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EXPERT GUIDE

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Introduction

None of us would have predicted that 2017 would come knocking at doors only to be welcomed by a President Trump with an impending Brexit at his shoulder... and yet it will. "It'll never happen," we scoffed, and yet it did. The past year has shaken us out of our misguided, apathetic slumber and into a new era of worrying political polarity, but in terms of psychology, both the American election and the British referendum have rattled open entirely new Pandora's boxes of research about how we cope during times of fear and anxiety.

The welcoming of 'post-truth' as the Oxford English Dictionary's word of the year attests to how emotions seemed to triumph over logic on both sides of the pond, while a fascinating study into the psychology of binary thinking released this year highlighted how in such fraught circumstances we tend to make judgments more quickly, regardless of facts – tellingly, we are also drawn to simple, decisive leaders. Several studies have also showcased how physical differences in the brain predispose us to being either liberal or conservative, and it is our underlying thought processes which determine whether we are attracted to a certain leadership style over another. Both June and November's unexpected results were also troubling yet fascinating insights into the 'them-and-us' mentality and of our need to feel a sense of control when times are tough.

Nearly half of all Americans reported that it has been a source of stress in their lives, with 51% stating they were afraid of the outcome. Risky as it is to make predictions about the future, especially ones so tied into political rhetoric, Hillary Clinton's accusations of the 'Trump effect' seem to have some basis – developmental psychologists have shown that by the time they start nursery, children have absorbed many of the implicit racial attitudes of the adults in their culture. How this bodes for the next generation of politicians and voters remains to be seen.

Before we collapse into shivering shadows of our former selves, however, this year's Expert Guide sees some fascinating research from Dr David Wolgroch on how to deal with trauma. His piece on PTSD, describing it as 'a natural process...gone awry' also contains the comforting line – 'it turns out that people are much more resilient than we think'. Meanwhile, Jennifer Weston discusses how our distorted work-life ethic of more, better and faster is disrupting our eating habits, and proposes 'mindful eating' – and perhaps we could all do with some more self-awareness in these uncertain times.

PSYCHOLOGY SNAPSHOT:

$300 BILLION

The amount workplace stress costs American businesses each year

440,000

The number of cases of work-related stress, depression or anxiety in 2014/15 in the UK

Stress is more prevalent in public service industries such as **education, health care** and **public administration**

43%

Percentage of working days lost due to ill health in the UK workplace in 2014/15

In the UK, women have a higher rate of work-related stress than men

44%

Percentage of adults who claim their job affects their overall health

8 IN 10

Number of workers affected by workplace bullying in the UK

£100 BILLION

The amount that lost productivity and sick leave as a result of workplace stress costs the UK

3 MILLION

Number of work-related injuries in 2014 in the United States

48%

Percentage of the British workforce who said they were stressed most of the time and 47% cited performance as a key issue

MOST COMMON CAUSES OF WORK-RELATED STRESS IN THE UK:

80% - job insecurity
78% - workload
63% - bullying or harassment
68% - lack of support from colleagues or superiors
55% - lack of clarity on role
52% - limited opportunity to manage work patterns

Sources: Huffington Post, Health and Safety Executive, Harvard Gazette, Essential Skillz

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Weight loss from the inside-out: thoughts from a mindful eating advocate

By Jennifer Weston

With the trends in obesity on the rise within the UK and Ireland, there is much for public health authorities and health care providers to do in terms of improving the health and life expectancy of the general public. Statistics from the 2014 Health Survey in England (HSE) estimate that 61.7% of adults in the UK are classified as overweight or obese and although this trend is slowing down, it steadily continues to rise. In recent years, research and funding into weight management services has increased in some areas of the UK, however these tend to operate on a referral system and are not always accessible, leaving the general population to fend for themselves. Faced with a myriad of ever-changing and conflicting nutritional advice, it comes as no surprise that individuals continue to struggle with making changes to their lifestyles in order to improve general health. Contributing towards this confusion is a growing accessibility of processed foods with a lower nutritional value, fast food outlets and takeaway services.

In addition to this, today's work-life ethic of 'work-more and live-fast' does not lend itself well to encouraging long-term and sustainable health behaviour change. Lifestyle change is not convenient, whereas accessing external resources are much more amenable to the general public. When it comes down to making lifestyle decisions about change, many, if not most, individuals rely on their automatic thoughts to do the work. Often this quick and convenient thinking leads to seeking out quick and convenient external resources bypassing any self-reflection on the internal mechanisms that are so vital to making long-lasting changes. As an example, a person who thinks "I need to lose weight" will next consider external ways how to lose weight and may purchase a gym membership or select a diet plan to follow. Thus not giving any consideration to their own personal and internal resources such as motivation (why do I want to lose weight?), self-efficacy (do I have the ability to make this change and make it last?), self-esteem (do I have the confidence to engage in managing my weight and am I worth it?), problem-solving ability (what will I do if I start to lose track or if I am in this situation or that situation?). For a more comprehensive list of external and internal resources see *table 1.*

This is where health care practitioners in the weight management field need to impact. By bringing awareness to the importance of changing from the inside-out through emphasising the benefits of internal resource-seeking and the effectiveness of this on health and happiness. One way in which this can be achieved is by raising the profile of mindful eating in the form of psychoeducation and training.

External Resource-Seeking	Internal Resource-Seeking
Finding and following nutritional advice	Reflecting on own motivation
Starting a diet plan/calorie-counting	Examining and understanding current eating habits and behaviours
Restricting food intake/purging	Assessing impact of mood on consuming food
Purchasing a gym membership	Using own senses to assess level of hunger
Purchasing exercise equipment for the home	Allowing physical sensations to guide choices
Engaging in a weight loss programme	Finding pleasure in food and exercise
Joining a weight loss community group	Cultivating gratitude and self-compassion

Table 1. External and internal resource seeking behaviours in weight management

What is mindful eating and what are the benefits?

Mindfulness or mindful meditation as it is otherwise known has been defined by Jon Kabat-Zinn as, "paying attention, in a particular way: on purpose, in the present moment, and non-judgementally." This involves intentionally re-focusing one's mind onto the very moment one finds their self in, leaving any judgement aside for that moment including any self-criticising thoughts. Attention is purposefully placed on what is going on inside the mind and body and what is happening in the immediate environment, therefore awareness is brought to thoughts and bodily sensations including physical sensations and external senses such as sounds and smells. In applying mindfulness to eating and drinking, intentional focus is placed on all aspects of consuming food:- purchasing items, food preparation, cooking/baking, plating up food and consuming food. Throughout this whole process attention is given to our thoughts and emotions via a variety of strategies including guided mediation and imagery exercises. Awareness is also cultivated to bring an understanding to eating behaviours and habits therefore food is not always present in practicing the mindful eating approach. A recent review of mindfulness in eating behaviours details the mechanisms by which weight regulation can be achieved through this approach and therefore will be broken down in this article. See *Box 1 (next page)* to see how mindful eating works.

There is a wealth of empirical research which shows the effectiveness of mindful eating interventions or programmes on weight regulation in comparison to a variety of control groups including dieting and no treatment controls. However there tends to little in the way of long-term follow up and this is an area of research which needs to be addressed.

Challenges in promoting this approach to the wider public

With mindful meditation interventions for health conditions and mental health issues becoming more salient within healthcare research and services, the general public are quickly becoming more aware of the benefits of practicing mindfulness. However there continues to

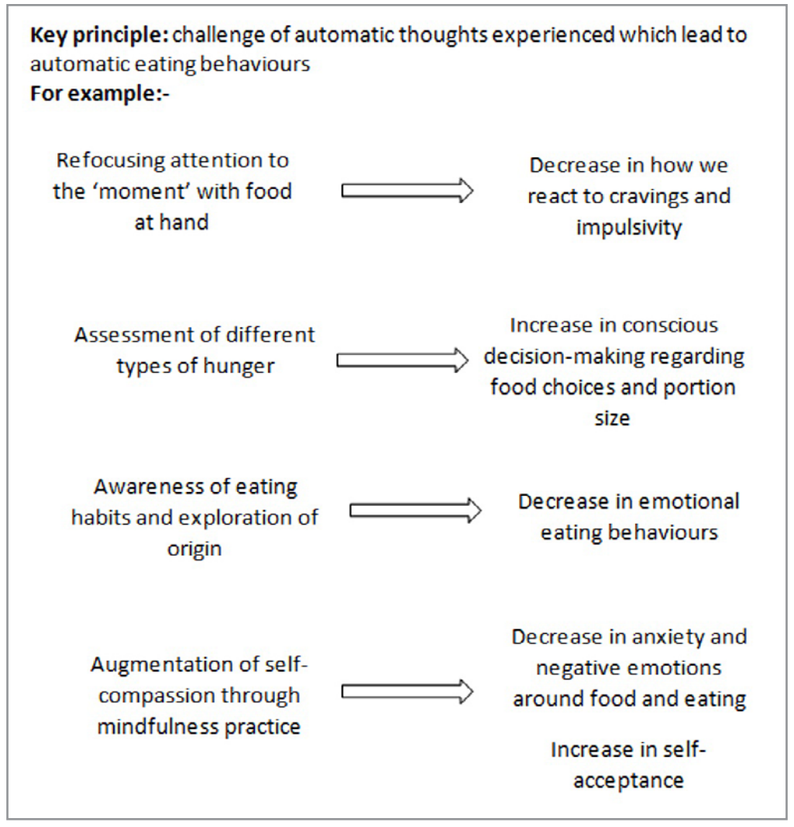
be barriers within the wider public in terms of both an understanding of the concept of mindfulness and mindful eating and the commitment and motivation required to engage with it on a regular basis. Firstly, mindfulness is often described as a Buddhist practice and this may impact on individual perceptions of relevance. Although mindful meditation originates from Buddhism, modern mindfulness differs in approach and techniques. It is the responsibility of researchers, practitioners, clinicians and teachers to publicise more relevant definitions and informative material in order to ensure mindful eating programmes more accessible. Secondly, mindfulness is not an easy activity to engage with initially and for some it does not come naturally. To tackle this caveat, it is vital that this is an essential part of mindfulness teaching and training. Participants should be aware of the challenges of mindfulness and mindful eating and given the appropriate tools to support with them. This could be provided in the form of 1-1 or group motivational interviewing techniques, tasks and activities.

Final thought

Eating mindfully is not a weight management approach per se. It can lead to enormous self-progression in terms of self-development and self-acceptance. In a world where both women and men are subjected to images of often Photo-shopped body image ideals there is a need – now, more than ever to promote a kinder and more gentle approach to health behaviour change.

Jennifer is a health psychologist, and founder of Horizon Shine Ltd, a psychological coaching service. As an expert in behaviour change she motivates and supports adults to thoughts and behaviours in order to live happier and healthier lifestyles. She has developed both face to face and online multi-disciplinary group interventions in the areas of mindful eating and fitness (MeFIT) and mindful compassion. Jennifer is also affiliated to Edge Hill University in Lancashire as an Tutor in Psychology and guest lectures at the University of Central Lancashire. Her research interests lie in the concept and development of self-compassion and its role in recovery from trauma.

Box 1. How mindful eating works!



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Autism: A continuum of emergence

By Dr. Jennifer Greene CPsychol BSc HONS DEdChPsy

Since the first documented cases of autism conditions by Leo Kanner in 1943 and Hans Asperger in 1944, conceptualisation of autism spectrum disorders has shifted greatly. It is now evident that it is not a rare childhood disorder. Over the past three decades, billions of funds have been invested in to researching and understanding the causes of autism spectrum disorders. However, research to date has not produced a single causal link but produced a complex picture of associated genetic, environmental and neurological factors. What has been confirmed through empirical research is there a number of genetic variations in individuals with autism (Abrahams and Geschwind, 2008), and neurological differences in how the brain develops (Courchesne, Carper at al. 2003), demonstrating a varied and complex etiology and heterogeneity

It is also important to note that our general understanding of the brain and how it works is still limited, for instance recent research by the Human Connectone Project highlights just how little is still understand about the complex mechanisms of the human brain. It may besomewhat naïve to assume that the neurological difference reported is as simple as typical (non-autistic) versus atypical (autistic). The range of individual difference can vary so much across what is described as the autism spectrum, that a recurring phrase often used best encapsulates this, which is 'when you've met one person with autism, you've met one person with autism'. The rangeof inter-connecting variables from genetics, cognition, environment, personality and other factors meansresearching causes is an onerous task.

This does not provide solace for many parents and families, particularly following a recent diagnosis. For parents seeking information on autism via the web, it yields a minefield of confusing, misleading and contradictory claims that it can be an exhausting emotional cocktail of uncertainty, despair and hope.

The supposed 'epidemic'

The suggestion of an 'autism epidemic' rose to prominence in the 1990s, alongside tenuous links that the cause was the MMR or other childhood vaccinations. Although these links have proven to be unfounded (Stehr-Green, Tull et al. 2003; Thompson, Price at al. 2007), the murmurings of epidemic and concerns of vaccinations have not yet faded. It may appear that there are increased numbers diagnosed,

however changes in our recognition, diagnosis, support and inclusive practices, genetics and societal views has shifted widely over the years that tracking back to ascertain whether there has been a rise in numbers is futile. Steve Silberman, in his book 'Neurotribes', provides the most accurate examination of this reported phenomenon to date.

At present, diagnosis in the UK involves multidisciplinary assessment and the use of interview and observation schedules (e.g. ADOS, ADI, DISCO, etc.) to assess for marked difference in social communication and interaction, and social imagination; based on DSM-V or ICD-10 criteria and follow NICE guidelines. Sensory needs are often commonly associated but not necessary in diagnostics. The National Autistic Society website report that there are currently 700,000 people in the UK on the autism spectrum. Although, this is probably not a true representation. To ascertain an accurate figure of numbers of individuals with autism continues to prove difficult. This is due to a number of reasons, for example changes in diagnostic criteria and inclusion criteria and terminology of prevalence studies varies when gathering data. For example, it is now becoming more widely recognised that the assumption autism affects four times more boys than girls is inaccurate. Judith Gould (Consultant Clinical Psychologist) and Sarah Hendrickx (adult and author with Asperger syndrome) report that autism presents differently in women and girls, and the most widely used diagnostic tools have not been designed to assess girls accurately. Meaning there is likely to be a whole cohort of women and girls missing from the prevalence data. In one London borough I have worked, figures are as high as 145 children diagnosed per year over the last five years (94 aged 2-5 years old, and 51 aged 5-18 years). Prevalence studies widely vary in estimations from 1.4 per 10,000 (Al Farsi, 2011) in the population to 350 per 10,000 people (Dillenburger et al.,, 2015).

> *"Reportedly only 15% of autistic adults in the UK are currently in full-time paid employment (cited on www.auitsm.org.uk)."*

Support across the lifespan in the UK

So where have we got to in the UK? Although services have improved greatly, with early identification, better support and inclusive practices in schools and more access to training for teaching staff and professionals in education, health and social care. Across the UK, services remain inconsistent and patchy at best. The SEN CoP (2014) and Autism Act (2009) highlight how there is still a long way to go in reaching a consistent pathway of support across the lifespan. Children with autism are usually supported within mainstream classes in primary however transition to secondary school and post 16 is often difficult. Adult diagnostic services need further development, as do treatments and support for mental health and well-being. The so called 'epidemic' of children are already reaching adult services, and although much time has rightly been invested on early identification and intervention, it has been at the expense of developing support post secondary school. Beyond secondary, adequate autism provision and support in further education, training and employment is limited, and reportedly only 15% of autistic adults in the UK are currently in full-time paid employment (cited on www.auitsm.org.uk).

The concept of neurodiversity rose to prominence in the 1990s in the U.S.; it can be defined as naturally occurring cognitive variations with distinctive strengths, which appear as a result of normal variations in the human genome. The autism neurodiversity movement in the UK is growing in strength, to promote the voice of individuals with autism by individuals with autism.. Autism understanding across the general public is changing, it appears to have moved away from the 'rain man' representation to a variety of representations reaching mainstream literature, theatre and screens (e.g. *The Reason I Jump*, *The Curious Incident of the Dog in the Night-time*, Temple Grandin's biopic, Sheldon in '*The Big Bang Theory*', etc.). Support or inclusion in the wider community is emerging by providing 'autism friendly screenings' in cinemas and theatre and Manchester airport has produced an autism specific booklet to download from their website. No doubt this is a result of parental organisations, self advocacy groups and charitable organisations raising awareness. However, for the general public 'autism' remains a mysterious condition, which many have heard of, however understanding does not usually extend beyond some vague notion of unusual social behaviours.

Into the future

The question that keeps most parents I work with up at night, and many siblings too, is 'what will happen when [parents] are no longer around?' I am not the first to highlight that the billions of funds that goes to research in causes and even more concerning, to medical interventions, needs to be redirected to provide ongoing, improved and new social, psycho educational interventions and support services ,that will make a real difference to the day to day lives of individuals with autism, and their families.
Although it is now largely accepted among parents and many professionals (i.e. teachers, psychologists, speech therapists) working closely with individuals with autism, that the most effective approach is to build on the strengths and interests; there seems to be a lack of flexibility in processes and systems to fully enable this. When such provisions do exist, it is often only accessible to a limited few, available for a short period of time or under-resourced. There is an on-going need for training of educational staff (in early years, primary, secondary, college and university) and flexibility within educational systems to provide adequate and evidence based practices that are based on the individual needs of each child or young person with autism.

Awareness also needs to continue to be raised beyond educational provision to the wider community (police, hospitals, supermarkets, transport staff, service industry staff, criminal justice system, etc.) and employment market. If autism is less mysterious, there will be less fear of difference, less exclusion and more understanding and inclusion. society needs to change to make the every day life of individuals with autism less disabling, allowing for strengths and talents to develop, only then will we have a truly neurodiverse community.

Finally and most importantly, to properly plan for the fortune of autism we need to ask people with autism what it is they need, and we need to listen.

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Jennifer worked as a behaviour analyst, early years educator and assistant psychologist with children and families whom have diagnosis of autism in Ireland, prior to commencing a Doctorate in Educational & Child Psychology in London, in 2007. Jennifer completed her doctoral thesis on 'Support groups for Siblings of Children with Autism'. Jennifer has published a peer reviewed article and book chapter, and presented at the BPS: DECP Conference (2012), HCPC Primary Care Conference (2012), and XI Autism-Europe International Congress (2016).

Research areas: autism, early years transitions, autism interventions & models of support

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The Misdiagnosis of Adjustment Disorder

By Professor Robert J Edelmann

Having undertaken medico-legal assessments, largely in relation to personal injury claims, for almost three decades I have seen numerous reports prepared by my psychology and psychiatry colleagues. In that time I have witnessed the diagnosis of Adjustment Disorder used with increasing frequency in relation to responses to a range of situations. These include minor road traffic accidents, trips and falls where physical symptoms have seemingly persisted in the absence of any identifiable physical pathology and negligence claims following surgical procedures, often for cosmetic purposes, where the person is unhappy or dissatisfied with the outcome.

Adjustment Disorder as a diagnostic category has had a rather chequered history with some being highly critical of its use (e.g. Casey et al., 2001). Indeed, Strain and Deifenbacher (2008) have described it as a subthreshold disorder "between normal behaviour and the major psychiatric morbidities". However, if one considers that behavioural and emotional difficulties lie along a continuum from slightly concerning to clinically significant conditions that warrant a psychiatric diagnosis then the key issue is discerning a slight difficulty from one which is disruptive to everyday functioning. There is obviously a difference between feeling somewhat down or sad and being clinically depressed, between being a bit anxious and being fearful to the extent of being phobic or suffering regular panic attacks, and being emotionally troubled after an accident rather than suffering from Post Traumatic Stress Disorder. One can also be reasonably certain that if the person's emotional and behavioural difficulties are such that a Psychiatric diagnosis is warranted then they will be struggling to cope with everyday life. In all these instances it is possible to derive evidence from diagnostic interview schedules and psychometric measures to augment one's clinical experience in order to diagnose Depression, an Anxiety Disorder or Post Traumatic Stress Disorder with a reasonable degree of certainty.

Unfortunately, as Strain and Deifenbacher (2008) note in relation to Adjustment Disorder: "secondary to the subjective nature of the diagnosis, diagnostic tools to aid clinicians in identifying this condition are significantly lacking". It is thus perhaps not surprising that prevalence rates are highly variable with between 5% and 20% of individuals in outpatient health treatment having a principle diagnosis of Adjustment Disorder while as many as 50% receive such a diagnosis in hospital psychiatric consultation settings (DSM-5). The key principle, however, should be that, as with a diagnosis of other psychiatric conditions, if a psychiatric diagnosis is warranted then the person will be struggling to cope with everyday life. This is alluded to in the diagnostic criteria as specified in both the DSM 5 and ICD10 as indicated below.

DSM 5 Diagnostic criteria for Adjustment Disorders

A. The development of emotional or behavioural symptoms in response to an identifiable stressor(s) occurring within three months of the onset of the stressor(s)

B These symptoms or behaviours are clinically significant as evidenced
by one or both of the following:
(i) marked distress that is out of proportion to the severity and intensity of the stressor, taking into account the external context and the cultural factors that might influence symptoms severity and presentation.
(ii) significant impairment in social, occupational or other important areas of functioning

C The stress-related disturbance does not meet the criteria for another
mental disorder and is not merely an exacerbation of a pre-existing mental disorder.

D. The symptoms do not represent normal bereavement

E. Once the stressor or its consequences have terminated, the symptoms
do not persist for more than an additional six months.

“If the person is maintaining all aspects of their life in exactly the same manner as prior to the index event, then, although they may be upset by the index event, it would seem highly unlikely that the distress they are experiencing is clinically significant”

ICD10 F43.2 Adjustment Disorder

States of subjective distress and emotional disturbance, usually interfering with social functioning and performance, arising in the period of adaptation to a significant life change or a stressful life event. The stressor may have affected the integrity of an individual's social network (bereavement, separation experiences) or the wider system of social supports and values (migration, refugee status), or represented a major developmental transition or crisis (going to school, becoming a parent, failure to attain a cherished personal goal, retirement). Individual predisposition or vulnerability plays an important role in the risk of occurrence and the shaping of the manifestations of adjustment disorders, but it is nevertheless assumed that the condition would not have arisen without the stressor. The manifestations vary and include depressed mood, anxiety or worry (or mixture of these), a feeling of inability to cope, plan ahead, or continue in the present situation, as well as some degree of disability in the performance of daily routine.

Unfortunately, in both the DSM 5 and ICD10 definitions, disruption to social functioning is only a possible and not an essential element of the disorder. This means that symptoms of marked or subjective distress can be taken as an indicator of Adjustment Disorder. How though does one assess ‘marked distress’? In essence Adjustment Disorder can be taken as simply implying that the person has not adjusted or coped well with an identifiable stressor. However, such distress must be “out of proportion to the severity and intensity of the stressor” (DSM-5) and should “usually interfere with social functioning and performance” (ICD10). Interestingly, the SCID-5, a diagnostic interview schedule developed specifically to aid in the diagnosis of DSM5 defined psychiatric conditions, specifies questions “as needed” relating to any affects of symptoms on relationships, work, taking care of things at home or in relation to other important parts of the person's life to facilitate the diagnosis of an Adjustment Disorder. If the person is maintaining all aspects of their life in exactly the same manner as prior to the index event, then, although they may be upset by the index event, it would seem highly unlikely that the distress they are experiencing is clinically significant. In such contexts one would have to assume that a diagnosis of Adjustment Disorder is inappropriate. Unfortunately minimal emotional or behavioural difficulties often seem to be taken as indicating Adjustment Disorder and one would have to assume that the disorder is being diagnosed too frequently and erroneously.

In any research based study where patients with psychiatric diagnoses are compared then rigorous methods, including diagnostic interview schedules to aid diagnoses or key evidence to support a particular diagnosis is expected. Simply referring to clinical experience on its own is not considered to be a sufficient basis for a diagnosis. Such rigour is not expected for therapy purposes in clinical contexts where clinical experience is sufficient to offer a possible diagnosis. One would assume that in terms of diagnostic rigour a medico-legal assessment should be more akin to a research study than an assessment for purposes of therapy. It is a great pity then that evidence based rigorous assessments in relation to Adjustment Disorder in medico-legal contexts often seems to be sadly lacking.

Professor Edelmann is Chartered Psychologist, an HCPC Registered Clinical, Forensic and Health Psychologist and a Fellow of the British Psychological Society. From 1986 until 1997 he was involved in Clinical Psychology training at the University of Surrey where he also directed a master's programme in Health Psychology and in 1996 established and directed one of the first master's programmes in Forensic Psychology in the United Kingdom. He has over 100 publications including six books. He is currently Professor of Forensic and Clinical Psychology on a part-time basis at the University of Roehampton as well as a Consultant Clinical Psychologist.

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Understanding Trauma

By Dr David Wolgroch, Chartered Clinical Psychologist

Sadly, you, or someone close to you, experienced a traumatic event. That is not really surprising since 60% of men, and 51.2% of women are likely to experience a traumatic event (one in which they were frightened of death or serious harm, felt helpless, and remain very distressed about) in their lifetime. Most people will get over it adequately within one month. 8% of the victims may continue to suffer Post Traumatic Stress reactions one year after the unfortunate incident and only one third of these individuals will continue to experience stress beyond one year.

When the symptoms of stress continue six months after the traumatic incident, clinicians begin to assess for Post-Traumatic Stress Disorder, or PTSD. The diagnosis of PTSD may involve a clinical interview that can include a formal and structured interview based upon the recognised criteria for PTSD. The symptoms include: Re-experiencing the trauma (e.g. Flashbacks), Persistence of symptoms (e.g. disturbed sleep and concentration, hyper vigilance, exaggerated startle response), Impairment of functioning (e.g. social, occupational), and Duration (over one month). Individuals may present with all, or some, of these symptoms.

Then, there are three categories of PTSD: Simple (no other factors relevant other than the specific trauma incident), Complex (prior experiences colour one's reaction and ability to cope with the current crisis), and Delayed (symptoms appear long after the traumatic event, even several years later).

One helpful way to conceptualise Trauma is to understand PTSD as a natural process vital for survival that has gone awry. Whenever we perceive something in the environment, the first port of entry in the brain is the Amygdala, which is a small Pecan shaped structure in the mid-brain that all animals have. The Amygdala quickly decides if the event is dangerous and requires us to run or fight. It responds to visual, olfactory, auditory and tactile sensations only, since it is located before the "thinking" part of the brain.

Should the perceived event evoke danger we go into survival mode. The Amygdala, quite cleverly, remembers these sensations, which permits us to react even more quickly in the future. So, if you are attacked by a wild tiger, the Amygdala will store the image, sound or even smell of a tiger in memory thereby allowing us to react even more quickly should a second tiger threaten us.

Individuals who have undergone a traumatic event may respond in a similar manner. The perception of stimuli that are stored in the Amygdala (e.g. the sound of a siren, a dark alley, a large lorry) will evoke an immediate and irrational response as if we were, yet again, in danger. That is why it is not uncommon for traumatised individuals to overreact to seemingly benign stimuli and say things like, "I know that I am safe, but sight of a large lorry makes me feel afraid."

Treatment is designed to help the individual process the stored traumatic memory properly so that the rational mind can mediate this reflexive response and understand things in context.

There are several ways in which this is achieved:

1. Trauma Specific CBT and Individual Therapy
2. Specific techniques, such as EMDR and Narrative Therapy, geared towards processing the trauma.
3. Medication.
4. Group Therapy and Internet based forums.
5. Support for carers, employers and colleagues.

> *"Most people will undergo a period of stress and anxiety following a traumatic incident, but manage to resume full functioning within one year, providing that they have some support"*

At times, a traumatic event may evoke repressed and unresolved memories of trauma and stress from one's past, such as an unresolved bereavement, accident, or emotional crisis. PTSD may also appear years after the actual trauma. For instance, a Holocaust survivor can suddenly feel flooded and overwhelmed by traumatic memories of the war in later life. In a way, one can consider this a positive sign. Individuals find a way to delay reactions to stress in order to get on with life and to cope, but find that these memories arise much later in life when we feel more secure and able to "open the box" and address the trauma more effectively. Hence, it is not a question of whether to address the traumatic memories, but when.

It turns out that people are much more resilient than we think. Most people will undergo a period of stress and anxiety following a traumatic incident, but manage to resume full functioning within one year, providing that they have some support, manage to engage positively with work and personal life, and adhere to healthy perceptions of coping. If the specific reactions to trauma continue over six months it is recommended to seek professional advice. With treatment, the vast majority of PTSD sufferers manage to resume expected functioning and regain confidence. If one is fortunate, one can come out of this feeling even stronger and enriched by the experience. We call this "Thriving."

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Improving Access to Psychological Treatment with Patient-Led Appointment Scheduling

By Professor Timothy A. Carey

Timely access to effective and efficient services is an important component of successfully resolving mental health problems. A large amount of evidence has been accumulated through Randomised Controlled Trials (RCTs) regarding the efficacy of various treatments but very little research effort has been directed towards establishing what the ideal treatment protocol should be. Given the disparity between the research context of an RCT and the clinical settings in which treatments are delivered translating the findings from research to practice has not been straightforward.

RCTs of psychological treatments typically use manualised treatments which are delivered according to regular, standardised time frames. These time frames are established a priori by the researcher or research team prior to the conduct of the study. For example, some researchers might develop a 12 session treatment protocol of cognitive behaviour therapy (CBT) which is to be delivered weekly over a three month period. In routine clinical practice, however, patients typically vary in their attendance patterns. The numbers missed of and cancelled appointments which are costly to services are strong evidence of the fact that patients make their own decisions about when to attend even if that is different to what the therapist has recommended.

Furthermore, patients accessing psychological treatment in clinical rather than research settings, do not attend the number of appointments that manualised treatments are designed to provide. There is in fact a substantial disconnect between the number of sessions treatments are designed to be and the number of appointments patients attend. Typically researchers design treatments to be greater than ten sessions whereas patients typically attend between four and six sessions on average. Guidelines for treatment also recommend lengths of treatment that far exceed what most patients require. The NICE guidelines for the treatment of depression, for example, recommend that if people are receiving CBT they should receive 16 to 20 sessions over a three to four month period. It is the case, however, that very few patients ever attend that many sessions and yet they still experience benefits from the treatment.

It is seldom recognised that the evidence provided by RCTs is evidence of what *can* be effective but not evidence of what is *necessary* for effective outcomes. For example, demonstrating with an RCT that 12 sessions of Treatment A is more efficacious than 12 sessions of Treatment B is *not* a demonstration that 12 sessions of treatment A is *required* for satisfactory outcomes. Clearly, designing treatments to be longer than what most patients require is inefficient and may contribute to compromised access to services.

An extended program of research that began in rural Scotland and has continued in remote Australia has investigated a patient-led model of service delivery. In this approach, systems are established so that patients, rather than clinicians, determine when and how many sessions of psychological treatment will be scheduled. Patients make appointments to see a psychological therapist in much the same way they would make an appointment to see a GP. Patients are able to attend as often as they need to for as long as they need to within the constraints of the service context.

"Although patient-centred care is promoted in many health contexts it still seems to be the case that the primacy of the patients' views and experiences are neglected or overlooked in many cases"

The flexibility of this approach appears to suit many patients. On the other hand, if some patients prefer a structured program of regular appointments they are able to arrange their treatment that way as well. Also, if a therapist has sound clinical reasons for wanting to schedule an appointment with a patient they are certainly able to do so. Perhaps the therapist is concerned about risk so arranges to see the patient within the next couple of days or during the next week. It is still the case, however, if the patient is a voluntary user of the service then they can still decide whether or not they attend as the therapist has recommended.

The patient-led model of appointment scheduling has generated remarkable improvements in waiting times and access to services. In one district, a waiting list of 15 months was reduced to less than a month over a period of less than five years even though not every clinician in the district was using this method. One of the important mechanisms seems to be that when patients make their own appointments, they are very likely to attend. So the numbers of missed or cancelled appointments is very low.

Some therapists become concerned that if they don't know when a patient is coming back then they won't be able to structure therapy accordingly. A transdiagnostic cognitive therapy called the Method of Levels (MOL; www.methodoflevels.com.au) is ideally compatible with the patient-led model of appointment scheduling. In MOL each session is approached as a discrete problem solving opportunity with the patient determining the topic of the session. Therapy is not constructed in a linear step-wise fashion but, rather, develops organically according to the ongoing interplay between the patients and the environments within which they function.

MOL can be delivered as either a low intensity or high intensity therapy but it is the patient who decides what intensity they require. If they need less therapy then they schedule fewer appointments. If they require a greater intensity they schedule more appointments. In one of the first clinics to trial the patient-led approach there were four sessions a week with two therapists providing two sessions each. Patients, therefore, could make four appointments a week if they wanted to. Despite this, no-one did. Patients made appointments when they wanted to spend time working through the distress they were experiencing.

Because of its transdiagnostic nature MOL does not have the same limits that disorder specific treatments can have in working with people who have comorbid presentations. Given the high rates of comorbidity in clinical practice this makes MOL a very useful resource.

Both patient-led appointment scheduling and MOL therapy are part of a "patient-perspective" approach to mental health care. Although patient-centred care is promoted in many health contexts it still seems to be the case that the primacy of the patients' views and experiences are neglected or overlooked in many cases. Patients can be at the centre of deliberations while health professionals make decisions about them and to them and for them. A patient-perspective approach, on the other hand, ensures that the perspective of the patient is the driver of treatment decisions. Perceptual Control Theory (PCT; www.iapct.org; www.pctweb.org) offers an inside-out explanation of behaviour and clarifies why the patient's perspective is so important.

The patient-led approach to appointment scheduling, along with MOL, are ways of promoting control and empowerment with patients. It may still be the case that patients won't always make the decisions we would want them to make but they will become clearer about the things that are important to them in their life and the direction they would like their life to take. Patient-led appointment scheduling puts decisions about treatment frequency and duration where they should be: in the hands of the patients. Paradoxically, perhaps, this shift in locus of decision-making has had an extremely favourable impact on waiting times and access to services. It really is time we let patients take the lead when it comes to decisions about them and their lives.

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Redefining Leadership: Diverse and Global Perspectives

By Jean Lau Chin, EdD, ABPP

As our communities become increasingly global, and countries throughout the world become increasingly diverse, we must examine leadership and psychology within a global and diverse perspective. A digital age of rapid change, instantaneous communication, and increased mobility characterises the 21st Century. Good and effective leadership is essential if we are to promote international business, global economic, social and psychological well-being, and intercultural peace and harmony. Are we ready to meet the challenge?

Why isn't there more diversity among our leaders in the world today? Barron's 2016 list of the World's Best CEOs consists of 30 men; 2 are Chinese, 2 are Indian, and 1 is Brazilian. Women make up 23% of chief executives in US organisations (US Bureau of Labor Statistics, 2009) and only 2% of Fortune 500 companies (Infoplease, 2009). Numbers by race/ethnicity are harder to come by although Whites make up 84% of board seats on Fortune 100 companies. Are white western men the ones most able to exercise good leadership and influence? Disparities in representation, earnings, discrimination and access remain as bias continues to favor those already dominant in society and leadership.

Forbes 2015 of The World's Most Powerful People lists nine women out of 73—a mere 12%; this contrasts with Fortune's list of *2015 World's Greatest Leaders*, of which 26% are women. Why this difference? Fortune's list show more women as leaders because their criteria was about transformational and significant change reflecting *influence* while Forbe's list show fewer women as leaders because their criteria was about *power* to influence and control resources.

Issues of power often result in different and double standards used to evaluate women and minorities less favourably that are rooted in stereotypes about social identities even when actual leadership behaviours are the same. Because leadership models are strongly influenced by Western norms and reflect the leadership largely of white, heterosexual men (Den Hartog, 2004), female leaders are often viewed as weak and indecisive, Asian leaders as modest and passive, Latino leaders as emotional and unstable, and Black leaders as angry and confrontational.

Rost (1991, p. 102) redefines leadership with an emphasis on change and flexibility in thinking as "an influence relationship among leaders and followers…not based on authority, but on

persuasion". Graen & Uhl-Bien (1995) expands this to the exchange that occurs between leaders and members as opposed to leader traits while Rodrigues (2001) calls attention to the shift from individual leaders to teams, processes, and member diversity. Chin & Trimble (2014) integrates this to propose a diversity leadership model that emphasizes diversity, difference, inclusion and change. It emphasizes the values, world views, and diversity of leaders and followers which interact with one other. It emphasizes the centrality and intersectionality of multiple social identities, lived experiences, and social and organisational contexts.

Prior to the 21st Century, political leadership was characterised by a conqueror-colonising mentality by Western countries based on military power. This placed leadership in a global context of power, exploitation, and privilege designed to exploit national resources (e.g., copper, fisheries, labor, lumber, or oil) of the countries being conquered. The Industrial Revolution of the 20th Century brought about the mass production of goods that changed our way of living. Leisure time became a commodity and affluent material consumption a goal. The threat of nuclear destruction, however, gave way to collaborative models of leadership as countries sought peace and nuclear disarmament while the Women's Movement and Civil Rights Movement of the 1960s ushered in demands for empowerment and shared leadership.

> *Many who have made transformational changes have been portrayed as "iron ladies", for example, Corazon Aquino, Ellen Johnson Sirleaf, Yingluck Shinawatra & Dilma Vana Rousseff who rose to power through revolution*

Leadership in the 21st Century is marked by innovation, technology and change with a shift from production of goods to the delivery of services and information bringing about demands for different kinds of leadership. China, Japan, Africa, and Latin America, "third world countries" once colonised by Western power for cheap labor and rich resources now seek liberation and self-governance. With their productivity now far outpacing that of "advanced" Western nations and the proliferation of multinational corporations in the global economic market, the 21st Century marks our interdependence and need to cooperate if we are to achieve world peace, create a sustainable environment, eliminate terrorism, and promote global economic and social wellbeing.

This means redefining leadership explained by leadership traits to the multiple social identities that leaders bring. It means valuing and respecting differences across dimensions of diversity, i.e., race, gender, ethnicity, sexual orientation, religion and disability. It means recognising the privilege that dominant groups experience against the oppression that minority groups face. How do leaders and members remain authentic in such an environment? Can they bring all of their identities to their leadership?"

Diverse leaders coming from minority groups often must learn the rules of the game and play by them as they enter the power elite. This often shapes their identities and leadership behaviours as they conform to become more like those already in power. We saw this historically as female leaders rose to power; it was their relationship with powerful men that enabled them to break the taboo against female leaders. Dowager Cixi, Empress of China and Cleopatra, Queen of Egypt were two such examples where the social zeitgeist led them to be viewed as invalid and tyrannical leaders who seized power and ascended to power through their alliance with and seduction of powerful men of their times. Despite their major social reforms and military conquests, they are remembered primarily for their "feminine wickedness", seductress powers, and "iron-willed" characters.

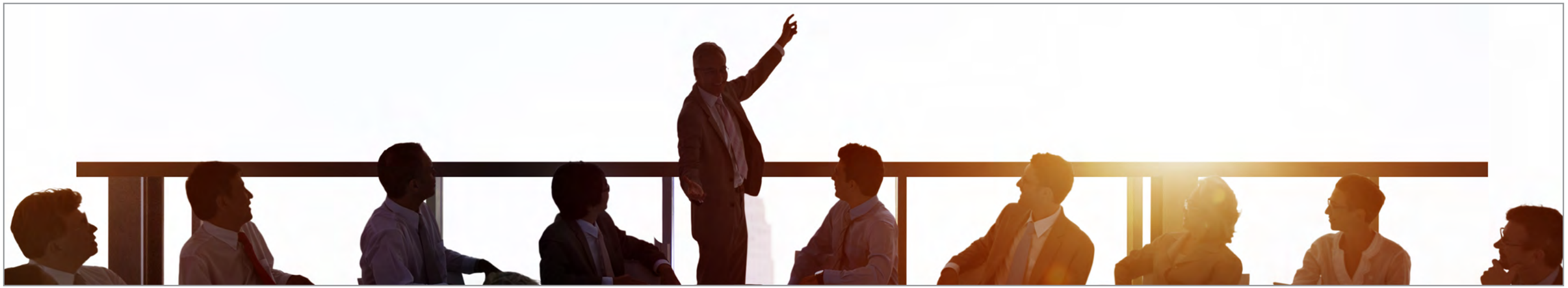
Some of the most powerful female political leaders since continue to be portrayed by these gendered expectations. Many who have made transformational changes have been portrayed as "iron ladies", for example, Corazon Aquino (Phillipines), Ellen Johnson Sirleaf (Liberia), Yingluck Shinawatra (Thailand), Dilma Vana Rousseff (Brazil) who rose to power through revolution and Golda Meir (Israel), Margaret Thatcher (England), Angela Merkel (Germany) who rose to leadership from within the system. Their alternate portrayal as "mothers" or saints reflect society's ambivalence about strong women. Racial/ethnic minority leaders similarly are constrained when perceived as "exceptions" to their race when they made an accomplishment, when they are commonly asked "how their group thinks".

The question is: Does Difference Makes a Difference? The answer is a resounding "Yes" because the privilege held by dominant group members often render them oblivious to or disbelieving of these experiences that those from minority groups face. For example, an African American woman being straight forward and assertive may be perceived as confrontational and intimidating while an Asian American woman being respectful, indirect and modest may be perceived as passive. Female Native American leaders may emphasize "standing beside, rather than behind, their men in an effort to preserve and protect their tribal treaty rights", but then be faulted for not holding their own as women (Chin & Trimble, 2014, p. 283). We have pilot data on diverse leaders to show that being different often means: (i) being the one and only, (ii) always being the outsider, (iii) having to work twice as hard to be ½ as good, (iv) always having to prove yourself, (v) being challenged on your competence, or (vi) having to be extraordinary. It often means living in two different worlds as they negotiate between different communities.

So what kinds of leaders do we want for the 21st Century? Command and Control types of leadership are probably on their way out. There is simply not one model for a diverse population. The research literature increasingly points to transformational, collaborative and relational oriented leadership styles as models for 21st Century leadership —redefining leadership based on change, relationships and influence.

Transformational leadership is characterised as: visionary, promoting change, inspirational, innovative, and charismatic (Burns, 1978) became popular in the 1980s as US corporations began to experience rapid change internationally and multinational corporations began to flourish. Eagly, Johannesen-Schmidt, & van Engen (2003) found female leaders to be more transformational than male leaders. Charisma as a characteristic, however, is problematic because it defines male charisma—i.e., someone with a commanding presence exuding confidence, strength, and a personal magic or appeal that arouses loyalty or enthusiasm. Women's charisma is often more associated with being warm, nurturing and interpersonal, i.e., about persuasion and smiles.

Collaborative Leadership is characterised as: strategically choosing to cooperate in order to accomplish a shared outcome and accepting responsibility for building or helping to ensure the success of a heterogeneous team (Rubin,



2009)—shifting from power to empowerment and emphasizing social responsibility. It became popular amidst the social zeitgeist of the '60s to eliminate gender and racial/ethnic inequities, reflecting the lived experiences of oppressed groups.

Task vs. Relational Leadership dichotomizes: task oriented leaders as focused on getting the job done, planning and organising, being independent, assertive, and competent vs. relational oriented leaders as focused on people, building relationships, and being expressive and nurturing. As women have often been found to be more relationally oriented suggestint that they base their judgments more on intuition and emotions compared to men who base them on a rational calculation of the means and ends. Consequently, task oriented competencies are more associated with leadership success which Korabik (1990) criticises as creating a double bind for female leaders who must "take charge" like their male colleagues, but must be warm and nurturing like women are expected to.

Asian, Arab, and non-Western leaders have also been found to place more emphasis on relationships over tasks. Miscommunication often occurs in cross-cultural negotiations where they often view an initial negotiation as a process merely to confirm belongingness and to evaluate the relationship for long-term gain Western leaders often view all negotiations as confirming authority and establishing dominance.

Several non-Western models of leadership introduce different perspectives and new constructs if we are to redefine leadership. The caliphal-prophetic model of leadership rooted in Arab culture and strongly influenced by Islamic religion and the Confucian leadership model steeped in Chinese traditions and values are two such examples. Though both models derive from a male dominant perspective and are hierarchical common to Western models of leadership, they draw on different cultural values and social systems. Both incorporate the concept of benevolent paternalism—an expectation and responsibility of the leader to be humanistic, responsible for a family's welfare, to maintain social harmony through relationships, and the belief that improvement of one's life can be attained through a group orientation—a construct more foreign to Western leadership. Benevolent paternalism in which leaders are authoritative but lead with beneficence has been found in Iran (Ayman & Chemers, 1983), India (Kao, Sinha, & Wilpert, 1999) and China (Cheng, Chou, Wu, Huang, & Farh, 2004).

The construct of Ren-Qing plays a central role in the Asian culture in regulating behaviour in social life, business matters, and leadership, yet is foreign in Western culture. While it is an interpersonal relationship, it involves a moral obligation to maintain the relationship, and governs social protocol of reciprocity involving gifts and favors in the long run (Yan, 1996). It is associated with appropriate equity and fairness as an essential guiding factor for successful leadership (Li, 2013).

Lastly, Lee (2004) offers a Daoist leadership model drawing on Eastern culture and Daoism for application in Western leadership. Using water as a metaphor for leadership; Lee posits that it is: (i) altruistic because it is essential for human life, (ii) adaptable because it modes itself to the shape of its container, (iii) humble because it is always on bottom, (iv) soft but strong because it can mold mountains as it flows, and (v) clear and transparent. The model is egalitarian and urges a benevolent use of power using a humanistic orientation by following natural laws of harmony with nature and among humans. This model contrasts with command and control type models and condones minimal interference on followers, provides an ethical framework for followers to take ownership of tasks, and employs "soft tactics," such as persuasion, empowerment, modeling, teamwork, collaboration, and service.

In conclusion, we examine the current gap in leadership theories and redefine leadership to be relevant and effective in a diverse and global society. A Daoist leadership model offers new insights into other forms of leadership while relationship oriented, collaborative, and transformational styles of leadership have potential for diversity leadership if modified. We will face a future that will demand new leadership skills. Are you prepared to live, work and lead in the future?

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> *A Daoist leadership model offers new insights into other forms of leadership while relationship oriented, collaborative, and transformational styles of leadership have potential for diversity leadership if modified*

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