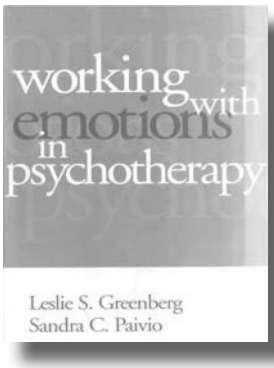
Sandra Paivio received her PhD in psychology from York University in 1993 where she studied with Les Greenberg. She is one of the developers of emotion-focused therapy particularly applied to complex relational trauma (EFTT). Dr. Paivio currently is a practicing clinical psychologist, Head of the Psychology Department, and Director of the Psychotherapy Research Centre at the University of Windsor. She is an internationally recognized scholar and therapist with more than 20 years of experience. Dr. Paivio is an invited member of the American Psychological Association (APA, Division 56) committee to develop treatment/best practice guidelines for complex trauma.

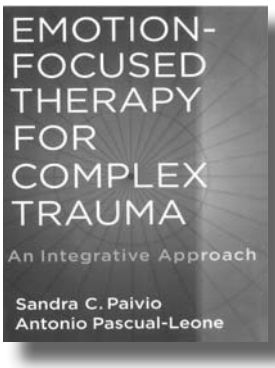
Dr. Paivio is author of numerous publications and conference presentations on psychotherapy and problems related to trauma. She is co-author (with Les Greenberg) of Working with Emotion in Psychotherapy and author (with Antonio Pascual-Leone) of a recent book, Emotion-Focused Therapy for Complex Trauma, published by APA. Her research has focused on evaluating the efficacy of emotion-focused therapy and on in-session processes of change – the latter is most relevant to clinical practice. She has been extensively involved in clinical training with graduate students and professionals and maintains a part-time clinical practice.

### About the Workshop

**Day One** will present material on the nature of complex trauma, including the central roles of attachment relationships and emotional processes in the development of disturbance. This will be followed by distinguishing features and advantages of the EFTT treatment model. The morning will conclude with guidelines for assessing and addressing the different types of emotions and emotional processes typically observed in trauma therapy, including avoidance and dysregulation of emotion. The afternoon of day one will focus on the two inter-related change processes in EFTT - a safe and empathic therapeutic relationship and trauma work - and present guidelines for promoting these processes.

**Day Two** will begin with guidelines and strategies for promoting client self-development, including reducing fear and avoidance of emotional experience and transforming shame and self-blame. The afternoon will focus on strategies for confronting trauma feelings and memories (exposure), and for resolving attachment injuries with particular perpetrators. The workshop will conclude with a discussion of issues related to therapy termination. Numerous videotaped examples will illustrate key therapy processes and each period will conclude with opportunities for questions and discussion of issues.




SPECIAL OFFER
NEW ZEALAND ONLY
CLOSES
14/03/2011

**Introduced by Dr Michelle Webster, Director Institute for Emotionally Focused Therapy**

Workshop claimable for active CPD with Psychologist Board of Australia.
Endorsed specialist CPD for Clinical & Counselling Colleges (Australian Psychological Society)

# REGISTRATION FORM

## WORKSHOP WITH DR SANDRA PAIVIO 2011


### INSTITUTE FOR EMOTIONALLY FOCUSED THERAPY

ABN: 18 085 501 837
PO BOX 97, 83 JOHNSTON STREET
ANNANDALE NSW 2038
Website: www.EFTherapy.com
Email: Admin@EFtherapy.com
PH: (02) 9552-2977 FAX: (02) 9660-8233


### Workshop on Emotion-Focused Therapy for Complex Trauma

This workshop is designed to help you:

1. Understand central roles of attachment relationships and emotion in development of disturbance from complex trauma
2. Understand distinguishing features and advantages of the EFTT treatment model
3. Learn how to assess and respond to core emotions and emotional processes typically observed in trauma therapy
4. Understand processes essential for developing safe and empathic therapeutic relationships
5. Understand how to help clients confront trauma feelings and memories
6. Learn strategies for promoting client self-development
7. Learn a step-by-step process for helping clients resolve interpersonal trauma
8. Integrate EFTT principles and strategies into your current professional practice

Participants will be introduced to the EFTT approach, the theoretical and research underpinnings of the approach, and the interventions used in the therapy.

SPECIAL OFFER
NEW ZEALAND ONLY
CLOSES
14/03/2011

### PROGRAM DAY 1

**EFTT Theory and Primary Change Processes**
(Alliance Development and Trauma Work)

**Morning**: Complex Trauma and the EFTT Treatment Model
**Period 1:**
The nature of complex (versus single incident) trauma
APA treatment guidelines/recommendations for best practices
The EFTT treatment model (theory and research, phases and tasks of therapy; intervention principles)
Videotape demonstration
**Period 2**:
Assessing emotions and emotional processes in trauma therapy
Distinguishing between adaptive and maladaptive emotions
"Emotional processing" in EFTT
Videotape demonstration
**Afternoon:** Cultivating the Alliance & Introducing Trauma Work
**Period 3:**
Intervention principles and goals of alliance formation in Phase One
Conducting the first three sessions
Videotape demonstration
**Period 4:**
Introducing trauma work and the imaginal confrontation procedure
The process of resolving interpersonal trauma
Addressing emotion regulation difficulties
Videotape demonstration

### PROGRAM DAY 2

**Promoting Self-Development, Resolving Attachment Injuries, and Termination**

**Morning:** Promoting Self Development in Phase Two
**Period 1:**
The process of resolving intra-psychic conflicts
Reducing fear and avoidance of emotional experience
Transforming shame and self-blame
Videotape demonstration
**Period 2:**
Memory work for accessing, exploring, and resolving self-related difficulties
Videotape demonstration

**Afternoon:** Resolving Attachment Injuries in Phase Three and Therapy Termination
**Period 3:**
Promoting healthy anger experience and expression
Promoting sadness and grieving losses
Videotape demonstration
**Period 4:**
Addressing termination issues
Workshop wrap-up

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### APPLICATION

**Workshop Location** _____
**Name**:_____
**Address**:_____
_____
_____**Postcode**: _____
**Phone**:_____**Email**: _____
**Amount:**_____ ☐ Cheque to IEFT enclosed

**Credit Card Payments (Visa or Mastercard only)**
Card Number:_____
Name on Card:_____
Expiry Date:_____
Signature:_____

☐ I have read, understand and accept the terms and conditions of registration (available at: **www.EFTherapy.com)**

### SPECIAL OFFER, NEW ZEALAND

(Application prior to 5pm AEST 14/03/2011)
☐ NZ$495 (New Zealand Residents only)

### REGULAR REGISTRATION

☐ NZ $550 (New Zealand Residents only)

All fees include GST, participant notes and folder.

Morning and afternoon teas and lunch is provided.

### PROFESSIONAL DEVELOPMENT POINTS ARE AVAILABLE

Your professional assocation: _____

**Contact IEFT Administration for any further details.**


100921 Workshop Flyer
101214 Flyer NZ indd

## CLASSIFIED

NEW TRAINING

# EFFECTIVE RELIEF FOR STRESS AND TRAUMA

## Affect Regulation Therapy using Neuroplasticity

**Event One:**
Lessons for effective psychotherapists from recent neuro science. 1 April, 2011.

**Event Two:**
Master Brief Affect Regulation Therapy. 1, 2 & 3 April, 2011.

**Event Three:**
Master Long Term Affect Regulation Therapy. 5, 6, 7 & 8 April, 2011.

**Venue:**
Rydges Harbourview Auckland

**Successful recovery from stress and trauma requires a body and mind therapy.**
Learn practical ways to use implicit and explicit memory and discover how
Affect Regulation Therapy has these essential benefits for clients:

■ *Rapidly improves mood* ■ *Creates effortless change*
■ *Achieves a broader range of personality development*

To register on-line, download brochures and read articles, go to **www.affectregulationtherapy.com**
or contact us on **61 2 9418 3692** (Sydney, Australia) and email **info@bestmindset.com.au**

# The Mindful Way
# cultivating the practice of being more fully with mind, body & heart
## for professionals in all walks of life

*Mindfulness is not something you have to get or acquire. It is a rich resource of aliveness already within you, waiting for your attention, as you further your learning, enrich your work in this world, and connect with the wisdom of wholeness.*

People who will benefit from this often hold some of the following questions:

- *How can I slow down when all around me is speeding up?*
- *What wisdom am I missing as I "think" my way through big issues?*
- *I keep reading about the value of being mindful….but how can I experience the practice?*
- *What if I let go …what might come to me?*

Your hosts are Marijke Batenburg and Lisa Markwick. We are psychologists with mindfulness at the core of our life & work. Marijke is a practicing clinical psychologist & Lisa is an experienced leadership facilitator & coach.

See www.mindfuladventures.co.nz and www.mindfulpsychology.co.nz for details or call Marijke on 09 630 9297, or Lisa on 021 313323.

**What to expect**

The programme consists of 8 weekly 2 ¼ hour sessions in the early evening, and one full day retreat (on a weekend) between weeks 6 and 7. The course is offered in Auckland beginning 6.15pm on these dates:
**Thursday February 3rd 2011**
**Wednesday June 8th 2011**
**Wednesday October 26th 2011**

With only about 12-15 people in the group it is highly participatory, experiential and supportive. The group will provide you with:

- Guided instruction in mindfulness meditation
- Gentle mindful stretching
- Group dialogue and guidance in conscious conversation to enhance awareness and discernment
- Daily home practices and journaling (about 30-40 min per day)
- Home practice materials including readings and mindfulness meditation CDs

You will be asked to commit to fully participate and to attend all sessions with a spirit of patience and perseverance.

**This is ancient wisdom for skilfully navigating today's world**

## CLASSIFIED

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# From
# DEPRESSION/ ANXIETY
# to
# Living Mindfully

**A new approach to preventing relapse. This is mindfulness - based cognitive therapy programme for anxiety or depression**

## Programme For 2011

The course is 8 two hour sessions and held on Monday evenings 6.15pm - 8.30 pm

Course # 19 2 May 2011
Course # 20 29 August 2011

**Venue:** 64 Valley Rd, Mt Eden
**Cost**: $600 incl GST
(a flexible payment option is available)
Cost includes pre-programme consultation, programme notes, CD's and one day retreat

**Enquiries: Mindful Psychology**
**(09) 630 9297**
or marijke@mindfulpsychology.co.nz

www.mindfulpsychology.co.nz