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AOTEAROA NEW ZEALAND
SOCIAL WORK

VOLUME 34 • NUMBER 1 • 2022

ISSN: 2463-4131 (Online)

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Contributions to the building of social work knowledge in Aotearoa New Zealand and beyond

Te manu kai miro, nōna te ngahere; te manu kai mātauranga, nōna te ao.
The bird that eats the miro berries, theirs is the forest; the bird that consumes knowledge, the world is theirs.

We are pleased to introduce this first issue of *Aotearoa New Zealand Social Work* for 2022. In its small way, we believe the journal is one source of knowledge and sustenance for social workers. Available freely to all, the journal provides access to social workers to recent research, much of which is local and conducted by practitioners undertaking small-scale studies, alongside the contributions of academic researchers. Contributions to the journal have reported on the concerns of direct practice, as well as discussions of research and policy that impact on the profession, and many have explored new conceptualisations for understanding both our discipline and diverse social issues. This issue again demonstrates a critical engagement with a range of people impacted by political, economic and social conditions such as children with disabilities, women, older adults, gender diverse people seeking health care, social work students, and social work practitioners working in the field. Supervision is often well-represented in the journal and this issue publishes two new contributions. We also carry articles that contribute to the record of our own development as a profession in Aotearoa New Zealand. These articles come together to contribute to a body of knowledge to support social workers and what they encounter in their day-to-day work.

While we are an Aotearoa journal, supported by the ANZASW, we increasingly have an international reach. We can see that in several ways. Firstly, there are various analytics we can draw on. Since the editorial collective first began monitoring unique visitors to the journal website, we have noticed a steady year-on-year growth from almost 14,000 in 2017 to almost 40,000 in 2021 (with a growth in unique users of over 10,000—over 25%—in the last year alone). The proportion of international visitors has also grown from 43% in 2017 to 49% during 2021. The proportion of international visitors is down a little from 55% in 2020 so we can assume the rapid growth in overall users in the last year must include larger proportion of visitors from Aotearoa. Secondly, we can see that our publications are being cited in international literature.

We also welcome contributions of articles and commentaries by authors from countries other than Aotearoa New Zealand. We are pleased to note that this issue contains articles by Indian and Canadian authors.

Staniforth et al.'s article entitled "The Council for Social Work Education in Aotearoa New Zealand: A brief history" presents an interesting account of the work of Council since its inception in the mid-1990s. Drawing on Council archival material including minutes, reports, memos and the recollections of previous Presidents, the article recounts the evolution of the nomenclature of the organisation and constitutional developments. Several key issues that have guided much of the Council's collective action are examined: mandatory registration of social workers; relationships between Council member

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institutions and wider sectoral groups such as the Social Workers Registration Board; resourcing of the social work education sector and the Council itself; and bicultural commitments. While the Council membership have not always agreed on a variety of matters their collaborative endeavours are occurring in an environment where they are competing for students; as Fraser, a previous President noted, the Council are "all concerned about the same things which gave us a common focus and drive". Staniforth et al. note the forthcoming changes in the polytechnic sector and the likelihood of a shift in relationships and power in the Council. Increases in the fees of the international associations to which the Council belongs and no sign of adequate funding for the education sector by the Tertiary Education Commission are continuing challenges for the Council, along with other policy/practice issues.

Cox et al.'s article on student hardship reviews the literature relating to this pressing concern. Social work education, with its combination of classroom and fieldwork learning, presents unique challenges to students and their ability to access and survive their social work education. As student loans and allowances become more difficult to access due to constricted criteria, and their rates become increasingly inadequate in the face of steeply rising living costs, most students top up their income with paid employment during study. However, for social work students, the full-time nature of long periods of fieldwork placement makes this option unachievable, leading to intense hardship. Particular gaps in the research remain in understanding the intersecting effects of ethnicity, gender and disability and, in particular, the impact on Aotearoa New Zealand students of this phenomenon.

In the first of two supervision focussed articles, "Registered social workers' supervision across areas of practice in Aotearoa New Zealand", Kieran O'Donoghue reports on a quantitative study of social workers' experience of supervision. This article examines the supervisory experiences and views of registered social workers across the practice areas of statutory services, health and non-government organisations (NGOs). Drawing on data from 266 postal survey respondents, the article establishes a baseline for supervision across areas of practice in Aotearoa New Zealand and discusses the implications any differences have for the supervision of registered social workers. O'Donoghue found that supervision in health and NGO areas was more professional, clinical, cultural, reflective and involved more positive content within a more constructive supervision climate than supervision in the statutory area. O'Donoghue recommends that the significant difference in quality of supervision be addressed through changing the supervision climate, developing the capability and expertise of supervisors and separating professional/clinical supervision from line management.

In "Asking the 'dumb' questions: An evaluative survey of reflective supervision with statutory child protection social workers", Matt Rankine and Andrew Thompson draw on data from the pre/post online evaluation of an action research intervention study with supervisors and supervisees in Oranga Tamariki (statutory children's service). The study contained three separate parts: development of a learning community with OT supervisors (Rankine & Thompson, 2021); thinking aloud in supervisor–supervisee dyads; and an online evaluation pre- and post-intervention of the action research study.

The aim of the online survey was to measure participants' supervision practices, and the extent to which perceptions of confidence, reflection, professional learning and resilience improved over time. The results from the survey demonstrated that social workers had increased confidence as they built reflective capacity, resiliency and improved their supervision practice. The study identified the importance of developing learning spaces that enhance reflective supervision for supervisors and supervisees in child protection.

In “Responses to abuse, neglect, and trauma of children with intellectual disability: Experiences of social workers and health practitioners in Aotearoa New Zealand”, Kim Simpson et al. report on a study which focused on exploring the experiences and perspectives of social workers and health practitioners to abuse, neglect, and trauma among children with intellectual disabilities. The authors draw on data gained via a focus group and a more in-depth exploration and investigation with four experienced social workers with the aim of providing a wider perspective of practice and policy issues among children with intellectual disability.

The findings show that, to ensure safety and implement support interventions, practitioners need to be equipped with knowledge about disability and its related needs. Furthermore, to influence significant change, a strong relational practice with children with intellectual disabilities, their whānau and family is vital. Simpson and colleagues urge social workers to draw on relational practice, socio-ecological frameworks, human rights and social justice, and advocacy to develop appropriate assessments and interventions to improve the wellbeing of children with intellectual disabilities.

In “Loneliness and boredom in residential care: Voices of older adults”, Myunik Panthi Mail reports on a phenomenological qualitative study conducted through participant observation, in-depth interviews with 24 residents and key informant interviews with 10 staff members in a residential care setting in Aotearoa New Zealand. The findings emphasise the presence of loneliness and boredom in residential care despite the efforts made by the settings to provide activities and support. Staff and family support helped to alleviate loneliness and boredom and participants employed individual coping strategies. Collaboration between social workers, health professionals, nursing staff and activities staff is essential to identify and minimise the risk of loneliness and boredom. Social workers need to identify concerns, limitations and problems that affect residents’ participation in activities. Collaboration between social workers, care workers and activities coordinators is important in offering diverse and meaningful activities.

Francis et al. explore the personalities of single and married women in their quantitative study in India. The importance of studying married and single women in India has become more pertinent because of the changing attitudes towards unmarried women, increased literacy rate of women, and their involvement in politics and economic development. The authors suggest that there were no significant differences in personality between single and married women in their sample of 52 women. This raises questions about traditional views which suggest that women should be married and therefore that status attached to marriage should be challenged, including by social workers. Social workers, especially those working in women-centred practice, can support the agency and citizenship of women in Indian society. Social workers also have a critical role in ensuring gender-inclusive practices are occurring at a micro-level, in communities, and also at the policy table.

In “It takes a village: Advancing attachment theory and recovering the roots of human health with the Circle of Seven Essential Needs”, Mike Sosteric and Gina Ratkovic (Canada) note that Bowlby’s attachment theory (AT) remains a popular way to understand infant, child, adolescent, and even adult and family dysfunction. However, they argue that attachment theory is a reductive theory that ignores a wider range of human needs and has caused significant hardship and trauma. AT develops within Eurocentric and ideologically rooted presumptions that existing capitalist socialisation processes (processes that foreground gender, a gendered division of labour, individuality, self-sufficiency, independence, and early detachment from parents and family) are necessarily an advance over earlier, more collectively oriented, systems. The authors note the importance of recent scholarship that is beginning to ask critical questions about the dominant European systems of socialization of children.

In this conceptual article, Sosteric and Ratkovic suggest the replacement of AT with a less ideological, healthier, and more empirically informed approach to socialisation and social care—one that might help us explore how to build a society capable of actuating the full potential of all its citizens. Sosteric and Ratkovic assert that the only way to actualise full human potential is to move the locus of human health and full development away from a single woman, or even a single nuclear family, to a village, a community, and a society that understands the complexity of human needs.

There are three viewpoint articles in this issue. First up, in "Challenging the status quo of gendered cancer care", Lizzie Waring notes that LGBTTQIA+ users of health services are at a higher risk for certain cancers yet access relevant screening and healthcare less frequently than cis-gendered, heterosexual women. Literature reports fears of discrimination and experiencing disrespectful care from health professionals. Women's Clinics in health endorse a gender binary, with an assumption of cis-gendered heteronormativity. Waring argues that, as social workers, we have responsibilities under the Code of Ethics and our SWRB Core Competencies to advocate for change and challenge the status quo.

Maddison Little also explores gender-affirming health care in her viewpoint: "Is banning conversion therapy enough? Aotearoa New Zealand and access to gender-affirming healthcare". Little notes that recent legislation before the New Zealand Parliament has promoted much discussion of conversion therapy acknowledging that it causes harm and is linked to serious mental health issues. Little conducted a literature search to explore what information is available in Aotearoa New Zealand, and internationally regarding conversion therapy and access to gender-affirming healthcare. She found that, despite this practice presenting a significant health issue for transgender and non-binary people, it is under-researched in Aotearoa New Zealand, particularly in social work. She makes some recommendations for future social work investment in better advocacy for transgender and non-binary people.

Tim Dare's contribution responds to an article published in this journal in 2021 (Gulliver et al. 2018). Dare's commentary is prompted by Gulliver et al. (2018) which contributes to both practical and academic interest in social licence. In "Qualitative research: Surveys, social licence and the integrated data infrastructure", Pauline Gulliver and her co-authors explored the social licence to include data in New Zealand's integrated data infrastructure. In the course of doing so, they advance a specific definition of social licence. Dare writes to argue that this definition cannot be an adequate definition of social licence due to conceptual difficulties.

There is a growing literature on the myriad ways that Covid-19 has impacted on social work practice and education. We are pleased to add another brief practice note to record some of the innovative responses to the pandemic. In a practice note "Community connections—A wellbeing response to supporting staff during the pandemic 2020-2022 in Aotearoa New Zealand" Emily Sheffield et al., of Community Connections, Aotearoa New Zealand, report on an intervention designed to support staff working remotely during a Covid-10 lockdown in 2021.

Finally, we offer three book reviews. Tony Stanley has reviewed *The Routledge International Handbook of Social Work Supervision* edited by Kieran O'Donoghue and Lambert Engelbrecht and *The Aotearoa Handbook of Criminology* edited by Elizabeth Stanley, Trevor Bradley, and Sarah Monod de Froideville. Liz Beddoe has reviewed *Shame and social work: Theory, reflexivity and practice* edited by Frost, Magyar-Haas, Schoneville and Sicora.

As always, if you are thinking about submitting an article for a future issue, do feel free to approach Liz Beddoe or any other member of the editorial collective. We are proud of our open-access, zero fees journal. Published quarterly, we particularly welcome work offering research and critical perspectives on contemporary policy developments, indigenous social work, post-colonialism, anti-racism, feminism, and progressive social work theory, policy and practice in all fields.

The journal also publishes book reviews and encourages short, topical pieces offering readers' critical commentaries, review essays, analyses of policy or practice developments, and practice notes and reports on research-informed practice innovations.

Liz Beddoe

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ORIGINAL ARTICLE

QUALITATIVE RESEARCH

The Council for Social Work Education in Aotearoa New Zealand: A brief history

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ABSTRACT

INTRODUCTION: Despite tertiary social work education commencing in Aotearoa New Zealand by 1950, it was not until the mid-1990s that social work educators established a unifying body (the Council). The Council aimed to promote teaching and research in social work within Te Tiriti o Waitangi obligations, and enhance relationships and collaboration within the sector.

METHODS: A qualitative, critical realist research methodology has been utilised, analysing interviews with eight people who have served as president of the Council or chair of the field education sub-committee since the Council's inception. Data were augmented with Council archives, including minutes and reports.

FINDINGS: Themes of registration, relationships, resourcing and bicultural commitments were identified. These provide an overview of key issues that have impacted on social work education in Aotearoa over the past 25 years and record the rich stories of some of the key people involved.

CONCLUSIONS: Social work educators established a forum to unify their voices and enhance standards in social work education. Ongoing professionalisation and developing regulation of social workers became a Council focus. Future challenges for the Council include ensuring its viability and operation, responding to bicultural responsibilities and strengthening the voice of social work educators in a state-regulated environment.

KEYWORDS: Social work education; social worker registration; course accreditation; bicultural responsibilities

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This article provides an introductory account of the Council for Social Work Education of Aotearoa New Zealand. Tertiary social work education in Aotearoa New Zealand formally commenced in 1949 and further detail regarding its history and context is available in Nash (1998) and others (for example, Dale et al., 2017; Staniforth, 2018). However, a unifying body for social work educators was not established until the 1990s (although an Education Committee had existed within the social work professional association). This group was initially named the New Zealand Association of Social Work Education (NZASWE), later Aotearoa New Zealand Association of Social Work Education (ANZASWE), and then renamed as the Council for Social Work Education of Aotearoa New Zealand (CSWEANZ)/ Kaunihera mo ngā Mahi Mātauranga

Toko I te Ora (hereafter "Council" will be used when referring to the organisation). Information has been drawn from Council archival material including minutes, reports, memos, the recollections of the people who have acted as president of the body, as well as a longstanding field education sub-committee chair. More detailed histories of the Council, including its field education sub-committee, are yet to be written[1].

Method

While the three authors have varying aspects to their ontological positions, they would all describe themselves as holding subjectivist views on how knowledge is perceived (Bryman, 2012). As to the epistemological orientation for this research, the authors held a critical realist framework which posits that there are things that are *facts* and how they are interpreted can vary. This approach is compatible with historical research and oral histories (Braun & Clarke, 2013; Fyfe, 2003; Houston, 2001).

In 2016, the first and second authors (both were Council members at the time), agreed to undertake a project to develop an archive for CSWEANZ. That year, the first author was awarded a summer scholarship to archive historical material related to CSWEANZ/ANZASWE/NZASWE, as well as to interview the presidents of the Council. The third author was awarded a student scholarship and undertook six of the eight structured interviews for this project.

Ethics approval was obtained for this project from the University of Auckland Human Participants Ethics Committee on November 1, 2016 (for [3] years, Reference Number 018270), which was then extended for a further three years, until November 1, 2022.

Each of the seven past chairpersons or presidents (and the one long-term chair of the field education sub-committee) was invited to participate in an audio-recorded interview and was also asked to give permission for the interview recording to be archived with CSWEANZ. Interviews were held between December 2016 and October 2020. The interviews were transcribed and participants were encouraged to make any amendments for publication. Seven of the eight participants agreed to have their audio recordings archived with CSWEANZ. Interview transcripts were then uploaded into NVivo and a thematic analysis in line with Braun and Clarke's (2013) six-stage model was conducted. Twenty nodes were created; themes were developed which form the basis of this article. Table 1 lists the research participants and their roles.[2]

Context and history

There is some debate around when the NZASWE was first established. An anonymous and undated summary of ANZASWE (electronic file dated 2006) indicates that it was formed in 1993, "as a result of the expansion of tertiary institutions offering professional social work courses."

Table 1. Participants

Participants	Roles	Years	Institution	Date of interview
Gavin Rennie	Council President	1995-2004	Unitec	31/1/2017
Carole Adamson	Council President	2005-2007	Massey	7/12/2016
Lynne Briggs	Council President	2008-2010	Canterbury	16/2/2016
Allyson Davys	Council President	2011-2013	WINTEC	25/1/2017
David McNabb	Council President	2014-2017	Unitec	9/2/2017
Sarah Fraser	Council President	2017-2019	NMIT	9/11/2020
Neil Ballantyne	Council President	2019-2020	Open Polytechnic	30/10/2020
Kathryn Hay	Field Education Subcommittee chair	2006-2016	Massey	1/2/2016

In another document, dated 2004, written by the president Gavin Rennie, NZASWE's beginning was recorded as being in 1995. Hunt's (2020) thesis documents suggest that it was established in 1996, while Mary Nash's (1998) well-documented history of social work education in Aotearoa offers another date. Using insider knowledge of the situation as convenor of the New Zealand Association of Social Workers (NZASW) Education and Training Standing Committee, Nash (1998) claims that:

> …the Association of Schools of Social Work Education, [was] formed in 1997. This organisation was established as tertiary level educators became increasingly alarmed at the lack of accreditation systems for their courses of study and the consequent potential they saw for lowering standards of social work education if the only nationally recognised qualifications were to be a National Certificate and a National Diploma registered with NZQA. (pp. 429–430)

Regardless of the actual starting date of the Council, it was not until 2004 that ANZASWE became an incorporated society with a constitution (Rennie, Chairperson's report December 2, 2004). An updated constitution was subsequently approved in February 2014 (Minutes Special General Meeting, 26 February 2014, Auckland) with further amendments made during that year and a final version signed by President McNabb and some executive members in November 2014.

The seven main objects of the organisation were formally documented in its constitution (see Table 2). Carole Adamson (president 2005-2007)

Table 2.

General Objects of ANZASWE, 2004 (Constitution and Rules of Aotearoa New Zealand Association of Social Work Education (Incorporated Society) 2004)	General Objects / Whāinga of CSWEANZ, 2014 (Constitution and Rules of Council for Social Work Education of Aotearoa New Zealand Incorporated (CWSEANZ). Ko ngā Ture Kāwanatanga me ngā Tikanga o te Kaunihera, e aro pū ana ki ngā Mahi Mātauranga Toko i te Ora, o te Koporeihana Aotearoa. June 10th, 2014) (signed by President McNabb November 11th, 2014)
• To promote the scholarly pursuit of teaching and research in schools and departments of social work that offer education that leads to a recognised professional social work qualification. • To ensure that social work education is in accordance with the articles of Te Tiriti O Waitangi, with a commitment to promote an indigenous identity for social work education in Aotearoa New Zealand. • To promote and support social work, social services and community work education. • To maintain close relationships with the social work sector that includes Statutory, Community, Health, NGOs, and the Social Work Registration Board. • To collect and publish information about the functions and needs of tertiary social work, social services and community work courses. • To encourage and contribute to the scientific base of social work education by the publishing of scholarly journals, monographs and collections of papers. • To organise conferences on social work education as appropriate. (ANZASWE, Constitution at 2004)	a. To promote the scholarly pursuit of teaching, research and publication within social work programmes in Aotearoa New Zealand. b. To promote that social work education occurs is in accordance with the articles of Te Tiriti O Waitangi, with a commitment to promote an indigenous identity for social work education in Aotearoa New Zealand. c. To promote and support collaboration across social work, social services and community work education at local, national and global levels. d. To maintain close relationships within the social work sector, which includes professional bodies such as the Aotearoa New Zealand Association of Social Workers (ANZASW), the Tangata Whenua Social Workers Association (TWSWA), the Social Workers Registration Board (SWRB) and statutory, community, health, education and non-government organisations. e. To organise or contribute to hui and conferences on social work education as appropriate. f. To uphold, promote and advocate the professional principles of social justice, social responsibility and human rights. g. To advocate for the needs and resourcing of the education sector and its students to government, regulatory and professional authorities and social work/services agencies.

> We had good attendance and that reflects a commitment that people have to trying to be collaborative, trying to build a voice and by sitting around the table having discussions … what's on top, what are the important issues, how are we going to deal with these things? It does produce that sense of solidarity … we've got small providers who are quite isolated, not just geographically, and it's good for people to be able to hear the issues being voiced in perhaps slightly different ways by other people. To have a voice.

The rules and constitution of the Council outline that membership was available to each of the tertiary education providers offering social work education which leads to a recognised professional social work qualification. Each member (one per provider) has one vote at Council meetings and shall nominate a representative who usually is the head of school or convenor of the programme, or their representative, to attend meetings. The Council has an elected executive who serve two-year terms (that may be renewed for a further two years) that includes a president (the president chairs the meetings—sometimes people referred to themselves as the chair rather than president), vice-president, secretary, treasurer and four to seven members. All schools pay membership to the Council and, to date, these fees have included membership to the Asian and Pacific Association for Social Work Education (APASWE) and the International Association of Schools of Social Work (IASSW). Minutes indicate that the Council has usually met three times a year with the AGM generally being held in November or December.

While the organisation was originally known as NZASWE, it changed its name to ANZASWE in line with similar changes that had occurred within the professional association, recognising the importance of its bicultural mandate. In June 2009, its name was changed to CSWEANZ. Lynne Briggs (president 2008-2010) that this change occurred principally due to the confusion caused by the name being so close to that of the professional association of social workers, Aotearoa New Zealand Association of Social Workers (ANZASW), stating:

> … I'd get mail addressed to the President of ANZASW that would come to me, they were writing to the wrong [body], so there was a lot of confusion for both the profession and the general public around both bodies.

A website was developed in 2018 (http://csweanz.ac.nz/) which holds the organisation's information in a secure, but accessible, site for the continually rotating membership.

Findings and discussion

The major themes from the interviews revolved around *registration*, *relationships*, *resourcing*, and *bicultural commitments*. Within each of these major themes there are also sub-themes.

Registration

The issue of registration of social workers, including its consequences for social work education, was the most consistent topic or theme that the Council has considered at its meetings. When NZASWE began, the profession and other social work stakeholders had actively begun the process of moving towards a registration system (Hunt, 2016, 2017, 2020) and much of NZASWE's time and energy were devoted towards this development. Rennie, the inaugural president, recalls some of the early discussions about registration:

> When registration [was first discussed] there was a general feeling that most people liked the idea of registration, but … there was quite a strong feeling amongst a number of people, that registration [should be] in the hands of a body like ANZASW rather than setting up a new body.

Kieran O'Donoghue (Waikato Institute of Technology member at that time) coordinated a submission to the Social Services Select Committee on the Social Workers Registration Bill on behalf of NZASWE. Under General/Summary, the submission stated that the Council was in favour of statutory registration, but argued it needed to also include reference to policy which reduced inequality and to organisational cultures which supported frontline social workers. The submission also stated:

> Clearly, for this Bill to be effective in delivering what it espouses it must focus wider than purely the person of the social worker and take cognizance of the social environment in which social work occurs. A focus purely on the social worker without addressing the resourcing of social work and the education, training and supervision of social workers is nothing short of social policing. (O'Donoghue, 2001, p. 2)

Rennie also recalled views of NZASWE regarding the type of legislation that should be brought in:

> Child, Youth and Family were fairly slow at getting on the [band] wagon, in terms of registration, because they had so many unregistered social workers, and we saw the need for an incremental thing to come in, not an immediate thing. But also, we held a position which said if there was going to be registration it should be compulsory to be really effective.

Following the enactment of the Social Workers Registration Act 2003, ANZASWE continued to be preoccupied with the demands on social work education of the new legislation:

> We regularly met with the [SWRB], and there were pluses and minuses in doing that because it became a major part of why we were meeting, and it [dominated] what we were doing. (Rennie)

Feedback on the Social Workers Registration Act

Following the passing of the Social Workers Registration Act 2003, the newly appointed Crown Entity, the SWRB, established an Education Advisory Group (EAG) in 2004. The EAG was chaired by Buster Curson, deputy chair of the SWRB. Minutes from ANZASWE meetings indicate that there were several Council members who sat on the EAG that met regularly with the SWRB Standards and Practice Committee of SWRB through 2004–2005. Members of ANZASW were also members of the EAG (ANZASWE minutes December 7 2005).

The Council continued to be actively involved in the process of consultation and feedback about registration issues. David McNabb (president 2014–2017) recalled that:

> … we did give feedback regarding the Social Workers Registration Act and there's been a fair amount of change and development of some key policies, [for example] going from three to four years [bachelor degrees]. Some of the other changes included [requirements for] qualifications for staff, some of the field work standards and how tight they should be.

In 2017, as mandatory registration was being considered, the Select Committee on Social Workers Registration Legislation Bill provided a consultation document which suggested that employers would have the power to determine what social work was, and who would be defined as a social worker. Sarah Fraser (president 2017-2019) commented that "the way the Bill was framed raised a serious concern that organisations and employers could dodge the added cost of employing registered social workers by simply changing job titles". Many social work stakeholders were concerned about these issues, including education. Fraser recalls that responding to this proposal and others:

> … [was] the focus of the Council's work for the early part of the year [2017]. A number of Council members including Neil Ballantyne, Carole Adamson and Kieran O'Donoghue worked extensively alongside ANZASW and other bodies to offer an alternative to the [Select] Committee's recommendations. A submission was then made from the Council to Minister Sepuloni in May to support the proposed amendments. This effort had a huge impact on the way the Act finally came through, much to the relief of educators and others in the profession.

State control of education accreditation

While the Council was generally supportive of registration, it came with some loss of autonomy for the education sector. Accreditation for social work programmes had sat with social work bodies, including the New Zealand Social Work Training Council (established 1973), later replaced by the New Zealand Council for Education and Training, then Te Kai Awhina Ahumahi Industry Training Organisation in the Social Services. ANZASW established a professional accreditation process for social work programmes (Hunt, 2020; Hunt et al., 2019; Nash, 1998). The process of accreditation was transferred to SWRB after the 2003 Act came into being. Adamson recalled this transition:

> It was a time of a certain amount of resistance of the responsibility … for recognition of social work programmes to be taken away from ANZASW and moved to the crown entity of the SWRB, because that was in my perspective, changing the Treaty relationship. It was changing the responsibility for standards within the social work profession, and within social work education, taking it away from the profession and putting it with the state.

The minimum qualification for registration

The SWRB brought in accreditation standards for social work programmes over time. Hunt et al. (2019) outlined how the qualification criteria for social worker registration in Aotearoa New Zealand were initially established with a historical two-year Diploma in Social Work recognised alongside a new benchmark of a three-year bachelor degree. The education sector mainly accepted this decision. However, of more contention was the SWRB's subsequent requirement that all undergraduate social work programmes should be four years long. While the universities had a tradition of four-year programmes, the polytechnics and the wānanga did not. This was a divisive issue within the Council. Some members were against this standardisation, arguing that the extra year required would disadvantage some groups:

> I think the move to a four-year degree has got serious social implications. I think it's likely to whiten programmes, exclude Māori and Polynesian [students] because it's another year and just changes the social nature of the students who do the course … there's some dangers of elitism coming in … I think the pluses of having a three-year and a four-year was that people had choices. (Rennie)

McNabb echoed some of Rennie's concerns in that the move from three to four-year programme requirements had created:

> [A] split basically between university and non-university … the three-year programmes not seeing the argument as to why they should change to four-year. And [negative] impact on students and equity issues, cost of it etc., and that we should put more emphasis on post qualifying resourcing people in employment, [such as] assisted first year of employment [and] internships.

Allyson Davys (president 2011-2013) provided an alternate perspective:

> I did not think it was good for social work education to have two standards, to have polytechnics three years and universities four years … immediately, you've got a two-tiered system. If you're going to say any degree is similar to another one, we have to have similarity, but not everybody agreed with that. And so that did become quite a divisive issue [which] did again emphasise the [group] divide.

Davys added that, having observed that the SWRB had granted accreditation to Bethlehem Tertiary Institute and Open Polytechnic based on them having four-year degrees, there was little point in opposing the move to four-year programmes as "it had already been decided". Having reached this point, CSWEANZ supported the polytechnics in this transition:

> Through CSWEANZ we ran two or three workshops in Hamilton where we invited all of the Polytechnics … to discuss what it would look like, how we could actually be collaborative, how we could look at the interface between the programmes so that students could actually move more easily from programme to programme … we started to say "OK as a group what are our strengths and how can we be collaborative and supportive of one another?" (Davys)

Requirements for educators

The SWRB signalled that, by June 2017, all people teaching in social work theory or skills papers needed to be registered and have a minimum of a master's degree. There were some social work educators who were philosophically opposed or not comfortable with the notion of becoming registered. Rennie, for example, stated that:

> [W]e … didn't feel that we were doing very much social work and therefore we were going to resist being registered as social workers.… But a decree came [from the SWRB] that we just had to be registered and so those of us who were social workers did [do that].

Davys recalled that these requirements often made it difficult to recruit and fill social work teaching vacancies. For Fraser, the issue was at the forefront of her time as president of CSWEANZ. She described:

> [There] was a deadline set by the SWRB for all social work academic staff members to be registered and have completed their master's degrees or submitted their PhDs by the end of June 2017. While people had known that this expectation around qualifications existed, it was considered an aspiration to work toward, rather than a requirement with a fixed date…. The notification of the deadline came as a shock to a number of programmes. It had significant ramifications because it meant that anyone who was teaching social work theory or practice papers (including fieldwork coordination), but did not have a master's or PhD, would be unable to teach or coordinate those courses. This was a huge concern for many programmes trying to grow their academic workforce with staff enrolled on PhDs and master's, but not in a position to complete in the designated timeframe.

Shifting relationships over time

The work of the Council required constant liaison with several key sectors. It was evident from the interviews with all participants that negotiating and strengthening relationships was one of the important roles of the president.

With key stakeholders

The Council liaised with a number of key stakeholders including ANZASW, SWRB, Oranga Tamariki, Industry Training Organisations and the health sector. Briggs described her time as president between 2007 to 2010 as one where conflict existed between many stakeholders:

> What I remember most was sorting things out with the SWRB, and getting on with them, and making good partnership and relationships. And being very aware that ANZASW and their executive at the time were…in a lot of conflict with the SWRB. My aim as president was to not be in conflict with [SWRB] and to work with them as much [possible] and also to try and establish a better relationship with ANZASW again, because we were all members of ANZASW, it was a very confusing, very conflicting time.

Davys took over as president from Briggs and continued to work on the relationships with SWRB and ANZASW. She described that, during her two-year tenure:

> We established relationships with ANZASW and had regular meetings with the SWRB. About the time that I became president we actually started to meet in [SWRB] offices and they were very hospitable [and] an easier relationship built up there.

Davys also discussed the importance of having the education sector represented on the SWRB. She described that the previous president had been a representative on the SWRB and when she vacated that position there was no assurance that education would continue to be represented, "and so [we made] representation both to the Minister and to the SWRB about the importance of the education sector having a voice on the SWRB".

The relationship with SWRB continued to be of prime importance. During McNabb's tenure, Jan Duke from the SWRB routinely attended CSWEANZ meetings:

> Every meeting [we] meet with the SWRB officials and again we try and collaborate. I think we do fairly well most of the time. The tension is that they're our regulator as well, so in the end they come in and tell you what they demand to keep your recognition as a programme.... Sometimes different programmes are not happy with some aspect of the SWRB, or how the recognition of a programme's gone, or how some policy's been interpreted. So again, we try and address that, either in the Council, or individually. (McNabb)

McNabb also reflected that the Council welcomed the establishment of the Tangata Whenua Social Workers Association (TWSWA) as another important relationship to develop.

The Council consistently sent representatives to the Social Work "Alliance" Group which had been established to network key stakeholders in the professional social work space. Fraser describes this:

> Throughout 2017–2018 CSWEANZ also continued its presence on the "Alliance". This had begun as a network of "peak" social work bodies made up of representatives from CSWEANZ, ANZASW, TWSWA, SWRB, and the Social Services ITO. Over time, membership broadened to include the [Public Services Association] PSA and many of the bigger social work employers including [Oranga Tamariki] OT, Health, Non-government Organisations [NGOs], etc.

Another important relationship that has evolved is that of the Council and the statutory child welfare organisation. ANZASWE archives hold a "Memorandum of Collaboration" signed by Rennie and Paula Tyler of Child Youth and Family Services (CYFS)[3] in February of 2005. Other records include minutes from meetings between the two organisations. Davys also recalled:

> … we instigated regular meetings with the then new chief social worker … there was a process [for that] to be a regular meeting, it didn't necessarily happen ...

> it was about negotiating relationships; [about] establishing the credibility of social work education with those other broader committees.

This relationship has fluctuated and has, at times, seen the sides being dichotomised as the needs of the employers and the importance of academic freedom and critical thinking. Ballantyne described some of these ongoing tensions:

> It's important for our students and for academic staff to take a critical stance towards employing organisations. Partly because the State is a problem for the people we work for, our service users, our clients. And some of the actions of the State and some [State] social policies need to be critically reviewed. And the agencies of the State, including organisations like Oranga Tamariki, as we've seen recently, can be part of the problem. So, the idea that we all have to be a partnership is one thing, but [being] subordinate to the views of employers needs to be resisted.

At various points over the years, members of the Council have met with social work leaders of District Health Boards. Adamson attended the March 2006 annual meeting of the District Health Board (DHB) Social Work Leaders Council and following this it was proposed that the Council appoint a liaison to attend the annual DHB leaders meeting (Rennie, correspondence April 3rd, 2006 to Michelle Derrett, Working Party Co-ordinator DHB Social Work Leaders Group).

The relationship between CSWEANZ and the SWRB continues to evolve. Ballantyne (president 2019–2020) described some of the current and future issues: "they're in the middle of looking again at programme recognition standards and this new workforce planning document, and they've got a role now in … workforce planning" (see for example, https://swrb.govt.nz/workforce-survey/).

Another issue being considered is the move by the SWRB towards charging increased fees to programmes for regulatory processes. Ballantyne commented:

> [T]here was not much we seem to be able to do, apart from concede. So, one of the conversations we [the Council] were having today is "Is that the best we can do? What can we do to stand together? How can we hold the SWRB to account as users of their services as much as people are subject to their conditions?"

At the time of publication, the SWRB is currently engaged in reviewing its Education Programme Recognition Standards and CSWEANZ should have a role to play in that process.

Internal relationships

Rennie believed that, during his tenure, relationships between the polytechnic and university schools within the Council were good. While there may have been different foci for each of them:

> After a while the universities saw themselves as taking a different approach to some of what was going on, you know their programmes were probably more research based [and] I always saw the differences between the programmes as opportunities.

Adamson described the interesting relationships that exist(ed) within members of the Council, who were often competing for the same share of student enrolment:

> We were all independent and in many ways we're competitors but we were trying to work collaboratively on behalf of social work education, on behalf of social work, and therefore the communities, and the students. And so, there's always that push-me pull-you tension between firstly trying to collaborate, which means that we have to

> agree on things, we have to have robust debate, [and] some sense of direction.

This was reiterated by Fraser, who remembered that "when I first started attending the CSWEANZ meetings … back in about 2006, there was quite a split at times, with some distrust and frustrations between the different institutions". Similarly, Davys recalled:

> [T]here was always a tension between the universities and the polytechnics and the wānanga. Sometimes that tension was [overt] and often it was exacerbated, because there was a time when in fact the universities would go and talk as a group, and then the polytechnics would go and talk as a group and there was a certain sort of divide there.

The requirement for a four-year BSW, mentioned previously, also placed stress on Council relationships. By the time that McNabb took office in 2014, all programmes were required by the SWRB to have four-year undergraduate degrees. McNabb considered that tension:

> I think that's faded hugely. Maybe it's a combination of some of the mix of who is around the table, you've had some people who've been staff in both institutions people like Wheturangi [Walsh-Tapiata] who were a long time at Massey [University] and [then] with the Wānanga.... I think has probably just helped even out the sense of "look we're all educating together and we're on this track".

Fraser related how, during her tenure, there were some contentious issues that had brought the Council together (including the requirement for staff to have at least a master's qualification and concerns around employers being able to identify who was "doing social work" in the proposed mandatory registration bill).

> We were all concerned about the same things which gave us a common focus and drive. I think because it was all so relevant and concerning it meant that we had really good representation at every Council meeting—people did make the effort to get there and to have their say, so that was really good.

The unification of the Council continued with Ballantyne noting that the social work programmes appear to be working better together with common challenges from the regulator outweighing competition between educators:

> One of the things about the new political order has been a move away from competitiveness between organisations that are still there. I think the managers of these organisations still see themselves in competition … but it has seemed less intense and so I found there to be a greater willingness … to collaborate. I think that would be just the very, very beginning stages of that and I think we can do a lot more to work together.

Bicultural commitments

Reflecting the bicultural imperatives identified within the broader social work profession, the General object of the 2004 and 2014 versions of the Constitution indicate that the Council's mandate was:

> To ensure that social work education is in accordance with the articles of Te Tiriti O Waitangi, with a commitment to promote an indigenous identity for social work education in Aotearoa-New Zealand. (ANZASWE, 2004, 3(point ii), p. 1; CSWEANZ, 2014, 3(b) p. 1)

How this was demonstrated within the Council was an issue for ongoing discussions.

The Council

Despite the constitutional mandate, there was initially no requirement for Tangata

Whenua representation on the Council executive. This was amended by 2014, with the introduction of a statement on Māori representation in the current constitution:

> It is desirable, under the principles of Te Tiriti o Waitangi for at least one member of the Executive to be Tangata Whenua. If no member of the Executive is Tangata Whenua, then the Executive will ensure that consultation with a Māori member and/or representative of CSWEANZ shall occur. (CSWEANZ, 2014, 7(a), p. 3)

There is communication from ANZASWE (December, 2002) to Rongo Wetere and Rory Truell (then Te Wānanga o Aotearoa chief executive and director of the School of Applied Social Sciences, respectively), inviting them to meet with Rennie to discuss the Wānanga's membership on the Council. Records from 2004 indicate that Te Wānanga o Aotearoa was by then represented on the Council. Te Wānanga o Raukawa also came onto the Council at a later date. Having these wānanga on Council was beneficial to the Council as a whole, but Tangata Whenua members likely experienced the pressure of having to "educate" other institutions and "hold the line" in terms of the Council's bicultural and treaty commitments (author one and two's observations).

The position of president has seldom been contested at the AGM, and, on more than one occasion, the sitting president has remained in the role for more than one term as there have been no other people indicating an interest in this role. While there is aspiration for having Tangata Whenua in the president role, it is author one and two's observation that Tangata Whenua Council members are often overburdened by multiple roles and expectations.

Fraser indicated an ongoing concern around Māori representation on Council:

> When I first started attending, we were nearly all Pākehā New Zealanders, and predominantly women. While it is a concern that Māori social work educators remain under-represented, we are much more diverse culturally now I think, which has got to be good.

Staffing and curriculum

Council meetings have often focused on staffing issues for education providers, including appropriate cultural representation. Rennie indicated that it had been difficult for many of the institutions represented on the Council to recruit Māori staff:

> Some of us struggled to find suitable Māori staff but of course the, under the Treaty, it wasn't just a question of having Māori staff it was also about Pākehā staff and Pākehā students being aware of the Treaty.

This was reinforced by McNabb:

> I used to think [the staffing difficulty] was just in the non-university area but I've heard from some universities that they too are struggling, needing to have PhD qualified staff to be in the university sector but covering all these other bases too; social work registered, needing a practice base, being research active, having teaching ability, teaching competence and "oh by the way having finished your PhD and being onto your next project" is a huge one. And then when you say "oh we want Māori staff or staff who've got competence to teach Māori models of practice, bring that perspective and have that knowledge" is huge, much less Pasifika, much less some of the other refugee migrant background communities that people can represent.

McNabb described how people like Wheturangi Walsh Tapiata and Shirley Ikkala bridged various institutions and provided challenges regarding the social work education sector and the ability to train social workers to work competently with Māori. McNabb considered the role that such people played on CSWEANZ in the Wānanga's kaupapa approach and:

> How they might be sharing that … with non-wānanga programmes, which is the majority of programmes around the country. Who arguably could all improve how we educate, how we run our programmes for graduates to be better equipped to work with Māori and [stronger] analysis around our Treaty commitment and bicultural commitment. I think that's a huge opportunity and I see the Council as a vehicle to help make that happen.

Decolonising of social work education

There remains much to do around decolonising social work practice and education in Aotearoa (McNabb, 2019), and the Council understands they should play an active role in this process. Ballantyne echoes Adamson's earlier statement on solidarity:

> How does the Council connect with those bicultural processes in a more routine way than we have been doing? In decolonising the curriculum and doing that in a positive productive way in partnership with our colleagues in the wānanga. There are some conversations in the Council about that now … we could lead the way … we use the words all the time, but it's actually quite painstaking work to do this properly. There is no point in people reinventing the wheel at every institution, each time competing with each other, about which one of us does it best. The only way to do it is collectively and in partnership with our wānanga colleagues.

Resource issues

Resourcing has been an ongoing issue for the Council, both in terms of its own operation, and in its advocacy for social work education.

Internal

The Council has never been funded other than through membership fees paid by the institutions belonging to it. Rennie, who was in term for nine years, describes that his involvement as chair and some of the administrative functions were essentially subsidised by his employer:

> I [stayed] for so long because I was lucky enough to have a PA [personal assistant] for a lot of that time so [as Head of School for Unitec], so it meant that the paper kept flowing as a result of that, because it's very easy to take on these things, but if you haven't got some help it can become just another job really.

All roles within the Council are done on a voluntary basis. Adamson described this in relation to the Australian social work educators' counterpart:

> We do any of the roles with what is now CSWEANZ on top of our day jobs.... In comparison for example, the social work educators in Australia have a small amount of admin support that they pay for out of their membership. It's currently four hours a week or [more] and it's going up, but that runs a website [and they've] got a journal, we don't. We're a lot smaller, more amateurish in that sense.

External

Review of social work minutes and correspondence indicate that, since its inception, the Council has been advocating for changes to social work education funding in Aotearoa New Zealand . Funding of tertiary programmes is calculated according to different rates. While other professional programmes such as nursing, teaching and medicine are funded at rates that recognise the increased costs associated with practicum, social work education is funded at the same rate as other social sciences. For 2022, social work is $6,589, teaching is

$10,475, and engineering and health sciences is $12,118 per EFT (Tertiary Education Commission [TEC], 2022). While this low rate of funding impacts on all aspects of social work education, it is most keenly felt in relation to being able to locate and sustain quality placements for students. Kathryn Hay, field education sub-committee long-term chair, discussed the impact of low funding rates:

> What it means is that social work education is not funded to support students on placement, and that means that we can't pay agencies, that we have really limited money to be able to go and visit students as many times as we might want to. To an extent that might also limit the resourcing of staff inside the tertiary provider as well, so if we had different funding … then we could do a lot more to strengthen field education.

International association

There has always been a strong relationship between the Council and its international parent bodies. The Council has maintained membership in the regional and international educators' associations, and these memberships are the major costs associated with the organisation. Having all of the social work schools in Aotearoa New Zealand be members of CSWEANZ and be paid members of IASSW ensured each school paid a reduced rate for bulk membership and that there was a spot on the Board of IASSW for Aotearoa. Various Council members have represented Aotearoa on IASSW and other international bodies.

Rennie was a board member of IASSW from 1997 to 2010 and served as treasurer of that organisation from 2004 to 2010. Mark Henrickson (CSWEANZ member 2009–2014) was on the IASSW Board from 2012–2018 serving in a number of roles including Asia Pacific representative (2010–2014), NZ reprepresentative (2012–2014), and treasurer (2014– 2018). He represented the Asia Pacific region of IASSW on the Joint Committee on the Definition of Social Work as well as the revision of Global SW Statement of Ethical Priniciples (2014–2018). McNabb was CSWEANZ representative on IASSW from 2015 and remains in post to date. Barbara Staniforth coordinated the Asia Pacific Amplification of the Global Definition of Social work for APASWE, alongside Miriama Scott, for the International Federation of Social Workers Asia-Pacific (IFAP) from 2014 to 2016. Tracie Mafile'o holds an ongoing role as an APASWE Board member (since 2017). CSWEANZ also supported the establishment of the Social Work Resource Centre of Oceania under the auspices of IASSW to build Pacific capacity for social work education (Mafile'o, 2019), for which Mafile'o is coordinator.

Recently there has been concern expressed about the cost of membership in the IASSW and APASWE. Ballantyne described some of the recent questions that have been raised as to how Council funds are spent:

> … and it [being a member of IASSW] is something that's good to do but … it was consuming more than two thirds of our budget … and we were acting as collection agents for the International Association. And was that really what we should be doing and did it take away from … organising conferences and events for us here in Aotearoa, or developing ideas and position papers and so on?

Fraser maintained:

> Throughout the two years I was president there was a strong commitment across Council for all our schools to be members of the International Association so that we could have a seat on the executive. I know that there is now some debate about this, given the cost of it. To me it was unbelievably valuable for us as a profession in small, somewhat isolated, country to have a strong voice on the international stage.

CSWEANZ has also maintained a relationship with different Australian bodies. Briggs described that when she was president of the Council that she sat as the Aotearoa representative on the Australian Council for Heads of School. After Briggs became part of the Australian Heads of School group, the relationship was strengthened, "we actually changed the name to [Australia New Zealand Association of Social Work Educators] which includes a New Zealand representative and so there's a bit more binding of the two Councils".

Another relationship has existed between CSWEANZ members and Australian and New Zealand Social Work and Welfare Education and Research (ANZSWWER)[4] which is an independent commentator on social work and welfare education with membership from social work and welfare educators, field supervisors, practitioners and students in Australia and New Zealand. Among other things, ANZSWWER produces a peer-reviewed journal, *Advances in Social Work and Welfare Education,* twice a year. Council members, Liz Beddoe, and then Adamson, have been editors of this journal. This role provided membership on the Executive on the Board of ANZSWWER.

Changes

It appears likely that there are changes in the wind regarding CSWEANZ. As many organisations experienced during the Covid-19 crisis, the ways that the Council has communicated have shifted. Under Ballantyne's presidency, there was an increased use of technology, including establishment of the CSWEANZ website, and the use of Loomio to communicate. While CSWEANZ usually met three times a year, this was not possible during the pandemic. Ballantyne described the use of the new platform:

> We found a way of continuing our business, we've moved on to an … asynchronous discussion called Loomio. And we've had most of the business there and extending the meeting over two weeks of people dropping in and out and then concluded up with a Zoom meeting just to wash up and see if there's anything left … and people were quite pleased that they got on board with it … I acknowledge it doesn't replace … kanohi ki te kanohi [face-to-face] meetings, that's always important, but as a supplement to it.

There are some significant changes occurring in the education sector, with the polytechnics coming under the umbrella of a parent organisation—Te Pukenga / New Zealand Institute of Skills and Technology (NZIST)—with a convergence of social work programmes slated for 2023. This will shift social work education, and also the composition of CSWEANZ, requiring flexibility, which Ballantyne considered:

> [T]here's a growing recognition that we … need to have a good long hard look at ourselves and decide on what our mission is, how we want to shape ourselves for the future…

Conclusion

This article has provided an overview of some of the key recollections from each Council president since its commencement in the 1990s. Put together and set within the contexts of time and place, the interviews have provided a rich repository of some of the key issues that have impacted upon social work education in the past 25 years. Registration, relationships, resources, and responding to bicultural mandates tell some of the story of social work in this country.

While the Council was initially concerned with early course accreditation, it was clear, from the interviews and archives, that responding to the proposals and requirements of social work registration have preoccupied the Council. With mandatory registration now achieved, there remain further policy / scope of practice issues to address.

Relationships within the Council have shifted over time with universities, polytechnics, wānanga and PTEs at the same table and often competing for the same students. With the polytechnic programmes soon to come under the same provider, it will be interesting to see how relationships and power shift within the Council. Relationships with external bodies such as the child welfare organisation, health boards, or the SWRB have been a focus, and all presidents spoke about the importance of these.

The Council has relied strictly on the membership fees paid by the various Council members, with no other funding sources. This has likely impacted upon the scope of the Council to engage in some of its objectives, such as encouraging research or hosting conferences. The lack of funding for any administration of the Council is of concern. The archiving of documents about the Council has only occured as a result of this research project and information is not currently stored in an accessible and searchable data base. With staff churn and increased stress upon the tertiary social work programmes due to Covid-19 and other factors, there has been inconsistent membership of the Council and it has been difficult to fill executive positions, including that of secretary. This is likely to lead to further gaps in the historical record occuring.

While strong links and relationships have existed with international bodies, this is in question now as the Council grapples with the high cost of membership in these associated bodies. The other key resourcing issue that the Council has attempted to change is increasing the funding per EFT for social work education, decided upon by TEC. To date they have had no success, but this remains an important goal.

Finally, one of the most important areas for consideration is how social work education and the Council respond to the imperatives of biculturalism and decolonisation as mandated by Te Tiriti o Waitangi.

The Council has provided an important forum for social work educators to come together and attend to the various objectives outlined in its constitutions. Social work education continues to evolve and it will be interesting to see how the Council responds to ensure that it is fit for purpose.

Notes

1 While the leader of the field education sub-committee from 2006–2016, Kath Hay, was initially interviewed for this article, material from that interview will be mainly presented in a subsequent article on the Council's field education sub-committee.

2 Research interviews were completed in 2020 and the current president is Dominic Chilvers who was not interviewed.

3 The statutory child protection and welfare services in Aotearoa New Zealand have undergone a number of reviews, ministerial reshuffles, rebrandings, and name changes over the years including: The Child Welfare Division of the Department of Education (1925–1972); Social Security Department (1939–1972); Department of Social Welfare (DSW) (1972–1992); Children and Young Persons Service (CYPS) (1992–1999); Child Youth and Family Services (CYFS) (1999–2006); Child Youth and Family (CYF) (2006–2017); Ministry for Vulnerable Children (Oranga Tamariki (April 2017–October 2017); Oranga Tamariki (OT) Ministry for Children (October 2017–present).

4 ANZSWWER was previously known as the Australian Association for Social Work and Welfare Education (AASWWE).

Submitted 25 October 2021

Accepted 18 March 2022

Published 13 May 2022

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ORIGINAL ARTICLE

THEORETICAL RESEARCH

Social work student hardship:
A review of the literature

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ABSTRACT

INTRODUCTION: Student hardship in social work has become the subject of research in recent years. Social work students face particular challenges because of the financial, social and emotional demands of long, unpaid, clinical placements.

APPROACH: This article reports on a literature review conducted prior to a mixed-methods study commenced in 2019. This review informed the development of a survey of social work students and recent graduates and a set of qualitative interviews that will be reported elsewhere. A further review was conducted in July 2021 to inform the analysis.

FINDINGS: A recurring theme throughout much of the reviewed social work literature examined for this project has been the intensity of struggle that students face in their study. Across the reviewed literature, students, educators, and researchers suggest interventions to reduce hardship. Gaps remain in our understanding of the intersectional factors of ethnicity, gender and disability and, in particular, the impact on Aotearoa New Zealand students.

KEYWORDS: Student hardship; student wellbeing; social work students; social work education

AOTEAROA
NEW ZEALAND SOCIAL
WORK *34(1)*, 22–35.

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Students in Aotearoa New Zealand are struggling (Gharibi, 2018). The continuation of neoliberal economic policy has seen the corporatisation of tertiary institutions and an ensuing shift away from supporting student learning and towards treating education as an economic equation (Strauss & Hunter, 2018). Strauss and Hunter (2018) posit that this is due to the dominant neoliberal ideology of "individual responsibility, privatisation, competition and performance-based accountability" (p. 880) which favours a small, tightly regulated public sector. Similarly in Australia, Thornton (2016) argued that the unending push for higher profit and lower investment reflects that these institutions have become a private, rather than a public, good. The high barriers to accessing student income support forces many to borrow money through the student loan scheme, or to undertake paid work, and even this is often insufficient to meet their financial needs (Gharibi, 2018). Beyond Aotearoa New Zealand, although reflecting a similar economic and political environment, Gair and Baglow (2018a, 2018b) and Landstedt et al. (2017) drew attention to the casualisation of employment and the calculated erosion of workers' rights as part of the economic landscape that students must grapple with. This has led to student hardship across several axes—financial difficulties, stress on family as they struggle with parenting or care responsibilities, and negative impacts on health and wellbeing as students are stretched between competing aspects of their lives without reliable institutional support.

The demands of professional placements on social work students are particularly challenging and can exacerbate the hardship many are already experiencing. Despite widening access to students from working-class and diverse ethnic and cultural backgrounds, tertiary institutions around the world remain places of inequality (Curtis et al., 2012; Gair & Baglow, 2018c; Hosken, 2018a, 2018b; Michell et al., 2017; Thornton, 2016). While many social work educators are committed to social justice and equity among their students, there is "little evidence that educators, universities or professional bodies are hearing tertiary students' voices and working collaboratively with them for change" (Gair & Baglow, 2018c, p. 213, 2018a, 2018b, 2018c). Thornton (2016) argued that the political and economic environment, as well as the tertiary education sector, require serious reform for students to be well-supported, healthy, and financially secure.

This article reports the findings of a literature review conducted first in 2019. The review sought to identify published research on social work student hardship in Aotearoa and elsewhere. There was significant research reported in Australia but little specifically about social work students in Aotearoa New Zealand. Themes developed from the review included income support; debt and financial hardship; the impact of caregiving responsibilities; health and wellbeing; class and ethnicity, and the impact of placements on students' wellbeing. This review informed the development of a survey of social work students and recent graduates and a set of qualitative interviews that will be reported elsewhere. A further review was conducted in July 2021 to inform the analysis. A final section reviews the arguments in the literature for change in social work education.

FINDINGS

Income support, debt and hardship

In 2018, 335,000 domestic students were enrolled in tertiary education in Aotearoa New Zealand (Ministry of Education [MOE], 2019, p. 1), with 154,608 drawing from the national student loan scheme (p. 24). In 2019, the median debt for people leaving tertiary education was $31,960 for those who completed a bachelor's degree, and $38,060 for a postgraduate degree (MoE, 2019). In 2019, 2927 social work students were enrolled in Aotearoa New Zealand; a breakdown of these students by age, ethnicity and gender is provided in Tables 1 and 2 (data from Social Workers Registration Board, (SWRB) 2019). The majority of these students are full time and most are likely to have student loans, although this information is not available.

Table 1. Aotearoa New Zealand Social Work Students 2019 by Gender/Age

Female	2544 = *86.91%*
Male	375 = *12.81%*
Gender diverse	7 = *0.24%*
Not identified	1 = *0.04%*
24 or younger	919 = *31.40%*
25 to 29	547 = *18.69%*
30 to 39	698 = *23.85%*
40 to 49	521 = *17.80%*
50 to 59	217 = *7.41%*
60 or older	25 = *0.85%*

Source: Social Work Education Providers: Annual Report 2019 (SWRB, 2019).

In their research analysing interviews with 70 tertiary students from around Aotearoa New Zealand in 2014–2015, Nissen et al. (2019) asserted that, although student debt is often considered to be "good debt", many students feel shame and stigma about their debt and anxiety about how it will impact on their future. Some students described their debt as "painful", "eye-watering", "scary", "astronomical", or "unreal" (pp. 250–251) with one participant saying her debt made her feel 'weak, a bit sick and quite panicky' (p. 250).

Unrau et al. (2019) also found that 86% of their American social work student

Table 2. Social Work Students 2019 by Ethnicity

Māori	864 = *29.52%*
New Zealand European/Pākehā	1399 = *47.80%*
British/Irish	77 = *2.63%*
Other European	71 = *2.43%*
Australian	32 = *1.09%*
Samoan	200 = *6.83%*
Cook Island Māori	76 = *2.60%*
Tongan	127 = *4.34%*
Niuean	69 = *2.36%*
Tokelauan	12 = *0.41%*
Fijian	41 = *1.40%*
Other Pacific Islander	38 = *1.30%*
South East Asian	16 = *0.55%*
Chinese	39 = *1.33%*
Indian	65 = *2.22%*
Sri Lankan	5 = *0.17%*
Japanese	8 = *0.27%*
Korean	12 = *0.41%*
Other Asian	39 = *1.33%*
Middle Eastern	12 = *0.41%*
Latin American	9 = *0.31%*
African	48 = *1.64%*
Other	59 = *2.02%*

Source: Social Work Education Providers: Annual Report 2019 (SWRB, 2019).

participants ($n = 357$) had multiple debts from student loans, credit cards, personal loans and two-thirds of the students found their student debt unmanageable. Food-insecure social work students were more likely to have more loan debt than those food-secure students (Miles et al., 2017). Additionally, women were 1.7 times more likely than men to consider their debt unmanageable, while single parents were 1.4 times more likely than non-single parents to find the same. There were smaller, but still notable, differences between people who were the first in their family to attend university when compared to their peers. Similarly, there were clear differences between age groups, with increasing age correlating with perceived unmanageability of debt. This reflects the findings of Baglow and Gair (2019), who found that Australian social work students over 25 were more likely to be struggling financially compared with their younger peers. Earlier Australian research reported that mature-aged students were more likely to live in a lower income area and work part-time during their studies and furthermore were less likely to be employed before completing their courses (and after) in the first year of graduation than younger students (Heagney & Benson, 2017).

Student debt thus exacerbates financial inequality between groups, in contrast to the dominant neoliberal ideology that asserts debt is tied to individual behaviour (Nissen et al., 2019). Nissen et al. (2019) stressed that this individualist approach to student debt obfuscates the political and economic forces that have shaped reliance on student loans when accessing tertiary education. The debt accrued in education is then carried forward into their careers as social workers. Unrau et al. (2019) drew attention to the contradictory reality that social workers are often working with clients who are subject to economic injustice yet are struggling with personal debt of "crisis proportions" (p. 14) because of their professional education.

Family and community responsibilities and hardship

Balancing family responsibilities with study was a common theme throughout the literature, particularly for students who are caring for others. Students with children can face serious challenges when trying to split their time between study and parenting, and report feeling guilty about having to sacrifice family time and commitment (Agllias et al., 2016; Hulme-Moir, 2022). Tones et al. (2009) found that students aged between 35 and 44 were the most likely to struggle balancing family obligations and study. Mature students in general had to carefully divide their time, with one respondent saying, "when you've got an assignment due tomorrow and you've got three kids you cannot say 'well kids, you cannot have dinner tonight', you've got to cook" (Tones et al., 2009, p. 509). In a study of 2320 Australian social work students, Baglow and Gair (2019) found that there were clear differences between younger students (*n* = 819) and students over 25 (*n* = 1501) regarding family responsibilities. A total of 41% of mature students agreed that parenting or other family duties impacted their studies "a lot or greatly" compared to 15% of younger students. Even more stark was the finding that students over 25 were 20 times more likely to have to pay regularly for childcare than their younger peers. Mature-aged students may have additional hurdles to enter higher education due to their complex circumstances than younger students. Heagney and Benson's (2017) study compared the access rates to higher education among lower socio-economic backgrounds from 2007 to 2013 provided by the Department of Education and Training in Australia. The data showed the number of entry-level students aged over 25 years did not increase, while students below 25 years have steadily increased during the period.

Students with parenting and broader family responsibilities self-reported having poorer academic grades than their peers (Ryan et al., 2011). Of those with children, 41% said parenting commitments impacted on their studies, with more than half of those stating their studies were impacted "a lot" or "greatly". In particular, mothers said that appropriate family support while they were studying posed a problem, reflecting the gendered divisions of family responsibilities in wider society. In their research with working-class Australian women in social science degrees, Fraser et al. (2016) and Michell et al. (2017) found that, although the participation of women attending tertiary education had changed positively over time, some mature female students still faced entrenched discriminatory attitudes from family and friends. Mature-aged, first-in-family women may face several challenges. In a study of motivation and persistence behaviours of five mature-aged women from first-in-family backgrounds, Delahunty and O'Shea (2021) found that their conception of possible self was shaped by family history and was compounded by traditional gender positionality. Their earlier work decisions were reflected by gendered expectations—lower-paying female occupations such as retail, banking, and administration. Despite hardship during their studies in higher education, they rarely lacked motivation and were persistent in transforming from their possible self to define a future self through university learning experiences (Delahunty & O'Shea, 2021).

The added stress of materially providing for children is articulated by one research respondent, who said they often go without so their children are "taken care of in relation to food and medication" (Gair & Baglow, 2018a, p. 39). Women with children may feel burdened supporting themselves and their children. Miles et al.'s (2017) study reported that a third of students had at least one child under 18 living in their households and that, in the previous 12 months, 35% of students had *sometimes* worried about running out of food, and 15% of students had *often* worried about food running out. It is absolutely vital that women with caregiving duties receive both interpersonal and financial support (Michell et al., 2017).

An extensive literature review by Hemy et al. (2016) on the struggles of social work students attending placement pointed to a dynamic of both family stress and family support. Despite the pressure to juggle responsibilities, many students found their whānau, friends, or communities a source of support and inspiration for their studies (Hemy et al., 2016; Michell et al., 2017). Findings from Martin (2010), in her study of Australian university students who had experienced mental distress during their studies, showed around 28% of respondents considered family and friends to be the most supportive elements in their lives. Similarly, a study of social work students at a Canadian university found students were more likely to draw support from family or friends than from professionals or services (Reid & Poole, 2013). In contrast, Collins et al. (2010), and Fraser et al. (2016) found mixed results in perceived levels of support from spouses, partners, relatives, and friends. Some authors argued that combined support from family, friends, peers, communities, and institutions can bring positive outcomes (Meadows et al., 2020). Peers in the course are an additional significant source of support as they can discuss course-related and personal issues with others with similar experiences (Heagney & Benson, 2017). However, struggling students may not reach out for support. Considine et al. (2020) found in their study that social work students without a bursary felt social isolation and exclusion as they did not have time to arrange to meet their peers outside of the course due to engaging in paid work.

Broader cultural, religious, and community obligations can come into conflict with the demands of university education. Students can feel torn between their different roles, and some reported feeling like they were neglecting responsibilities and traditions because of the words or actions of family members (Agllias et al., 2016).

Health, wellbeing and hardship

This ongoing tension between the different facets of student life can have a detrimental effect on health and wellbeing (Collins et al., 2010; Gair & Baglow, 2018a, 2018b; Landstedt et al., 2017; Martin, 2010; McAuliffe et al., 2013). The accumulated stress of years of financial hardship and forgoing necessities to survive can cause or exacerbate mental distress (Gair & Baglow, 2018a, 2018b; Landstedt et al., 2017). A two-year longitudinal study of 454 British undergraduate students found that greater financial stress was linked to higher rates of stress, depression, anxiety, and alcohol dependence at baseline (Richardson et al., 2016). Both Richardson et al. (2016) and Unrau et al. (2019) suggest that the *perceived* relationship between student debt and mental health is more important than the actual level of debt when understanding student distress. Debt may threaten not only students' psychological, but physical, safety. Miles et al.'s (2017) study showed that 72% of food-insecure students were more likely to not be able to afford to see a doctor due to financial barriers in comparison with food-secure students (28%).

Students who are coping with illness, disability, or mental distress can struggle to meet deadlines and face penalties or exclusion without adequate support (Martin, 2010). The *Kei te Pai? Report on Student Mental Health in Aotearoa* survey, which had 1762 respondents from universities across Aotearoa New Zealand, found that the mean level of psychological distress according to the Kessler Psychological Distress Scale was 28.1, indicating a moderate level of distress (Gharibi, 2018). This was not distributed evenly across all groups—gender-diverse people, people with disabilities, and non-heterosexual people were significantly more distressed than their peers. Sexual and gender minority (SGM) groups should be included in analysis of student hardship in higher education as these students face higher rates of stress, greater financial concerns and lower social support than heterosexual peers in higher education (Holloway et al., 2019). Studies by Gair and Baglow (2018a, 2018b) found that social work students, in particular, experience an increased financial hardship, and the balancing act of study, paid work and other commitments impact mental health vulnerability by undertaking the required, mostly unpaid, placements.

Students can feel unsafe or uncomfortable when deciding whether to disclose illness, disability, or mental distress to their lecturers, tutors, and other people in positions of power over their studies and future careers, as well as to their peers (Martin, 2010; Newcomb et al., 2017). Because of the stigma associated with accessing mental healthcare, participants in an Australian study of social work and human services students constructed service users as "others", people to be "studied and attended upon rather than members of the student body" (Newcomb et al., 2017, p. 686). A study of postgraduate social work students and their attitudes towards people with serious mental illness (schizophrenia, bipolar disorder, or major depression) found that more than half of these students would not want someone with a serious mental illness to babysit their children or marry into their family (Corravubias & Han, 2011). However, Corravubias and Han (2011) noted that this stigma was less likely in people with friends or family who had experienced serious mental illness. Educational interventions, which included videos, discussion groups, and meeting and talking to people who had experienced mental illness was shown to reduce stigma amongst a cohort of Spanish social work students (Rubio-Valera et al., 2016). Leadership from social work lecturers and tutors who have experienced mental distress is a crucial factor in normalising living with mental illness (Reid & Poole, 2013; Todd et al., 2019).

Stigma about mental distress, which is largely influenced by students' cultural and social environments, is likely a critical reason why many are reluctant to disclose and seek help from university or other mental health services (Meadows et al., 2020; Newcomb et al., 2017). United Kingdom findings showed that students often seek help from their family, friends and peers rather than institutions, and thus were reluctant to seek help from all available sources (Heagney & Benson, 2017). Some students are un willing to ask for assistance as they see themselves as the helper, not the helped (Meadows et al., 2020). Research by Martin (2010) showed that nearly one-third of participants had not disclosed their mental health needs because they were worried others might think they were lying, wanted special privileges, or were not really "bad enough" (p. 265). A participant in research by Reid and Poole (2013) said that, after disclosing their mental health status on the first day of placement they were told by their field educator they should find another line of work. Supporting social work students who are struggling with their mental health can be complex (Todd et al., 2019). Balancing the rights of students with disabilities that may make academic or practice-based achievement difficult must, of course, be weighed against the rights of clients to receive competent and safe care, as well as satisfying professional regulations. Todd et al. (2019) cautiously suggested reflective questioning for social work educators that refocuses competency around fitness to practise rather than biomedical diagnostic labels.

Support services in tertiary institutions have often been experienced as unhelpful or even detrimental to students' mental and emotional wellbeing (Martin, 2010; Newcomb et al., 2017; Reid & Poole, 2013), while others found these services were not available when they needed them (Tones et al., 2009). One student in Martin's (2010) study was told they could not access mental healthcare through their university because "there were too many students who needed the service more" (p. 269), revealing the effects of austerity. More than a third of respondents in Aotearoa New Zealand waited two weeks or longer for an appointment with university mental health support (Gharibi, 2018). This is particularly important when considering that many students cannot afford mental healthcare outside of subsidised or free university services (Gair & Baglow, 2018a).

Class, ethnicity and hardship

In exploring the impact of financial strain, juggling family and community responsibilities, it is apparent these struggles were not experienced equally across all student groups. The structural inequities of the wider world—including, but not limited to, wealth, ethnicity and gender—shape student experiences in social work education. Reflecting the highly gendered social work workforce, many of the findings of this review illustrate struggles that are particularly felt by women, however, class and race have been less frequently analysed. Unrau et al. (2019) found that students who were struggling financially were more likely to be a single parent, a non-white student, a first-generation student, to have been through the child care and protection system, or to have been previously homeless. Investigating the impact of regulation on social work education, Hosken (2018a, 2018b) argued that the rigid expectations of the Australian Association of Social Workers (AASW) and tertiary institutions, requiring 1000 hours of unpaid professional placements, deepens the class schism between who can become a social worker and who cannot. One participant in Hosken's (2018a) ethnographic research, a lecturer in a BSW programme, said that "[s]ome students from working-class areas in our local community, asked if the AASW just wanted social work students from wealthy families who had gone to elite schools" (p. 15). This same participant revealed that an AASW representative told her that "if people cannot afford to undertake the course, they probably should not study" (p. 16), illustrating the ideological justifications that help perpetuate structural injustice. As well as the financial and interpersonal struggles that students from working-class and poor backgrounds face in accessing tertiary education, some students report feeling out of place and like "an imposter" (Michell et al., 2017, p. 184).

In their Kaupapa Māori research of Indigenous students studying towards entering the health workforce, Curtis et al. (2012) asserted that Indigenous students face additional barriers in accessing tertiary education. As well as unequal rates of academic achievement that make it less likely that Indigenous students will enter higher education, those who do will probably attend a culturally alienating non-Indigenous, "foreign and unfriendly environment" (p. 10). Students with learning difficulties from minority backgrounds may experience disadvantages in relation to race and gender. An English study of the effect of learning difficulties, ethnicity and gender on the completion of a social work degree, found that the intersection between race, gender and learning difficulty impacts on academic performance (Liu, 2017). Black female students with learning disabilities were at higher risk of incompletion compounded by inadequate supports from their educational institutions (Liu, 2017). Research has also provided evidence of the additional challenges posed by Indigenous social work students (Pallas et al., 2022; Zuchowski et al., 2013). In a small Australian study with 11 Aboriginal and Torres Strait Islander social workers and social work students, Zuchowski et al. (2013) found that the racism endured by Indigenous people during their social work education reflected their broader life experiences. The structural, systemic, and interpersonal racism and violence that Aboriginal and Torres Strait Islander people have been (and are) subjected to in health, justice, and child protection made placements in these areas very difficult for some students. When participants raised issues of racism and discrimination in the classroom and on placement, they were dismissed or disbelieved. For some participants, these ordeals were "intensified by prior experiences of racism and violence" (p. 56). Indigenous students in this research faced the contradictory pressures of being cast in the role of an "expert" on the lives, languages, and traditions of *all* Indigenous clients, while having their cultural knowledge dismissed. Hosken (2018b) draws attention to the contradiction of the espoused professional commitment to equity and diversity and a curriculum that is overwhelmingly Western. She asserts that students from minority ethnic and cultural groups do not see their "knowledge, culture or experiences reflected in positive or normative ways" in social work classroom or field education (p. 832).

In Aotearoa, most social work students are women (averaging about 86%) as reported by the SWRB (2019) and the efforts of widening participation have led to more students from diverse backgrounds, leading to disadvantage at the intersections of gender, race, class disabilities, and sexualities and genders. Hosken (2018a) analysed the narrative of a South Sudanese social work student from a refugee background, who detailed her struggles to balance childcare, income, and the necessities of placement while in a country where she fears for the safety of herself and her children. She said: "Isn't social work about human rights? How is setting up placements so only young people, with no children, and with money from their parents can easily complete them about human rights?" (Hosken, 2018a, p. 15).

The inequitable policies of social work regulators which make it difficult for marginalised students to access or complete social work education can be understood as "replicating its predominantly white-Euro, settler, middle-class history, protecting its symbolic and material capital and interests" (Hosken (2018a, p. 19). Although other aspects of structural inequity and discrimination in tertiary education (such as ableism, heterosexism, and transphobia) are important. Sexual and gender minority students face unique challenges such as bullying, isolation, discrimination, harassment that can diminish interest in academic careers and increase lower retention (Holloway et al., 2019). "The multiplicity of oppression may be a consequence of the intersection of individual's multiple identities" (Liu, 2017, p. 228). A combination of student identities may create multiple disadvantages within education systems of power and domination. To eliminate multidimensional disadvantages in social work education and training, further research into these areas would certainly be useful to better understand the hardship of particular groups of social work students.

Placement and hardship

A recurring theme in the literature has been the intensity of struggle students face while on placement. For students who rely on paid work to survive, unpaid full-time placements can be extremely problematic (Gair & Baglow, 2018a, 2018b; Hodge et al., 2020; Johnstone et al., 2016; Ryan et al., 2011). Gair and Baglow (2018a, 2018b) found that many students are forced to take time off work or leave employment altogether as they embark on placement, with some saving up years of annual leave in anticipation of losing their income. Other students used savings intended for house deposits, by freezing mortgage repayments on their home, or even selling their home (Gair & Baglow, 2018b). Johnstone et al. (2016) revealed similar challenges, with 76% of students forced to give up necessary shifts at their paid work to undertake placements, while 63% incurred extra expenses like travel, purchasing appropriate clothing, and paying for childcare. More than a third (37%) of respondents had sought monetary gifts from friends and whānau to survive during placement (Johnstone et al., 2016). Those who were not able to give up paid employment while on placement reported working incredibly unsafe hours, with one respondent stating they had worked "100 days straight" (Gair & Baglow, 2018a, p. 53), and another "seven days a week for four months" (Johnstone et al., 2016, p. 488). Financial hardship can rise during placement due work-related clothing, transport, childcare costs, and reduced income from paid work (Meadows et al., 2020). In Heagney and Benson's (2017) study, most mature-aged students value work-integrated learning of placement; however, they faced enormous challenges balancing work and family responsibilities and managing their finance while on placement. Considine et al. (2020) reported that students without a bursary stopped enjoying their placements due to constant financial-related anxiety and lack of time for assignments. In Hodge et al.'s (2020) study, one participant said her exhausted placement experience: "I do not remember the last time I did not feel tired or out of energy….My health deteriorated on several occasions throughout both placements due to stress" (p. 7).

As well as the difficulty of unpaid placements, students have drawn attention to the lack of sick and bereavement leave available while on placement (Gair & Baglow, 2018b; Hosken, 2018a). These stresses during placement impact health and wellbeing (Hodge et al., 2020), and many students struggle to find time to practise proper self-care, showing a "critical and depressing disconnect" between the values and the realities of the profession (Gair & Baglow, 2018b, p. 53). Some students reported the start or exacerbation of mental illness, exhaustion so severe they had to be hospitalised, near-misses while driving because of excessively long hours, and complete burn-out by the end of placement (Gair & Baglow, 2018b). Adding to the financial and time-management challenges, students must grapple with the professional challenges of placement that might pitch them into a state of educational disequilibrium. Ying (2011) found that students who had not yet undertaken a placement in their MSW degree had a better sense of self-efficacy and self-esteem, and lower instances of depressive symptoms than those who had completed a placement.

The multiple demands of placements create further academic strain on social work students. Students must negotiate time spent on practice learning, family duties, socialising, and employment, with assignments that are still required as part of their education. Meadows et al.'s (2020) focus group study of BSW students in Aotearoa New Zealand reported that students modified the standards they set for their academic performance. According to Ryan et al. (2011), students feel forced to submit academic work they are not happy with just to get it done as their time is so stretched while on placement. Unfortunately, the logistics of field education are not tenable for some—19% of respondents in one study had to change their course progression because they could not reasonably undertake placement (Johnstone et al., 2016). Others have felt so overwhelmed with the prospect of juggling their various roles that they have considered leaving placement uncompleted (Gair & Baglow, 2018b). Many participants in Meadows et al.'s (2020) study recognise that layers of support are necessary to sustain and maintain their wellbeing throughout the learning journey.

Action on student hardship

Across the reviewed literature, students, educators, and researchers suggested several interventions to reduce hardship. These were across student, institutional, and structural levels, with some that were specific to professional placement. The integrated intervention of micro and macro levels is essential. At the student level, enhancing student mindfulness and resilience was recommended, especially regarding placement (Gair & Baglow, 2018a; Ying, 2011). Earlier professionals' high rate of burnout, professional stress, and compassion fatigue may be associated with initial placement and a lack of professional experience; therefore, teaching self-care to social work students earlier is significant (Miles et al., 2017).

In Aotearoa New Zealand, Meadows et al. (2020) introduced a programme called "He Arawhata", which allows students to enhance their emotional intelligence and self-care skills alongside the academic curriculum. The programme integrates small structural tutorials known as "Nga Roopu Awhi", which refers to "shelter in quiet water". Students are allowed to have time to think reflectively in a safe environment; "focusing on the cognitive and affective needs of each individual as they negotiate their academic and social work professional worlds" (Meadows et al., p. 59). The process enhances students' self-awareness and sense of self-worth during their social work course. He Arawhata aims to prepare students for the demands of practicum and a career in social work.

Literature cautions an emphasis on individual problem framing and solutions. Gair and Baglow (2018a) argued that a focus on individual student responsibility should not be at the expense of institutional and structural reforms that address the root causes of student hardship. Similarly, Thornton (2016) cautions against framing the psychological health of students as an individual problem. According to Thornton (2016), neoliberalism "sloughs off responsibility for stress" (p. 48) in an effort to depoliticise the problem. She states that the influence of a competitive post-qualification labour market, as well as the increasing costs of tertiary education, cannot be understated.

Most authors called for improved, more accessible mental health services on campus (Gair & Baglow, 2018a; Gharibi, 2018; McAuliffe et al., 2012), requiring a shift in institutional responses. Where mental health services are partially funded by the student body via fees, inaccessible or insufficient services to meet demand is especially unacceptable (Gharibi, 2018). Martin (2010) urged universities to adopt a wellness approach, rather than on disease or deficit. McAuliffe et al. (2012) argued that a "whole-of-university" approach is required, with better guidelines around responding to mental distress, while Gair and Baglow (2018a), Collins et al. (2010) and Reid and Poole (2013) assert that peer support groups would be useful. Better training for academic staff to recognise and respond to mental distress is recommended (Martin, 2010; Ryan et al., 2011), and educators should model safe disclosure of service use or mental distress (Newcomb et al., 2017; Reid & Poole, 2013). A student-centred model for support systems would be effective and integrating information about student supports in the curriculum is a good way to "bring supports" to student's attention (Heagney & Benson, 2017).

Social work educators should engage students in dialogue about their experiences with poverty and hardship (Gair & Baglow, 2018b, 2018c). Collins et al. (2010) advocates for maintaining a low staff–student ratio, as small tutorial groups assist building both strong peer-to-educator and peer-to-peer relationships. Heagney and Benson (2017) found that receiving supportive comments from individual academic staff helped mature-aged students cope better, while regular and early feedback were factors in their success, contributing to building confidence and motivation to continue their studies. Respondents in research by Agllias et al. (2016) suggested that free social activities at university and access to common areas with shared facilities (like seating and microwaves) were important, so students could socialise and support each other without having to spend their limited income. Tones et al. (2009) suggested providing academic and social integration support services specifically targeted to mature-aged students to make their transition back into education easier. Peer interaction can overcome social isolation and offer personal and course-related support for each other (Heagney & Benson (2017).

Indigenous students and students of a minority ethnic or cultural background need culturally safe education and placements (Curtis et al., 2012; Pallas et al., 2022; Zuchowski et al., 2013). Curtis et al. (2012) argued that, in the Aotearoa New Zealand context, tauira Māori need ongoing culturally appropriate academic support (extra tutorials, study groups) and pastoral support (spaces for cultural practices including sharing kai, help accessing financial assistance). To create culturally safe institutions, curricula must be reformed, educators and staff must be well trained, and the workforce must be developed by supporting more Indigenous and minority ethnic background people into academic and general positions (Curtis et al., 2012). The Aboriginal and Torres Strait Islander participants in Zuchowski et al. (2013) recommended increasing Indigenous staff, providing cultural mentors, and ensuring a thoughtful approach to matching Indigenous students with a placement. Similarly, a study of SGM health care students (including social work) found that having academic mentors was effective (Holloway et al., 2019). For contextual, structural, environmental and personal issues to be addressed, social work educators need to increase their self-awareness (Liu, 2017).

To reduce hardship during placement, several studies recommended more flexible arrangements between social work students, their universities, and placement organisations (Gair & Baglow, 2018b; Johnstone et al., 2016; Ryan et al., 2011). Meadow et al. (2020) suggest that programmes build an extra "catch-up" week, integrating fieldwork hours into the year (excluding semester and study breaks), allowing for sick leave and adjusting to the flexible needs of students. A request for flexible hours can be not only considered under extenuating circumstances, but in response to other work or family commitments and financial costs (Hodge et al., 2020). Students reported that transport allowances to cover placement travel would be helpful (Johnstone et al., 2016). Gair and Baglow (2018b) argued that introducing sick or bereavement leave entitlement into placement agreements is necessary. They suggest the situations of mature-aged students with childcare responsibilities should be approached differently than those of their younger peers, as they will likely have different placement needs. Johnstone et al. (2016) stated there is a clear need for professional social work associations to investigate the feasibility and appropriateness of the structure of social work placements in the current economic context if they wish to support the health and wellbeing of future practitioners.

Many of these suggestions for change are simply not possible without addressing how social work programmes, and tertiary education providers generally, are funded and organised. Similarly, state-administered income support through grants, benefits, loans, and scholarships are clearly insufficient to meet student needs and must be increased if student hardship is to be combatted effectively (Johnstone et al., 2016; Gair & Baglow, 2018a, 2018b; Gharibi, 2018; Ryan et al., 2011). A mixed-method study by Yeung et al. (2019) into the NGO social work study award funded by the Ministry of Social Development provides an example of an alternative model. This award paid for a potential student working in community settings to attend a qualifying social work programme, with study-related funds to the NGO employer, including support to backfill the employee's position. Yeung et al. (2019) affirmed that the award had a clear benefit for Māori and iwi-led organisations, with 35% ($n = 37$) of the 107 survey participants identifying as Māori. Past recipients said, in the interview component of the study, that the award provided financial security during their study and a "decrease in stress and pressure" (Yeung et al., 2019, p. 7), with the organisations benefiting from upskilling their staff.

DISCUSSION: GAPS IN THE LITERATURE

An intersectional analysis is vital to understanding and addressing systematic inequalities in higher education as one category of analysis is insufficient. Gender, race, class, abilities are subject to sexism, racism and class bias that, intersecting, can produce complex relations of power and (dis)advantage (Nichols & Stahl, 2019). Social work is often perceived as a traditional female caregiving role, leading to systemic discrimination. For instance, in traditional female-dominated professions such as social work, nursing and education, clinical placements are unpaid, whereas traditionally, more male-dominated professions such as law, medicine, and engineering *are* paid (Hodge et al., 2020). This gendered nature of financial stress and its impact on wellbeing needs to be further explored.

Such an intersectional analysis of cultural, religious, and community responsibilities and student hardship has not featured strongly in the literature reviewed for this project, although many aspects of student identities are traversed. Given the multi-cultural nature of Aotearoa New Zealand, particularly our Māori, Pasifika, and large migrant groups, and the way health disparities and economic inequalities intersect with ethnicity, this was deemed an important aspect to investigate. It is noted that much of the research reviewed did not include demographic information like age, ethnicity and (dis)ability of students, meaning that differences between students are not easily discernible. Indigenous and minority background students with broad, non-nuclear, family caring responsibilities, who face very different demands on their time, were not always clearly identified in the literature. The literature often fails to address how economic inequalities intersect with ethnic/cultural dimensions within the demands of social work study. The recent review by Pallas et al. (2022) has highlighted the needs of Indigenous students and suggested more support is needed to ensure accessible and appropriate field education experiences but did not explore economic factors. Similarly, a deeper examination of how recent migrants and resettled students experience demands was not identified. All these missing dimensions and the lack of a significant body of local research support the need for further research in the context of Aotearoa New Zealand.

CONCLUSIONS

The prevailing neoliberal ideology that views education as an economic commodity means that those in powerful positions in our society are unlikely to champion the shift that is needed without significant pressure. This review has identified many common struggles faced by social work students in several countries. Reducing these challenges requires a shift in how our society treats students in higher education. Gair and Baglow (2018c) argued that the dire situation of many social work students requires a "revisiting of emancipatory, critical, anti-colonialist and other radical pedagogies in university curricula, and collaborative social action to implement change" (p. 213). To enable participation in social work education in Aotearoa New Zealand in a manner that is responsive to the particular aspirations and challenges of Māori and Pasifika, and addresses the needs of all, especially members of marginalised communities, our programmes may need significant review. In order to achieve this and, cognisant of the gaps in the local literature, we advocate that student hardship needs to be more comprehensively understood in Aotearoa New Zealand.

Submitted 1 August 2021

Accepted 28 February 2022

Published 13 May 2022

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ORIGINAL ARTICLE

QUANTITATIVE RESEARCH

Registered social workers' supervision across areas of practice in Aotearoa New Zealand

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ABSTRACT

INTRODUCTION: This article examines the supervisory experiences and views of registered social workers across the practice areas of statutory services, health and non-government organisations (NGOs.) The article aims to establish a baseline for supervision across areas of practice in Aotearoa New Zealand and discuss the implications any differences have for the supervision of registered social workers.

METHODS: Demographic data from 266 postal survey respondents was descriptively analysed. A one-way ANOVA and Tamhane T2 post hoc tests were applied using IBM SPSS 24 to explore variances in means for the independent variable of Area of Practice across 10 scales about the respondents' supervision experiences.

FINDINGS: Differences were identified in the workforce profile of each area, and there were significant differences in supervisees' experiences of supervision across areas of practice which reflected each area's different supervision culture, policy, and practices. The findings show that supervision in health and NGO areas was more professional, clinical, cultural, reflective and involved more positive content within a more constructive supervision climate than supervision in the statutory area.

CONCLUSIONS: A significant difference was found between the quality of supervision experienced by social workers in health and NGOs and their statutory social work colleagues. This needs to be addressed through changing the supervision climate, developing supervisor capability and the uncluttering of supervision through separating professional/clinical supervision from line management. This study provides a foundation for further research that compares supervision across practice areas.

KEYWORDS: Supervision; areas of practice; Aotearoa New Zealand; survey

AOTEAROA
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WORK *34(1)*, 36–54.

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This article is focused on registered social workers' experiences and views of their supervision across statutory (mostly public child welfare), health and non-governmental organisations (NGOs) in Aotearoa New Zealand and aims to identify any differences in registered social workers' supervision across these areas. The data presented are from a national survey of registered social workers' supervision, which aimed to establish a baseline for their supervision and compare it with the Social Workers Registration Board's (SWRB) policy and guidelines. This is the third article from the survey and presents an additional analysis across areas of practice which was too substantial to be included in the first article, which explored registered social workers' personal and professional characteristics and identified differences in supervisees' supervision experiences according to ethnicity, experience as a social worker, recognised qualification, sexual orientation, type of registration and gender (see O'Donoghue, 2019a). The second article examined the 138 supervisors' responses to supervisor-specific questions and found significant differences about the area of practice, ethnicity, experience as a social worker and supervisor, social work qualifications and supervisory education and training (O'Donoghue, 2019b). This article examines registered social workers' experiences and views across the three largest areas of practice in Aotearoa New Zealand. It aims to establish a baseline regarding supervision experiences across each area, identify any differences, and discusses the implications of the differences as they apply to the supervision of registered social workers.

Background

Research on social work supervision demonstrates that high-quality supervision improves worker and organisational outcomes and is associated with improvements in client outcomes (Benton et al., 2017; O'Donoghue, 2021; O'Donoghue & Tsui, 2015; Tsui et al., 2017). Few previous studies have specifically explored the differences in supervision across specific practice areas (O'Donoghue, 2021; O'Donoghue & Tsui, 2015; Sewell, 2018). Recent research reviews identified only one study that compared social work supervision across different areas of practice, namely, Scott and Farrow (1993); O'Donoghue (2021); O'Donoghue and Tsui (2015); and Sewell (2018). Scott and Farrow (1993) surveyed statutory child welfare social workers and hospital social workers in Victoria, Australia. From a descriptive analysis of the supervision functions, they identified minor differences between the statutory social workers and hospital social workers, with the latter conforming more with the local professional supervision standards than the former.

In the last decade, there has been specific research about supervision in child welfare, health and NGO settings (Geißler-Piltz, 2011; McPherson et al., 2016; Rankine et al., 2018; Robinson, 2013; Sewell et al., 2021; Wilkins et al., 2017). British research about child welfare supervision has identified what happens in supervision, how it is recorded, a lack of time and space for reflection and supervision having primarily a managerial focus (Beddoe et al., 2021; Saltiel, 2017; Wilkins et al., 2017). British researchers have also explored the relationship between supervision, practice, and clients and found that supervision focused on social work practice was associated with improvements in client outcomes (Bostock et al., 2019; Bostock, Patrizo, Godfrey, Munro et al., 2019; Wilkins et al., 2018). In North America, researchers have identified that child welfare supervision relationships varied according to agency culture, that supervisees were satisfied with strength-based supervision, and there was a relationship between work self-efficacy and supervision (Julien-Chinn & Lietz, 2015; Lietz & Julien-Chinn, 2017; Zinn, 2015). An Australian qualitative study identified effective child welfare supervision needed to have a safe supervisory relationship supported by knowledge and leadership within an empowering organisational and community context (McPherson et al., 2016). A recent local study involving four statutory social work supervisors in a learning community found that providing protected space for evaluating, critiquing and developing supportive supervision practice within a pressured statutory environment can enhance supervisors' critical reflection and practice (Rankine & Thompson, 2021). Overall, this research highlights that, while there have been advances and improvements in child welfare supervision such as strength-based supervision, practice-focused supervision, and the creation of safe spaces for critical reflection, agency culture and a managerial focus dominate and impact the provision of quality supervision.

In health, the supervision of social workers occurs in a multidisciplinary context and amid the politics of the health professions. Geißler-Piltz's (2011) study on the supervision in the health care system in Germany found that the medical domination of health institutions impacted supervision to the extent that social workers had an ambivalent view of supervision in which they valued its contribution to their professional socialisation, yet also felt it did not have a solid connection to their work. A recent study in Ontario, Canada, with health social workers found that most were engaged in administrative and supportive supervision. However, only half participated in clinical supervision, with half of these participants receiving interprofessional supervision from a supervisor from another health profession (Sewell et al., 2021). This study also found that newly qualified social workers had more frequent supervision than their more experienced colleagues and that the frequency of supervision reduced over time. In short, these studies identify a challenging environment for social work supervision in health systems and settings. Turning to supervision in NGO settings, a comparative qualitative study in NGO organisations in Australia and the UK found that among social workers who worked with refugees and migrants that over half of UK participants and a few Australians did not receive formal or informal supervision. In addition, the approach to supervision across NGOs was inconsistent and did not provide adequate support to workers (Robinson, 2013). Similarly, a local, Aotearoa New Zealand study identified that social workers in child and family support NGOs struggled to safeguard sufficient space for reflective supervision in a demanding neoliberal contracting environment (Rankine et al., 2018). In a further study, Rankine (2019) compared internal and external supervision amongst dyads from child and family support NGOs, with five of the eight dyads participating being external supervision relationships. Rankine (2019, p. 44) concluded that external supervision was "a valuable space for participants to openly discuss practice and critically reflect on their work". He also noted that external supervision varied across NGOs in both quality and availability. This was due to its cost and the funding available to agencies. In summary, supervision in the NGO setting also occurs in a challenging environment and is inconsistent in its provision.

Within Aotearoa New Zealand, it has been noted that "supervision differs across fields of practice" and in the "form, functions, models and approaches" (O'Donoghue & Tsui, 2012, pp. 12–13). Statutory child welfare supervision has been traditionally provided by a supervisor with line management responsibility and involved the traditional administrative, educative and supportive functions (Field, 2008). In contrast, supervision in Health involves a dual model of a peer colleague providing the professional supervision and a manager or team leader providing the administrative supervision (Shepherd, 2003). In the NGO field, mixed provision was common with professional supervision provided by an external contractor and managerial supervision provided by a team leader or manager (O'Donoghue, 2010). Despite these known differences, there has been no research in Aotearoa New Zealand that has compared the experiences and views of supervisees across different areas of practice.

Method

The questionnaire was based on a previous instrument used in 2004 and was updated following a review of supervision research (see: O'Donoghue, 2019a; O'Donoghue & Tsui, 2015). It consisted of multi-choice questions about the respondents' background and 5-point semantic differential and Likert type scales. The internal reliability was assessed with Cronbach's Alpha, and 9 of the 10 scales had adequate internal consistency (i.e., >0.5) (see Table 1). Six were

Table 1. Internal Reliability

Scale	Alpha
Participation in forms of supervision	.425
The emphasis of supervision	.612
The experience of types of supervision contact	.522
Statements concerning the supervision climate	.934*
Focus of supervision	.690
Methods and processes	.741*
Aspects of supervision sessions	.893*
Model or approach used	.862*
Content of sessions	.869*
Overall satisfaction and evaluation	.770*

**Indicates internal reliability*

greater than 0.7, generally accepted as good internal reliability (Helms et al., 2006). The participation in forms of supervision scale, which had the lowest score (0.425), did not have any implications for the use of the data collected because it aligned with Schmitt's (1996, p. 352) criteria of a measure that "has other desirable properties, such as meaningful content coverage", with the content, in this case, being participation in a range of forms of supervision across 12 months. The questionnaire had content, criterion and face validity because it addressed the content and criteria about social work supervision and its constitutive elements as described in the supervision literature (Kadushin & Harkness, 2014; O'Donoghue & Tsui, 2015). It also built on the constructs from a previous instrument used in a 2004 postal survey of supervision, which was conducted before the establishment of social worker registration in Aotearoa New Zealand (De Vaus, 2014; O'Donoghue et al., 2005).

A postal survey was chosen over other methods because the publicly available Social Workers Registration Board Register contained details of each person's workplace but not email addresses. A random sample of 708 social workers was drawn from 4388 registered social workers in 2014. The data collection occurred between December 2014 and February 2015; 20 questionnaires were returned undelivered, and from the 688 questionnaires presumed to have been received, 278 were completed and returned. The overall response rate was 40.4%, lower than the expected response rate of 50%, based on the 2004 survey (O'Donoghue, 2010). The overall sampling error was calculated to be 5.7% at the 95% confidence level, which is within the parameters of 4% and 8% at the 95% confidence level, which is deemed acceptable (Field, 2018). Some 96% (266) of the respondents identified their area of practice as statutory, health, or NGO. The remaining 4% (12) consisted of 10 whose area of practice was education and training and two in private practice. Because of the small number within the education and training and private practice areas, these areas were excluded from this analysis. The questionnaires were analysed using IBM SPSS 24. This analysis involved descriptive statistics and a one-way ANOVA to compare the mean results from the 10 scales with the independent variable of Area of Practice. Where significant differences were identified, Tamhane T2 post hoc tests were applied to identify the differences between the statutory, health and NGO groups. Tamhane T2 tests are a conservative test used when the variances are unequal, and samples differ, which was the case as the area of practice groups are unequal in number, and the standard deviations are varied. Sauder and DeMars (2019, p. 37), recommended the use of the Tamhane T2 test as part of the "better safe than sorry" approach because it is one of four tests that controls for Type 1 error (i.e., the mistaken rejection of a true null hypothesis) in "real-data research (i.e., groups are often unequal, and population variances are almost never equal for demographically based groups)" (Sauder & DeMars, 2019, p. 37). The null hypothesis is that there are no significant statistical mean differences between the area practice groups. The eta squared coefficient ($\eta2$) was used to measure the effect size. The effect is deemed small at 0.01, medium at 0.06 and large at 0.14 (Pallant, 2013, p. 264). The alpha level was set at 0.05.

Massey University Human Ethics Committee approved the study.

The limitations of the survey are the reliance on the respondents' reports, social desirability bias, and missing data bias. Missing data was addressed by leaving the cells in IBM SPSS 24 blank and reporting the number of respondents throughout the article (Pallant, 2013).

Respondents' characteristics

The overall distribution of the 266 survey respondents across the areas of practice was that 40.9% ($n = 109$) worked in statutory social work (most working in public child welfare), 36.1% ($n = 96$) were in health, 23% ($n = 61$) NGOs. A comparison with SWRB 2014/15 annual report showed 27% of registered social workers worked in public child welfare, 25% in health, and 23% in NGOs (SWRB, 2015a). When the 17% who were not practising were discounted, 32% in public child welfare, 30% in health, and 28% in NGOs. This means that the survey sample was over-representative of those in statutory and health settings and under-representative of the NGO sector.

The respondents' personal characteristics as they relate to each practice area are presented in Table 2. It is difficult to ascertain how

Table 2. Personal Characteristics by Area of Practice

Area of Practice		*Statutory*		*Health*		*NGO*		*Total*		*2013 census Social Work sub-group*	
Personal Characteristics		N	%	N	%	N	%	N	%	N	%
Gender	Female	87	79.9	85	88.5	49	80.3	221	83.1	13464	73.5
	Male	20	18.3	10	10.4	9	15	39	14.7	4869	26.5
	Diverse	2	1.8	1	1.1	3	4.7	6	2.2		
Total		109	100	96	100	61	100	266	100		
Age	20-29	1	0.9	0	0	2	3.4	3	1	(15- 24yrs)1191	6.4
	30-39	17	15.7	11	11.6	2	3.4	30	11.5	(25-44yrs) 6708	36.6
	40-49	32	29.7	31	32.2	19	32.8	82	31.3	(45-64yrs) 9363	51.1
	50-59	39	36.1	31	32.2	22	37.9	92	35.2	(65yrs & over)	
	60-69	19	17.6	23	24	13	22.5	55	21	1074	5.9
Total		108	100	96	100	58	100	262	100		
Ethnicity	Māori	22	20.2	10	10.4	17	27.8	49	18.4	2,700	14.7
	NZ European/ Pakeha	57	52.3	56	58.3	36	59	149	56	10,218	55.7
	Pacific Peoples	8	7.3	7	7.3	4	6.6	19	7.2	1,494	8.2
	Indian	6	5.5	5	5.2	1	1.6	12	4.5	-	-
	Other	16	14.7	18	18.8	3	5	37	13.9	3,918 *	21.4*
Total		109	100	96	100	61	100	266	100		
Sexual Orientation	Same-sex	9	8.9	9	10.7	7	12.5	25	10.4		
	Bisexual	2	1.9	3	3.6	3	5.4	8	3.3		
	Heterosexual	90	89.2	72	85.7	46	82.1	208	86.3		
Total		101	100	84	100	56	100	241	100		

**People of Indian ethnicity are included in this group.*

representative their characteristics are of the wider social worker population due to a lack of reliable workforce data at the time of the survey. The comparisons made with the 2013 New Zealand Census Social Work sub-group have limitations. For example, the census asked a binary question about sex identity rather than gender and was not responsive to sexual and gender diversity (Statistics New Zealand, 2013). In addition, there were no questions about sexual orientation in the 2013 and 2018 New Zealand census, and previous estimates of prevalence are unreliable statistically and problematic (Henrickson et al., 2007; Statistics New Zealand, 2021). The respondents' professional characteristics are detailed by area of practice in Table 3. Likewise, it is difficult to ascertain how representative these characteristics are of registered social workers at the survey time. There was limited reliable workforce data available that compared these characteristics amongst each area group.

Overall, the respondents' personal and professional characteristics provide background about the respondents and each area of practice group.

Findings

The findings reported concern the differences for the forms of supervision participated in, the overall emphasis, logistics, types of contact, the supervision climate, focus, methods and processes, their supervisors' use of ideas from supervision models or approaches, the aspects and contents of sessions, as well as the supervisees'

Table 3. Professional Characteristics by Area of Practice

Area of Practice		***Statutory***		***Health***		***NGO***		***Total***	
Personal Characteristics		**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Type of Registration	Provisional	9	8.3	2	2.1	0	0	11	4.2
	Full	100	91.7	92	95.8	60	100	252	95.1
	Temporary	0	0	2	2.1	0	0	2	0.7
Total		109	100	96	100	60	100	265	100
Recognised Qualifications	Section 13	4	3.8	1	1.1	2	3.2	7	2.7
	Diploma	31	28.7	23	24.2	15	24.6	69	26.1
	Bachelors	42	38.9	34	35.7	30	49.2	106	40.1
	PG Dip	13	12	12	12.6	7	11.5	32	12.1
	Masters	15	13.9	22	23.2	7	11.5	44	16.7
	Other	3	2.7	3	3.2	0	0	6	2.3
Total		108	100	95	100	61	100	264	100
Social Work Experience	1-5 years	10	9.4	13	13.5	7	11.7	30	11.5
	6-10 years	25	23.6	8	8.3	15	25	48	18.3
	11-15 years	25	23.6	24	25	11	18.3	60	22.9
	16- 20 years	15	14.2	18	18.8	10	16.7	43	16.4
	21-25 years	13	12.3	17	17.7	8	13.3	38	14.5
	26-30 years	13	12.3	7	7.3	7	11.7	27	10.3
	>31 years	5	4.6	9	9.4	2	3.3	16	6.1
Total		106	100	96	100	60	100	262	100

overall satisfaction and evaluation of their supervision.

Forms of supervision

The respondents rated on a scale their level of participation over the previous 12 months (where 1 = "none" and 5 = "high") in each of the forms of supervision. The 12 forms included represented the differing ways supervision is construed and practised in Aotearoa New Zealand (O'Donoghue & Tsui, 2012). Table 4 presents the means and count for each area group, the overall mean and count. The one-way ANOVA and the effect size are shown where mean differences were statistically significant.

The mean differences for individual supervision indicate that supervisees working in health and NGOs participated in more individual supervision than their statutory social work colleagues. For clinical/professional supervision, the differences show that supervisees in health participated in more clinical/professional supervision than their NGO and statutory colleagues. NGO supervisees also participated in more clinical/professional supervision than their statutory colleagues. For external supervision, supervisees in NGOs participated in external supervision more than their colleagues in health and statutory, and supervisees in health participated in external supervision more than those in statutory.

Overall emphasis

The respondents rated the overall emphasis of their supervision on a scale (where 1 = "not at all" and 5 = "almost always"). Table 5 shows there were differences in the emphasis on practice with clients, well-being and development as a worker, and the environment of the workplace. For all

Table 4. Participation in Forms of supervision by Area of Practice*

Area of Practice	**Statutory**		**Health**		**NGO**		**Overall**		**One-way ANOVA**	η^2
Form of Supervision	**M**	**N**	**M**	**N**	**M**	**N**	**M**	**N**		
Individual	3.61	93	4.45	85	4.27	55	4.05	243	F (5, 237) =6.583, p<.001**	.122
Clinical/ Professional	3.13	97	4.45	93	3.92	59	3.83	259	F (5, 253) = 13.111, p<.001**	.206
Internal	3.78	102	3.76	89	3.67	54	3.71	252		
Peer	3.26	94	3.23	92	3.52	54	3.32	248		
Managerial/ Administrative	2.76	90	2.56	85	3.24	50	2.79	233		
External	1.59	87	2.59	86	3.8	56	2.56	240	F (5, 234) =15.02, p<.001**	.243
Team	2.51	90	2.12	84	2.83	54	2.45	236		
Group	2.27	86	2.02	83	2.42	53	2.21	229		
Cultural	1.92	86	2.07	84	2.37	54	2.10	233		
Student or Fieldwork placement	2.15	87	2.07	83	1.88	48	2.05	228		
Cross-disciplinary/ Interprofessional	1.44	85	1.94	81	1.86	50	1.72	224		
Other	2.0	6	3.0	6	2.8	5	2.59	17		

**Level of participation ranged from 1 ("none") to 5 ("high").*

***Mean differences are significant (p<.05).*

Table 5. Overall Emphasis of Supervision by Area of Practice

Area of Practice	*Statutory*		*Health*		*NGO*		*Overall*		*One-way ANOVA*	η^2
Overall emphasis	M	N	M	N	M	N	M	N		
Management of your work	3.96	108	3.74	93	3.97	60	3.89	273		
Your practice with clients	3.36	107	4.24	95	4.27	60	3.88	274	F (5, 268) =10.495, p<.001**	.164
Your well-being and development as a worker	3.17	107	3.94	95	3.98	61	3.65	275	F (5, 269) =7.853, p<.001**	.125
The environment of your workplace	2.98	108	3.57	93	3.69	61	3.36	274	F (5, 268) =5.173, p<.001**	.079
Other	3.38	8	3.53	15	3.60	5	3.57	30		

**Level of emphasis ranged from 1 ("not at all") to 5 ("high").*
***Mean differences are significant (p<.05).*

three items, the results reveal that greater overall emphasis was put on the supervisee's practice with clients, the supervisee's well-being and development as a worker, and the workplace environment within supervision in health and NGOs than statutory social work.

Logistics

Several multi-choice questions concerned the logistics involved and included the number of supervisors, the type of supervision agreements or contracts, the frequency of supervision contact and the average length of supervision sessions. Table 6 presents the logistics by area of practice and indicates that over half of supervisees in statutory and health have one supervisor. In contrast, over two-thirds of supervisees in NGOs have two or more supervisors. For supervision agreements, health and NGOs had a higher percentage of supervisees with written supervision agreements than their statutory colleagues. Conversely, the statutory area had a greater percentage who did not have a supervision agreement or had an oral agreement than NGOs and health.

Table 6. Logistics by Area of Practice

Logistics		*Statutory*		*Health*		*NGO*	
		N	%	N	%	N	%
Number of Supervisors	1	59	55.2	50	52.1	18	30
	2	32	29.9	29	30.2	30	50
	3	4	3.7	8	8.3	7	11.7
	4	6	5.6	6	6.3	5	8.3
	5	5	4.7	2	2.1	0	0
	Other	1	0.9	1	1.0	0	0
Total		107	100	96	100	60	100
Type of agreement	None	16	14.9	1	1	5	8.2
	Oral	13	12	8	8.4	5	8.2
	Written	71	65.7	81	84.4	45	73.8
	Other	1	0.9	1	1	0	0
	Oral and Written	7	6.5	4	4.2	5	8.2
	None and Written	0	0	1	1	1	1.6
Total		108	100	96	100	61	100
Frequency of contact	Daily	1	0.9	0	0	0	0
	Weekly	12	11.1	2	2.1	11	17.7
	Fortnightly	35	32.4	14	14.7	13	21
	Monthly	44	40.7	72	75.8	34	54.8
	Other	16	14.8	7	7.4	4	6.5
Total		108	100	95	100	62	100
Length of Session	0-30 minutes	3	2.8	0	0	0	0
	31-59 minutes	68	63	46	48	20	32.3
	60-89 minutes	31	28.7	47	49	36	58
	90-120 minutes	6	5.5	2	2	6	9.7
	Other	0	0	1	1	0	0
Total		108	100	96	100	62	100

The results for frequency of contact show a greater percentage (43.5%) of supervisees in statutory had at least fortnightly supervision contact compared to those in NGO (37.7%) and health (16.8%). The situation was reversed for monthly contact, with there being a higher percentage of supervisees in health (75.8%) than NGO (54.8%) and statutory (40.7%). The results for length of sessions show that nearly two-thirds of supervisees in statutory have shorter sessions than many of their colleagues in health and NGO. Overall, the results about the logistics indicate differences in the logistical arrangements of supervision across the three areas for the number of supervisors, the type of agreements, frequency of contact and length of sessions.

Types of supervision contact

The respondents indicated on a scale (where 1 = "not at all" and 5 = "almost always") their experience of a range of types of supervision contact. Table 7 shows differences for formal individual meetings and ad-hoc, informal, open-door consultations. For formal, individual meetings, these meetings occurred more frequently for NGO supervisees than for their statutory colleagues. Whereas, for ad-hoc, open-door consultations, statutory social workers consulted more frequently with their supervisors on an ad-hoc basis than their colleagues in health.

Climate

The respondents recorded their level of agreement (where 1 = strongly disagree and 5 = strongly agree) for nine statements that concerned their views about their supervision climate pertaining to safety, trust, choice, and relational and power dynamics. Table 8 shows differences for

Table 7. Frequency of Types of Supervision Contact by Area of Practice*

Area of Practice	***Statutory***		***Health***		***NGO***		***Overall***		***One-way ANOVA***	η^2
Form of Supervision	**M**	**N**	**M**	**N**	**M**	**N**	**M**	**N**		
Checking in concerning work plans and activity	3.81	105	3.42	96	3.87	60	3.68	272		
Case consultations	3.70	105	3.76	95	3.64	61	3.67	272		
Formal individual meetings and sessions	3.35	104	3.51	95	3.95	60	3.56	270	F (5, 264) =3.365, p<.01**	.06
Ad-hoc informal open door consultations	3.92	103	3.17	93	3.52	60	3.55	266	F (5, 260) =4.392, p=.001**	.078
Reviews/debriefings of specific work or situations	2.98	102	3.28	92	3.70	60	3.26	265		
Co-working	2.43	104	2.52	95	3.0	59	2.59	269		
Formal team sessions	2.18	103	1.94	93	2.41	58	2.14	264		
Observations (either live or recorded)	2.06	102	2.01	93	2.42	59	2.09	265		
Formal group sessions	1.88	101	1.84	93	2.25	60	1.96	265		
Other	2.75	4	2.83	6	3.0	3	2.85	13		

**Frequency ranged from 1 ("not at all") to 5 ("almost always")*

***Mean differences are significant (p<.05)*

Table 8. Supervision Climate Statements: Level of Agreement by Area of Practice*

Area of Practice	***Statutory***		***Health***		***NGO***		***Overall***		***One-way ANOVA***	η^2
Climate Statement	**M**	**N**	**M**	**N**	**M**	**N**	**M**	**N**		
I can safely discuss ethical issues in supervision	3.71	107	4.52	96	4.72	61	4.26	276	F (5, 270) = 11.439, p<.001**	.175
My supervision is always open and honest	3.58	108	4.44	96	4.64	61	4.16	277	F (5, 271) =12.933, p<.001**	.193
The power dynamics are well managed	3.55	108	4.38	96	4.66	61	4.14	277	F (5, 271) = 11.747, p<.001**	.178
The relationship with my supervisor is constructive	3.52	107	4.40	96	4.54	61	4.10	276	F (5, 270) = 12.310, p<.001**	.186
I trust my supervisor	3.43	109	4.44	96	4.56	61	4.08	278	F (5, 272) =14.239, p<.001**	.207
I can safely share my emotions in supervision	3.29	108	4.32	96	4.44	61	3.96	277	F (5, 271) =13.175, p<.001**	.196
My supervisor has more expertise in supervision than me	3.27	107	3.96	96	4.28	60	3.78	275	F (5, 269) =5.885, p<.001**	.099
My supervisor has more expertise in practice than me	3.05	108	3.95	96	4.08	61	3.62	277	F (5, 271) =7.586, p<.001**	.123
I have a choice of supervisor	1.82	107	3.74	96	3.75	61	3.04	276	F (5, 270) =26.968, p<.001**	.333

**Level of agreement ranged from 1 (“strongly disagree”) to 5 (“strongly agree”)*

***Mean differences are significant (p<.05)*

all of the statements, with the apparent theme being that NGO and health had higher means and therefore a higher level of agreement than statutory. The higher means across all climate statements for NGO and health indicate a more supportive supervision climate for NGO and health supervisees than for their statutory colleagues.

Focus, methods and processes

The respondents recorded their level of agreement (where 1 = strongly disagree and 5 = strongly agree) for five statements about the focus of supervision. Table 9 shows that health and NGO supervisees had a higher level of agreement about the focus of their supervision on safe and ethical practice, the supervisee’s needs, and learning and development than their statutory colleagues. Health supervisees also had a higher level of agreement on the focus given to client issues in their supervision than their colleagues in statutory social work.

The respondents recorded their level of agreement (where 1 = strongly disagree and 5 = strongly agree) for the eight methods and process statements. Table 10 shows that health and NGO social workers had a higher level of agreement about the extent to which their supervision was anti-oppressive, linked theory and practice, strength-based, reflected on client-worker interactions and used a problem-solving process than their statutory social work colleagues.

Table 9. Focus of Supervision: Level of Agreement by Area of Practice*

Area of Practice	***Statutory***		***Health***		***NGO***		***Overall***		***One-way ANOVA***	η^2
Focus Statement: We focus on	**M**	**N**	**M**	**N**	**M**	**N**	**M**	**N**		
… safe and ethical practice	3.49	106	4.40	96	4.38	60	4.04	274	F (5, 268) =13,542, p<.001**	.202
…client's issues	3.75	108	4.19	95	3.88	60	3.94	274	F (5, 268) =3.017, p<.001**	.053
…the supervisee's needs	3.29	108	4.02	96	4.18	61	3.78	276	F (5, 270) =9.828, p<.001**	.154
…agency requirements	4.11	109	3.43	96	3.63	60	3.73	276		
…the supervisee's learning and development	3.26	109	3.82	96	3.78	60	3.61	277	F (5, 271) =4.995, p<.001**	.084

**Level of agreement ranged from 1 ("strongly disagree") to 5 ("strongly agree")*
***Mean differences are significant (p<.05)*

Table 10. Supervision Methods and Processes: Level of Agreement by Area of Practice*

Area of Practice	***Statutory***		***Health***		***NGO***		***Overall***		***One-way ANOVA***	η^2
Methods and Process Statements:	**M**	**N**	**M**	**N**	**M**	**N**	**M**	**N**		
Our supervision is anti-oppressive	3.42	107	4.12	95	4.31	61	3.91	274	F (5, 268) =9.117, p<.001**	.145
Our supervision is strength-based	3.37	108	4.10	96	4.36	61	3.89	276	F (5, 270) =11.271, p<.001**	.173
Our supervision is outcome focused	3.76	108	3.68	95	3.92	61	3.77	275		
Our supervision uses a problem-solving process	3.28	107	4.07	96	4.03	61	3.76	275	F (5, 269) =2.669, p=.022**	.047
In supervision we have a shared agenda	3.61	108	3.87	95	3.82	61	3.75	276		
Our supervision is task focused	3.80	107	3.65	96	3.64	61	3.72	275		
In supervision we reflect on the client–worker interactions	3.14	106	3.95	96	3.93	61	3.62	273	F (5, 267) = 7.865, p<.001**	.128
In supervision we link theory and practice	2.61	107	3.54	96	3.53	60	3.17	274	F (5, 268) = 9.170, p<.001**	.146

**Level of agreement ranged from 1 ("strongly disagree") to 5 ("strongly agree")*
***Mean differences are significant (p<.05)*

Use of Ideas from Supervision Approaches and Models

Table 11 details the supervisees' rating of their views about their supervisor's use of aspects or ideas from a range of supervision models/ approaches on a scale (where 1 = "not at all" and 5 = "almost always"). The differences identified across areas for strength-based, reflective, feminist, eclectic, cultural and narrative were that health and NGO supervisees experienced these approaches more than statutory social workers. While the differences for adult learning and solution focused were that the NGO supervisees had a greater experience of these approaches than their statutory colleagues.

Aspects of supervision sessions

Table 12 displays the results for the occurrence of specific aspects of the supervision sessions, which the respondents rated on a scale (where 1 = "not at all" and 5 = "almost always"). The specific aspects were based on Morrison's (2005) elements of a session, which O'Donoghue et al. (2005) adapted to the Aotearoa New Zealand context and developed into an 11-item scale to measure their occurrence within supervisees' sessions. There were mean differences across almost all aspects except for the prioritisation of items. Health and NGO had higher means than statutory for preparation, checking in, discussion, summarisation and review, evaluation and closure. NGO also had higher means than statutory for the occurrence of karakia, action planning, agenda setting and decision-making. Overall, the findings suggest that NGO and health supervisees experience a greater occurrence of more aspects of a supervision session than their colleagues in statutory.

Table 11. Supervisor's Use of Aspects/ideas from Supervision Approaches and Model by Area of Practice*

Area of Practice	*Statutory*		*Health*		*NGO*		*Overall*		*One-way ANOVA*	η^2
Approaches/ Models	M	N	M	N	M	N	M	N		
Strength-based	3.42	105	4.22	94	4.49	57	3.97	268	F (5,262) = 12.786, p< .001**	.196
Solution-Focused	3.67	107	4.00	94	4.22	58	3.92	271	F (5, 265) = 3.286, p=.007**	.058
Reflective	3.31	106	4.21	95	4.31	58	3.90	271	F (5, 265) = 12.492, p<.001**	.191
Task-Centred	3.88	107	3.68	94	3.79	57	3.80	270		
Adult learning	2.83	101	3.35	93	3.68	56	3.24	262	F (5, 256) =4.115, p=.001**	.074
Eclectic	2.70	100	3.54	91	3.60	57	3.22	260	F (5, 254) = 6.293, p<.001**	.110
Narrative	2.63	98	3.19	94	3.47	58	3.05	262	F (5, 256) = 4.206, p=.001**	.076
Cultural	2.08	103	2.75	92	3.11	57	2.55	264	F (5, 258) = 6.044, p< .001**	.104
Feminist	1.80	99	2.52	91	2.48	56	2.29	258	F (5, 252) = 8.623, p<.001**	.146
Kaupapa Māori	1.92	101	2.11	92	2.53	57	2.12	262		
Pasifika-based	1.41	97	1.63	92	1.58	57	1.53	258		
Other	3.0	3	3.33	9	2.67	6	3.11	19		

**Use ranged from 1 ("not at all") to 5 ("almost always")*

***Mean differences are significant (p<.05)*

Table 12. Occurrence of Aspects of Sessions by Area of Practice*

Area of Practice	Statutory		Health		NGO		Overall		One-way ANOVA	η^2
Aspects of supervision session	M	N	M	N	M	N	M	N		
Discussion of item(s)	3.73	107	4.20	96	4.35	60	4.07	275	F (5, 269) = 5.299, p<.001**	.090
Action Planning	3.60	107	3.89	96	4.25	60	3.86	275	F (5, 269) = 3.972, p=.002**	.069
Decision-making	3.63	106	3.73	94	4.15	60	3.79	272	(F (5, 266) =3.160, p=. 009**	.056
Checking- in	3.31	106	3.93	96	3.97	60	3.71	274	F (5, 268) =4.826, p<.001**	.083
Preparation	3.25	106	3.73	92	3.93	60	3.59	270	F (5, 264) = 4.389, p=.001**	.077
Summarisation and review	3.00	106	3.65	96	4.00	60	3.48	274	F (5, 268) =6.537, p<.001**	.108
Agenda setting	3.16	106	3.56	95	3.68	60	3.42	273	F (5, 268) = 2.669, p=.031**	.039
Prioritisation of items	3.16	106	3.41	95	3.70	60	3.37	273		
Closure	2.72	107	3.51	96	3.68	59	3.25	274	F (5, 268) = 6.125, p< .001**	.096
Evaluation	2.59	106	3.22	96	3.29	59	2.99	273	F (5, 267) = 3.845, p=.002**	.066
Karakia	1.20	102	1.33	92	1.93	57	1.41	263	F (5, 257) = 4.549, p=.001**	.079

**Occurrence ranged from 1 ("not at all") to 5 ("almost always")*

*** Mean differences are significant (p<.05)*

Content of Supervision Sessions

The respondents indicated on a scale (where 1 = "not at all" and 5 = "almost always") the occurrence of specific items that were discussed in their supervision sessions. There were significant mean differences for 10 of the items discussed in supervision sessions items (see Table 13).

The differences between groups were that NGO and health had higher means than statutory, for ethical issues, supervisees' concerns or matters, boundaries, professional development, stress, cultural matters, complex and challenging cases and the supervision relationship. NGO had a higher mean than statutory for success stories and statutory had a higher mean than health for supervisors' concerns. These results show that the occurrence of discussions about ethical issues, the supervisees' concerns or issues, boundaries, professional development, stress, cultural matters and complex and challenging cases were more common in supervision for health and NGO supervisees than their statutory colleagues. The discussion of success stories occurred more often for NGO supervisees than statutory. For statutory supervisees, the occurrence of discussions about their supervisor's concerns or matters was more common than for supervisees in health.

Overall satisfaction and overall evaluation

The respondents rated their overall satisfaction with their supervision on a scale (where 1 = "not at all" and 5 = "completely satisfied"). Their overall evaluation of supervision was rated on a scale (where 1 = "poor" and 5 = "excellent"). Table 14 presents the results for overall satisfaction and evaluation. The significant mean differences for overall satisfaction and

Table 13. Occurrence of Items Discussed in Sessions by Area of Practice*

Area of Practice	***Statutory***		***Health***		***NGO***		***Overall***		***ANOVA***	η^2
Content of sessions	**M**	**N**	**M**	**N**	**M**	**N**	**M**	**N**		
Complex or challenging cases	4.02	107	4.46	96	4.38	60	4.26	274	F (5, 268) = 3.128, p=.009**	.055
Supervisee's concern or matters	3.32	106	4.04	96	4.36	59	3.83	273	F (5, 267) =10.417, p<.001**	.163
Caseload review	3.69	108	3.64	96	3.63	59	3.64	274		
Workload	3.64	108	3.60	95	3.62	60	3.63	275		
Professional Development	3.10	108	3.88	96	3.80	59	3.55	275	F (5, 269) =7.176, p<.001**	.118
Ethical issues	2.93	107	3.84	96	3.88	58	3.50	273	F (5, 267) =12.101, p<.001**	.185
Success Stories	3.13	108	3.55	96	3.88	55	3.47	274	F (5, 268) = 4.550, p=.001**	.078
Team issues	3.34	107	3.33	96	3.28	60	3.32	275		
Boundaries	2.68	104	3.37	94	3.63	56	3.15	266	F (5, 260) = 8.200, p<. 001**	.136
Stress	2.75	106	3.42	96	3.39	59	3.14	273	F (5, 267) = 5.124, p<.001**	.088
Problems with Management	2.72	108	2.97	96	3.19	58	2.93	274		
Problems with the Organisation	2.80	108	2.97	96	3.03	58	2.93	274		
Supervisor's concerns or matters	3.20	109	2.60	94	2.92	59	2.89	274	F (5, 268) =4.215, p=.001**	.073
Personal issues	2.65	107	3.01	96	3.10	58	2.89	273		
Problems with colleagues	2.78	106	2.93	96	2.97	58	2.88	272		
Cultural matters	2.39	106	2.94	94	3.19	58	2.79	270	F (5, 264) = 4.619, p<.001**	.080
Performance Management	2.89	107	2.56	96	2.88	59	2.75	274		
The supervision relationship	2.26	106	2.77	96	2.86	57	2.58	270	F (5, 269) =2.726, p=.02**	.049
Other	3.29	7	3.86	7	2.50	4	3.42	19		

**Occurrence ranged from 1 ("not at all") to 5 ("almost always")*

*** Mean differences are significant (p<.05)*

Table 14. Overall satisfaction and overall evaluation***

Area of Practice	***Statutory***		***Health***		***NGO***		***Overall***		***ANOVA***	η^2
	M	**N**	**M**	**N**	**M**	**N**	**M**	**N**		
Overall Satisfaction	3.21	109	3.96	96	4.20	61	3.73	278	F (5, 272) = 12.775, p<.001***	.067
Overall Evaluation	3.20	108	3.89	94	4.20	61	3.70	275	F (5, 269) =12.057, p<.001***	.083

**Overall satisfaction ranged from 1 ("Not at all") to 5 ("Completely satisfied")*

**Overall evaluation ranged from 1 ("Poor") to 5 ("Excellent")*

**** Mean differences are significant (p<.05)* evaluation show that health and NGO had higher means than statutory. This means that supervisees in health and NGOs are more satisfied with their supervision than their colleagues in statutory social work. They also had a more favourable evaluation of their supervision than their colleagues in statutory social work.

Discussion

Generally, the results have identified that supervisees in health and NGO areas had more satisfying, supportive and practice focused supervision than their statutory colleagues. Health social workers' greater participation in clinical/professional supervision, and NGO higher participation in external supervision, together with a greater overall emphasis on the supervisee's practice with clients, the supervisee's well-being and development as a worker and the environment of the workplace within the supervision, than statutory social workers. This difference appears to reflect the administrative and case management supervision emphasis within child welfare supervision (Dill & Bogo, 2009; Wilkins et al., 2017). The results concerning the number of supervisors showed that the majority of supervisees in statutory and health had one supervisor. In contrast, those in NGOs had two or more, which was indicative of their greater participation in external supervision. For supervision agreements, there was a greater percentage of supervisees who did not have a supervision agreement, or had an oral agreement in the statutory area than health and NGOs, which perhaps suggests there was less checking and follow-up concerning supervision agreements and compliance with the supervision policy in statutory social work than the other areas. This arguably would pose a potential challenge to the social workers' ability to comply with any request made by the SWRB for their supervision agreement when renewing their practising certificate and raises questions about organisations' awareness and compliance with SWRB's expectations concerning supervision (SWRB, 2015b).

The differences for the types of supervision contact showed firstly that NGOs had more individual formal meetings than their colleagues in statutory social work and secondly that statutory supervisees consulted their supervisor more on an ad-hoc basis. These results seem to indicate that supervision contact for statutory social workers was less planned or more ad-hoc and appears to indicate a supervision culture driven by crises (Hawkins & McMahon, 2020). These findings also reflect the British, North American, and local literature, which emphasises the lack of time and space for reflection and supervision, the influence of managerialism and the variability of agency culture (Beddoe et al., 2021; Rankine & Thompson, 2021; Zinn, 2015).

The mean differences across all climate statements further emphasises this with health and NGO having a more supportive supervision climate than statutory. The less supportive climate for supervision in statutory social work was characterised by less choice of supervisor, lower trust of the supervisor, who was perceived to have less expertise in supervision and practice. These environments lead to a less open, honest and constructive relationship in which the power dynamics were not as well managed, and it was less safe for supervisees to discuss both ethical issues and their emotions. Arguably, this climate parallels that, within this field of practice, which was highly influenced by politically driven child protection reforms which promulgated a risk-focused, investigative, child rescue practice climate in the face of variable public confidence and high scrutiny (Hyslop, 2021). Such an environment is not ideal for quality supervision and contributes to low trust and supervisees' experiencing challenges in the use of power, authority and relational dynamics within supervision (Young, 1994).

The findings detailing what is focused on in supervision reflect health's professional or clinical supervision focus through having a greater focus on safe and ethical practice, the supervisee's needs, learning and development, and client issues than statutory. Similarly, NGOs' greater participation in external supervision is apparent in their greater focus on safe and ethical practice, the supervisee's needs, learning and development than statutory. The methods and process statements findings showed that supervision for health and NGO supervisees was more anti-oppressive, linked theory and practice, more strength-based, more reflective on client–worker interactions, and had greater use of a problem-solving process than statutory. These results further reinforced that supervision for health and NGOs was more professional or clinical and more reflective than that of statutory. The greater reported use of supervision approaches and models by their supervisors amongst health and NGOs supervisees added to the previous findings of linking theory and practice in supervision and further illustrated the extent to which supervision was more professional or clinical and reflective than statutory. The results concerning the aspects of supervision session where NGO and health supervisees had more experience of most aspects of a supervision session than their statutory colleagues suggests that statutory supervisees experience less structure within their supervision sessions and arguably supports the findings related to less experience of individual sessions and greater experience of ad-hoc contact or meetings.

The differences concerning the occurrence of what was discussed in supervision reinforced that for health and NGO supervisees, there was a greater occurrence of professional, clinical, cultural, reflective, supervisee focused, and positive content discussed than their statutory colleagues. Contrastingly, the only content that was more commonly discussed in statutory supervisees' supervision was their supervisor's concerns or matters, which arguably suggests a more managerial supervisor-led content.

Given all the differences discussed above, it was not surprising that health and NGO supervisees were more satisfied and evaluated their supervision more favourably than their statutory colleagues. Overall, the findings indicate that supervision of social workers in health in Aotearoa New Zealand, is in reasonably good shape and is professional, clinical, reflective, and conducted in a supportive supervision climate. The results also show a wider difference between supervision of health social workers and statutory social workers than the minor differences found by Scott and Farrow (1993). The results of this survey are markedly different from the ambivalence reported in the German study of supervision within health settings and the lack of participation in clinical supervision reported in the Ontario study (Geißler-Piltz, 2011; Sewell et al., 2021). The NGO supervision findings show a more positive experience of supervision than those reported in the comparative UK and Australian study (Robinson, 2013). The results are also more positive about the experience of reflective supervision than Rankine et al. (2018). The reason for this is likely due to the widespread participation in external supervision, which ensures that NGO supervisees were supported and had space to reflect on their well-being and professional development (Rankine, 2019).

Implications

The findings show that the supervision experiences of NGO and health supervisees were more satisfying and better than their statutory colleagues. This was because they experienced more professional, clinical, reflective and supervisee focused supervision. They also had greater participation in both clinical/professional supervision and external supervision and a more supportive supervision climate than their statutory colleagues. The implications of these findings concern how the experiences of statutory social work supervisees might be improved through learning from NGOs and health. Given the passage of time since 2015, when the survey was conducted, questions arise about, “Whether the differences identified are present today? “Has the situation changed?” “Is it worse or better?” Since 2015, statutory child welfare has been involved in constant change. There have been several reviews of its practice, the most recent are the Ombudsman’s *He Take Kōhukihuki: A Matter of Urgency* and the Waitangi Tribunal’s, *He Pāharakeke, he Rito Whakakīkīnga Whāruarua: Oranga Tamariki Urgent Inquiry* (Ombudsman, 2020; Waitangi Tribunal, 2021). These reports detail that, despite Oranga Tamariki updating its supervision policy and providing training for supervisors in 2018, supervision is provided inconsistently and is predominantly task focused rather than engaging in critical reflective practice. In other words, they resonate with recent research into child welfare services in the UK (Beddoe et al., 2021; Saltiel, 2017; Wilkins et al., 2017). Recent local research involving statutory social work supervisors in a learning community identified that supervisors inhabit a “cluttered supervision space” influenced both managerial demands and expectations and the need to ensure safe practice and support practitioners (Rankine & Thompson, 2021, p. 98). Rankine and Thompson (2021) asserted that the learning community approach may be a pathway for statutory supervisors to create an environment conducive to more critically reflective conversations in supervision and provide a starting point for the development of supervisor capability and a culture change in statutory social work. Their research highlights the importance of prioritising space for reflection to support a professional approach to supervision rather than a managerial led one. In contrast, the experiences of health and NGOs supervisees from this survey show a more professional, clinical, reflective and supervisee focused supervision occurring within a supportive supervision climate. Notably, supervisees in health and NGOs have a greater ability to choose their supervisor because their supervision is either clinical/professional with a peer or with an external supervisor. If statutory social work supervision is to improve its supervision climate, providing supervisees with a greater ability to choose their supervisors would build trust and strength in the supervision alliance, which is foundational to effective supervision (Davys, 2002; O’Donoghue et al., 2018). It would also necessitate separating line-management from professional practice supervision and require an investment in building supervisor capability so that the professional supervision model and training aligns with the recommendations of *He Pāharakeke, he Rito Whakakīkīnga Whāruarua: Oranga Tamariki Urgent Inquiry* concerning better and more consistent supervision across all sites (Waitangi Tribunal, 2021). Recent UK research suggests that professional supervision focused on improving the practice of social workers is more likely to be associated with improvements in the outcomes for children and families (Bostock et al., 2019; Bostock, Patrizo, Godfrey, Munro et al., 2019, Wilkins et al., 2018). For such a significant change to occur for statutory social workers, the support of the professional and regulatory bodies in Aotearoa New Zealand is needed. They need to unequivocally state in their respective supervision policy documents that supervision of social work practice is a specialist role and is separate and different from line management.

Conclusion

This article aimed to establish a baseline regarding supervision experiences across each area of practice, identify any differences across areas, and discuss the implications of the differences as they apply to the supervision of registered social workers. The strengths of the findings are that a baseline for each of the three areas has been established, which is something that future researchers can build upon. Differences in supervision across the three areas have been identified, showing that supervision in health and NGOs was more professional, clinical, cultural, reflective and involved more positive content within a more constructive supervision climate than statutory social work. For health and NGO social workers, the findings differ from the international literature and present a more positive portrait of supervision. The statutory social work findings align with recent reports from the Ombudsman, Waitangi Tribunal, and child welfare supervision research in which supervision is described as inconsistently provided and is predominantly task focused rather than engaging in critical reflective practice (Beddoe et al., 2021; Saltiel, 2017; Wilkins et al., 2017). The limitations of the findings are that the data is from 2015, and it is difficult to ascertain how representative it is of registered social workers. Nonetheless, it is recommended that line-management and professional practice supervision be separated in the supervision of statutory social workers and that they have a greater ability to choose their supervisors. In addition, it is also recommended that the professional and regulatory bodies in Aotearoa New Zealand revise and emphasise in their supervision policy documents that the supervision of social work practice is a specialist role that is separate and different from line management.

Submitted 1 October 2021

Accepted 5 March 2022

Published 13 May 2022

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“Asking the ‘dumb’ questions”:
An evaluative survey of reflective supervision with statutory child protection social workers

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ABSTRACT

INTRODUCTION: Reflective social work supervision is essential to professional development, building resilience and client work. However, in child protection, supervision is preoccupied with managing risk and meeting outcomes at the expense of analysis and critical reflection. Oranga Tamariki (OT), the statutory child protection organisation in Aotearoa New Zealand, has recently been scrutinised for poor supervisory practice. The authors worked alongside OT social work supervisors and supervisees to explore ways to generate resilience, learning, self-awareness and develop practices that support reflective capability and well-being in supervision.

METHODS: This article presents data from the pre/post online evaluation of an action research intervention study with OT supervisors and supervisees. The aim of the online survey was to measure participants’ supervision practices, and the extent to which perceptions of confidence, reflection, professional learning and resilience improved.

FINDINGS: The findings are reported from key areas within OT supervision: the frequency of supervision sessions, the functions of supervision, engagement in reflection, supervision-changing practice, resilience and longevity in social work careers and the supervision of supervisors.

CONCLUSIONS: The results from the survey showed social workers had increased confidence as they built reflective capacity, resiliency and improved their supervision practice. The study identified the importance of developing learning spaces that enhance reflective supervision for supervisors and supervisees in child protection.

KEYWORDS: Supervision; social work; child protection; critical reflection

Supervision is a cornerstone of effective social work practice, a professional process that encompasses reflection, education and case management (Kadushin & Harkness, 2014). Despite considerable literature indicating the value of supervision to practice on worker and organisational outcomes (Carpenter et al., 2012; Pitt et al., 2021), research relating to supervision which supports practitioners and their relational work with service users is only beginning. Wilkins et al. (2018) has indicated “practice-focused” group supervision has a “golden thread” between supervision, practice, family engagement and decision making. “Systemic” group supervision has been identified as significant in creating more purposeful and relational engagement

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between social workers, children and families (Bostock, Patrizo, Godfrey, & Forrester, 2019; Bostock, Patrizo, Godfrey, Munro, et al., 2019)

Supervision, particularly statutory child protection social work, is buffeted between professional and organisational accountabilities informed by a context of risk management and outcome delivery (Davys & Beddoe, 2020; Wilkins et al., 2017). For some time, international literature has impressed upon us the need to improve child-protection social work services and provide space for reflection (Beddoe et al., 2021). Reflective supervision is essential for critical analysis and effective decision-making in these statutory professional spaces (Rankine, 2017). However, authors such as Wilkins et al. (2017) argued, from a British local authority perspective, that reflective supervision remains unclear in definition, how it is currently provided and how it is measured for effectiveness. The diverse support needed for statutory social workers to utilise and receive reflective supervision in statutory organisations requires drastic and creative changes in practice thinking.

The Ministry for Children, Oranga Tamariki (hereafter OT), the Aotearoa New Zealand statutory child protection organisation, is the site of the current research. The organisation has been criticised in recent reports related to the over-representation of tamariki Māori (children) within the welfare system and the organisation's procedures and the legislation (Boshier, 2020; Office of the Children's Commissioner (OCC), 2020; Waitangi Tribunal, 2021). The lack of reflective supervision was identified in all the reports. It is within this context that the authors promote supervision as the critical practice tool to build reflective and responsive social work that achieves better outcomes for tamariki and their whānau (family).

The current action research study with OT social work supervisors and supervisees explored reflective supervision practices and aimed to strengthen practitioner development. The focus of the study was to explore further approaches that generate resilience, learning, self-awareness and to develop practices that support reflective capability and well-being for both supervisors and supervisees. The study contained three separate parts: development of a learning community with OT supervisors (Rankine & Thompson, 2021); thinking aloud in supervisor–supervisee dyads (Rankine & Thompson, in press); and an online evaluation pre- and post-intervention of the action research study.

This article concentrates on the pre/post evaluation of the action research intervention study from an online survey with OT supervisors and supervisees. The online survey was completed by all supervisor and supervisee participants who were actively involved in the study. The aim of the survey was to evaluate participants' current supervision practices and the extent to which confidence, reflection, professional learning and resilience had improved or not.

Social work supervision

Supervision is a lifelong, professional process that is central to learning in social work (Davys & Beddoe, 2020). The supervisor is responsible for the supervisee meeting organisational, as well as personal and professional goals (Morrison, 2005). According to O'Donoghue (2003), social work supervision should model best social work practice with clients. To meet the multi-faceted nature of organisational, professional and personal goals in supervision, the structure of supervision has provided a foundational understanding of the various functions required in sessions. These include providing administrative, educative, supportive and mediative functions for the supervisee (Kadushin & Harkness, 2014; Leitz et al., 2014; Morrison, 2005). However, it is also critical that supervisors use an approach underpinned by reflection and learning which assists supervisees to develop and use skills and knowledge within the ever-changing practice landscape of social work (Morrison, 2005).

Reflective supervision is a supervisory approach that emphasises learning, knowledge development, accountability and transformation in practice (Davys & Beddoe, 2020). Reflective supervision moves beyond a task-focussed structure and stimulates collaboration, analysis and emotional regulation (Franklin, 2011). Reflection (Kolb, 2014; Noble et al., 2016), and critical reflection (Fook & Gardner, 2007; Rankine, 2018), are essential elements underpinning reflective supervision. Both are necessary for critical examination, re-imagining, learning and developing alternative ways of practising.

The importance of supervision is recognised within social work professional standards. Within Aotearoa New Zealand, social workers have a mandatory obligation, through the regulatory body, the Social Workers Registration Board (SWRB), to receive and participate in supervision. The SWRB have identified that supervision is central to ensuring social work competence and is a requirement for social work registration (SWRB, 2016). The SWRB's Code of Conduct includes expectations that participants in supervision critically reflect on practice and supervisors ensure that supervision is culturally relevant and responsive for Māori (SWRB, 2016).

Supervision in statutory child protection organisations

Child protection social work is challenging and emotionally charged for the practitioner (Davys & Beddoe, 2020). These social workers require a balance of skills between managing bureaucracy, complex decision- making and child abuse casework (Kelly & Green, 2019). Within this demanding context, it becomes vital that the social worker receives opportunities for reflection and support in supervision. The supervisor is often the social worker's line manager and juggles several administrative responsibilities, including organisational accountability to managing risk, performance and case management. Escalating acuity of casework, dwindling resources and the associated media and public scrutiny of child protection work has left social work practice controlled by managerialism and neo-liberalism (Beddoe, 2010; Rankine & Thompson, 2021). These wider, systemic pressures leave little space for professional aspects of social work practice such as emotional support, reflection and critical reflection (Wilkins et al., 2017). Moreover, the associated tick-box nature of a managerial approach does little to promote the best interests of children and families (Pitt et al., 2021).

As Aotearoa New Zealand's statutory child protection agency, OT recently has been under considerable scrutiny regarding practice and the use of supervision. The Ombudsman highlighted the lack of reflective supervision and critical practice in social work practice with families where the focus was merely on task completion and outcomes (Boshier, 2020). In particular, the decision making of social workers was criticised for a lack of assessment and the associated impacts of these practices on outcomes for Māori (Waitangi Tribunal, 2021). The OCC (2020) highlighted the urgency for strengthening and implementing supervision policies and practices that address institutional racism and support effective work with Māori. "Hipokingia ki te kahu aroha, hipokingia ki te katoa", the initial report by the Oranga Tamariki Ministerial Advisory Board (2021), has identified a significant gap in social work training and the need to develop an organisational culture that supports staff through reflective supervision.

OT's statement of intent over the next three years has a clear focus towards accountability of practice and developing a positive culture and relationships in social work (OT, 2021). Underpinning this commitment to practice, supervision within OT has been reviewed through Professional Supervision Policy and Standards. These standards outline OT's commitment to improving a social worker's practice through effective supervision and improving outcomes for children and families (OT, 2017). The Professional Supervision Policy outlines the significance of reflective supervision as key to the supervisor's role and the critical examination of the supervisee's thoughts, feelings and actions (OT, 2017). The Standards provide a benchmark for supervision: promoting quality practice with regular supervision sessions, focusing on the supervisee's needs, supporting effective work with Māori and cultural diversity, and supervisors having appropriate levels of skills, knowledge and competence (OT, 2017). Whilst the Professional Supervision Policy and Standards espouse effective supervision practice as essential to child protection social work, the implementation of these changes in practice continues to raise significant concern (Waitangi Tribunal, 2021).

Research of supervision

Research in social work supervision nationally and internationally has grown considerably over the last two decades (O'Donoghue, 2021; O'Donoghue & Tsui, 2015; Sewell, 2018). The literature takes the stance, similar to OT's Professional Supervision Policy and Standards (OT, 2017), that supervision is a fundamental ingredient for high-quality and effective social work practice (Wilkins et al., 2017). Social work supervision in social work can promote self-care (Rankine, 2017), provide professional development (Nickson et al., 2020), build resiliency (Beddoe et al., 2014), and reduce burnout and intention to leave (Carpenter et al., 2012; Leitz & Julien-Chinn, 2017; Mor Barak et al., 2009).

For reflective supervision to be relevant to practice, wider contextual factors need critical examination. These contextual factors include power dynamics, dominant structures and discourses that impact on, and influence, social workers' work with service users (Noble et al., 2016). Social work supervision generally lacks this depth of analysis (Rankine, 2018). The development of reflective supervision allows for anti-oppressive and culturally sensitive practice to emerge (Hair & O'Donoghue, 2009); which is essential when working with Māori.

The complexity of child protection work requires organisations to further develop reflective supervision for its workers. Carpenter et al. (2012) recognised the practice imperative for social workers to receive emotional support and the resources to develop and maintain reflective thinking. However, the effect of supervision on practice is an area of research that requires further evaluation (Wilkins et al., 2018). To date, Watkins (2020) has stated that evidence supporting supervision is weak, particularly for worker and client outcomes. It was the authors' intent in the current study to explore supervision practices that generate resiliency, learning, self-awareness and develop supportive reflective capability for supervisors and supervisees. And build supportive learning communities within the practice environment.

Research design and data collection

The online survey was one part of a study to evaluate the two action research methods (Rankine & Thompson, 2021) working with supervisors and supervisees in OT. The authors, with research and practice experience in supervision, collaborated with the participants to explore and deepen reflective practice. The other research methods involved the development of a learning community with OT supervisors and a *thinking aloud* process with supervisor–supervisee dyads to deepen the reflective capacity and well-being within supervision. The questionnaire was designed for supervisors and supervisees to complete at pre- and post-intervention stages of the action methods.

The questions in the survey were influenced by recent research related to supervision and longevity in role (Leitz et al., 2014; Leitz & Julien-Chinn, 2017), resiliency (Beddoe et al., 2014), improving spaces to reflect in supervision (Beddoe et al., 2021), improving practice for children and families (Bostock, Patrizo, Godfrey, & Forrester, 2019; Watkins et al., 2018) and developing support and supervision of supervisors (O'Donoghue, 2021). To ensure validity, the questions were reviewed and refined by the authors and input was also requested from other experts in the supervision area with extensive experience. The questionnaire consisted of contextual questions related to frequency of supervision; the functions of supervision; engagement in reflection; supervision developing practice; supervision assisting resiliency; supervision improving confidence to change existing practice; and perceptions of supervision promoting positive outcomes for children and families. Supervisees and supervisors were also asked separate additional questions on the survey. Supervisees were asked the additional question "Does supervision support longevity in your social work career?" Supervisors were additionally asked "How often do you receive supervision?" and "How often do you engage in reflection while receiving supervision?". Data were measured used a five-point scale ranging from *not at all* to *all of the time.* The exceptions were Question one that measured frequency of supervision from *never* to *weekly* and Question two related to the functions of supervision from *not important* to *very important.* Each question also asked for a qualitative response to provide further description to the answer provided on the five-point scale. A final qualitative question was asked on each survey regarding any further participant comment related to supervision in the survey. Internal reliability was not measured and mean scores were used due to the small sample size and the different scales used in the questionnaires. The time between each survey (pre- and post-intervention) was approximately one year. The purpose of participants completing the online survey twice was to evaluate the supervisors' and supervisees' views around current supervision practices and the extent to which confidence, reflection, professional learning and resilience had improved.

Participants employed at a regional OT office were invited to become involved in the study through the distribution, by the regional senior management team, of an information sheet to all care and protection social work staff. Participants completed and sent the signed consent form to the authors. The questionnaire was distributed by a web collector where the survey link was electronically sent to participants. Participants then received an electronic link via email to complete the online survey through the SurveyMonkey website. This was done prior to becoming involved in the interventions and after the study had been completed. An independent contractor completed a report on the data and provisional findings from the online surveys. The study was approved by the Human Participants Ethics Committee at the University of Auckland and consent obtained from the Chief Executive of OT, the Regional Manager of the appropriate OT site and Senior Advisor of Regional Operations.

Four supervisors and six supervisees participated in the online survey. The online survey provided both quantitative and qualitative data which were analysed descriptively and manually (Excel was used for quantitative data) due to the nature of the data and sample size. Frequency graphs were created for most of the quantitative questions to facilitate comparisons across pre- and post-intervention stages. Qualitative data were coded manually. Where data were collected as a five-point differential rating scale, mean scores were calculated as a useful indicator related to the question.

Findings

The pre- and post-intervention survey explored the following key areas of supervision within OT: the frequency of supervision sessions; the functions of supervision; engagement in reflection; supervision changing practice; resilience; longevity in social work career; and the supervision of supervisors.

Frequency of supervision sessions

The supervisors and supervisees were asked to indicate how frequently they received/provided supervision. At pre- and post-intervention phases, the mean frequency of supervision remained the same as *once a fortnight* (see Figures 1 and 2). However, supervisees reported receiving less supervision at the post-intervention phase (for example, two supervisees stated *sometimes* and one supervisee stated *once a month*). Supervisees reflected, in their qualitative comments, on their own experiences of becoming more senior workers and therefore the frequency of supervision was consistent with OT policy. The policy details that new staff should receive weekly supervision, reducing to fortnightly after the social workers have 12 months' experience (OT, 2017).

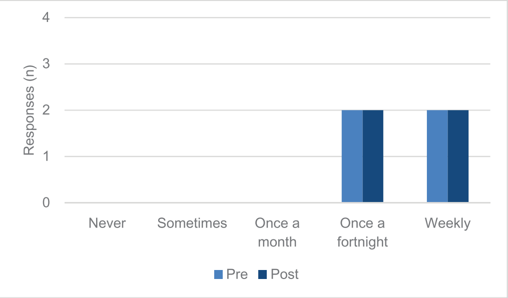

Figure 1. How Often Do You Provide Supervision? (Supervisors)

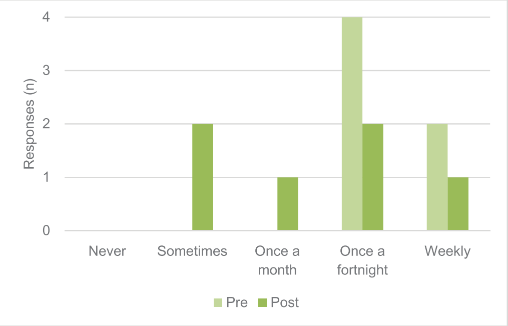

Figure 2. How Often Do You Receive Supervision? (Supervisees)

From the survey, some supervisors felt that more supervision of social workers was required: "I think supervision should be weekly, to both meet the requirements of the Ministry where we demonstrate consultation on casework, and reflection, where we explore the emotional impact of the work more."

The supervisees indicated that they participated in weekly or fortnightly supervision. However, for some, this was also subject to supervisor availability. The availability of their supervisor meant that supervision was not as frequent as they would like, with one supervisee stating, "According to the availability of my supervisor, it is when we can have it." Some supervisees indicated that the frequency should be determined by the needs of individual social workers, e.g., "I like to be guided and gauge by actual need rather than policy" and "We agree that we can meet any time there is a need." These statements were made post-intervention when there was also reduced availability of supervisors (as stated above).

The functions of supervision

Both supervisors and supervisees were asked to rate the importance of four specific supervisory functions on a 5-point scale (1 = *not important*; 5 = *very important*). These supervisory functions align with key literature and are necessary in meeting professional and organisational needs (Davys & Beddoe, 2020; Kadushin & Harkness, 2014; Morrison, 2005). For comparison purposes, mean scores have been calculated for each function/participant group (Table 1).

Supervisors rated the importance of all four functions in supervision higher than did supervisees. At the post-intervention stage, supervisors rated all four functions as of lower importance, and supervisees rated managerial (2.67) and mediation (2.33) functions as lower.

Table 1. Mean Scores For Supervisory Functions

Importance of supervision function in supervision	Supervisor		Supervisee	
	Pre	Post	Pre	Post
Managerial matters	3.75	3.00	3.17	2.67
Professional development	4.50	3.50	4.33	4.33
Support	5.00	4.75	4.67	4.67
Mediation	4.25	4.00	3.33	2.33

Participants were also asked to describe the types of issues brought to supervision via an additional qualitative question. Supervisors mostly raised caseload management, as the "pressing" topic. Other issues included providing case updates, professional development/training opportunities, administration (such as leave, human resource matters, policy, IT systems), managerial (such as performance or conduct), practical coaching (such as dealing with difficult clients), internal and external relationships, and issues of a more personal nature (for example, work–life balance, stress management). Despite mediation listed as a potential function in the quantitative part to this question, supervisors did not comment on this further.

Caseload management was also frequently mentioned by supervisees (this included receiving guidance, direction, and advice on cases). In contrast to the comments made by supervisors at the pre-intervention stage, there was more of a focus on personal issues or feelings in the session. For example, "overall experiences and feelings towards work"; "things relating to my wellbeing"; and "how I am feeling due to personal circumstances and the significant impact these have on my work". Other topics mentioned by supervisees included professional development/training, understanding of processes/practice standards, relationships, and task-orientated issues (such as delays in completing work as per policy).

The nature of the topics brought to supervision were slightly different for supervisees. At the post-intervention stage, supervisees were bringing different issues to their supervision with comments suggesting a greater amount of reflection at meetings. Supervisees spoke often about supervision being an opportunity for "support", as well as a chance to reflect on "personal views and how they influence practice." Supervisees were more eager to discuss cases and their thinking and decisions. This was so they could reflect further and identify areas they could "improve on and grow."

Engagement in reflection

At pre- and post-intervention, supervisors and supervisees were asked to indicate the frequency of reflection occurring in supervision sessions. As seen in Figures 3 and 4, supervisors perceived that the frequency of reflection increased across the two timeframes (see Figure 3) with two supervisors stating *most of the time* and one *half the time*. Whilst supervisees indicated a slight decrease in reflection occurring in their

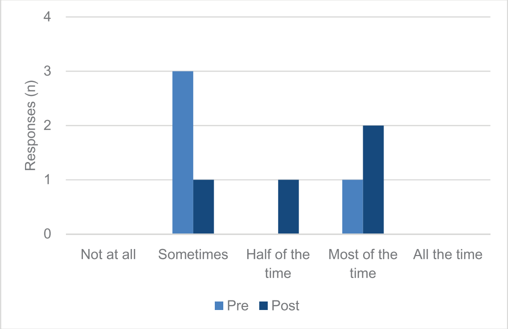

Figure 3. How Often Do You Think Reflection Occurs During the Supervision You Provide? (Supervisors)

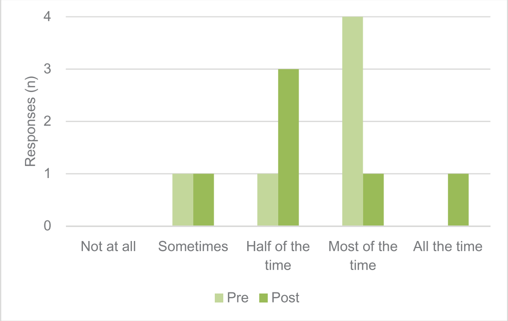

Figure 4. How Often Do You Engage in Reflection During Supervision? (Supervisees)

sessions (see Figure 4) with three supervisees at post-intervention stating *half the time*. The decrease corresponds with the reduction in frequency of supervision for supervisees over the time of the study.

One supervisor made a further clarification about the level of engagement of reflection in supervision not being enough due to demands and time pressures:

> Not enough time to be as reflective about particular practice as I'd like. In this extremely busy work most social workers just want the quick answers and to be able to get on with things! An hour once a fortnight is never going to be enough (not even once weekly) to cover all functions of supervision and keep up with all task-focus/casework as well as give good reflection time to the complexities of this work.

In addition, the supervisors and supervisees were asked a qualitative question to describe *how* reflection occurred during supervision sessions. The supervisors highlighted a range of strategies that they used, for example, asking open questions, revisiting initial thoughts/beliefs/biases, allowing silence and reframing statements. The strategies that the supervisors used were based around a specific case discussion or plan. One supervisor described that some supervisees feel challenged around the process of reflecting:

> I often find that asking questions to get social workers to reflect on their decisions are seen as a threat, and are viewed that you are challenging their practice for disciplinary reasons. I also find that social workers feel challenged to explain their case analysis, they will often tell you about the information they have gathered, and the plan they are putting in, but not about why that plan is the right one.

In contrast, supervisees identified a range of issues that they brought to supervision to reflect on. Casework featured consistently and supervisees would bring concerns, "errors or mistakes", case complexities and difficult decisions to supervision. Positive experiences when working with children and families or "wins" were also seen as useful: "Reflecting on the positive practice I have done and also the impact this has on a child/young person and/or their family and how I felt about that." Supervisees also raised professional development areas for further reflection such as specifically asking for feedback from a supervisor, critical thinking and exploring alternative perspectives and possible personal bias.

Supervision changing practice

Supervisees positively responded to supervision being helpful towards improving their practice. All participants responded that supervision improved practice either *most* or *all the time* across the two survey times (see Figure 5). It was noted the mean decreased at post-intervention to *most of the time* as one supervisee felt that supervision had slightly reduced in helpfulness in improving practice.

The supervisees were asked to provide an example of a time that supervision had improved their practice. A range of positive experiences were shared. For one supervisee the sharing of feelings and previous experiences was helpful to shift pre-existing patterns, values and beliefs:

> I have shared openly my concerns about families that do not engage openly with

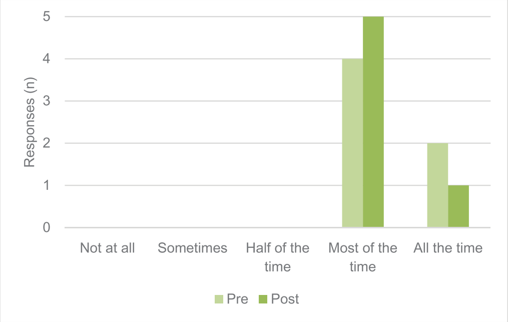

Figure 5. Is Supervision Helpful Towards Improving Your Practice? (Supervisees)

> Oranga Tamariki. My supervisor was able to advise me of times where she had engaged with families in her position and had received similar experiences. My supervisor asked me questions about my desire to support families in their times of needs and asked about how it made me feel when families weren't ready to engage.

Another supervisee realised the value of supervision in exploring doubts and fears when working with a specific family and working through the best decision that could be reached at the time:

> I find supervision has improved my practice when I had doubts about a decision I had made regarding one of my cases and through supervision I was able to reflect and be guided by my supervisor to realise I had made the right decision.

Supervisors and supervisees were both asked whether supervision assisted with developing confidence in making changes to practice (see Figures 6 and 7). Supervisors overall were less likely than supervisees to indicate that confidence had improved as a result of supervision. At pre-intervention, two supervisors rated this as *sometimes* or *half the time*. This was perhaps due to the supervisor's tentativeness and self-critique in their own skills and abilities within supervision. By post-intervention however, two supervisors rated this as *most of the time*.

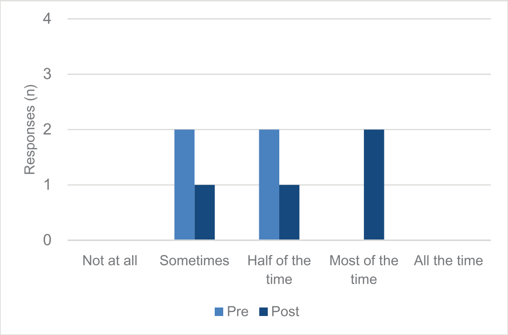

Figure 6. How Confident Do You Think Supervisees Are Towards Making Changes to Their Practice? (Supervisors)

In comparison, five supervisees at post-intervention felt supervision had developed their confidence *most of the time*. Both participant groups noted that confidence was present at least some of the time. There was an increase across pre- and post-intervention, with more supervisors and supervisees feeling that confidence was improved *most of the time* at post-intervention.

When supervisors were asked for specific examples relating to confidence and change in practice, supervision was highlighted as helping supervisees stay in the job despite difficulties, overcoming overwhelmingness, developing greater empathy, delivering better outcomes to clients through *seeing* cases from the client perspective.

> There are times with newer workers where they become overwhelmed with what is happening in families and forget to find out why things are happening (as the why is where the effective intervention strategies sit). I think that by asking the right questions about why, this has helped social workers de-escalate and think about interventions that are better targeted and less invasive.

Supervisees identified the value of supervision towards the development of plans when working with families and creating a better understanding of procedures and processes. One supervisee expressed that, "If I come away from supervision with new ideas, or having

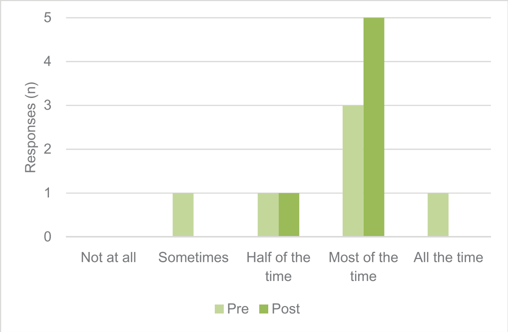

Figure 7. How Confident Are You Towards Making Changes to Your Practice? (Supervisees)

processed how I can do something differently, or more confidence in myself, I feel able to make changes." Another supervisee spoke about how supervision developed their confidence in making connections between theory and their practice:

> Supervision helps me to be confident in my practice and ensure I have made decisions based on policy/ theory and can back up my decisions. An example is discussing a court plan I was filing and working through each step and what I was trying to achieve both short and long term. I ensured I could explain how each step was child centred. I was challenged by using theory and good practice until I was clear.

In addition to the more general questions outlined earlier, both supervisors and supervisees were asked whether supervision enhanced confidence in their ability to improve outcomes for children and families. Supervisors and supervisees gave some specific examples:

> A social worker extremely anxious about attending multidisciplinary meetings is now regularly and confidently hosting/ facilitating groups of professionals all working with a child/family. Lots of assurance, talking through worries etc in supervision. Initially supported social worker at meetings, modelling facilitation, slowly taking "back seat" at their pace and eventually withdrawing from meeting (leaving them to it). (Supervisor)

> I think that supervision has helped me to improve an outcome for a child by being feeling supported in my decision-making for a child regarding a need for a separate bedroom for two siblings in a home who needed their own space due to a history of sexual abuse and they now have their own bedroom and this is already having an improvement for them. (Supervisee)

Resilience and longevity in social work career

The supervisors and supervisees were asked whether supervision increased supervisee resilience. By post-intervention, the supervisors felt that supervisees' resilience was increased as a result of supervision *half of the time* (Figure 8). However, from their supervision sessions, supervisees felt more resilient between pre- and post-intervention, with high levels of resilience identified at the post-intervention stage (Figure 9). This included three supervisees stating *most of the time* and two supervisees stating *all of the time*.

The qualitative question asked supervisors what they do to encourage resilience with supervisees. Supervisors provided a range of responses at pre- and post-intervention stages including "[giving] credit where credit is due"; affirming competence; normalising experiences; providing clarity; creating collegial/peer support opportunities; talking

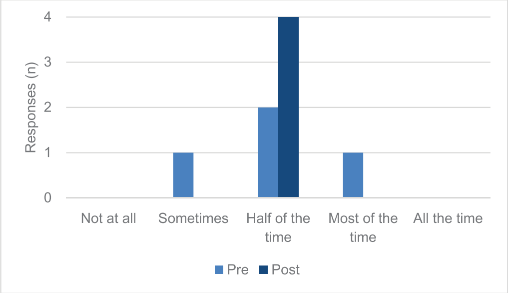

Figure 8. To What Extent Do You Think Your Supervision Increases Resilience in Your Supervisees' Work? (Supervisors)

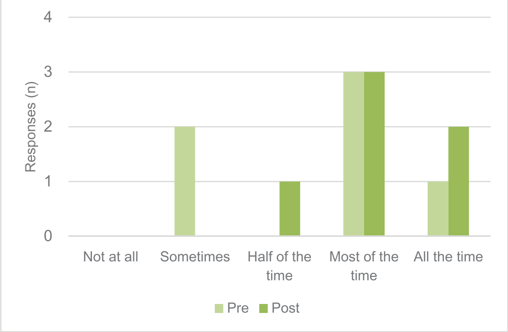

Figure 9. Does Supervision Increase Resilience in Your Work? (Supervisees)

through difficult situations; and offering advocacy or other support. The importance of maintaining a structured work–life balance and promoting self-care was also discussed: “I talk to them about taking breaks, finishing on time, structuring their time and keeping their passion for the work alive.”

Supervisees were asked in what ways supervision increased their resilience. For many supervisees, having the opportunity to talk with a supervisor who had a professional understanding of their situation and potential concerns was seen as key to developing resilience:

> It gives me somebody to talk with when I have had a difficult encounter with a client, family member or other professional. Having supervision with a person who has experienced the challenges of the job is important because I am a new social worker and talking through the challenges helps me put them into perspective. This encourages me to process what I have experienced, which positively affects my resilience.

Supervision was seen as a way for supervisees to seek reassurance, “separate the personal and professional spheres”, gain confidence, and “cope with the everyday nature of the work”. Trust and respect in the supervision relationship was also mentioned by several supervisees as being helpful for their resilience so that there was a plan to “truthfully sharing worries” and “asking any ‘dumb’ questions.”

Supervisees felt that supervision supported their longevity in their role and social work career. The majority of supervisees indicated that longevity was supported at least *most of the time* (see Figure 10). Five out of six supervisees stated that supervision promoted their longevity *most of the time* or *all of the time* by post-intervention.

Qualitative findings supported the quantitative data outlined in Figure 10.

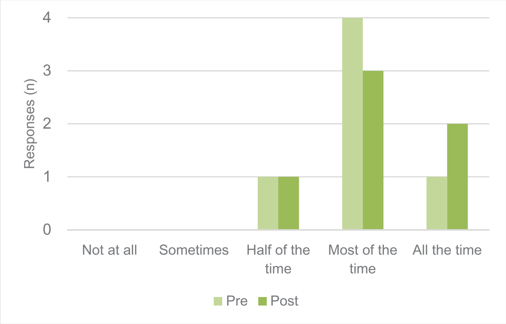

Figure 10. Does Your Supervision Support Longevity in Your Social Work Career? (Supervisees)

Supervisees consistently indicated that supervision had helped them “settle into the job”, feel “supported” in the role, and as a result, increased their job satisfaction. Not only did supervisees identify that longevity in their social work career was supported by good supervision, but it was adversely impacted when the supervisory relationship was not working well:

> When I have a positive relationship with my supervisor I am able to better manage stressful times. When I do not have a good relationship with my supervisor I feel more overwhelmed by my work and believe that I cannot do this job much longer for the sake of my mental health and general wellbeing.
>
> I have always found it beneficial to have an engaged and thoughtful supervision session, to help me stay positive and recognise the good that I do in my work … I have thought about leaving several times, generally when I have felt least supported.

Supervision for supervisors

Supervisors were asked to consider their experience of their own supervision, both in terms of frequency and their own engagement in reflection (Figures 11 and 12). The majority of supervisors indicated they received supervision themselves *sometimes* or *once a month*. At the post-intervention stage, supervision frequency had slightly increased

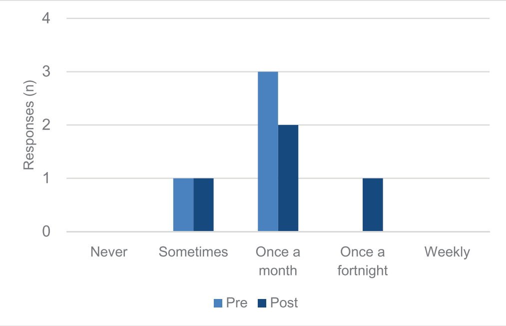

Figure 11. How Often Do You Receive Supervision? (Supervisors)

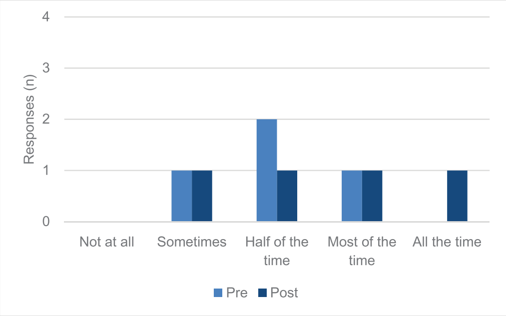

Figure 12. How Often Do You Engage in Reflection While You Are Receiving Supervision? (Supervisors)

with one supervisor indicating that they were receiving fortnightly supervision.

Qualitative comments indicated that supervisors felt their own supervision was often "overlooked", which could leave them feeling "isolated" as "no one else in the office who would understand the unique pressures of the job".

One supervisor stated that their supervision "tends to get overtaken by other things that come up and take over as being urgent". Supervision that was provided externally was viewed as positive as the supervisor "did not bring their own political agenda into the supervision" and "sessions are reflective, rather than collusive".

In relation to engagement in reflection, the majority of supervisors engaged in reflection at least *half of the time*. At post-intervention, there was a slight increase with one supervisor stating they now reflected *all the time*. When asked how their own supervisors encourage reflection, the techniques mentioned were similar to those discussed previously. These skills and techniques included open questioning, reframing, use of silence, and encouraging discussion. One supervisor felt that reflection did not occur during their own supervision sessions (although this was not realised in the quantitative aspect to the question) and said, "I can't comment as this has not been the case previously and may not happen."

Discussion

The results from the survey showed an overall increase in the participants' perceptions of their confidence in reflection, resiliency and improvement in practice in supervision from pre- to post-participation in the study. The focus of the action research study, using thinking aloud interventions and a learning community, was to explore approaches that generate resilience, learning, self-awareness and to develop practices that support reflective capability and well-being for both supervisors and supervisees in OT. The findings from the online surveys indicated that participant perceptions, related to their professional development and reflective supervision, since the interventions had shifted positively.

The frequency of supervision, as outlined by the participants, connected with existing organisational policy and professional mandate (OT, 2017; SWRB, 2016). However, there was mention by participants that supervision should be drawn by need, rather than just meeting procedure. The four supervisory functions outlined in the survey align with supervisory functions within key literature (Davys & Beddoe, 2020; Kadushin & Harkness, 2014; Leitz et al., 2014; Morrison, 2005). These supervisory functions assist in providing necessary structure in the supervision session and meeting professional and organisational needs. Support and professional development were indicated by supervisors and supervisees alike as central to supervision. The significance of supervisory support in sessions remains consistent with other studies (Leitz & Julien-Chinn, 2017). However, the *pressing* topics raised in supervision by supervisees were predominantly managerial matters and case direction—typical within a statutory child protection environment where the supervisor has line management and caseload responsibility for the supervisee (Beddoe, 2010). After the implementation of the learning community with OT supervisors and the thinking aloud process with supervisor–supervisee dyads, managerial aspects to supervision became less relevant as participants indicated that a reflective and supportive space was more important. This realisation by participants is consistent with Wilkins et al. (2017) and Beddoe et al. (2021) in tackling the need to create reflective spaces that meet statutory social workers' professional needs rather than supervision which is line management.

The supervisors and supervisees were asked to describe *how* reflection occurred during supervision sessions. The feedback regarding reflective supervision was very positive overall. Supervisors (who had also had the experience of participating in the learning community and thinking aloud process) indicated that there was an increase in reflection in supervision over time. Skills that are strengths-based encourage reflection and are essential to ongoing learning. These skills were central to the action research methods. Strengths-based training for supervisors has led to changed perceptions from supervisees and supervisors and promoted positive change in supervision (Leitz et al., 2014; Leitz & Julien-Chinn, 2017). The supervisors in the survey highlighted the strengths-based skills used to foster reflection but it was noted by both supervisors and supervisees that reflection centred around casework and meeting outcomes. However, supervisors commented that there was not enough reflection for social workers generally. These comments suggest that, whilst supervision occurred regularly, reflection and learning is not prioritised due to pressing managerial agendas monopolising supervision time. Leitz and Julien-Chinn (2017) have stressed the significance of support in supervision and the time away from other systemic pressures for supervisors to provide consistent supervision. The debate continues over how busy supervisors juggle competing commitments around line management and reflection with their supervisees.

Pitt and others (2021) have critiqued the ambiguity and often diluted understanding of reflection in supervision by social workers. Wilkins et al. (2017) have maintained that reflective supervision in statutory social work is not clearly defined and generally is described as case management. Supervisors in this study also indicated that social workers became defensive and struggled to reflect on their plans with families. Social workers, particularly in statutory settings, need a safe space in supervision to explore their work, be challenged, be able to identify the use of power and ethical considerations (Cousins, 2019). Support for social workers to unpack their practice is crucial and requires a range of approaches (Wilkins, et al., 2017). Pitt et al. (2021) also argued that, whilst considering a different perspective in supervision may be the beginning of reflective supervision, statutory social work needs to consider a more critical lens—that of exploring power, inequality and social justice. The participant comments in the data presented an absence of aspects related to culture and work with Māori. Crucial to current criticism aimed at OT is the ability of social workers to explore wider environmental issues impacting on social work decision making involving whānau Māori and develop culturally relevant practice (Waitangi Tribunal, 2021). Within the managerial and crisis-driven environment of child protection, it is imperative that social workers have a space to critically reflect and advance decision making in their practice with children and families (Rankine & Thompson, 2021).

Supervisors and supervisees were confident that supervision was associated with changes in practice. These findings correspond with other literature that has identified supervision as positively associated with completing work and job satisfaction (Carpenter et al., 2012; Mor Barak et al., 2009). Recent research reviews on supervision have emphasised the gap between supervision directly impacting on worker and client outcomes (Watkins, 2020) and parallels the criticisms directed at OT and the lack of supervision in practice decision making (Boshier, 2020; OCC, 2020; Waitangi Tribunal, 2021). In contrast, the qualitative examples from the supervisees in this study emphasised the value of supervision in providing clarity with child-centred decision making and guidance on practice issues—important factors associated with developing whānau-centred practice and providing solutions to OT practice. Similarly, supervisors and supervisees felt that supervision had improved their confidence after participation in the research. The online survey also provided direct examples of how supervisors and supervisees saw supervision relating to positive interventions for children and families. These examples included hearing the views of others, managing heightening emotions, taking time with complex decision making and making the *right* decision. Identifying strengths and resources in the supervisor–supervisee relationship has a parallel relationship with the supervisee and work achieved alongside families and children (Leitz & Julien-Chinn, 2017). These examples highlight the importance of OT social workers reflecting on their work through supervision and relating positive changes in their work with children and families.

Resilience in the workplace is often linked to effective supervision. A study by Beddoe et al. (2014) highlighted participants' need for reflection, safe exploration of emotions and that receiving constructive feedback in supervision was central to creating resiliency. Participants in this study also connected the significance of supervision with resilience in the workplace. Supervisees significantly identified an increase, post-intervention, in their resilience and willingness to stay in their role because of supervision with their supervisor. Supervisees additionally identified that, when there was not adequate support or a good supervisory relationship with their supervisor, there was a strong desire to leave their role. The qualitative comments concurred with previous citations that talking about obstacles, self-care and feeling supported made supervisees more resilient and likely to stay at work.

The supervisors who participated in the online survey were specifically asked about their own supervision. The supervision of supervisors should be key in the development of practice and reflection, but curiously, is an area not explored in literature and research (Patterson, 2019). Despite supervision being offered approximately once a month, there was also mention from supervisors that supervision would be overlooked for other urgent tasks. Reflection may be present in the supervision of supervisors half of the time and the opportunities for external supervision assisted in disengaging with organisational agendas. Overall, the frequency of supervision for supervisors and the level of reflection increased over the duration of the study. Patterson (2019) suggested that managers should be replicating the practice that they provide to frontline practitioners and strive to ensure reflection over surveillance in a learning culture. Supervisors also need training and reflective supervision to ensure safe and accountable practice. Ongoing training and supervision as professional development should go in conjunction with one another (Leitz et al., 2014). In response to criticism in the recent reports (Oranga Tamariki Ministerial Advisory Board, 2021; Waitangi Tribunal, 2021), supervision within OT needs to reflect a bi-cultural lens with Māori-centred principles. This promotes social and cultural differences in supervision and decolonises existing supervision practices (O'Donoghue, 2021). Protected spaces for OT supervisors to explore, evaluate and critique decision making involving whānau Māori and wider environmental issues need to be urgently prioritised in the development of social work practice (Rankine & Thompson, 2021). Embedding a culture of reflection and learning requires commitment within every aspect of the organisation, including supervisors and managers. This focus on improving supervision in OT requires future evaluative research that encompasses bi-culturalism and is Māori-focused.

Limitations

The experiences and reflections are representative of the supervisors and supervisees in this study. The data collected from the online survey and the research are not generalisable. The survey may have transferability to other supervisees' and supervisors' views and mean scores across other OT sites in the organisation. Given the small sample size, participant experiences of supervision, understandings of reflective supervision and cultural diversity were not holistically captured. Reflective supervision in this context, is predominantly formed from a Tauiwi (non- Māori) lens and does not encompass concepts of Te Ao Māori (worldview) or other cross-cultural notions of cultural humility and sensitivity. Further studies that utilise a Māori framework, cross-cultural considerations and include studies by Māori for Māori supervisors and supervisees in OT are recommended for future research. The data collection from the online survey represents the supervision situation for social workers at two particular points: pre- and post-research. Whilst the survey provides an indication of changes in supervision over this duration in time, there are limits to the reliability and validity of this data directly. Whilst this study provided some initial investigation around supervision changing practice outcomes for social workers and their work, the impact of supervision on client outcomes needs to be central to further research in supervision (Watkins, 2020). Further studies, similar to Wilkins et al. (2018), Bostock, Patrizo, Godfrey, and Forrester, (2019) and Bostock, Patrizo, Godfrey, Munro & Forrester, 2019) that explore practitioner work alongside effective practice with service users, are central to an Aotearoa New Zealand research agenda which builds towards better children and whānau, aiga (family) outcomes. Despite the limitations outlined, this study contributes towards the evidence base of supervision literature in social work practice in Aotearoa New Zealand, specifically supervision practices in OT. Such opportunities provide an examination of current practice that highlight strengths, potential changes and the opportunities to develop reflective supervision and alternatives to social work practice with families.

Conclusion

Creating opportunity for reflection and learning in supervision is an ongoing tension in statutory social work as managerial agendas continue to prevail. The recent criticisms from the OCC, the Ombudsman and the Waitangi Tribunal detail the ongoing concern directed at OT around inclusion in decision making with children and families—particularly Māori—and the protected space for social workers to learn and reflect on their practice. To ensure responsive and reflective practice in supervision at OT, committed to better outcomes for tamariki and their whānau, child protection social workers need space that promotes learning and critical decision making. This study has highlighted the value of creating learning spaces for both supervisees and supervisors to critique and develop supportive practice which complement reflective supervision. Future bi-cultural and Māori-centred research is essential for improving reflective supervision and outcomes for children and families.

Submitted 3 December 2021

Accepted 22 March 2022

Published 13 May 2022

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ORIGINAL ARTICLE

QUALITATIVE RESEARCH

Responses to abuse, neglect, and trauma of children with intellectual disability:

Experiences of social workers and health practitioners in Aotearoa New Zealand

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ABSTRACT

PURPOSE: Children with intellectual disabilities are three to four times more likely to be abused and neglected than their peers without intellectual disabilities. While the Children's Action Plan and Children's Act (2014) aim to keep children safe and ensure their needs are met, much of the focus still treats children as a homogenous group with limited reference to children with disability. The current research focused on exploring the experiences and perspectives of social workers and health practitioners to abuse, neglect, and trauma among children with intellectual disabilities.

METHODS: In 2020, eight participants were first involved in a focus group to provide a wider perspective of practice and policy issues of abuse, neglect, and trauma among children with intellectual disability. This was followed by a more in-depth exploration and investigation with four experienced social workers to understand the issues and challenges in supporting this cohort of children and to identify what best practices are needed to strengthen service provision.

FINDINGS: Results of the study indicated that, to ensure safety and implement support interventions, practitioners need to be equipped with knowledge about disability and its related needs. Furthermore, to influence positive and transformative change, a strong relational practice with children with intellectual disabilities, their whānau and family is paramount.

CONCLUSION: Practitioners are urged to draw on knowledge and skills, such as relational practice, socio-ecological frameworks, human rights and social justice, and advocacy to develop appropriate assessments and interventions to support children with intellectual disabilities and their wellbeing.

KEYWORDS: Children; intellectual disabilities; abuse; best practice; relational practice

AOTEAROA NEW ZEALAND SOCIAL WORK *34(1)*, 72–87.

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Child abuse and maltreatment is a substantial problem with wide-ranging negative impacts on health and wellbeing. In Aotearoa New Zealand the definition of child abuse is defined in the Oranga Tamariki Act (1989), Children's and Young People's Well-being Act (1989): "*child abuse* means the harming (whether physically, emotionally, or sexually), ill-treatment, abuse, neglect, or deprivation of any child or young person" (New Zealand Government, 1989 Section 2). Research has found that children with intellectual disabilities are three to four times more likely to be abused and neglected than their peers without intellectual disabilities (Jones et al., 2012; Sullivan & Knutson, 2000). Research conducted by Rouland and Vaithianatha (2018) reported that one in four children in Aotearoa New Zealand under the age of 17 years were likely to have had at least one "report of concern" relating to an alleged form of abuse to Oranga Tamariki, of which 10% were substantiated. With the additional estimate of one in 10 children with intellectual disability who have experienced substantiated abuse (Oranga Tamariki, 2020) and looking at data collected between 2015 and 2019 (92,114 tamariki/children), it would suggest that in each of these years there are, on average, 1,845 children with intellectual disabilities who have experienced abuse that come to the attention of child protection services in Aotearoa New Zealand. Given that it has already been noted that children with intellectual disabilities are three to four times more likely to be abused than their peers without intellectual disabilities, it would not be inconceivable to suggest that the prevalence of abuse is much higher for children with intellectual disabilities. Social workers and health practitioners have been criticised for their lack of understanding and ability to assess abuse when working with children with developmental disabilities (Algood et al., 2011). Disability status is often disregarded in the assessment of maltreatment despite it being a contributing factor for maltreatment (Brandon et al., 2011; Cook & Standen, 2002). In the past two decades, research has identified several gaps and inconsistencies in how social workers and health practitioners have responded to abuse, neglect, and trauma of children with intellectual disability (Brandon et al., 2011; Franklin & Smeaton, 2018; Jones et al., 2017). As children and people with disabilities now have longer life expectancy due to advances in medical treatment and better support services, the numbers of children with intellectual disabilities will continue to increase globally, indicating the importance of enhancing knowledge and skills to support their needs. This article, derived from a Master's of Social Work thesis, sought to bring an Aotearoa New Zealand perspective to the growing concerns and challenges faced by practitioners working with this cohort of children in response to abuse and trauma, and to establish a deeper understanding of the contributing factors that are needed to improve assessment, intervention, relationship building, and future support.

Previous studies have estimated that children with intellectual disabilities have a significantly higher risk of being victims of abuse, neglect, and trauma. They are more likely to experience multiple incidents of abuse over extended periods of time due to lower socio-economic status and impoverished material circumstances which can exacerbate the stress levels of parents (Algood et al., 2011; De La Sablonniere-Grif et al., 2021; Sullivan & Knutson, 2000). Research has also shown that children with intellectual disability and their whānau and family are often unable to access the necessities of life such as food, heating, affordable/accessible housing, specialist appointments, and the ability to easily access financial entitlements (Wynd, 2015). Some children with intellectual disabilities have had more re-referrals into child protection services than other groups of children in the system due to the additional challenges of parents' lack of knowledge of child development, lower socio-economic contexts and parents with drug and alcohol issues (Connell et al., 2007; Dakil et al., 2011; Perrigo et al., 2018). In addition, concerns were raised when care assessment was conducted informally based on observations rather than a confirmed diagnosis from a qualified professional; this further complicated reporting and the ability to provide appropriate interventions and support (Perrigo et al., 2018). Broadhurst et al. (2010) argued that some social workers and health practitioners chose to define child abuse from their own understanding, and this created adverse effects on how responses were made to assessment and service delivery. This can be seen when practitioners see the disability as only a condition, which can prevent them to identifying potential abuse (Cooke & Standen, 2002). For example, some social workers and health practitioners may only connect a behaviour, such as self-soothing by rubbing their genitalia, as part of the condition of the disability instead of looking at underlying reasons for the redness or bruising. This could lead to social workers focusing only on intellectual disability to make a recommendation on "behaviour management" instead of following best practice guidelines to assess for abuse and neglect (Manders & Stoneman, 2009; Ofsted, 2012).

Another concerning assumption is that children with intellectual disabilities are less likely to report being abused (Briggs, 2006; Jones et al., 2017; Lightfoot, 2014). Successful interventions to address child abuse and harm reduction can only be achieved if assessments are conducted properly, systematically, and rigorously (Stalker et al., 2015). For children with intellectual disability, effective interventions create more positive outcomes developmentally, behaviourally, and socially to enhance the child's wellbeing (National Academies of Sciences, Engineering and Medicine, 2016). Research has found that medical and healthcare professionals are more likely to be successful in identifying abuse when assessments are informed by a multi-disciplinary response and staff receive regular training in child maltreatment, assessment, and interventions (Schertz et al., 2018). Recognising the role of parents in the child's development is also important and should be supported to enable them to advocate for their child to the best of their ability (The Royal Australasian College of Physicians, 2013). A clear understanding of the wider issues, such as care needs, grief and loss, isolation for parents/caregivers, and disability education for parents, are key practice components in carrying out effective assessments and interventions (Sen & Yurtsevery, 2007; Stalker et al., 2015).

Social workers in child protection services, however, have been reported to be ill-equipped to support families and whānau with children with intellectual disabilities, and this is not surprising given that research has indicated that they tend to have limited exposure to knowledge about intellectual disability while in tertiary education (Jones et al., 2012; Manders & Stoneman, 2009; Mogro-Wilson et al., 2014). Despite a growing trend in the tertiary education sector to include disability studies in undergraduate studies (Meekosha & Dowse, 2007), some social work educators reported that specialised training was beyond the scope of what they could offer, and the responsibility should sit with the social workers' employers (O'Reilly & Dolan, 2017). However, Kim and Sellmaier (2020) have argued that equity and inclusivity in society must be seen in social work education where social work students of all abilities are able to actively participate in programmes and contribute to the ongoing development of the curriculum and wider structures to reflect the diversity of students. Others have emphasised that, when social workers are resourced and have relevant hands-on disability knowledge and experience, they are generally more competent and confident in working with people with disabilities (Haney & Cullen, 2017). Prynallt-Jones et al. (2018) called for attention to the unavailability of disability specific education in the tertiary arena and ongoing professional development once social workers and health practitioners are in practice, instead of relying on parents/caregivers for developing their knowledge of intellectual disability.

Much of the existing research on child welfare and child abuse in Aotearoa New Zealand has reflected a generic focus on children with social and environmental vulnerabilities such as poverty and substance misuse, but with limited reference to children with intellectual disability and their experiences with abuse, neglect, and trauma. Within the neo-liberal political context, it has been argued that the focus is on "troubled families" in child protection practice, which fails to engage meaningfully and purposefully with whānau and families who are in challenging and vulnerable situations (Hyslop, 2016). As such, the child requires *fixing* to ensure they go onto be a contributing member of society, and the parent is seen as solely responsible for the vulnerability of their child (Featherstone et al., 2014; Wacquant, 2014). Social work scholars have criticised the neo-liberal agenda for forcing social work practice to assume an interventionist approach, focusing on discipline, and punishing the poor, with little thought given to wider influential factors such as poverty (Hyslop, 2009; Keddell, 2017). Relational practice is a crucial social work response to the complex lives that whānau and family lead, in part due to the underlying psychological dynamics that can be present, such as stress, grief, anger, and trauma (Ruch et al., 2018). Kandel and Merrick (2007) have established that whānau and family and their children require consistent support throughout their child's life by putting appropriate interventions in place, not only in their day-to-day lives but also interventions that are responsive to the changing needs and significant events in education, health, and family systems. When practitioners support parents with education about their child's disabilities and how to support them, they are more likely to increase their resilience and capacity to bounce back from challenging times (Machalicek et al., 2015).

In Aotearoa New Zealand, a small number of research studies have called for addressing the relationship between child abuse and disability and other lived experiences (Peters & Besley, 2014; Wynd, 2013). There is also some evidence of preventative sexual violence initiatives, but these are at a foundational level and require significant expansion and revision to provide education to children and adults with intellectual disability if they are to be equipped with the knowledge and skills to safeguard themselves against sexual abuse (Moore et al., 2020). Given the limited local research regarding violence against children with intellectual disability and the infamous position of being rated as having one of the highest rates of child abuse in the OECD, it is critical that further research on this subject be conducted to capture the prevalence in Aotearoa New Zealand and to identify the support and resources that would keep children with intellectual disability safe from harm. In examining how practitioners responded to abuse, neglect, and trauma among children with intellectual disabilities, the current research aimed to explore how they identified disabled children who are at risk of abuse, neglect and trauma, the kind of interventions and strategies used, strengths and challenges in service provision and professional development required to enable better support for this group and their family and whānau.

Methods

Study design

This research was undertaken using a qualitative research approach drawing on the interpretive underpinnings of this methodology (Holloway & Galvin, 2016), which captured the participants' subjective experiences (Ryan et al., 2007) of responding to abuse, neglect, and trauma of children with intellectual disabilities. This method allowed movement from structured, open-ended questions to "unexpected data" (O'Leary, 2017, p. 240), providing opportunities for the participants to share information that has not been identified in similar research. A focus group was first used to draw on the experiences of participants who had similar professional backgrounds and significant knowledge of the research topic (Patton, 2015; Yin, 2016). The expert knowledge gathered in the focus group interviews was then examined to inform and validate the development of the semi-structured interview template for in-depth, individual interviews. The strength of using the semi-structured, individual interviews was the ability to capture the participant's thoughts and experiences through a shared conversation between the interviewer and the participant (Hunter Revell, 2013; Ryan et al., 2007).

Study participants

A purposive sampling method was chosen with the intention to recruit participants, social workers, and health practitioners, who had professional experience of working with children with intellectual disabilities who had experienced abuse, neglect, and trauma (D'Cruz & Jones, 2004; O'Leary, 2017). For the focus group interviews, the eligibility criteria to participate involved qualified social workers or other health practitioners who held senior positions in management, policy, or practice leadership and had at least five years' relevant experience in working with children with intellectual disabilities and had supported them with abuse, neglect, and trauma experiences. Recruitment was conducted through emailing study invitations to non-government organisations (NGOs) across the Waikato and Hauraki regions and the first author's professional networks. Two focus groups were conducted. The first one with four participants (three in clinical psychology and one in social work) was conducted in mid-August 2019 while the second group with three participants in clinical psychology, physiotherapy and occupational therapy was organised in late August 2019. One participant, a senior social worker, who could not attend either of the focus groups was keen to be involved; hence, an individual interview was organised. Most of the participants had extensive experience (more than ten years) in the disability field and had worked in a variety of sectors including mental health, education, health, community, and justice. They were all considered to be senior practitioners, and some had their own private practices. All identified themselves as of New Zealand European descent and two were born abroad.

After the completion of the focus groups, individual interviews were commenced; qualified social workers with at least 3 years' practice experience of supporting children with intellectual disabilities were recruited. The aim was to gain a wider understanding of issues and challenges from front-line social workers who have been supporting this cohort of children and to further investigate what best practices are needed to support and strengthen service provision. Participants were recruited through NGOs in the Waikato area and permission was also sought from Aotearoa New Zealand Association of Social Workers (ANZASW) to circulate an advertisement through their website to invite potential applicants. Four participants were successfully recruited for interviews between September and November 2019, with two of them with lived experience in having a family member with intellectual disability. Among the four participants, two participants were of New Zealand European descent while the other two identified as Māori and Pasifika, respectively.

This research was approved by the Massey University Humans Ethics Committee (SOA 19/18). Before conducting the focus groups or individual interviews, participants were provided with information about the research, the process, and given the assurance of confidentiality over their data. Informed consent, voluntary participation, minimising any potential conflict of interest and secure data storage, were adhered to in the guidelines set by the institution where ethics was approved. Participants were assigned pseudonyms to protect their identity. They all signed the consent forms.

Data collection

The first author facilitated the two face-to-face focus group interviews in neutral spaces in the community and each lasted between 60 and 90 minutes. A focus group schedule was used to ensure transparency of process and the wellbeing of the participants (Barbour, 2007). The protocols included: a welcome, introduction of the facilitator, consent form, a review of the subject and the valuable role the participants would play in sharing their stories for this study, and what the expectations were of the day, housekeeping—toilets, emergency, and refreshments. The individual interview that was supposed to be part of the focus group was conducted in a mutually agreed venue for 40 minutes. All the interviews were digitally recorded. The individual interview was transcribed verbatim while a summary of key points was written from the two focus groups.

Following a preliminary analysis of the focus groups, a series of four in-depth interviews was conducted. Two participants were interviewed face to face in a mutually agreed place and time while two other participants were interviewed via Skype in the privacy of their own offices. All interviews were digitally recorded and lasted for approximately 90 minutes. All interview transcripts were sent back to the participants for member checking and approval.

Data analysis

The focus group data were initially analysed prior to conducting the individual interviews to ensure the semi-structured interview covered essential aspects to address the research topic. After consulting with the second and third authors, it was deemed appropriate to analyse both the focus group and individual interviews to provide a comprehensive perspective. Thematic analysis was used to generate the key themes (Bryman, 2016). Inductive logic was used to ensure authenticity and ethical practice was maintained throughout the data analysis process (Elliot & Timulak, 2005; O'Leary, 2017). Integration of multi-methods in research has become more prevalent and important to produce better understanding of the experiences of an issue investigated (Moran-Ellis et al., 2006). In the current research, initial quotes and themes from the focus group were placed alongside the individual interviews, followed by a summary of how the two sets of data were connected, converged, diverged and/or complemented. The first author then assessed all elements of the data from both focus groups and individual interviews (Silverman, 2011). Thus, upon finding a new theme in a transcript, all prior transcripts were re-examined to ensure relevance and consistency. Once the initial inductive process was completed, the data were analysed from a deductive perspective to see if there was any validation of previous research and knowledge. The use of focus groups and individual interviews contributed to triangulation to add "breadth or depth to our analysis" (Fielding & Fielding, 1986, p. 33) to enhance the topic (Fenech Adami & Kiger, 2005). The qualitative research approach provided a framework which captured the subjective experiences of Aotearoa New Zealand social workers and other health practitioners and laid the foundation for the discussion of themes identified.

The motivation for this research came from the first author's professional practice and experience in the disability sector and it was important to acknowledge the first author's background as part of the research instrument and the bias that may affect the study as a result (Morrow, 2005). During the research process, the first author also learnt to be mindful of (and at times suspended) her own insider's view to allow more flexible and fluid development in the research process and analyses to focus on the participants' narratives to speak for the research. To address trustworthiness, the first author engaged in reflective field notes and memo writing after each interview and data analysis was discussed with the second and third authors.

While the use of integration of two sets of data was a strength in the current research to enhance the richness of the issue concerned, this research was limited by the small sample size. Therefore, caution must be applied, as these findings may not be transferable to all other social workers and health practitioners with different social and cultural backgrounds and/or working with Māori, Pasifika, or other ethnicities. Although the focus of the research was not purposely on Māori, it is important to acknowledge that Māori children (0–14 years) have higher disability rates than other ethnic groups according to the Disability Survey 2013 (Statistics NZ). In addition, Māori / Pasifika children known to Oranga Tamariki are 1.6 times more likely to have an intellectual impairment than other ethnicities known to Oranga Tamariki (Oranga Tamariki–Ministry for Children, 2020). Despite the limitations, this study adds to our understanding of Aotearoa New Zealand social workers and other health practitioners' responses to abuse, neglect, and trauma of children with intellectual disability.

Findings

Two themes that emerged from the data analysis are presented in this article: (1) the intersection of disability knowledge and competence to practise, and (2) the relevance of relational practice.

The intersection of disability knowledge and competence to practise

Identifying children with intellectual disabilities who have experienced trauma, abuse, and neglect is a challenging task. It requires social workers and other professionals to respond to abuse appropriately by drawing on their professional practice, underpinned by knowledge, skills, and bi-cultural Te Tiriti o Waitangi practice. While most participants reported that they learnt from working with this group of children to develop their skills, knowledge, and practice, navigating the nuances of disability and abuse was complex. Jill (a social worker) stated that "we must be willing to engage with people around them who know the child better than we do, and who might be able to provide good information about any changes in the child's behaviour." Colleen and Rose (both social workers) identified that communication and child-focused assessment tools were critical for best practice.

Complications can occur when the social worker or health practitioner has limited knowledge of disability, and this was apparent in the accounts of most of the participants. Sarah (a social worker) identified several crucial factors that impeded responsiveness to reports of concern by child protection services. Firstly, she talked about the lack of disability knowledge among social workers, such as limited understanding of intellectual disability to enable them to skilfully write good quality reports that reflected the requirements of support for children with special needs. Secondly, other issues such as lack of support for whānau and family, gaps in service delivery (e.g., respite) and the inability to identify and analyse care and protection concerns clearly and concisely to engage care and protection services have also impacted on timely service provision. Given the lack of knowledge about disability, professionals often had to rely on parents or caregivers to interpret what the child was saying. This meant more time was required to build a relationship with a child with intellectual disability than a neuro-typical child. When the child lacked communication skills or had alternative communication requirements, this made it more difficult to understand and identify potential indicators to assess abuse and its impact on their health and wellbeing.

Many of the participants also indicated that identifying and reporting abuse was not always easy, and it could become very problematic, particularly when there was tension between child protection and community agencies as to whether there was a care and protection issue or a disability issue. Rachel (a social worker) said "I have to work really hard to convince them [statutory care and protection organisation] to take on these cases. They show a lack of understanding and there needs to be an awful lot more education." Jill (a social worker) shared, "I do know that children with intellectual and physical disabilities are more vulnerable to abuse because they are less likely to have the ability to identify that they have been abused," making disclosure and support planning challenging. Even when the incident was proven to be a care and protection issue, some of the participants reported that children with intellectual disability were not removed from the home because their care needs were too high and a suitable placement could not be found despite all their siblings being removed, leaving the most vulnerable child behind. Jane (a clinical psychologist) expressed her frustration and a sense of powerlessness about the lack of clear guidelines to initiate a clear response,

> [T]here have been so many times where I have felt that the child has been let down by care and protection, at what stage do I write a more general letter about this child, what can I do as a professional, to elevate or escalate.

Their perceptions of children with intellectual disabilities being vulnerable to abuse, resulting in severe negative impacts, were supported by Jones et al. (2012) who found that abuse, neglect, and trauma did not exclude children with intellectual disability, but that these situations were often not rigorously investigated, disclosed, or discussed. Such inconsistent responses were highlighted by participants as at times their concerns were brushed off because of the problematic nature of having a clear and confirmed identification of abuse among children with intellectual disability (Algood et al., 2011; Ofsted, 2012; Taylor et al., 2015).

Despite the ongoing frustrations reported by many participants due to the lack of clear and consistent responses to address abuse, neglect and trauma experienced by children with intellectual disabilities, participants like Alice and Joanne (both clinical psychologists) expressed a strong sense of duty and responsibility to continue advocating for the rights of these children. Without doing this, they felt that there would be no hope of change at a systemic level locally and/or nationally. Three social work participants, Colleen, Jackie, and Rachel, expressed strongly that a solid knowledge base and placement opportunities in disability should be included and taught in social work undergraduate studies, moving away from "the medical model to a social model of disability." Rose (a social worker), however, acknowledged that it was not always possible to cover all fields of practice within the social work curriculum, but social workers should be supported by their employers to attend workshops on disability as part of their professional development. Rose also said that utilising supervision to engage in critical reflection and discussion on how to improve practice when supporting children with intellectual disabilities was paramount "to make it safe for the family, for the person, for the individual", stating "it comes down to good quality supervision, your training, ongoing development, and you as a person." It is imperative that social workers and health practitioners do not respond to disclosures of abuse, neglect and trauma with disbelief or inaction to ensure that children with intellectual disabilities are not left in environments which are harmful (Franklin & Smeaton, 2018; Jones et al., 2017; Robinson & Graham, 2019).

Relational practice

To provide effective support to children with intellectual disability who have experienced abuse, neglect, and trauma, it is crucial for social workers and health practitioners to build trusting and respectful relationships with whānau and families. Relational practice was strongly emphasised among participants as one of the major practice approaches to ensure support and interventions are delivered adequately and sensitively to children with intellectual disabilities and their whānau and families. Vital to building successful relationships is the notion of being empathetic and non-judgemental. Pam (a physiotherapist) said, "respecting and hearing both the families and the child's voice as best you can, and then really hearing what it is they really need from me that is what makes it so successful." Participants understood the significance of this practice, where drawing from a participatory, therapeutic, and strengths-based position could not only contribute to trustful and meaningful relationships but also transform practice holistically (Teater, 2014).

Relational practice positioned the social workers and health practitioners in a space where they were able to draw on their disability knowledge and understanding of the wider societal challenges and capture, not only the explicit, but also the implicit experiences of the whānau and families. There was a collective agreement in the first focus group about the value of working with a child and their family from a young age until their teens, giving them an in-depth life-course of knowledge that enabled them to make good decisions. Sarah (a social worker) said, "if a crisis happens you can put it in the context of the family, this is not a crisis for them, this is something they go through regularly." These parents often struggled with grief and loss that was associated with not having a "normal" child which led them to feel angry, despair, and doubtful of the future for the care of their children. Findings from the study recognised that children with intellectual disability and their whānau and families were more likely to be isolated, marginalised, and discriminated against, making them more vulnerable than other whānau (and family). To minimise this vulnerability, focus should be on how to develop a relational, humanistic, client-centred way of practising where professionals can build connections based on trust and established relationships to support good quality assessments and interventions. Jackie (a social worker) felt that parents did not need to be experts but "if the parent feels more confident in their parenting or has a greater awareness of their child's needs and understanding of behaviours that are happening, I also see that as a success." The need for parents to receive education about their child's intellectual disability was often mentioned. Most participants verbalised the difference it made in the lives of children with intellectual disability if their parents were proactive and "willing to learn about their children and be realistic" about their child's abilities and needs, as reported by John (a clinical psychologist).

Relational practice is informed by the context of whānau and family life; therefore, it is critical that social workers and health professionals understand the additional challenges and difficulties experienced by parents/primary caregivers in raising a child with disabilities. Participants acknowledged the challenges and issues in raising a child with intellectual disability, but when combined with financial hardship, inadequate housing, gaps in service delivery, isolation, stigma, and social exclusion, these became more overwhelming for the whole whānau to manage. These additional pressures can also have a negative impact on the parents' emotional resilience, potentially causing an increase in stress and anxiety and impacting on their ability to meet the needs of their child with intellectual disability (Murray, 2018; Sen & Yurtsevery, 2007; Wynd, 2015).

Discussion

The social workers and health professionals who contributed to this research provided rich insights into the responsiveness to abuse, neglect, and trauma of children with intellectual disability in Aotearoa New Zealand. Those insights were supported by a growing body of research focusing on the lack of knowledge, competence, and confidence among social workers in the area of disability and its connection with child maltreatment. Differences in dealing with suspected child abuse and neglect may be due to different cohorts (Maclean et al., 2017; Sullivan & Knutson, 2000), identification approaches (Ben-Arieh & Haj-Yahia, 2006) and organisational settings (Louwers et al., 2012). To ensure that children with intellectual disability receive reliable assessments, collaborative, exemplary, and evidence-based practice in a multi-disciplinary team using a comprehensive "medical interview", "child interview", and “anogenital and sexually transmitted infection tests” to form a pathway to develop a report about alleged abuse, are required (Vrolijk-Bosschaart et al., 2018).

In addition to inconsistent responses and lack of resources to aid diagnoses and assessment, participants also identified a sense of ambivalence among practitioners towards the context of abuse among children with intellectual disability. Social workers and other health practitioners are often seen as performing a delicate balancing act by juggling the demands of the law, upholding the established social relations within the family and whānau, the cultural contexts of the whānau (and family) and the child, and moral responsibility to their professions. The current research has highlighted that identification of abuse and neglect rests upon social workers’ own values and beliefs, and concerns about the potential outcome for the child if reported (e.g., family breakdown) and the persistent assumptions that children with disability do not get abused (Franklin et al., 2015; Kelly & Dowling, 2015; Palusci et al., 2015). Other research has also indicated that professionals such as teachers felt conflicted and lacked confidence to report abuse due to their loyalty to the families they have worked with, supported, and built trusting relationships with (Schols et al., 2013). These studies demonstrated that the process of reporting abuse among children with intellectual disability is not straightforward because of practitioners’ behaviours and assumptions hindering reporting and perpetuating the under-reporting of these situations. As more evidence appears in the literature to indicate that disabled children are more likely to be at risk for child abuse than neurotypical children (Heinonen & Ellonen, 2013), it is vital that practitioners do not respond to disclosures of abuse, neglect and trauma with disbelief or inaction to ensure children with intellectual disabilities are not left in environments that are harmful (Franklin & Smeaton, 2018; Jones et al., 2017; Robinson, 2015; Robinson & Graham, 2019). Furthermore, the accumulative experience of life events such as family violence and poverty may erode the resilience of a person with intellectual disability more than peers without intellectual disabilities, making it more critical for social workers and health practitioners to understand the impact on wellbeing across their lifespan (Wigham & Emerson, 2015). Participants in the current study highlighted that, when social workers and health practitioners neglect the wider systemic influences, including inaccessibility to social and material resources and poverty (Jones et al., 2017), the trauma experienced by the child is exacerbated (Thomas-Skaf & Jenny, 2020). Kam (2020) has further emphasised that skills such as relational, advocacy, dedication, empowerment, and seeing their role as “not just a job” (p. 781) are crucial in supporting disabled people.

Most of the participants reported that they developed their knowledge and competence in working with children with intellectual disabilities and their whānau and this “learn on the job” experience was consistent with existing literature (Jones et al., 2012; Manders & Stoneman, 2009). The consequences of a lack of disability knowledge can impact on social workers and health practitioners’ abilities to provide adequate or even optimal care for this cohort of vulnerable children. Participants in the current research expressed concerns of some practitioners’ inability to recognise the results of abuse from behavioural changes over disability and have prompted the call for including disability as one of the main fields of practice in their profession’s qualification and training. This was observed in the growing body of literature, which showed positive outcomes for social workers who felt more confidence in working with the disability community when they acquired disability knowledge in their undergraduate study (Meekosha & Dowse, 2007; Mogro-Wilson et al., 2014). Although there has been progress in developing and including disability in the teaching curriculum, John and Schrandt (2019) identified that some social work students struggled to identify the difference between intellectual disability and mental health. As such, there is a significant way to go in equipping new graduate social workers to work competently and confidently with children who have an intellectual disability.

What has been identified in the literature is that social workers and health practitioners could inadvertently or intentionally perpetuate the societal perceptions of what disability means due to the generationally and historically entrenched medical model of benevolence, treatment, and management (Geoffrey, 2014; Meekosha & Dowse, 2007). The social model of disability provides an opportunity for social workers and health practitioners to, not only challenge their own perceptions and prejudices about disability (Flynn, 2020), but to also move beyond individual and victim blaming models to develop new and transformative ways of practice (Munford & Bennie, 2015). These practices should focus on enabling more time to build relationships, develop purposeful assessment tools and enhance social workers and health practitioners as champions for equity and equality to address deficits and barriers in the social and physical environment and in social policy. Supporting children with intellectual disability to live in a safe and nurturing environment and recognised as valued members of society are all important elements to ensure that their citizenship and rights are respected. In doing so, when a child with intellectual disability requires therapeutic interventions—just like their peers without intellectual disabilities—in response to abuse, neglect, and trauma, there should be no societal and structural barrier of prejudice impeding them from accessing a counsellor or psychologist (Adams & Leshone, 2016; Bigby & Frawley, 2010).

Building relationships with children with intellectual disabilities is key to safeguarding them from abuse, neglect, and trauma. It was identified by several of the participants that there have been limited therapeutic interventions for these children due to the misconception of their cognitive inability to experience trauma and to actively participate in the therapeutic process. Findings in recent research evidence have challenged this notion by showing that indicators of post-traumatic stress disorder were no different in children with intellectual disability or without (Mevissen et al., 2016). Results have shown that therapeutic interventions using different methods of engagement such as eye movement desensitation and reprocessing and play therapy, can have positive results in supporting children with disabilities, enabling them to strengthen their coping skills and resilience (Mevissen et al., 2016; Mora et al., 2018). To work successfully and supportively with children with disability and their whānau and family, findings in the current study have confirmed that it requires social workers and health practitioners to draw on their widely used professional skills and professional principles. These include anti-oppressive and rights-based approaches, adherence to ethical and moral obligations, advocacy and working in partnership to build trustful and respectful relationships as reflected in social work and health practitioners' professional codes of ethics (ANZASW, 2013; Occupational Therapy Board of New Zealand, 2015; Physiotherapy Board of New Zealand, n.d; Psychologists Board, 2012).

One of the major key concerns expressed by the participants was the lack of consistency in recognising, assessing, and responding to the initial allegation of abuse of children with intellectual disability within the community and within the child protection triaging system. This requires practitioners to practise confidently and competently. A possible solution could be the introduction of multi-disciplinary approaches with comprehensive and wide-ranging professional knowledge of children with intellectual disability and their experiences of abuse, neglect, and trauma (Vrolijk-Bosschaart et al., 2018). To do this well, this may also require social work education to focus on learning the importance of applying a social model of disability across the life span to reduce the discrepancy of seeing disability as separate from human development and to promote inclusivity and relational practice.

Services and support to children and young people with intellectual disability are increasingly being impacted by neo-liberal agendas of cost-cutting, high turnover of social workers and health practitioners and support workers, individual contracts, and individual responsibility, which has made services and support more precarious (Carey et al., 2018). Participants in the current study recognised that, to mitigate risks and abuse among children with intellectual disability and their whānau and families, social and transformative changes are also required at a macro level. A recent report published by Waikato District Health Board (WDHB, 2019) in the New Zealand "Disability Responsive Plan" developed in partnership with people with disabilities highlighted the need to address accessibility barriers such as transportation, diagnostic assessments and interventions occurring in a timely manner and the removal of financial obstacles for those under 15 with disabilities. Social change requires collective responsibility to be responsive to the specific needs of children with disability and to maintain their dignity (Munford & Bennie, 2015; Thomas-Skaf & Jenny, 2020).

This research argued for the integration of trauma-informed frameworks into social services in relation to organisations' policies, procedures, and vision statements, and regular trauma training with the intent of providing therapeutic support and minimising re-traumatisation (Fuld, 2018; Harvey, 2012; Munford & Bennie, 2015; Thomas-Skaf & Jenny, 2020). It has also been identified in the New Zealand Disability Strategy 2016-2026 (Office for Disability Issues, 2016) that one of the eight outcomes is specifically related to health and wellbeing, recognising that there is much work to be done to bridge the gap between policy and practice to address inclusive service delivery and outcomes for people with disabilities. The importance of social workers having the knowledge and understanding of intellectual disability and its related discourses will enable them to practise from a social, relational, rights-based model by developing better socio-political and cultural understandings of childhood disability, mental health, and illness (Munford & Bennie, 2015).

Conclusion

Overall, this research has provided an opportunity to gain a better understanding of social workers and health practitioners' experiences in supporting children with intellectual disability and their whānau and families. Their dedication and desire to make a difference in practice is admirable and provides important insights into moving forward to address abuse, neglect, and trauma of children with intellectual disability. The disability field is a unique field of practice that requires practitioners to be equipped with disability knowledge, competent practice skills and the ability to build respectful and sustainable relationships with children with intellectual disability and their whānau and families. To achieve this, social workers and health practitioners need to engage in critically reflective practice that enables them to establish trusting relationships and provide meaningful support to children and their whānau and families. This relational practice will be supported by an inclusive community, which values the experiences and contribution of children with intellectual disability and their whānau and families. Success will be evidenced when this group of children's wellbeing is treated with the same respect and dignity as their peers without intellectual disabilities, enabling them to live in safe and nurturing environments where they are free from abuse, neglect, and trauma.

Submitted 4 November 2021

Accepted 4 March 2021

Published 13 May 2022

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ORIGINAL ARTICLE

QUALITATIVE RESEARCH

Loneliness and boredom in residential care: Voices of older adults

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ABSTRACT

OBJECTIVE: Older adults may experience loneliness and boredom in residential care. The purpose of this study is to extend understanding of the experiences of older adults in residential care and identify factors that residents themselves believe contribute to loneliness and boredom. In addition, I aim to identify the strategies used to cope with these experiences and provide recommendations to enhance the quality of life in residential care.

METHODS: A phenomenological qualitative study was conducted through participant observation, in-depth interviews with 24 residents and key informant interviews with 10 staff members.

RESULTS: The findings emphasise the pervasiveness of loneliness and boredom in residential care despite facilities' efforts to provide activities and support. Staff and family support helped to alleviate loneliness and boredom and participants employed individual coping strategies.

DISCUSSION: Health professionals and social workers should recognise loneliness and boredom as issues and prioritise residents' individual needs and preferences to minimise the risk of loneliness and boredom.

KEYWORDS: Boredom; loneliness; older adults; phenomenology; residential care

AOTEAROA
NEW ZEALAND SOCIAL
WORK *34(1)*, 88–99

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Loneliness and boredom are an increasingly common problem in residential care (Adams et al., 2004; Jansson et al., 2020; Neves et al., 2019; Pinquart & Sorensen, 2001; Steele & Linsley, 2015) and have various adverse health outcomes such as disability, cognitive impairment and increased rates of mortality (Wright-St Clair et al., 2017; Gale et al., 2018). The transition to residential care can be traumatic and stressful and many older adults do not always receive consistent support from social services in meeting their emotional and social needs during this time (McKenna & Staniforth, 2017).

The risk factors for loneliness and boredom in residential care include unfamiliar environment, rigid routines and a standardised caring system. A homely environment and identity-promoting care are important in establishing a meaningful existence at the end of life (Osterlind et al., 2016). The home is attached to identity, feelings of comfort, familiarity and security among older adults (Bland, 2007; Jaye et al., 2015; Robertson & Fitzgerald, 2015; Wiles et al., 2009). Brownie et al. (2014) and Prieto-Flores et al. (2011) reported that the transition from home to residential care led to increased loneliness in older adults due to a loss of identity, independence and autonomy. It is also reasonable to suppose that the risk of loneliness is higher among older adults in residential care than those in the community due to multiple losses and disrupted meaningful engagement with friends, family and the community (Smith, 2012; Victor, 2012).

Rushed care, rigid routines, a lack of leisure opportunities, social engagement, and meaningful relationships, staff shortages and abuse tend to increase depressive symptoms and poor well-being (Bland, 2007; Brownie & Horstmansh, 2011; Harper Ice, 2002). Some studies have highlighted the importance of having social workers working alongside physicians, nurse practitioners, and registered nurses in care management (Donelan et al., 2019; McKenna & Staniforth, 2017). A flexible and comprehensive, person-centred caring culture and additional support is important to help older adults retain their identity, autonomy and independence (Paddock et al., 2019).

There has been very little research into loneliness and boredom in residential care. Previous Aotearoa New Zealand studies on loneliness have tended to be quantitative and have focused on older adults living in the community (Davies-Kelly, 2014; Jamieson, 2018; La Grow et al., 2012). This article instead draws on PhD research in which loneliness emerged as a major theme from the participants' descriptions of their experiences of leisure life in residential care facilities. The main objective of the research was to add to the knowledge on loneliness among older adults living in residential care and explore the impact of leisure experiences on their well-being. A qualitative approach was used to determine if, and why, older adults in residential care feel lonely and bored and how they cope with those feelings.

Literature review

Loneliness is defined as a subjective, unpleasant and distressing feeling associated with the lack or companionship or inability to establish satisfying relationships (Brownie & Horstmansh, 2011; Davies-Kelly, 2014; de Jong Gierveld, 1998). It has been argued that loneliness and social isolation are different concepts (Brownie & Horstmansh, 2011; Jamieson, 2018). Older adults can feel lonely without being socially isolated. Being part of a large social network does not necessarily protect an individual from loneliness. Previous studies instead suggest that older adults seek close and reliable relationships to satisfy their emotional needs (Adams et al., 2004; Brownie & Horstmansh, 2011).

Boredom refers to absence of meaning and purpose in a person's life or not being involved in activities or lack of interest. Babalet (1999, p. 631) defines boredom as "a restless and irritable feeling about an absence of interest or an anxiety about the absence of meaning in a person's activity and circumstance." Older adults who are dependent on others for their activity, but prefer not to be a burden, or who confine themselves to their rooms because of an unfamiliar environment tend to end up doing nothing. The feeling of having nothing to do, in turn, fosters a sense of boredom and loneliness (Harper Ice, 2002). Boredom is associated with a lack of meaningful relationships, roles and having a sense of control (Steele & Linsley, 2015).

Studies of residential care facilities have highlighted the prevalence of passivity or sedentary behaviour. Many residents sit alone in their rooms doing nothing or are left in front of the television all day (Brownie & Horstmanshof, 2011; Gine-Garriga et al., 2019; Leung et al., 2021; Li et al., 2020; New Zealand Labour Party, 2010; Wilcock & Townsend, 2009). Similarly, some studies have highlighted the prevalence of enforced idleness, with few opportunities and encouragement at the facilities for residents to participate in leisure activities (Cahill & Diaz-Ponce, 2011; Fiveash, 1998; Problem of idleness in old people's homes, 1929; Sarantakos, 1989; Smith et al., 2018). As a result of this passivity, sedentary behaviour, and enforced idleness in residential care, there is an increased risk of loneliness and boredom.

Research shows that loneliness among older adults is increasing not only in Aotearoa New Zealand, but also globally, and requires significant attention (Wright-St Clair et al., 2017; Jamieson et al., 2017; Ministry of Social Development, 2016; Ong et al., 2016; Vozikaki et al., 2018; Yang & Victor, 2011). According to a Ministry of Social Development (2016) report, loneliness is more prevalent among Aotearoa New Zealand adults aged 75 years and above than those aged 65–70 years.

A number of researchers have identified the deleterious effects of loneliness. For instance, it has been noted that older adults who are lonely and socially isolated are more susceptible to depressive symptoms, cognitive decline, dementia and frailty (Cattan et al., 2005; Wright-St Clair et al., 2017). In their study of community-dwelling older adults in Ireland, Conroy et al. (2010) reported that older adults with cognitive decline are more prone to loneliness and boredom due to a monotonous environment and an absence of cognitive stimulation and socialisation. Some studies have also noted that loneliness in later life increases the risk of serious physical health issues including heart disease, high blood pressure, Alzheimer's disease and the risk of mortality as well as the likelihood of admission into residential care (Adams et al., 2004; Beal, 2006; Gale et al., 2018; Ong et al., 2016; Pinquart & Sorensen, 2001; Schoenmakers et al., 2012). In other words, loneliness has a significant impact on the quality of life of older adults.

Methodology

This study was conducted using a qualitative approach within a phenomenological framework. Phenomenology has become a widely used qualitative method in several disciplines including nursing, health, and gerontology (Neubauer et al., 2019; Tuohy, 2013). A phenomenological framework was employed to understand the "life world" or "lived experience" of individuals in a social context as well as the process for making meaning of those experiences from the perspective of the study participants (van Manen, 1990). This approach is well-suited to exploring the lived experiences of loneliness and boredom in residential care as it allows participants to talk freely in their natural setting, which is important in understanding problems or issues from their perspective. Ethical approval for this study was obtained from the University of Otago Ethics Committee (Health).

Sampling and recruitment

This study applied two levels of sampling for the recruitment of participants. First, residential care facilities were selected from the lower South Island using stratified random sampling. The stratified random sampling method was chosen to examine the lived experiences of older adults in the facility's ambiance and care provision. Each facility was categorised into one of three groups according to the number of beds: large (80–125 beds), medium (50–79 beds) or small (25–49 beds). Random sampling was used to select two facilities from each stratum for a total of six facilities.

The data-gathering stage of the study began with the researcher observing residents in their facility settings and becoming familiar with their routines and the interactions they had with staff, friends and family members. Comprehensive field notes were taken during this period, as recommended by Creswell (2013). Doing so provided a rich context for data analysis and enabled the construction of rich, thick descriptions of the interviews and the context in which they were conducted.

Four participants from each of the six residential care facilities were selected to participate in semi-structured interviews. The interviews lasted between 30–120 minutes. Consent was obtained from each participant one day prior to the interview.

Of the 24 participants interviewed, 16 were female. Twenty participants identified as New Zealand European, three as Scottish and one identified as Māori. Their ages ranged from 71–94 years, with an average age of 85 years. Most participants were in their 80s and 90s. Pseudonyms are used to ensure the anonymity of the participants.

The final stage of data-gathering involved key informant interviews with staff members responsible for organising leisure activities for the residents. Ten staff members in total were selected from the facilities: four from the large facilities, four from the medium facilities and two from the small facilities. Only one staff member was selected from each of the small facilities because there were no other activities staff at those facilities. All key informants were female and their ages varied between 26 and 62 years. Their length of employment in the facilities varied between 4 and 34 years. Six key informants held diversional therapy qualifications and three held no formal qualifications.

Data collection

The study employed triangulation in the collection of data. Triangulation of data collection deepens the content of the data and increases the credibility of the findings (Creswell, 2003; Denzin & Lincoln, 1994, 1998; Fielding & Fielding, 1986). Data were collected through participant observations, in-depth interviews with residents, and key informant interviews with staff.

As mentioned earlier, semi-structured interviews were conducted with 24 residents and 10 key informants. The average length of interview with the residents was one hour. The inclusion criteria for participants were that they needed to be aged 65 years and above, reside in a residential care facility, be able to communicate well in English and be able to give consent. Participants who were unable to answer the interview questions were excluded from the study.

Data analysis

To analyse the data, I used Braun's and Clarke's (2006) six steps of thematic analysis as it is a widely used method in phenomenological analysis due to its flexibility, transparency, insightfulness and clarity in finding meaning in participants' accounts. I adopted a number of approaches, including coding by hand and using the qualitative software NVivo. This process helped me to identify different patterns and themes within the data and categorise the common themes. In the first and second steps, I produced the initial codes and reviewed the lines, sentences and paragraphs from the interview transcripts and field notes, including the participant observation notes. In the third step, after completing the initial coding and collation, I matched each code to broad themes. Codes were categorised and re-categorised to generate several broad themes and sub-themes from codes generated from the transcripts of participant and key informant interviews, field notes and participant observations. In the fourth step, I began developing coherence between each theme and the codes under it. I generated new themes where the codes did not cohere with each other to develop meaning. In the fifth step, I developed an accurate thematic map. I started to relabel the major themes by going back to the codes and sub-themes I had initially created. In order to improve credibility, my PhD supervisors reviewed the entire data set with coding, sub-categories, categories and themes. Based on their feedback and an analysis of all the data, a final set of themes was developed. In the sixth step, I began reporting and writing up the analysis.

The field notes not only added to the rich descriptions of the participants during data analysis, but also allowed me to critically evaluate my performance, biases and feelings as an interviewer (as recommended by Watt (2007). The observational data and accompanying field notes were referred to repeatedly during all steps of the analysis and guided the final reflections, analyses and discussion. The reflexive journal and advice from my mentors and colleagues on how to deal with dilemmas and emotions occurred during the research process.

Results

Loneliness and boredom emerged as important themes from participants' narratives of their lived experiences in relation to their adjustment to living in residential care and their participation in leisure activities. Five themes were identified from the participants' narratives: loneliness and boredom; activities; support from family and visits from friends; support from staff and co-residents in the facility; and coping strategies.

Loneliness and boredom

When asked about feelings of loneliness and boredom, the responses from the participants varied from "all the time" to "not at all". Those participants who reported that they felt lonely or bored were also asked how often they had those feelings and why. The results are shown in Table 1.

Eighteen participants reported that they felt lonely in the facility. Of these, 16 said they felt lonely sometimes. Ten participants reported that this was because they were not able to see their family very often. Two participants felt lonely because they missed their houses and their wives. Two participants felt lonely because they missed life outside the facility. Two participants felt lonely due to their health conditions. Two felt lonely all the time because of fewer leisure opportunities. Six participants stated that they did not feel lonely at present, but that they had felt lonely in the first few months at the facility.

Six participants reported that they never felt lonely because they kept themselves busy with different activities and socialised often with family and friends. Compared to the others, those participants were also more capable and mobile. For some participants, participating in activities was an opportunity to avoid monotony, whereas for others, the activities provided at the facility were not sufficient to reduce feelings of loneliness and boredom.

Table 1. Feelings of Loneliness and Boredom

	Participants	Reasons
Loneliness	18	
All the time	2	Fewer leisure opportunities
Sometimes	16	Unable to see family very often Missing their houses and wives Missing their outside life Health condition
Do not feel lonely	6	Keeping themselves busy with the activities
Total	24	
Boredom	20	
All the time	9	Offered activities catered towards female residents
Very often	2	Lack of contact with the family
Sometimes	5	Lack of social life
At weekends	4	No activities at weekends
Do not get bored	4	Keeping themselves active and occupied
Total	24	

A total of 20 participants reported that they felt bored. Among them, five reported that they felt bored sometimes. Two participants reported that they felt bored very often because of a lack of contact with family and friends and a lack of activities which interested them. Four participants mentioned that they felt bored because there were no scheduled activities in the weekends. All nine male participants said they felt bored due to a lack of activities which interested them. They also felt that most of the activities offered by the facility catered to female interests.

Activities

The participants' narratives highlighted the issue of enforced idleness in residential care due to fewer leisure opportunities as well as the increased risk of loneliness and boredom resulting from this. Some participants felt that the offered activities did not match their abilities and interests. However, despite the (perceived) loss of activities available, some participants managed to participate in self-led activities, whereas others participated in the activities offered by the facility regardless of whether they matched their abilities or interests.

The most common self-led activities pursued by the participants were walking, reading, listening to music or news, watching television, completing crosswords or other puzzles, talking on the telephone, and spending time with volunteers, friends and family members. A few participants also knitted and gardened.

The common facility-led activities were attending concerts and chapel, playing housie and bowls, completing crosswords/puzzles, and occasional van outings. Four participants helped staff with tasks such as raising funds, folding towels, picking and arranging flowers for the dining tables and folding papers for envelopes. Activities that provided opportunities to learn new skills and contribute to others were also meaningful to the residents. These provided them with feelings of achievement and contribution despite having chronic diseases and being dependent on aged care. Seven participants reported that they felt happy that they were still able to contribute to the community.

Nine participants reported that the activities in the facility were boring and did not interest them. Ten said they did not participate in the ongoing activities as they were happy on their own. Two participants had ambivalent opinions about their current leisure activities as they said they did enjoy them when they took part, but they were not activities they were particularly interested in:

> I am not really interested in you know but I do it [housie] because it's time-consuming things and that's why I do it. I quite enjoy it when I am doing it, but it's not my thing. (Lawrence, 88 years)

The facility staff reported that the activities benefitted residents in lifting their mood as they felt lonely, depressed and anxious when they remained idle. However, they also reported that, despite those benefits, the majority of the residents preferred to be on their own, rather than participate in the activities offered by the facility. Furthermore, some staff members stated that they felt the residents needed individual care and attention rather than activities, as they were in the facility to gain rest and enjoyment in their later life.

All participants noted a lack of activities that interested them. As a result of this, the majority of them said, "I don't bother to participate." A number of participants perceived that the institutions did not put enough effort into understanding what the residents really wanted when providing activities: "I don't think they organise lots here, they do sometimes but not very often"; "there is nothing that I can engage in". One participant reported that his mood became very low when he was left in his room with no activities (requiring him to take medication):

> There is not a lot that really gets my mind active working properly you know. We do have television in the room but everybody gets bored watching television all the time… [crying]. Sorry but when I am left in the room doing nothing, I feel lonely all the time. (Edward, 75 years)

The male participants also shared the experience of not being interested in the activities offered by the facility because they felt many of these were aimed towards female residents. One participant criticised the staff for not taking into account his suggestion of having a walking group.

Comments and stories such as these provide evidence that more attention needs to be paid to the kinds of leisure activities offered by facilities to combat feelings of loneliness and boredom.

Support from family and friends

All the participants felt restricted by the facility in maintaining and building their social networks as they did not have many opportunities to go out, they could not drive and they could no longer join the community. They did not see their friends and family very often due to geographical distance and busyness. Fewer family visits and lack of access to a telephone in their room to contact family increased the risk of loneliness and boredom among participants.

> My family used to come and see me when I was at home. . . I haven't got a phone to ring them so I have to go and ask for a phone. I have to ask someone, nurse, to ring my family. . . I had [a phone] at home with big numbers on it so I can see and pick up the phone on my own you see. (Helen, 94 years)

Many participants reported that living in residential care decreased the number of visits from family and friends. This often led to loneliness and sadness, especially for those participants with no visitors at all. In many cases, visits from friends were not common because they were deceased or had been placed in other residential care facilities and could no longer visit.

Some participants reported that they were not interested in forming new relationships with co-residents because of the prospect of their death. This was apparently because they had experienced the loss of their partners, siblings, children and friends over their long lifetimes and did not want to experience that same grief.

As suggested earlier, most of the participants were unable to maintain or develop connections with the outside community. They felt isolated as they were no longer able to join and contribute to the community groups they had been involved with previously. Only five participants reported that they were still in contact with the community they had lived in prior to coming to the residential care facility. This was possible because the community members were supportive and still visited them or took them to events.

Support from staff and co-residents

All the participants said that most of their day-to-day interactions were with facility staff rather than co-residents. However, due to the staff's workload, it was difficult to have conversations with them. The key informants acknowledged that they were unable to provide individualised attention to each resident despite this being important for them:

> I think the one-on-one contact is important for them because a lot of them don't have it. They don't have some of them coming in so I think more you know is being with someone for a time just talking to them. Care staff they don't have time because they [are] doing cares. (Activity Staff, 3)

Twenty-three participants stated that they went together to their meals, but nobody talked to each other. In some cases, they said they were not being approached, while others found it hard to talk to their co-residents as they felt their interests and status did not match. For example, one of the participants said she felt a difference in status because her co-residents were not as educated as she was. Some participants (22) stated that taking part in meaningful conversations and building relationships was very difficult due to many of their co-residents being very unwell. The residents who did not have dementia distanced themselves from those who did, and this increased the likeliness of isolation and loneliness among residents.

> You can't talk to because they can't talk to you umm . . . They are mostly stroke victims and dementia victims and they can't talk, some of them can't talk at all, some of them they can, but disjointed and that's what I find, there's no one that I can talk to apart from nurses. I can talk to them, but nobody else really. (Lawrence, 88 years)

Six participants had been able to form friendships with co-residents; however, this was not common. As suggested earlier, the main reasons the participants gave for not being interested in making friends were frailty, social status and the frequent deaths of co-residents. Less impaired residents described withdrawing from relationships with other residents in order to maintain their privacy and status. Many participants felt that the other residents were more cognitively impaired than themselves and were no longer able to communicate with them. Dave (76 years) explained that he felt lonely because he was "not having contact with people that [he] would like to."

Coping strategies

Participants reported that they felt lonely and bored all the time during their initial months at the facility, but many of them agreed that developing strategies of acceptance was important to thrive in residential care. Some participants had developed strategies to cope with the loneliness and boredom. Despite feelings of exclusion, the majority of the participants tried to maintain and reproduce their sense of connection to others through other sources. Some participants switched their active activities for passive ones such as listening to the radio, reading books, watching television, and talking on the telephone. One participant said she liked listening to the news so she could stay in touch with the outside world. For some participants, the telephone played an important role in avoiding loneliness and boredom as they could contact their family when they felt lonely and it gave them an opportunity to maintain their social relationships:

> I discovered the phone was very handy. I could do all sort of things on telephone that I could do just as well in person but I couldn't and at least a telephone gets me a chance to keep in touch with people. (Catherine, 90 years)

Participants also coped with feelings of loneliness and boredom through a positive attitude. Some participants with no family and friends preferred to be alone and justified this preference by referring to themselves as lifetime loners. One participant called herself a loner as she had lived on her own before entering residential care and preferred to continue to be on her own:

> I'm quite happy with what I am doing. As I say, leave me alone, I am quite happy here. Some says you shouldn't sit here whole day on your own and I said I listen to the radio. (Sarah, 94 years)

The social isolation in the facility seemed to be more difficult for the male residents than the female residents. Christine (87 years) shared that it would be hard for her husband as he was a social kind of person, but she was managing well as she had grown up as an only child and she was happy as long as she had a book to read.

Discussion

The findings of this study provide further indicative evidence that older adults in residential care in Aotearoa New Zealand are lonely and bored despite policies of person-centred care. The role of medical professionals, social workers and support workers is significant in identifying older adults who are feeling lonely and bored. The feeling of loneliness is often unidentified or overlooked or misinterpreted (Smith, 2012). Older adults have no opportunity to prepare for the transition (Osterlind et al., 2016). The rushed and urgent transition from hospital to residential care and multiple losses and routinised/standardised care have a negative impact on identity, autonomy, self-determination and empowerment, and well-being. The findings also suggest that the initial days in residential care were the most challenging and that advance planning and additional support are needed to minimise the trauma of the transition. The increasing frailty of older adults in residential care and their decreasing ability to participate in some activities places an added importance on understanding diverse needs, as one set of strategies does not meet the requirements of all.

It is clear from this study that participation in meaningful activities is important, not only in combatting loneliness and boredom, but also in enabling residents to maintain autonomy, self-determination and empowerment even when their physical and cognitive impairments affect their ability to participate in some activities. One-to-one conversations and activities that provided a feeling of contribution or connection such as helping staff with daily chores or outings with family, friends and staff seemed to help the participants maintain and develop autonomy, self-determination and empowerment. Conversely, failure to satisfy their need for meaningful engagement and social connection increased participants' feelings of loneliness and boredom.

The findings of this study are similar to those of Paque et al. (2018), in that loneliness in institutionalised life seemed to be linked to fewer leisure opportunities matching participants' interests and a lack of meaningful relationships with staff and co-residents. Roos and Manan's (2012) suggestion that offering group activities helps to build interpersonal relationships is not supported by this study. Many of the participants were not interested in joining group activities with other residents, but instead preferred to be on their own.

This study instead highlights the importance of frequent visits from family and friends, opportunities for outings and engaging in chores similar to those they would engage in at home for providing meaning and purpose to participants' lives. This is consistent with the findings of Koopman-Boyden et al. (2014), in that activity gives a sense of purpose and importance to older adults and enables them to live meaningful lives. Similarly, Adams et al. (2011) argued that individualised activity is important in fostering well-being because individual characteristics such as personality or gender impact on the choice, meaning and quality of activity. The findings from this study provided further evidence of a "one size fits all" strategy in residential care. Activities that are very meaningful to someone might be boring to others.

Loneliness and boredom have a negative impact on the quality of life of older adults in residential care. Opportunities for interpersonal communication and both formal and informal support are important for successful intervention (Davies-Kelly, 2014). More research is required to understand individuals' experiences of loneliness and boredom to meet the diverse cultural and individual needs of older adults in residential care in Aotearoa New Zealand. Overall, the findings of this study suggest that older adults in residential care are at risk of loneliness and boredom and understanding their experiences is pivotal in addressing these issues.

Limitations

There are limits on the generalisability of the findings from this study because the research was conducted in a small Aotearoa New Zealand city. However, the findings add to the understanding of the experiences of loneliness and boredom among older adults in residential care. In addition, participants from certain ethnic groups, such as Māori and Asian older adults, were underrepresented in this sample. Future research should address these sampling issues to increase the generalisability of the findings on loneliness and boredom. Furthermore, it would be important to consider residents with dementia. This study excluded the residents who were unable to answer the interview questions. A study focusing on residents with dementia only with multiple interviews and observations would be important.

Conclusion

This research contributes to a richer understanding of loneliness and boredom among older adults in residential care. The findings revealed that the transition from home to a residential care facility, fewer leisure opportunities, physical health and lack of meaningful relationships exacerbate the risk of loneliness and boredom. Person-centred activities, meaningful social contact, and the role of health professionals and social workers are important in meeting the diverse needs of residents. Further qualitative research with a focus on loneliness and boredom is necessary to extend the findings regarding the relationship between transition, enforced idleness, loneliness and boredom in residential care.

Implication for practice

- Collaboration between social workers, health professionals, nursing staff and activities staff is essential to identify and minimise the risk of loneliness and boredom.

- Social workers need to identify concerns, limitations and problems that affect residents' participation in activities. Collaboration between social workers, care workers and activities coordinators is important in offering diverse and meaningful activities.

- Social workers can play a key role in identifying and de-escalating psycho-social issues through information, counselling, and providing support to both older adults and their families in easing the transition process.

- One-to-one intervention is necessary to maximise residents' participation in activities.

- Residents' activity plans and activity engagement need to be continuously evaluated and updated as often as necessary.

- Further research is needed on the role of social workers in minimising the risk of loneliness and boredom.

Submitted: 21.7.21

Accepted: 10.02.22

Published: 13 May 2022

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ORIGINAL ARTICLE
QUANTITATIVE RESEARCH

Understanding the personality of single and married women: Implications for women-centred social work practice

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ABSTRACT

INTRODUCTION: In contemporary Indian society, there is now restructuring and reorientation of a women's role. The importance of studying married and single women has now become more pertinent because of the changing attitudes, increased literacy rate of women, and their involvement in politics and economic development. The present study aimed to understand whether the status of being "married" or "single" influences a woman's personality.

METHODS: The sample consisted of 52 women from New Delhi, India. The NEO-FFI-3 (McCrae & Costa, 2010) was used to measure the five domains of personality: neuroticism (N); extraversion (E); openness to experience (O); agreeableness (A); and conscientiousness (C).

FINDINGS: The analysis showed no significant differences in personality between single and married women.

CONCLUSION: It was concluded that the status of being married or single was, alone, not enough to differentiate their personalities. However, married women have varying moods and the capability for communicating and interacting with others more effortlessly in comparison to single women. This paves way for the demystification of the notion of marriage and provides avenues for deconstructing the position of marriage as a norm. Social workers should be aware of gender inequalities and bias, including about status of married and single women.

KEYWORDS: Women; single women; married women; personality; NEO-FFI-3; women-centred social work

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WORK *34(1)*, 100–112.

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Marriage is a destiny conventionally offered to women by society. In Indian society, marriage is a holy institution, one which must happen for a woman at a definite time as dictated by society. It is often seen as the sole justification for a woman's existence. Radical feminists perceive this as an imposition mainly owing to two things: the purpose is seen as reproduction for progeny and maternity; and secondly, the gratification of man's sexual needs alongside taking care of his family (Nuti, 2016). Clarke et al. (2010) also highlight the need and care perspective as another function of marital therapy. Whilst, for a woman, marriage is the only means of integration into the community, and if they remain unmarried, they are socially viewed as waste (Beauvoir et al., 2011). Kareem (2013) suggests that, in Indian society, marriage is seen as a norm that excludes and labels women as "outcasts" for their non-compliance.

Marriage is often used as a tool for women to be treated differently and deprived of their rights but also reminded of their duties. Idealisation and adherence to norms was an understood aspect of the marriage (Clarke et al., 2010). The gender disparity originating from popular socio-cultural beliefs also led to differential treatments and practices which are visible in today's society (Dahal et al., 2015). Traditionally, the status and the role of women in Indian society have been considered inferior to that of men, only married women were seen as complete beings. If a woman has not been married after passing a particular age, she is subjected to questions by her relatives and is looked down upon (Beauvoir et al., 2011). Remaining single is a choice that women can make in today's society and it is becoming a popular and accepted practice. Salve (2015) captures the sharp rise in the cases of single women in India claimed by Census of India 2011 which states that there is an increase of 39% in single women in India, the numbers rising from 51.2 million in 2001 to 71.4 million in 2011, according to census data. This could be viewed in the light of the resentment against the determinants stated in the above section. In this regard, Salve (2015) directly captures the issues of single women as well as married women through the narratives of both cohorts. The National Forum for Single Women's Rights (hereafter NFSWR) lists the context of prejudice and patriarchy to highlight the reasons for increased single-women-headed families over a period of time.

The shift

Over the past few decades, there have been changes in laws, attitudes and norms affecting women's status, roles, and development in Indian society. As a result of these changes, married women have ventured ahead of the traditional role of wife or mother, and have sought employment and careers outside their homes. These practices are reflected in the economic and social development of the nation (Liddle & Joshi, 1989). Rapid social changes in married and single women's careers and family roles are accompanied by a significant transition in their attitudes towards career and family. Researchers have highlighted that the complex relationships between a woman's objective roles and her subjective attitudes regarding these roles, affect her overall life satisfaction and sense of identity in society (Phillips & Imhoff, 1997).

The context of single women

Matlin (2011) said that single women are more likely than married women to work outside their homes. Most single women decide to marry later or not to marry at all because they are career-oriented. These women often report that being single allows them flexible working hours and geographical mobility. In contrast, a married woman may find it difficult to handle work and her family life. According to Klemer (1954), differences between a group of single and a group of married women might be found in six general areas: personality; family life background; circumstances; interest; behaviour; and physical attractiveness. The significance of studying married and single women in contemporary times is more relevant than ever because of the shifting attitudes of society towards the same. Central among them is the changing value system with an increase in women's literacy, participation of women in politics, economy and popular movements. The study explores how/if the status of being married or single influences a woman's personality.

Review of literature

Research studies on the themes of "single women", "married women", "marriage", "family living", "personality development", "career development", "gender roles", "life satisfaction", and "psychology of women" were reviewed using Boolean logic. Gilbert (2010) claimed that married women are less triumphant, more depressed, less healthy and more prone to die a brutal death than single women. Marriage is a good deal for men, but not so good for women. Men benefit physically and psychologically from marriage. She called this the "Marriage Benefit Imbalance". This term was first introduced by Bernard (1982). She argued that women were not valued for parenting and domestic responsibilities like men who work outside the home and that married men were happier and lived longer than single men while married women were less happy and lived shorter lives than single women.

A married woman has no time left for her hobbies or interests as her family depends on her. This is one of the main reasons why a married woman is seen as a liability at the workplace. But being single has its disadvantages. The availability of a willing sexual partner is a problem for single women. And the financial costs tend to be greater for those who live alone than those who share a household (Smith, 2013). Single women are also short of the emotional support that makes difficult decisions easy to accept (Bowerman, n.d.).

Married and single women differ in aspects of independence, money, free time and future (Bowerman, n.d.). A married woman can no longer live as an independent entity as her actions have to be considered from her partner's point of view whereas a single woman has to consider only her own interests in making decisions. Also, single women can spend their earnings as per their wishes without worrying about an annoyed partner. Being married is like a second job for a working woman as she also has to work at it for it to be successful. They also have to plan and raise the family. In contrast, single women seldom worry beyond their monthly expenses (DePaulo, 2019).

The Indian studies, on the contrary, focused on social, economic and political aspects of single and married women (Chacko, 2003; Nanda, 1992; Raj et al., 2010). There are also ample references for domestic violence and especially the research conducted during and since Covid-19 have captured the plight of the marital status of women during lockdown highlighting structural violence and intimate partner violence (hereafter IPV). The factors concerning singlehood and psycho-social factors are not delineated in many studies.

Method

The study aimed to understand whether the status of being married or single influences a woman's personality. The study was descriptive in nature and was conducted with a sample of 52 participants, i.e., 26 single and 26 married women from New Delhi, India. In the study *married women* refers to those women who were married at least for five years, and *single women* refers to those women who had never married. Employed women belonging to the age group 32-42 years and who were married or single were included. Ethics approval was obtained from the Institutional Research Conduct and Ethics Committee (RCEC), CHRIST (Deemed to be University), Bengaluru. The identified participants were provided with an information sheet to tell them about the study, and informed consent was taken in writing. A socio-demographic questionnaire was used to collect the socio-demographic characteristics and NEO-FFI-3 (McCrae & Costa 2010), Form S, a 60-item version of the NEO-PI-3, was used to measure the five domains of personality: neuroticism (N); extraversion (E); openness to experience (O); agreeableness (A); and conscientiousness (C) in single and married women.

According to the *APA Dictionary of Psychology*, neuroticism is characterised by a chronic level of emotional instability and proneness to psychological distress. Extraversion is characterised by an orientation of one's interests and energies toward the outer world of people and things rather than the inner world of subjective experience. Openness to experience refers to the individual differences in the tendency to be open to new aesthetic, cultural, or intellectual experiences. Agreeableness refers to the propensity to act cooperatively and unselfishly. And conscientiousness refers to the tendency to be organised, responsible, and hardworking (*APA Dictionary of Psychology*, n.d.).

The NEO inventories are a standard measure of the five-factor model, which is believed to be the scientifically proven approach for conceptualising the differences between individuals. Each of these five domains is independent and distinctive from the others, and it helped to obtain a quick understanding of the basic attitudinal, emotional, experiential, interpersonal and motivational personality styles of these women.

Table 1 shows some of the domain-specific items in NEO-FFI-3 (McCrae & Costa, 2010) for the five domains.

Participants were asked to respond to the items by marking any one of the five response options: *strongly disagree, disagree, neutral, agree* and *strongly agree*. The participants' responses were scored to get the domain scores for N, E, O, A and C and means were calculated for the five domains. The t for independent samples was then calculated for each domain to ascertain domain differences between single and married women. The t_{cal} and t_{crit} were drawn graphically. The t_{cal} obtained were tested for their significance using a two-tailed test, at 0.01 and 0.05 levels of significance.

Results

Table 2 shows the socio-demographic characteristics of the participants. In the current study, the total sample consisted of 52 participants (26 single and 26 married).

Table 1. Domain-specific Items in NEO-FFI-3

Domain	Items
Neuroticism	1. I am not a worrier. 6. At times I have felt bitter and resentful. 16. I rarely feel lonely or blue. 26. Sometimes I feel completely worthless. 56. At times I have been so ashamed I just wanted to hide.
Extraversion	2. I like to have a lot of people around me. 7. I laugh easily. 12. I prefer jobs that let me work alone without being bothered by other people. 17. I really enjoy talking to people. 32. I often feel as if I'm bursting with energy.
Openness to Experience	8. I think it's interesting to learn and develop new hobbies. 13. I am intrigued by the patterns I find in art and nature. 23. Poetry has little or no effect on me. 28. I would have difficulty just letting my mind wander without control or guidance. 53. I have a lot of intellectual curiosity.
Agreeableness	19. If someone starts a fight, I'm ready to fight back. 34. I tend to assume the best about people. 39. Some people think of me as cold and calculating. 49. I generally try to be thoughtful and considerate. 54. If I don't like people, I let them know it.
Conscientiousness	5. I keep my belongings neat and clean. 20. I try to perform all the tasks assigned to me conscientiously. 45. Sometimes I'm not as dependable or reliable as I should be. 50. I am a productive person who always gets the job done. 60. I strive for excellence in everything I do.

Source: McCrae & Costa (2010).

Of these, 29 (55.76%) belonged to the age group 32-37 years, and 33 (44.23%) belonged to the age group 38-42 years.

The means were obtained for each domain for single and married women. The *t* for independent samples was then calculated for each domain to ascertain domain differences between single and married women. Table 3 shows the t_{cal} and t_{crit} that were drawn graphically. Also, the t_{cal} obtained was tested for their significance using a two-tailed test, at 0.01 and 0.05 levels of significance.

Discussion

Neuroticism

The most ubiquitous domain of personality scales contrasts emotional stability with neuroticism. The common tendency to experience negative effects such as fear, melancholy, embarrassment, rage, regret, and aversion is the foundation of the neuroticism domain. Women high in neuroticism are prone to have irrational thoughts, to be unable to manage their impulses and to have poor coping strategies for stress than others. But women who score low on neuroticism are seen to be emotionally stable. They are generally composed, even-tempered, at ease, and they know how to face stressful situations without becoming disturbed. Aggression, anxiousness, depression, lack of sympathy, recklessness, self-consciousness and susceptibility are the facets of neuroticism.

According to Srivastava et al. (2003), diverse theories suggest different predictions about how the mean levels of different personality traits alter in adulthood. The five-factor theory proposes the plaster hypothesis: The different personality traits stop altering by the age of 30. It was found that neuroticism declined among women but did not vary among men.

The mean obtained for this domain for single and married women were 26.808 and 27.346, respectively. The obtained *t* value was -0.305 at t_{crit} 0.05 (±2.009) and 0.01 (±2.678). Since the t_{cal} was not significant, it was concluded that both married and single women are not significantly different for neuroticism. But the means show that some differences do exist, which could be due to a variety of factors. Married women have obtained higher means than single women. It seems that married women are more likely to experience anxiousness, aggression, jealousy, guilt and depression. They might react inadequately to stressors and take everyday situations as intimidating. They may also experience feelings of shyness or self-consciousness. Therefore, significant results could have been obtained if the facet scores were also determined and analysed.

Extraversion

Extraverts are sociable, but sociability is only one of the traits that encompass the domain of extraversion. Extraverts like people, prefer large gatherings and groups and are also confident, full of life and talkative. They desire excitement and inspiration and have a propensity to be cheerful. They are bubbly, active and hopeful. This domain of personality is strongly correlated with interest in innovative occupations. In this respect, introversion should be understood as the lack of extraversion rather than to

Table 2. Socio-demographic Characteristics of the Participants

Age group (years)	Single women frequency (%)	Married women frequency (%)	Total frequency (%)
32-37	18 (69.23)	11 (42.30)	29 (55.76)
38-42	8 (30.76)	15 (57.69)	23 (44.23)
Total Frequency (%)	26 (100)	26 (100)	52 (100)

Table 3. Means, t_{cal}, t_{crit} and Values of df for Each Domain for the Participants

Domains	Means		t_{cal}	t_{crit}		Significance
	Single women	Married women		α= 0.05	A = 0.01	
N	26.808	27.346	-0.305	±2.009	±2.678	Not significant
E	25.308	28.231	-1.917	±2.009	±2.678	Not significant
O	29.231	28.115	0.691	±2.009	±2.678	Not significant
A	28.115	28.923	-0.486	±2.009	±2.678	Not significant
C	30.462	30.5	-0.017	±2.009	±2.678	Not significant

be its opposite. Hence, introverts are aloof rather than unfriendly, independent rather than followers and even-paced rather than lethargic. Introverts prefer to be alone. This does not necessarily mean that they experience social anxiety. Even if they are not high-spirited extraverts, introverts are not depressing or gloomy. The facets of extraversion are warmth, gregariousness, assertiveness, activity, excitement-seeking and positive emotions.

According to Hosseinkhanzadeh and Taher (2013), extraversion, openness and conscientiousness had a significant negative correlation with life contentment, but agreement had a significant positive correlation with life contentment. The findings suggested that personality traits can explain 19% of the variation in life contentment. It was also found that the relations between income and education had no significant effect on life contentment. Life contentment is influenced by the relation between different factors, and one of them is personality traits.

The mean obtained for this domain, for single and married women were 25.308 and 28.231, respectively. The obtained t values were -1.917 at t_{crit} 0.05 (±2.009) and 0.01 (±2.678). Since the t_{cal} was not significant, it was concluded that both married and single women are not significantly different for extraversion. But the means show that some differences exist between the two groups. Married women have obtained higher means than single women on extraversion. It seems that married women are more enthusiastic, talkative, assertive, and gregarious. They have a propensity to enjoy interactions with humans and enjoy social gatherings. They tend to be energised when around people. But there have been instances where both groups gave the same responses to some of the questionnaire items. For example, participants S9, S10, M9 and M10, disagreed on the item "I don't get much pleasure from chatting with people." Therefore, there exists a contradiction, which could have been understood with the facet scores of this domain.

Openness to experience

Openness is a significant dimension of personality but is less well known than neuroticism and extraversion. The different elements of openness, namely, active imagination, sense of aesthetics, emotional awareness, preference for variety, intellectual inquisitiveness and independence of making decisions have frequently played a part in different theories and measures of personality. However, their coherence into a single broad domain is not familiar. Open individuals are curious about their inner and outer worlds and are prosperous experientially when compared to closed individuals. They experience both positive and negative emotions more enthusiastically and consider novel ideas and values than do closed individuals. People scoring low on openness are predisposed to be conventional in behaviour and outlook. They prefer familiarity to newness, and their emotional responses are a bit muted. The facets of openness are daydreams, aesthetics, thoughts, actions, ideas and morals.

The study conducted by Costa et al. (2001) reported that women are seen to be higher in neuroticism, affection, agreeableness, and openness to feelings, whereas men were seen to be higher in boldness and openness to ideas.

The means obtained on this domain for single and married women were 29.231 and 28.115 respectively. The obtained t value was 0.691 at t_{crit} 0.05 (±2.009) and 0.01 (±2.678). The obtained *t* value was not significant. Therefore, it was concluded that both single and married women are not significantly different for openness. But means show that differences do exist between the groups. Single women have received higher means than married women. It can be understood that married women were more closed to new experiences. They tend to be conventional and traditional in their outlook and behaviour and have a narrow range of interests. But single women are more likely to have more liberal views and do not support biased, authoritarian or ethnocentric opinions.

Agreeableness

Agreeableness is mainly an aspect of interpersonal tendencies. An agreeable person will be fundamentally altruistic. Such an individual is sympathetic and willing to help others and believes that others will also be equally helpful. In contrast, low scores on agreeableness or disagreeable and antagonistic people are narcissistic, doubtful of others' intentions and competitive. It is enticing to see the agreeable side of this domain as both socially preferable and psychologically better, and it is unquestionably the case that agreeable people are more admired than hostile individuals. The facets of agreeableness are trust, straightforwardness, altruism, compliance, modesty and tender mindedness.

The means obtained on this domain for single and married women were 28.115 and 28.923 respectively. The obtained t value was -0.486 at t_{crit} 0.05 (±2.009) and 0.01 (±2.678). The obtained *t* value was not significant, so it was concluded that both single and married women were not significantly different for agreeableness. But means obtained show a slight difference between the groups. Single women have 28.923 as the mean value. Married women may be more kind, sympathetic, cooperative, warm and considerate when compared to single women. Single women can be characterised by scepticism about the motives of others and they could be more likely to be scheming and competitive in their social relationships.

Conscientiousness

Differences in individuals in the process of preparation, organisation and execution of tasks are the base of conscientiousness. Conscientious individuals are focused, iron-willed and determined. Some individuals with high levels of conscientiousness become great musicians or athletes. On the optimistic side, high levels of conscientiousness are linked with scholastic and occupational success and on the pessimistic side, it may lead to annoying meticulousness, compulsive tidiness, or workaholic behaviour. The facets are competency, orderliness, dutifulness, achievement motivation, self-discipline, and thoughtfulness.

The means obtained on this domain for single and married women were 30.462 and 30.5 respectively. The t value obtained was -0.017 at t critical 0.05 (±2.009) and 0.01 (±2.678). Since the t_{cal} was not significant, it was concluded that both single and married women are not significantly different for conscientiousness. But the means obtained shows that there is a slight difference between the groups. Married women have obtained higher means for this domain. Married women may be more efficient, organised, self-disciplined, dutiful and aim for achievement. They may be more organised, dependable, hard-working, and reliable than single women. But since the difference is very small, nothing could be clearly said. Significant results could have been obtained with the facet scales for this domain.

Affective and interpersonal plane

It may be useful to consider pairs of domains or factor scores in terms of two-dimensional planes, which correspond, in many cases to particular areas of life. Two of these combinations have been extensively researched: the affective plane, defined by N and E, which represents the individuals' basic emotional styles and the interpersonal plane or circumplex, defined by E and A. E and O together are essential both for vocational interests and for selecting therapy.

The N + E mean for single and married women were 52.116 and 55.577, respectively. Married women are higher on the affective plane. They may have mood variability and vary between the extremes of positive and negative affect.

The E + A mean for single and married women were 53.423 and 57.154, respectively. Therefore, it is seen that married women are also higher on the interpersonal plane. It implies that they can communicate and interact with others easily. They also make use of persuasion, active listening, and leadership.

Limitations

There could be various possible explanations for the non-significant results. The sample size was minimal, which makes it difficult to generalise the findings to the wider population. With small samples, violations of assumptions are difficult to detect, even if they are present. Since the shorter form of NEO-PI-3 was used, the differences did not seem to emerge. The test may have also been susceptible to social desirability.

Many factors, which include genetics, parenting, environment, and societal variables, influence an individual's personality. Gender roles and the status of being married or single are only a set of potential factors that shape a women's personality.

Future directions for research

Even though this study produced meaningful and insightful results, it was limited. Further researching this topic by considering all the limitations discussed earlier, could significantly enhance our understanding of differences that exist between single and married women, which have remained invisible but perhaps are real and need to be tapped differently.

Implications for women-centred social work practice

The International Federation of Social Workers (IFSW) defines Social Work as a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing (included in the global definition of social work) (International Federation of Social Workers, n.d.).

Social workers work with people of all ages and genders and deal with different kinds of issues. But when working with either men or women, social workers need to be aware of the factors that influence gender-specific vulnerabilities. A women-centred social work practice requires them to be sensitive to the factors that intensify women's vulnerability. Social workers must critically study and understand women's status in society, to develop well-thought-out interventions for women and also for developing women's agency and citizenship.

Simavi is a non-governmental organisation that works for the social and economic empowerment of women and girls in Africa and Asia. They employ a women-centred approach that aims to engage women and girls at all stages of their programmes, i.e., from designing the programme to evaluating its impact (Simavi, n.d.). The Tata Institute of Social Sciences (TISS), Mumbai, India established a Centre for Women-centred Social Work in 2015, which focuses on enhancing interventions and work on women's issues. It also offers an MA Social Work in Women-Centred Practice which aims at preparing and equipping students with the necessary knowledge, attitude, practice and skills to work with women in different settings (TISS, n.d.).

A plethora of research is being conducted by social workers to study the issues of women extensively. Researchers focusing on the personality of single and married women and understanding how it influences their condition, status, role, resources and power in society can help in developing effective interventions for individual and interpersonal development, personality development and also behaviour modification for use in the diverse settings where social workers practise.

Human resource development and management

Leadership and Personality Development at Workplace

In the 21st century, both single and married women have started to come out of the confines of their homes, to live a better life, professionally and personally. Understanding the personality of oneself and others can help the women employees to make informed decisions in light of each individual's preferences, avoid conflicting situations, appreciate the diversity, find the right career path and improve upon one's decision-making abilities. This also helps them to appreciate their strengths and recognise their weaknesses, as well as those around them. The findings of personality studies can help workplaces to identify the areas for professional growth and to organise employee development programmes focusing on leadership development and personality development. Such employee development programmes can empower women employees and make them great leaders.

The World Young Women's Christian Association (YWCA) is a grassroots-driven worldwide movement rooted in the leadership of women, young women and girls. The YWCA's goal for 2035 states that "100 million young women and girls will transform power structures to create justice, gender equality and a world without violence and war; leading a sustainable YWCA movement, inclusive of all women" (YMCA, n.d.). One of the ways by which they aim to achieve this goal is by investing in and building young women's leadership.

Studying women's personalities is crucial as it contributes to one's leadership style. Kaiser and Hogan (2011) proposed that personality has an impact on the effectiveness of a leader. Even Hassan et al. (2016) stated that an individual's personality has an impact on one's leadership style, therefore, it should be considered while examining the effectiveness of the leadership. Özbağ (2016), in his research, found that out of the five personality factors, openness to experience, agreeableness and conscientiousness were found to be important antecedents for leadership.

Clinical and community practice

Individual and family counselling

Studying the personality traits of single and married women allows social workers to help women to understand themselves better, for instance, how they will think, feel and act in situations and their attitudes, motivations, strengths, weaknesses. They can also help them to identify the potential threats or problems they can have at home, or in their interpersonal relationships. Social workers can assist these women to develop the necessary skills to manage or address such problems and this will allow them to lead fulfilling lives.

Social workers can help women to develop their personality, eliminate maladaptive behaviour and adjust better in their social relationships through using casework and group work in family welfare, women and child welfare settings, marriage counselling centres, medical and psychiatric settings, correctional facilities and in residential institutions for women. Yorba-Perez (2014) argued that social workers should understand the preferences, lifestyles and behaviour of single women to provide essential microservices concerning family planning and women's health, birth control, pregnancy testing, HIV/AIDS testing, and screening for sexually transmitted diseases, etc.

Correctional social work

An individual's personality influences his or her behaviour, including criminal behaviour. Some of the earlier studies to study the relationship between personality and criminal behaviour were conducted by Hans Eysenck. At the core of his theory of criminal behaviour is the role played by the three personality traits, namely, psychoticism, neuroticism and extroversion-introversion. Eysenck and Eysenck (1973) in their study found that female prisoners are characterised by high scores for psychoticism, neuroticism and extroversion.

Mili et al. (2015) studied the increase in crimes committed by women between 2001 and 2011 which grew from 5.4% to 6.2%. They observed that the nature and brutality of crimes by women had undergone extreme changes. Earlier, only a few women were involved in monstrous crimes, but now they are being arrested for more complicated crimes.

In a correctional facility, a social worker's clients are individuals who have been, are, or may be imprisoned. Social workers can work with such women to change their criminal behaviour patterns, which implies understanding and developing their personalities. This will help women to successfully rehabilitate into society (Roy, 2017).

Social work with vulnerable sectors

Women are sometimes among the vulnerable sector of Indian society. The Constitution of India has granted equal status to women but they may still be considered vulnerable because of deep-rooted customs. Social workers who act as facilitators, advocates and counsellors play an important role in helping women defeat barriers to necessary social change. They can assist women to be catalysts of change by empowering them with the necessary knowledge, attitudes and skills to self-direct and self-govern their lives.

The National Commission for Women (NCW) was established by the Ministry of Women & Child Development, Government of India, with the vision to support women outside and inside their homes by empowering them to access rights and entitlements with equal opportunities to contribute to society. The NCW has cells focusing on policy monitoring and research, psychiatric/custodial homes reform, capacity building and women welfare among others. Research focusing on understanding the personality of women can contribute the findings for use by these special cells of NCW to develop the interventions required for the welfare, safety, skill development and empowerment of women.

Social welfare and development administration

The social directive of the social work profession is to ensure the wellbeing of all people, irrespective of the societies they belong to, i.e., urban, rural or tribal. To achieve this, social workers engage in community work, administration of social services, advocacy, policy formulation and research. The 11th Five Year Plan of India had emphasised the need to focus on single women, particularly those who chose to stay single. However, not much progress was made. But the 12th Five Year Plan addressed some of the issues affecting single women, like property rights, housing benefits, employment opportunities, and provided special privileges (Dhar, 2016).

Ministries and constitutional bodies at the state and central level are also concerned about social welfare and development. The Ministry of Women & Child Development, Government of India, introduced the SWADHAR scheme, which caters to the needs of women in difficult circumstances. The objectives of this scheme are met through strategies like vocational and upskill gradation training, counselling, and behavioural training. A Central Social Welfare Board (CSWB) was also established by the Government of India under the Ministry of Women & Child Development for the general welfare of families, women and children. Garcia-Sedeñto et al. (2009) through their study concluded that there is an association between personality and vocational interests. A study of the personality of single and married women could help social workers to develop tailored intervention programmes focusing on behaviour modification, personality and leadership development, skill development and much more.

Geriatric social work

In a study conducted by Maldonato et al. (2017), extraversion, openness to experience and conscientiousness were found to be associated with good cognitive health in old age. They concluded that individuals with high neuroticism and agreeableness scores would benefit from customised cognitive interventions to prevent age-related decline in cognition. Wilson et al. (2004) examined the relationship between personality and mortality in older individuals. They observed that the risk of death was double for those who are high on neuroticism and half for those who are high on conscientiousness. Friedman (2000) also supported this by stating that conscientiousness predicts longevity.

Geriatric social workers are responsible for caring for the elderly in diverse settings like hospitals, old age homes, daycare centres and clinics. They support the psychological, emotional, behavioural and social challenges of the elderly through counselling and therapy and by acting as mediators between the elderly and their caregivers. An assessment of the personality of the elderly is important to provide personalised care (Meuwissen-van Pol et al., 2019).

Conclusion

Marriage is an important social institution in Indian society. It is considered essential especially for women to live a meaningful life. A woman’s dignity and respect used to depend only upon her marital status. But over the past few decades, there have been incredible changes in laws, attitudes and norms affecting women’s status, roles, and development in Indian society. As a result of these changes, women today choose to stay single or marry and married women have ventured beyond their traditional roles for employment outside their homes. The present study aimed to understand whether the status of being married or single influenced a woman’s personality. While significant differences did not exist between single and married women, the latter may have mood variability and the ability to communicate and interact with others easily, in comparison to single women.

Many factors determine a women’s decision to be ‘married’ or ‘single’. Social changes, economic empowerment and higher education, among others, are crucial factors in this decision making. In this regard, a social work practitioner, especially an ubuntu practitioner requires collectivisation which asserts the need for harmony and social justice for co-existence. At the advent of increasing global concerns about gender-based violence and gender justice, ubuntu practitioners need to be gender inclusive at both micro-level of practice and at the policy level to bring attitudinal change concerning gender equality.

Submitted 19 April 2021

Accepted 4 March 2022

Published 13 May 2022

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ORIGINAL ARTICLE
THEORETICAL RESEARCH

It takes a village: Advancing attachment theory and recovering the roots of human health with the Circle of Seven Essential Needs

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ABSTRACT

INTRODUCTION: Bowlby's attachment theory (AT) remains a popular way to understand infant, child, adolescent, and even adult and family dysfunction. However, attachment theory, which has not changed significantly since its inception, is a reductive theory that ignores a wider range of human needs and has caused significant hardship and trauma. The limitations of this model, particularly when applied outside the Eurocentric and ethnocentric frames of mainstream psychology, are well known.

APPROACH: In this article, we suggest it is time to replace the reductive theory of needs that underpins AT with a comprehensive theory, one that could help us develop a less ideological, healthier, and more empirically informed approach to socialisation and social care; one that might help us answer Abraham Maslow's eupsychian question which is how to build a society capable of actuating the full potential of all its citizens.

CONCLUSIONS: The answer is simply this: the only way to actualise full human potential is to move the locus of human health and full development away from a single female, or even a single nuclear family, to a village, a community, and a society that understands humanity's complex constellation of needs and that is consequently and exclusively geared towards meeting those needs.

KEYWORDS: Abraham Maslow; John Bowlby; attachment theory; hierarchy of needs; circle of seven essential needs; eupsychian psychology

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In Western colonial psychology, attachment theory (AT) remains a respected and profoundly influential way to understand infant, childhood, adolescent, and even adult, attachment behaviour (Mercer, 2011). Despite criticism, attachment to attachment theory has not declined but has, with the birth of the internet, intensified (Rosabal-Coto et al., 2017), with "more articles being published on the subject in the last 5 years than the preceding 25 years combined" (Yip et al., 2018, p. 185).

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WORK *34(1)*, 113–127.

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Attachment theory itself derives from Bowlby's research on delinquent children (Bowlby, 1944) and his work with the World Health Organisation on institutionalised children in post-war Europe, both of which presented to him the reality that children in institutions or foster homes suffered serious cognitive and emotional impairment (Bowlby, 1966). Bowlby theorised the impairments were caused by maternal deprivation, or the absence of a loving and nurturing mother or "permanent mother-substitute," the so-called monotropic model (Voges et al., 2019). In his seminal research study, Bowlby asserted that separation from, and lack of attachment to, the primary female caregiver was an essential determinant of future mental health (Bowlby, 1966, p. 11).

Why did Bowlby focus on the mother and not something else, like under-staffing of an institution, physical confinement, or institutional violence, all of which are common experiences in institutional settings. Because, according to Bowlby, infants and young children were biologically primed to attach to mothers and this attachment itself was critical for long-term health. Why the mothers and not the fathers? Initially, psychologists theorised this was because mothers met the infant's physiological needs (Bowlby, 1982), but after Harlow's experiments, demonstrated that cuddle time or "contact comfort" was important, Bowlby suggested infants have a biologically rooted instinct to attach to the mother because they need protection from predators, because without that secure protection they would not be able to safely explore the world around them. This need for protection resulted, according to Bowlby, in the evolutionary development of an attachment behavioural system that motivates all living organisms to attach to their mothers (Bowlby, 1982).

Given the persistence and consistent respect afforded to his theory of attachment, one would think it quite special. However, even a quick perusal of Bowlby's book (1982) finds a purposely reductive perspective narrowly focused on safety and security needs and the attached mother's ability to meet these needs as the key driver of psychological and emotional health and pathology. Bowlby himself originally considered pathogenic outcomes may be driven by other factors and needs, like parental conflict, mixed emotional messaging, "an excessive demand for love and reassurance on the part of a parent" (Bowlby, 1966, p. 13), and even the need to learn (Bowlby, 1982, p. 223). He was also clearly aware of institutional drivers of physical, cognitive, and emotional disease, like under-staffing, physical confinement, institutional violence, and maltreatment (Follan & Minnis, 2010). Finally, he was aware of socioeconomic factors, like poverty, even going so far as to recommend dramatic increases in financial, medical, psychological, emotional, and daily supports (Bowlby, 1966) to facilitate better individual and family outcomes; however, he ultimately rejects an expanded conceptualisation of attachment and psychological pathology and reduces an otherwise complicated developmental situation in two ways. One, he reduces the causes and functions of attachment to the single biological need for safety and security. Two, he reduces the satisfaction of that need to the responsibility of a single, female caregiver.

Why does Bowlby reduce a complicated situation in this fashion? We can think of a few reasons. Number one, Bowlby was a scientist and among scientists there is an overtly stated preference for parsimonious theories—the application of Occam's Razor—because better theories are always simpler theories (Beck, 1943; Nelson, 1936). This principle likely motivated Bowlby to find the simplest explanation for the pathology he observed. Number two, Bowlby was heavily influenced by the Darwinian zeitgeist, citing him throughout his book *Attachment Theory*. His understanding of Darwinian theory suggested he reduce human behaviour to simple selection pressures. As he stated in his book, he wanted to find the "essential advantage" (Bowlby, 1982, p. 226) that led to the natural selection of attachment behaviour. For Bowlby, that was the protection from predators that mothers provided. Infants and children that attached and did not wander off into the wilderness would be more likely to survive, which would naturally select children with propensity to attach. This was the essential evolutionary advantage that drove the evolutionary development of Bowlby's "attachment behaviour system." A third reason for the reduction may have been ideological, a factor that has recently come to the attention of psychological theorists attempting to extricate themselves and their discipline from the suppressive influence of Eurocentric thinking and neoliberal ideology (Carr & Batlle, 2015). Essentially, Bowlby and others present a theory of human development and human pathology, a sexist model of child development, that is patriarchal and Eurocentric and that elevates a capitalist model of socialisation that pushes responsibility for childcare into the lonely lap of the isolated, unpaid homemaker because this allows for the cheap reproduction of the labour force (Gorz, 1999). Attachment theory, born from the loins of Eurocentric and patriarchal scientists, conveniently provides "scientific" justification for neoliberal policies that minimise the necessity and cost of state supports (Rippeyoung, 2013).

Parsimony, Darwinian reductionism, and capitalist/Eurocentric bias may explain the double theoretical reduction; whatever the reasons, however, a key question is: Is the doubly reductive nature of attachment theory a problem? The answer depends on the empirical sufficiency of the theory, whether or not the reductive focus has been harmful, and whether the popularity of the theory has limited our understanding of attachment and human development. If the theory does not reflect the actual complexity of reality, if it has caused harm in any way, and if it has undermined better theorisation, then the reductive theory is a problem.

It is possible to question the empirical sufficiency of the theory. As already noted, even a cursory reading of Bowlby's seminal work provides evidence against reducing human pathology down to an attachment failure. That is, Bowlby himself reports many contributing factors, like institutional violence, under-staffing, poverty, parental psychopathology, and more, all of which make the reduction of human pathology to maternal attachment highly suspect. Beyond Bowlby, awareness of the reductive, normative, Eurocentric, and colonial functions of AT have led to calls for rethinking (Carr & Batlle, 2015; McCarthy & Gillies, 2018; Neckoway et al., 2007). More recent theorists have rejected monotropic assumptions and acknowledged that children attach to more than just their mothers (Rutter, 1995, p. 551) and for more than just reasons of security. They attach to fathers when they are around, friends early on, organisations, priests, influencers, and workplaces as well. They attach to mothers and others because mothers and others meet their other needs, like the need for love or the need for truth or the need for esteem. Researchers have also pointed out attachment requirements extend beyond infancy and early childhood into a second "sensitive period" in adolescence where adolescents require "attachment security" as much as, or more, than infants and young children (Cassidy et al., 2013).

In addition to its obvious empirical insufficiency, the double reduction has indeed caused harm. Underlying gender stereotypes support an unequal division of labour in the home that privileges the male and requires a double-day from females. Notions that children are primed to attach to mothers, and that mothers are primarily responsible for mental and emotional health, help downplay the importance of costly community and state supports. Placing primary responsibility on an isolated female leads to negative mental and physical consequences for women, particularly single-parents (Hays,1998), who end up bearing the lion's share of a family's emotional labour (Strazdins & Broom, 2004), and who must also deal with the "inevitable accompaniment of maternal guilt" (Rosabal-Coto et al., 2017, p. 337) that accrues when they cannot complete the otherwise impossible task of raising a healthy child on their own. AT has also imposed serious disadvantages on Indigenous families, particularly through the child and family intervention systems (Choate et al., 2020) where "disorganized attachment" has been used as a marker of abusive parenting and as justification for child intervention and removal (White et al., 2019). It is also possible that the reductive focus has harmed children directly. Infants and children have many needs, not just a need for security. Reducing the constellation of needs to a single need provided by a single agent not only directs research attention but parental attention as well. Parents, and indeed an entire society, fixated on Bowlby's single need may very well end up undermining full child development.

Finally, Bowlby's reductive theorization may have also blocked critical awareness of the deficiencies of the Capitalist model of socialisation and it may have stymied more sophisticated and critical theorisation. The Eurocentric and ideologically rooted presumptions that extant capitalist socialisation processes (processes that foreground gender, a gendered division of labour, individuality, self-sufficiency, independence, and early detachment from parents and family) are necessarily an advance over earlier, more collectively oriented, systems means AT researchers have only recently begun to ask critical questions of the dominant European systems of socialization. It is important to ask these questions since, as critical theorists have long pointed out (Fanon, 1963), European systems of socialisation are incredibly toxic, having more to do with ideology and the imposition of capitalist-friendly socialisation (read worker training) practices and relational styles (Anyon, 1980; McCarthy & Gillies, 2018) conducive to worker exploitation and consumer accumulation than they are about health, wellbeing, and the actualisation of full human potential. The key point is, capitalist socialisation practices, which attachment theorists implicitly elevate, are arguably toxic. We can see the toxicity of the colonial socialisation system clearly when we look at residential schools which remove children and place them in violent institutional settings so that they can be trained and assimilated as worker bees; however, we do not see the toxicity when we look at the standard European practices, which also remove children from the home at an early age and place them in violent and underfunded institutional settings designed to prepare them for a place in the workforce via indoctrination and assimilation. When dysfunction, disease, and failed actualisation results, rather than looking at the colonial socialisation process in general, we lay the blame on mothers and their children.

Despite the questionable reductionist perspective initiated by Bowlby, there can be no doubt that attachment is an important thing, and that it is cross-culturally significant. The question is though, how to properly understand attachment? We suggest a simple way forward is to reduce the double reduction. Steps have been taken in this direction. The rejection of a monotropic view of attachment has opened awareness that we attach to more than just the mother. Research has demonstrated that we attach to other significant figures, groups (Murphy & Coats, 1999) and organisations (Frazier et al., 2015; Hazan & Shaver, 1990; Yip et al., 2018). While a step in the right direction, these attempts are insufficient. Not only have they failed to push back the conservative, monotropic narrative (Rippeyoung, 2013), but the theory retains its reductive focus on a single biological root of attachment (Kammrath & Clifton, 2018; Schore & Schore, 1994). As one scholar notes, "Bowlby's attachment theory, one of the last of the 'grand theories,' has not been replaced or extensively reworked" (Mercer, 2011, p. 42). Rejecting the monotropic model is not enough. Clearly, more is needed.

Expanding the base—The seven essential needs

One possibly fruitful way forward is to extend the biological basis for attachment beyond Bowlby's reductionist emphasis on the single need for safety and security to other established human needs. We suggest, therefore, the *Circle of Seven Essential Needs* as the model from which to understand, not only the significance and dynamics of attachment, but also the key parameters of human health and development. The circle is illustrated in Figure 1 below.

The circle represents the sum total of all needs that humans must meet if they are to grow up healthy and strong. The circle itself is organised into three concentric circles, an outer circle of basic needs and two inner circles, one representing our need for alignment and the other representing our need for connection.

Where did this circle of needs come from? It is inspired, in part, by Abraham Maslow's career-spanning efforts to provide a comprehensive list of human needs. His attempt began in 1943 with the publication

Figure 1. The Circle of Seven Essential Needs

of two seminal articles (Maslow, 1943a, 1943b) wherein he identified *two* hierarchies of needs: a hierarchy of basic needs which included physiological, safety, love/belonging, esteem, and self-actualisation needs, and a second "small hierarchy" of cognitive needs (Maslow, 1943a, p. 385), which included our biologically rooted needs to *know* "the facts" and *understand* how it all works together (Maslow, 1943a, p. 385). Maslow's theory was not static. As his work progressed, he expanded his original conceptualisation of basic and cognitive needs to include aesthetic needs (Maslow, 1954), the needs for creative outlets (Hoffman, 1999), and the need for "transcendence", which he set as the highest need. As he says in his notebook on eupsychian management, "We must ultimately assume at the highest theoretical levels of *eupsychian theory*, a preference or a tendency to identify with more and more of the world, moving toward the ultimate of mysticism, a fusion with the world, or peak experience, cosmic consciousness, and so on" (Maslow, 1965, p. 33, emphasis added).

By the end of his career, Maslow's theory had evolved to be quite comprehensive. So why not just use his conceptualisations or his iconic pyramid of needs to expand AT? Why a novel presentation? For several reasons. For one, his theory of needs is disjointed and scattered. He added to his theory throughout his career but was not able to provide an updated systematisation and refinement before his premature death. A second reason is that Maslow's original conceptualisation of needs as a hierarchy of prepotency has been criticised for being internally inconsistent (Bouzenita & Boulanouar, 2016), empirically weak (Soper et al., 1995), ethnocentric (Townsend & Wrathall, 1997), sexist (Nicholson, 2001), and neoliberal, encouraging us to focus "more on personal growth than on social reform" (Aron, 1977, p. 13). Some have suggested, quite correctly, that the characterisation of human needs in a hierarchy with "self" actualisation at the top of a pyramid reflects a form of western cultural and scientific hegemony (Bouzenita & Boulanouar, 2016) that privileges "individuality" and "individual improvement" over more family-oriented, socially embedded, collectivist needs and values (Yang, 2003). A third reason we provide a novel presentation is that to this day, Maslow's thinking is misrepresented in the psychological corpus. Psychologists have ignored his second pyramid of cognitive needs,[1] his addition of aesthetic needs, and his statements about the significance and importance of transcendence. Textbooks continue to present his theory with the iconic pyramid of needs, a pyramid which is not only a stale snapshot of his 1943 statements, but is in fact, and this is the fourth and final reason we need a new presentation, an ideologically rooted misrepresentation. Maslow never represented his theory as a pyramid, or in any geometric form (Bridgman et al., 2019) for that matter. The closest Maslow came to suggesting a geometric symbol was his use of a metaphor of nested boxes to caution against a simple listing of needs (Maslow, 1943b). In fact, the pyramid, Figure 2, is a co-optation and capitalist-friendly framing of Maslow's theory provided by a management consultant concerned to find a way to use Maslow's theory to inform more efficient and cost-effective methods to manipulate workers. The hierarchy appeared for the first time ever in a management periodical (McDermid, 1960) where it replaced alternative geometrical representations, like steps (Davis, 1957) and ladders (Wren, 1972), being discussed at the time.[2]

All the above may provide a justification and motivation for coming up with a new representation, but the question then becomes, why a circle? Not only because Ratkovic, a member of the Nakota First Nation in Saskatchewan, insisted upon a rework rooted in a more Indigenous circular view, but also because (as therapists, parents, and cat lovers who have converted nine adult feral cats to attached members of our family) this is what we have observed, that all organisms have a suite of needs and that they become attached when you

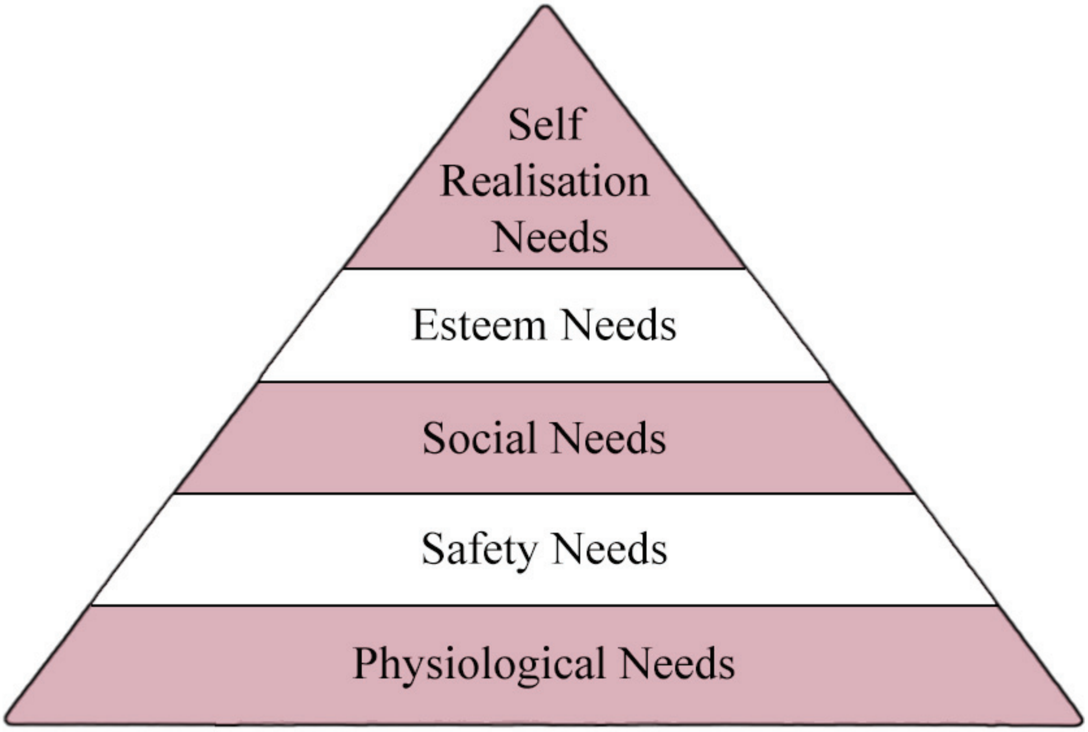

Figure 2. Management's Hierarchy of Needs

Source: McDermid's hierarchy of needs (McDermid, 1960)

meet these needs. It is also what Maslow himself was suggesting nearer the end of his life (Maslow, 1968, p. 33). Finally, it better represents the empirical reality, pointed to by many critics, that needs are not prepotent, that they are satisfied in parallel, and they are not organised into a hierarchy. If one wants their child to develop self-actualise (align) and transcend (connect), for example, their basic needs must be met consistently and *sufficiently* for extended periods.

Note that some have suggested that "Maslow's" pyramid is a "rip-off" of Indigenous thinking, specifically following his visit to the Siksika Nation in Alberta Canada (Feigenbaum & Smith, 2020). While Maslow was impressed with how strong and self-confident members of the Siksika Nation were compared to his contemporaries in the West (Maslow et al., 1982), and while it is reasonable to suggest significant influence, it is clear from his journals that his theories were already in mind prior to the visit. Furthermore, since the pyramid is a businessman's invention, it is clear that the pyramid does not rip-off from a Tipi, as some suggest (Blackstock, 2011). On the other hand, our circle of essential needs is influenced by Medicine Wheel teachings, specifically Indigenous notions of interdependence and connection. In addition, unlike the business pyramid, our circle of seven essential needs *can* be seen as the base of a Tipi, with the outer circle being where the community sits in a mutually supportive arrangement, the middle circle representing the members' connection with each other and with the inner circle, and the inner circle where the fire sits, both warming the community and connecting, symbolically via smoke, the community to the earth and to the creator.

The Circle of Seven Essential Needs – the basic needs

As illustrated in the illustration of seven essential needs above, the outer circle of basic needs includes five categories of basic needs. These categories, which include the *physiological*, *cognitive, emotional, psychological,* and *environmental needs,* are based largely on a systematisation of statements spread throughout Maslow's corpus. Our own additions are noted.

1 *Physiological needs* – Physiological needs include the need for substances (like food, water, vitamins, air), the need for physical activity (exercise), and so on. Meeting physiological needs keeps the body healthy and growing and is the basis for realisation of full physical and neurological potential.

2 *Environmental needs* – Maslow's original theorisation included a category of needs which he called "safety needs", meaning essentially safe environments. For reasons of theoretical clarity and as a pathway for including Maslow's later statements, we reconceptualise safety needs as *environmental needs* and include not only Maslow's original need for a safe environment, basically the foundation for Bowlby's original AT, but also Maslow's later suggestion that we need *aesthetically pleasing environments* at home, work, and everywhere (Maslow, 1954). Environments that are safe, nurturing, secure, calm, and aesthetically pleasing encourage, according to Maslow (1967, p. 197), "free, uninhibited, uncontrolled, trusting, unpremeditated expression of the self" and the expression of "pure spontaneity."

Note, we understand a safe environment to be an environment free from all forms of psychological, emotional, physical, spiritual violence and chaos. We go further than this however and stipulate children, adolescents, and adults also need a *stable* (including psychological, emotional, and parental stability) and *secure* (meaning a level of financial security that removes anxiety about work and survival) environment. Establishing these safe environments requires us to confront all forms of systemic violence, including racism, sexism, classism, and ableism.

3 *Cognitive needs* – The category of cognitive needs as proposed by Maslow include our biologically rooted need to know and understand the world, to know the facts and to theorise those facts (Maslow, 1943a).

4 *Emotional needs* – Maslow's original conceptualisation included a category of "love needs." These needs include our "love and affection and belongingness" needs (Maslow, 1943a, p. 380). To provide a container capable of expansion, we reconceptualise these needs more generally as emotional needs and include the needs for support, acceptance, and inclusion in family, friend groups, and society. Maslow indicated these needs are no less important for physical health and wellbeing than physiological needs. As he said, "No psychological health is possible unless this essential core of the person is fundamentally accepted, loved and respected by others and by himself" (Maslow, 1968, p. 196).

5 *Psychological needs* – Maslow's original theory included a category for esteem needs. According to Maslow, esteem needs contain two subsidiary sets of needs, "first, the desire for strength, for achievement, for adequacy, for confidence in the face of the world, and for independence and freedom. Secondly...the desire for reputation or prestige ... recognition, attention, importance or appreciation" (Maslow, 1943a, pp. 381–382). We reconceptualise these esteem needs as psychological needs and include in this expanded category the *need for power* and the

> need for *freedom.* Freedom was clearly on Maslow's radar. As he suggests, "Such conditions as freedom to speak, freedom to do what one wishes so long as no harm is done to others, freedom to express oneself, freedom to investigate and seek for information, freedom to defend oneself, justice, fairness, honesty, orderliness in the group are examples of such preconditions for basic need satisfactions" (Maslow, 1970, p. 47). Since freedom to do things requires power to do things, we include the need for power. As Maslow said, power is "the feeling of having some control over fate, of not being a helpless tool, a passive object, a cork on the wave which is tossed here and there by forces out of control" (Maslow, 1961, p. 2). To be in a healthy psychological space, we need to feel confident in our abilities, have solid self esteem, and have the power and freedom to grow and learn in line with our own needs and any community predilections.

To be clear, insufficient and inconsistent satisfaction of basic needs will lead to psychological, emotional, and physical atrophy as well as various forms of psychopathology. Sufficient satisfaction of the basic needs will provide the foundation for not only health and wellbeing, but also for satisfaction of the inner needs. Thus, children are biologically programmed to attach to those who help meet their needs.

The inner needs

Moving on to the inner needs, the first is the need for alignment. Alignment here refers to *inner alignment* and *outer alignment*. Inner alignment refers to cognitive, emotional, and behavioural alignment with one's inner self. If one has natural capacity as a musician, one aligns with that inner musician by thinking, acting, and behaving like a musician. Note that inner alignment is a functionally equivalent reformulation of Maslow's need for self-actualisation, which originally meant aligning with and "actualizing" one's "essential biologically based inner nature" (Maslow, 1968, p. 3). Although we feel self-actualisation does, in fact, reflect a real process of actualising one's essential inner nature, alignment is a superior term because it is, as we shall see below, culturally neutral, whereas Maslow's self-actualization, which elevates and privileges a Eurocentric, colonial, capitalist-friendly concept of individuality and individual development, is not, despite his claims (Maslow, 1968, p. vi).

The primary benefit of reconceptualising actualisation to alignment lies in its ability to lead us in the direction of less sexist, less Eurocentric, less colonial, less individualist ways of conceiving of human development and human attachment.
In line with this, in addition to inner alignment or "self-actualisation" we also propose a need for external alignment, which is our evolutionary programmed and biologically rooted need to align with family, community, traditions, ancestors, and so on. Outer alignment means essentially fitting in and expressing the norms, values, and beliefs of family, groups, community, etc. When we are aligned with our family, for example, we participate in family traditions, represent family values, and provide support for family members. Note, this need for outer alignment *drives our oft-observed and essential social nature and empirically observable attachment to groups and organisations*, something which organisations like Google and others are more than willing to exploit in their efforts to build a super-productive "herd" of employees (Akorede, 2018; Frazier et al., 2015).

The final inner need, the need at the centre of the circle, is the need for connection to *something more* than one's individualised, atomised, self. This need for connection is a reformulation of Maslow's need for transcendence, which he added to the top of his hierarchy of needs (Koltko-Rivera, 2006) after observing the prevalence of peak and mystical experiences in the general population (Sosteric, 2018a).
We rename the need for transcendence

to connection not only because there is considerable confusion surrounding the meaning of the term (Maslow, 1969), but also because transcendence itself is better understood as a step on the road to better connection and not the actual endpoint. Maslow himself suggested this when he said that one transcends ideology, "enculturation," "deficits," psychological trauma, the ego (Maslow, 1968, p. 37), emotional blockage, and so on, to heal, strengthen and establish connection with something more than the atomistic ego. When,

> [T]he distinction between self and not-self has broken down (or has been transcended) [there is now] less differentiation between the world and the person because he has incorporated into himself part of the world ... His self has enlarged enough to include his child. Hurt his child and you hurt him .... [he has fused] with the non-self ... [which includes] ... not only ... the world of nature ... [but] other human beings ... [to the point that] ..."selves overlap." (Maslow, 1967, p. 103)

Clearly, Maslow is speaking of connection to something more than the atomized, individual, "actualised" self. Note, Maslow's conception here is more in line and sympathetic with traditional cultures, shamanic practices, Catholic mysticism, Aboriginal dream times (Lawlor, 1991), and research on modern mystical experiences, all of which indicate the significance and importance of transcendence/connection not only to other human beings and human groupings, but to nature, the cosmos, but even to divine union with "God" (Ernst, 1997; Kalisch, 2006; St. Teresa of Avila, 2007; Steeman, 1975; Underhill, 2002). Evelyn Underhill points directly to the biological nature of this need when she says that we have an "innate tendency ... towards complete harmony with the transcendental order, whatever the theological formula under which that order is understood" (Underhill, 2002).

Both the need for alignment and the need for connection are arguably biologically rooted. Internal alignment ensures we enhance strengths while external alignment creates the emotional and psychological glue which helps people connect in families and wider groups, both of which facilitate survival, needs satisfaction, and the full development of human potential. It makes survival sense for individuals and individual families to align and connect with the tribe, the community, the town, the farmer's union, ecological organisations, etc., because this alignment facilitates inclusion in and attachment to groups, which in turn help individuals fully develop and thrive. A group, a village, for example, can help build homes, produce food, and provide protection for all its members. Groups can also help meet other of our needs, like our need for belonging and, in the case of occupational groupings, our need for self-esteem, mastery, or even purpose. Groups can even meet our need for alignment and connection. Religions and spiritual traditions, for example, like Christianity (St. Teresa of Avila, 2007), Sufism (Ernst, 1997), Buddhism (Bodhi, 2005), Zen (Suzuki, 1994), Indigenous spiritualities (Broker, 1983; Lawlor, 1991), and certain spiritually oriented authors, scholars and elites, all aim to meet our needs for alignment and connection to our inner self, to our community, to our spiritual guides, to our ancestors, and even to the creator. Authentic traditions always provide ethical, moral, and practical guidance (what we might call alignment/connection guidance) designed to facilitate stronger internal and external connection. Consider Catholic "commandments" like do not covet your neighbour's wife, or Buddhist stipulations to Right Livelihood, both of which facilitate attachment, connection, and community health. Maslow captures this normative aspect of alignment and its relationship to connection with his statements about "intrinsic conscience" (Maslow, 1968, p. 7) and his comments on the "bodhisattvic path" (Maslow, 1964).

Decolonising attachment—the Circle of Seven Essential Needs and eupsychian attachment theory

This brings us to an end of our brief exposition of the circle of seven essential needs and its relationship to AT. The argument is that Bowlby's original theory of attachment was a premature reduction designed to appeal to scientific principles and ideological prejudices rather than being informed by actual empirical reality, all of which may have facilitated translating unacceptable Eurocentric and capitalist-friendly perspectives into acceptability "at the expense of psychological well being" (Carr & Batlle, 2015, p. 172). Despite the limitations of AT, attachment is obviously important. Thus, the question becomes how to understand attachment without providing a capitalist-friendly, neoliberal reduction. The answer, we feel, is an expanded base, an expanded theory of needs. This is not exactly a revolutionary move. In 2013, Berk, while presenting Bowlby's reductionist model, nevertheless noted that, "By the second half of the first year, infants have become attached to familiar people who have responded to their needs" (Berk, 2013, p. 428). More recently, Harlow (2021) reviewed several studies which, when combined in their paper, represent a clear, almost Maslovian statement on how healthy parenting is parenting that meets our basic essential needs. It is a very small step from that article to the idea that to understand attachment, human pathology, and human development we should spend time better theorising human needs. The logical place to start, as we have seen, is Maslow; however, limitations require additional theoretical work and a more modern systematisation. The circle of seven essential needs overcomes these limitations. It provides a theoretically refined presentation that captures all of Maslow's needs in a culturally neutral and ideologically independent fashion, offers considerable inspiration for future investigation, and provides an opportunity to break the destructive colonial/European/capitalist agenda embedded in classic AT. It helps us break the agenda in two ways. Number one, it helps us move beyond suppressive Eurocentric models because it is impossible to argue that a single unpaid person can meet *all* the seven essential need categories identified in the circle. The only way to actualise full human potential is to move the locus of human health and full development away from a single female, or even a single nuclear family, to a village, a community, and a society that understands humanity's complex constellation of needs and that is consequently geared towards meeting those needs. In this extended view, healthy families, healthy teachers, healthy friend groups, healthy spiritual gurus, and even healthy organisations can form a *locus of attachment* that can contribute to the health and wellbeing of the child, adolescent, and adult by helping satisfy essential needs. This move has the added benefit of allowing theorists to re-evaluate collectivist practices, seeing these in a more positive light and perhaps even using them as an inspiration for developing healthier socialisation practices less corrupted by a capitalist agenda.

The second way this theoretical move helps us move beyond Eurocentric models is that it encourages us to ask Maslow's euspychian question (Maslow, 1961). The question is basically how do we create a society that can actuate full human potential, develop broader understandings of, and support for, developing the "ideal, authentic, or perfect godlike human being" (Maslow, 1968, p. 11). Reductive theories like Bowlby's prevent us from asking these questions because of their assumption that Eurocentric socialisation systems are superior. We already know what we need to do to create disciplined, highly productive workers, so we just need to do that better. However, expanding the needs base brings into stark relief the inadequacy of the European system, a system which arguably sacrifices complete satisfaction of essential needs, particularly our emotional, cognitive, and inner needs, at the altar of capitalist accumulation. Once we begin to see the inadequacy of the extant European system, we can begin to see our modern capitalist societies, with their environmentally destructive policies, eating disorders, out-of-control obesity rates, violence, depression, suicide, homelessness, and despair, as the toxic socialising (Sosteric & Ratkovic, 2016) shit piles they really are. The more we see that, the more we will be drawn to ask the question, “what’s the alternative”? The more we ask that question, the more we are drawn to engage with the real problem preventing the human species from finding solutions to the world-ending political, economic, ecological, and psychological crises currently unfolding on this planet, which is how to heal the human race from the damage wrought upon them by a system of socialisation geared to enriching a few, while impoverishing and destroying the many. The answer to that question is complicated but surely an important component is provided by the circle of seven essential needs underpinning a more sophisticated understanding of attachment. To heal the human and help them move forward, design a socialisation process that meets *all* their essential needs. Doing so will create healthy, happy, competent, intelligent, compassionate, and connected human beings less amenable to manipulation, more likely to connect and develop healthy and supportive communities and as the quote by Vine Deloria suggests, more likely to experience a once-more-common transcendent connection.

> Since writing the book, I have been gradually led to believe that the old stories must be taken literally, if at all possible, that deep secrets and a deeper awareness of the complexity of our universe was experienced by our ancestors, and that something of their belief, and experiences can be ours once again. (Deloria, 2003, p. xvi)

Of course, since this requires a fundamental revision in norms, values, economic practices, and political orientations, we realise this might sound impossibly utopian. However, in the ecologically and politically precarious, late-stage capitalist environment we currently find ourselves in, it is not outside the realm of possibility. Global economic productivity is sufficient to meet the physiological and environmental needs of all living humans. Guaranteed income plans, which would provide the reduction of work-life necessary to a reorientation of global priorities towards needs satisfaction, could be easily implemented if governments stopped spending so much money on weapons, consumer manipulation, and *system maintenance*. Finally, a looming survival crisis which will only be accelerated if current anti-democratic trends continue, will provide the collective motivation to make the necessary changes. The only thing preventing forward movement at this point is a recalcitrant elite too addicted to money (Sosteric, 2018b) and power to realise their survival is at stake as well. We feel it is only a matter of time, however, before they start to clue in as well. Once they do, change will be rapid. It is not a foregone conclusion to be sure, and we feel a regression to a global dark age is not outside the realm of possibility, but it is within the realm of possibility.

Orienting the theory

As noted in the main body of the text, the circle of seven essential needs emerged as the confluence of a number of related interests, discoveries, and personal and professional experiences. All told, the theory was motivated and shaped by six things:

1. Maslow’s own comprehensive but unrefined, unsystematised, and (as we discovered) hijacked statements about needs and human growth.

2. Ongoing misrepresentations of Maslow’s theory in the psychological literature, particularly the absence of his important cognitive needs, the complete dismissal of his key thoughts on mystical experiences and transcendence (Koltko-Rivera, 2006), and the ongoing reproduction of a colonizing, neoliberal-friendly pyramid to represent his thoughts.

3 Our shared awareness, nurtured by the critical work of scholars like Anyon (1980), Fanon (1963), Deloria (2003, 2006), and others that the colonial systems of socialisation and social control are geared towards erasing and suppressing full human capacity and potential in order to produce compliant cogs in the extant *regime of accumulation*, and that these systems are incredibly violent and damaging to everyone, Indigenous and settler alike (see for example our working draft on Toxic Socialization (Sosteric & Ratkovic, 2016)),

4 Our shared observations of needs, attachment, and psychological health and pathology in clients, kids, and feral cats (observations complicated enough to merit their own paper),

5 Michael's mystical experiences (experiences that we discovered are ubiquitous (Sosteric, 2021), psychologically and emotionally impressive (Bien, 2004; Miller, 2004), politically transformative (Sosteric, 2018c)), and therefore unwise to simply ignore.

6 Our ongoing discussion on how to develop grounded, Indigenous, non-European, decolonised theories of need, attachment, and development.

The gist of it is simple. Recognising that Maslow's theory was sophisticated, but unsystematised, incomplete, dated and colonised, recognising that current systems of socialisation are toxic and designed to damage and diminish humans in order to create cogs for the "System" (we see this damage daily in our interactions with clients), observing how satisfying *all* the needs of children leads to psychological, emotional, and physical health, observing that even adult feral cats can develop, over time, strong, tame attachments when you meet their essential needs (food, water, safety, security, etc.), observing the significance and ubiquity of "mystical" experiences, and being motivated to incorporate Indigenous knowledge systems which are non-hierarchical, circular, and embedded in lived realities, we took Maslow's needs, provided a more systematic categorisation, modified key concepts of self-actualisation and transcendence, and placed it all in a circle that emphasises not the need of the accumulating classes for the low-cost production of compliant, hard working, self-actualising workers, but the needs of individuals, collectives, and the planet as a whole for healthy, intelligent, empathic, and fully developed human beings. The result is a comprehensive theory of needs that rejects the individualised and hierarchical representation of a colonised psychology while presenting an Indigenous-inspired model for moving beyond the "one-dimensional" toxic capitalist system of socialisation.

Notes

1 Why has psychology ignored Maslow's second important hierarchy? It could be a simple oversight, but if it is, it points to a painful lack of rigour when dealing with Maslow's work. Another possibility is unconscious bias. The reality is, people are not told the truth about the capitalist system, its imperialist underpinnings, its exploitation of workers, elite manipulation of government, and so on. Perhaps insisting that children be told the truth of things so they can fully understand the world, things antithetical to the functioning of patriarchy, capitalism, brings an uncomfortable, unconscious challenge, and so they overlook this second hierarchy.

2 Management theorists Bridgman et al. (2019) recognise the intractable problems with the pyramid. They suggest the way forward is to use a ladder as the visual icon instead. Despite their suggestion that this better reflects the progressive potentials and intent of Maslow, a ladder in fact, and obviously, retains the heavily criticised hierarchical, individualistic, elitist, neoliberal, capitalist, and prepotent components of the theory, components ironically illustrated by the ladder image presented on page 86 of their article, an image which, remarkably, shows an imperialist male in a business suit planting an American flag at the top of a long, individualistic, and we can assume corporate, climb.

Acknowledgment: The authors would like to thank the editor, Ian Hyslop, and the anonymous reviewers for their helpful and supportive comments throughout the peer review process.

Submitted 10 November 2021

Accepted 24 March 2022

Published 13 May 2022

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Challenging the status quo of gendered cancer care

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ABSTRACT

LGBTTQIA+ patients are at a higher risk for certain cancers yet access relevant screening and healthcare less frequently than cis-gendered, heterosexual women. This can be attributed to fears of discrimination, feeling unrepresented, and past experiences of disrespect from healthcare professionals, especially in a gendered healthcare environment. The use of Women's Clinics in health endorses a viewpoint of binary gender, with an assumption of cis-gendered heteronormativity. As social workers we have responsibilities under the Code of Ethics and Core Competencies to advocate for change and challenge the status quo. We need to take action to improve healthcare experiences for LGBTTQIA+ patients. These include the correct use of inclusive language, changes to the physical environment, and practical changes to how we undertake routine examinations and engage with LGBTTQIA+ patients.

KEYWORDS: Transgender; gynaecology; equity; gender; sexuality; cancer

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WORK *34(1)*, 128–131.

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A note on language

Whilst every attempt has been made to use inclusive language, the author recognises that these are highly personal terms with individual preferences. The author identifies as a pansexual, cis woman, using she/her pronouns.

Gendered cancer care

"I showed up for my appointment and I was immediately told, 'You're in the wrong place, Sir'" (James, transman, queer, cervical cancer) (Bryson et al., 2020, p. 348).

Gendering healthcare and designating spaces that provide gynaecological care as *women's clinics* supports structural invisibility and the erasure of queer, gender-diverse, takatāpui and intersex patients (Taylor et al., 2016). Unfortunately, a number of studies have shown that many health professionals do not recognise understanding their patients' gender identity as critical to providing quality care. This lack of awareness and acknowledgement by the health professional then leads to further invisibility of that individual within the healthcare system, and diminishment of their identity (Burton et al., 2020).

We know from research that LGBTTQIA+ people are at a higher risk for certain cancers and experience higher morbidity and mortality related to specific cancers. Research has also found that LGBTTQIA+ patients are less likely to feel that they have been treated with respect and dignity when accessing hospital care (Buchting et al., 2015; Peitzmeier et al., 2017). The study by Peitzmeier et al. (2017) found that as many as 31% of transmen had avoided seeking necessary healthcare in the past year due to a fear of discrimination. Many participants spoke of balancing long-term risks of developing cervical cancer over short-term risks of being treated disrespectfully by healthcare providers. Non-cis patients also reported the added pressure of needing to educate their healthcare provider—which can then create even greater power imbalances between a patient and the healthcare professional, who is often seen as the expert. This pressure results in higher rates of missed appointments and feelings of invisibility within the system (Taylor et al., 2016; Temkin et al., 2018).

It is apparent that accessing healthcare is not necessarily safe for all. This can be seen most strongly in gynaecological cancer care where treatment and assessment are based on a cis-gender, heteronormative identity and expression (Taylor et al., 2016). Why does our medical system ignore gender as a social construct which acts as a structural barrier to quality health outcomes? Why do some patients say they have to use a different narrative in order to become *treatable bodies* and fit into a binary system? And why are we continuing to use outdated viewpoints when we know that the gendering of cancer environments can cause significant distress? We need to challenge the binary view of gender equated with biological sex in how we deliver healthcare (Sledge, 2019). If we view our systems and biases through a different lens, we can challenge these dynamics, and also consider the intersectional nature of them.

The social work role

As social workers, our role is to advocate, not just for our individual clients, but for systemic change and equitable access to services. These are fundamentals of the Social Workers Registration Board (SWRB) Core Competencies, and the Aotearoa New Zealand Association of Social Workers (ANZASW) Code of Ethics. The ethical principles of *mātātoa* (acting with moral courage), *kotahitanga* (solidarity and challenging injustice and oppression), and *manaakitanga* (supporting mana with respect, kindness and compassion) call us to ensure safe spaces, challenge injustice, oppression and marginalisation, advocate for equitable access to services, and engage in action to change the structures that perpetuate injustice in society (ANZASW, 2019).

How many of us working in healthcare truly act on the principles to which we have signed up as registered social workers? Are we doing all that we can to push for change to heteronormative healthcare? As social workers, we cannot remain ambivalent or complacent in these matters.

Being complacent to heteronormative healthcare goes against the core values of social work and makes us complicit with the status quo. Social change does not just happen, it requires us to engage with our social work competencies and ethical principles, to bring attention to issues, and to join with others to effect change. Everyone has the right to access appropriate healthcare in a safe and equitable manner. Human rights are non-negotiable and not for discussion based on individual beliefs or biases.

We have responsibilities to ensure that we are competent in working "respectfully and inclusively with diversity and difference… including sexuality, gender and transgender" (SWRB, 2021, n.p.). We have the opportunity to lead change and increase awareness in relation to the importance of gender and sexual identity. We must take responsibility for educating ourselves and other health professionals to provide the best care for patients. Gender identity is a complex and constantly evolving issue. As social workers, we must keep upskilling so we can work respectfully and inclusively.

Patient perspectives

To make gynaecological oncology safer for all patients and healthcare professionals, we need to challenge the cis-gendered, heteronormative assumptions that are inherent in healthcare. This is necessary to improve health outcomes and to increase equity for LGBTTQIA+ patients who are at a higher risk for certain cancers and who experience less equitable access to

Table 1. Summary of Patient Suggestions

Recommendations	
Language	Use gender neutral language (*people* rather than *women*) Use medical/biological terms over gendered terms Check with people about their individual terms
Identity	Ask patients about their pronouns and gender identity (not just binary gender options) Make forms inclusive and allow patients to enter their correct identity details Check with patients about their preferred terms
Environment	Use non-verbal indications of inclusivity (e.g., rainbow signs) Use posters and leaflets that are representative of all patients, not just cis-gender females Use signage with gender-neutral terms/medical terminology (e.g., *gynaecology* over *women*) Advertise inclusive, non-discriminatory policies and practices Support staff to welcome all patients and to not make assumptions based on presentation
Sexuality	If relevant, ask patients about the type of sex they have (if any), without assuming that penetrative sex is occurring Ensure the patient is fully informed in ways that meet their individual self-knowledge Do not assume the possibility of pregnancy
Practical	Consider booking appointments for early or late in the day to reduce waiting times Call patients by their correct name, especially if different to their medical records Avoid titles such as *Mr* or *Mrs* Consider a female-presenting support person to attend and to stand when the name is called If appropriate, support the patient to have more control over the examination (e.g., self-insertion of speculum) Consider admitting patients to a general ward, rather than a gynaecology ward Patients may experience gender dysphoria and require additional time and support

(Buchting et al., 2015; Burton et al., 2020; Gibson et al., 2017; Johnson et al., 2020; Potter et al., 2015; Taylor et al., 2016; Weyers et al., 2020)

healthcare. We may do this by changing our own practice and advocating for individuals and systemic change.

Table 1 draws together various authors' recommendations and research on inclusive and responsive care of LGBTTQIA+ patients based on patient suggestions.

Conclusion

As social workers we have a responsibility to challenge unjust and ineffectual systems. Remaining with the status quo of gendered clinics perpetuates a system in which some communities within Aotearoa most at risk for certain cancers feel unsafe accessing appropriate care. Research shows that our environments for cancer support and treatment are inadequate to treat LGBTTQIA+ patients and can contribute to the systemic invisibility of these patients and diminishment of their identify. We have an opportunity to support better care for all by educating ourselves and others and using a human rights lens on the way we currently provide care. When we make our healthcare environments more inclusive for LGBTTQIA+ communities, we take nothing away from cis-gendered women. What we do is create a space that is safer for all patients and improve healthcare outcomes.

He kakano i ruia mai i Rangiātea, e kore ia e ngaro.

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Is banning conversion therapy enough? Aotearoa New Zealand and access to gender-affirming healthcare

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ABSTRACT

The practice of conversion therapy and lack of access to gender-affirming healthcare is a significant health issue in Aotearoa New Zealand. Recently introduced legislation has sparked media coverage of the need for a ban of conversion therapy, with the current Labour government acknowledging that it causes harm and is linked to serious mental health issues. A literature search was conducted to understand what information is available in Aotearoa New Zealand, and internationally, regarding conversion therapy and access to gender-affirming healthcare. The findings reported here exemplify that, despite this practice presenting a significant health issue for transgender and non-binary people, the topic is significantly under-researched in Aotearoa New Zealand, particularly in the social work field. The following article considers the health, political, legal, and religious aspects of conversion therapy and access to gender affirming healthcare in existing literature, making recommendations for future social work research investment to better advocate for and support transgender and non-binary people.

KEYWORDS: conversion therapy, gender affirming, healthcare access

AOTEAROA
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WORK *34(1)*, 132–138.

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On 15 February 2022, the Conversion Practices Prohibition Legislation Bill was passed in Aotearoa New Zealand. The history of conversion therapy is contested, the modern, western version of conversion therapy was developed in response to pre-pubescent young people who did not dress in "normal" clothes that others with the same gender assigned at birth did and was later developed to include treatment of homosexual "deviancy" (Ashley, 2020). Conversion therapy has had well documented damaging effects, on a large and wide-ranging scale, on the LGBTQI+ community—this article focuses specifically on the experiences of transgender and non-binary people. Conversion therapy was developed as an anti-transgender therapy, and existing literarure clearly evidences that young, transgender and non-binary (TNB) people are more likely to experience conversion therapy than young cisgender people (Ashley, 2020; Higbee et al., 2020). These same young people also experience a lack of access to gender-affirming healthcare which has been described as "patchy" and inconsistent across different District Health Boards in Aotearoa (Fraser et al., 2021). Seeking gender-affirming healthcare is often where conversion therapy efforts occur for at least one out of five TNB people in Aotearoa (Veale et al., 2021).

Literature search

A literature review explored transgender and non-binary people's experience of conversion therapy and access to gender-affirming healthcare, making recommendations for future social work practice improvement in Aotearoa New Zealand. The literature review explored ethical, health, political, legal and religious related aspects to the practice of conversion therapy and possible ban, and the parallel issue of access to gender-affirming healthcare. Taylor and Francis Journals Online, Google Scholar and EBSCO Host were used to perform literature searches. The key search term "conversion therapy" paired with "Aotearoa" or "New Zealand" drew no results on Taylor and Francis or EBSCO Host. The *Aotearoa New Zealand Social Work* journal was also searched to identify any exisiting articles on conversion therapy or gender-affirming healthcare. All search terms drew no results; when searching "transgender" as a key term, only one article was produced related to aged care social work with gender minority people. The Google Scholar search produced articles and reports published by psychology and other medical professionals regarding conversion therapy in Aotearoa New Zealand which have been drawn on in this article. The key terms were searched again focussing on any international social work evidence, again there was very little research available regarding social work support for TNB people and even less in the advocacy space of access to gender-affirming healthcare. Some articles were identified regarding transgender people's experience of access to reproductive healthcare or "women's healthcare" settings and the findings in these mirrored that access to gender-affirming healthcare, was inconsistent and an area of huge stigma for many people.

The lack of existing research identified—especially in the social work field—is disappointing and something that requires investment for better support of TNB people in Aotearoa New Zealand navigating the healthcare system. Both access to gender-affirming healthcare and ending conversion therapy are areas where social work has an obvious role in advocacy on both a micro and macro scale; however, very limited literature exists around best practice. What is very clear from the literature identified from medical and legal fields is that access to gender-affirming healthcare is paramount to both the physical and mental wellbeing of TNB people and banning conversion therapy alone will not achieve this. Greater understanding and commitment to enacting change and accessible gender-affirming healthcare across the medical profession are essential and something that the social work field should assist in.

Definitions of main terms

Conversion therapy is an attempt to "change someone's sexual orientation to 'heterosexual' or their gender identity to 'cisgender'" (Higbee et al., 2020, p. 1). Conversion therapy is used by groups, organisations and mental health professionals by way of hypnosis, electric shock therapy, behavioural talk therapy and more. It is also used at a lower level by communities and parents through prayer, shaming and creating strict discipline environments (Higbee et al., 2020). Conversion therapy has been scientifically proven to be inefffective, to cause long-term psychological damage, and is condemned by many professional scientific bodies such as the American Psychological Association (Higbee et al., 2020).

Gender affirming healthcare is defined by the Aotearoa Transgender Health Reasearch Lab as "healthcare that is respectful and affirming of a person's unique sense of gender and provides support to identify and facilitate gender healthcare goals" (Oliphant et al., 2018, p. 4). This can include, but is not limited to, hormone therapy, provision of puberty blockers, surgery, speech language therapy, safe use of binders and laser hair removal (Oliphant et al., 2018).

Critical analysis of ethical, health, political, legal, and religious aspects of conversion therapy and access to gender affirming healthcare in existing literature.

Ethical and health aspects

Conversion therapy has serious ethical considerations that have major impacts on the health and wellbeing of TNB people. Bidell and Stepleman (2017) detail how health professionals historical consideration of LGBTQI+ people as "mentally ill or disordered, [has] supported and legitimized erstwhile moral, social, and legal stigmatization" (p. 1306). This stigmatisation, which includes offering and performing conversion therapy, has led to serious physical and mental health disparities for LGBTQI+ people internationally (Bidell & Stepleman, 2017). A major study surveying effects of conversion therapy on TNB people in Aotearoa New Zealand found it was "significantly associated with worse outcomes on all mental health variables" (Veale et al., 2021, p. 4). Exposure to conversion therapy also meant that participants were more likely to experience internalised transphobia, further detrimentally impacting their mental health. This evidence mirrors other large international studies such as Turban et al. (2020) who found higher rates of mental distress, depression, lifetime suicidal ideation, suicide attempts and hospitalisation rates following suicide attempts than TNB people who had not been exposed to conversion therapy. It has been widely reported that conversion therapy is not ethical, based on these detrimental health outcomes, and is at odds with the many ethical codes health professionals are bound by to care for people without stigma or bias, and not to do harm (Cramer et al., 2008). Absence of conversion therapy does not, however, equal access to gender-affirming healthcare and inequity in provision of gender-affirming healthcare persists in places where conversion therapy has been banned (Mendos, 2020). Provding gender-affirming healthcare is considered in Aotearoa to be part of medical ethical requirements to do no harm, as withholding it can exacerbate mental health challenges (Oliphant et al., 2018).

I could not source any social work literature from Aotearoa related to the ethics of gender-affirming healthcare, despite social work being available at many primary and public health care providers that provide gender-affirming healthcare. Some articles from the United States were identified regarding reproductive healthcare for transgender women and experiences of "women's healthcare settings" which evidenced inconsistency in medical advice, constant misgendering and assumptions made about their sexuality and reproductive desires by medical professionals (Gomez et al., 2020; Gomez et al., 2021). These experiences mirror the aforementioned practices that do not align with medical ethical requirements to do no harm and research participants expressed anxiety in accessing these services or avoiding them altogether (Gomez et al., 2021). Supporting access to gender-affirming care is in line with the values of the Aotearoa New Zealand Association of Social Workers (ANZASW) code of ethics, such as rangatiratanga, valuing diversity and advocating for self-determination, or manaakitanga, supporting the mana of all people and treating one another with respect (ANZASW, 2019). Broader literature on working with LGBTQI+ clients addresses the need for the social work field to advocate for equity and access improvement by "challenging systems that reinforce unequal power relations" (Phillips, 2014, p. 139). Phillips (2014) notes that policy, legal and institutional change is required to achieve changing power dynamics; Burdge (2007) goes further to recommend challenging the gender binary on a micro level and meso level with clients, colleagues, communities and work places can be done by social workers to enact change.

Political and legal aspects

Internationally, Brazil, Ecuador, Germany, Malta and Aotearoa New Zealand have banned conversion therapy and states within the US, Canada, Australia and Spain have done so too. A report commissioned by the United Nations Human Rights Office of the High Commissioner (2020) with submissions from over 33 nations and 94 organisations and professionals recommended an international ban on conversion therapy (Madrigal-Borloz, 2020). Aotearoa New Zealand did not make a submission, however the Transgender Health Research Lab NZ did. The New Zealand Labour Party campaigned in 2020 to ban conversion therapy if re-elected. This bill attracted 106,700 submissions during the select committee process, the largest amount of submissions in Aotearoa New Zealand history (Walters, 2021). At the third and final reading of the bill on 15 February 2022, all parties voted in favour of the bill with the exception of the National Party who chose to allow MPs to use a conscience vote, the bill was passed almost unanimously with 112 MPs in favour and 8 MPs against (Scotcher, 2021). In terms of access to gender-affirming care, no laws exist in Aotearoa stating it must be provided; however, all people have a right to non-discriminatory healthcare and guidelines from the the World Professional Association of Transgender Health have been specifically adapted to guide Aotearoa health professionals in providing gender-affirming healthcare (Oliphant et al., 2018).

Non-discriminatory healthcare is an area where again social work literature is minimal, but social work advocacy is evident. The ANZASW made a submission to the Justice Committee declaring its unequivocal support of the proposed conversion therapy legislation in New Zealand (ANZASW, 2020). The ANZASW suppported the bill during the select committee process on the basis that it would stop experiences of discrimination and harm inflicted on the rainbow community by current conversion therapy practices. The ANZASW submission directly tackled the controversy raised around potential for prosecuting parents, stating that, if it was removed, there was a possibility of finding loopholes to continue perpetuating harm and normal everday parenting was already protected under the proposed bill. If a parent were to practise conversion therapy on their child, their potential prosecution is consistent with the United Nations Convention on the Rights of the Child and the Oranga Tamariki Act 1989 which forbids parents from perpetrating serious harm to their children (ANZASW, 2020). The ANZASW also advocated for an amendment to the bill that would see social workers be protected like other healthcare practitioners in providing their services. This is not to say that healthcare practitioners are exempt and can provide conversion therapy but, that if clients are seeking therapeutic services regarding their sexual orientation or gender identity they can still receive these to support their wellbeing (provided it adheres to the usual ethical codes). The ANZASW argued that, while social workers are not part of the Health Practitioners Competence Assurance Act 2003, they are registered under a different but very similar Social Workers Registration Act 2003 with complementary ethical codes and should be extended the same protection. This recommended change was not included in the final Bill.

Religious aspects

Internationally, religious groups are amongst the strongest supporters of maintaining conversion therapy (Mendos, 2020). Many religious arguments in support of conversion therapy centre around being homosexual and transgender as a “choice” and to choose this is to sin, they also argue a ban of conversion therapy is an infringement on religious freedoms (Utter, 2019). These matters are addressed differently depending on the place laws are enforced. In the United States, state-wide bans on conversion therapy pertain only to medical professionals, people providing non-medical interventions based on their religious beliefs are allowed to do so (Mendos, 2020). The Conversion Practices Prohibition Legislation Bill 2022 provides some protection for homophobic and transphobic religious beliefs/principles as it is directed only at banning conversion practice that is performed with the intention of *changing* or *suppressing* the person's sexual orientation, gender identity, or gender expression, excusing general expression of religious beliefs (s5.2).

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2015) from the US Department of Health and Human Services makes the important distinction that increased health risks faced by TNB people are not experienced because of their identity but rather are products of environmental stressors and stigma created through multiple social systems such as family, school and religion. In the United States, evidence suggests that homosexual people seeking conversion therapy occurs "primarily among religious communities that view minority sexual orientations as undesirable or morally wrong" (SAMHSA, 2015,). This provides a difficult tension for lawmakers regarding freedom of religion and ethics as this freedom inevitably causes harm.

Again no social work literature was identified regarding the intersection of religion and conversion therapy or access to gender-affirming healthcare. However, using religion as justification for any kind of client intervention is against the code of conduct that all registered social workers must adhere to in Aotearoa. Priniciple 3 of the Code of Conduct requires that social workers "be aware of any personal or religious beliefs or moral positions you have and make sure these do not override a client's right to self-determination and to receive quality social work service" (Social Workers Registration Board, 2016, p. 9).

Recommendations for improving health and wellbeing services for transgender and non-binary people and the social work contribution

Banning conversion therapy is a step in the right direction; however, health services require serious improvement on all levels to provide equitable health outcomes for TNB people. In the United States, research policy papers have emphasized how the outlawing of conversion therapy must also include efforts by the government to increase access to gender affirming care simultaneously (SAMHSA, 2015).

At a macro and meso level, SAMHSA (2015) recommend the adoption of public and health policies that counter discrimination and increasing access to healthcare. Public policy countering discrimination is important to healthcare as all individuals providing healthcare are influenced by social and cultural norms that can be transphobic in nature. While social workers usually cannot create public and health policies, they can inform their creation through submissions and highlighting to members of parliament the need for stronger policies. Evidence of this is seen in the ANZASW's aforementioned submission to the select committee on banning conversion therapy. Academic social work in Aotearoa New Zealand can also be used to inform policies; currently very little exists in the conversion therapy and gender-affirming care field with it primarily coming from other health professions and sociology departments. The academic social work field should make a concerted effort to contribute to these areas that are heavily under-researched such as TNB people's experience of accessing gender-affirming care in Aotearoa New Zealand (Fraser et al., 2021).

SAMHSA (2015) highlight the need for greater information and training for healthcare providers. Limited studies have been completed regarding social work student competencies working with TNB people and those that have been published found that students are more likely to feel competent working with lesbian, gay and biexual people over transgender or non-binary people (McCarty-Caplan, 2020). Steps could be taken to include LGBTQI+ health in training or core papers in social work degrees to ensure graduating social workers are better equipped to work with TNB people. This could also be required as part of the Continued Professional

Development component of social work registration in Aotearoa and social workers could be champions for further learning about TNB people's health needs and rights in their workplaces. Social workers at primary healthcare providers could play an essential role in normalising conversations around gender identity and improving access to gender-affirming care. There are limited studies on non-binary youth and access to healthcare, but those that do exist show that non-binary youth are less likely to share their identity with their GPs meaning they do not access the correct care and advocacy in this space would likely improve health outcomes (Clark et al., 2018).

This kind of advocacy is not only limited to social workers working directly in the health sector, as an approachable social worker "first conversation" about gender identity between a client and professional could be had in any area of social work such as community, family and school settings. Social workers in schools could engage in fostering inclusive school policies that will ensure TNB students are accepted and celebrated for who they are, and an environment where parents can be supported if necessary by the social worker and school environment as their child may access gender-affirming healthcare.

On a micro level, social workers can undo gender binary constructs in their own practice and immediate world, and provide practical supports to TNB clients. In professional practice, social work academics such as Witt and Medina-Martinez (2021) and Burdge (2007) implore social workers to challenge their practice and reflect on how they may reinforce gender binary stereotypes or harmful messaging. In very simple terms this could be failing to ask what pronouns people use or making assumptions about how people identify, appearing uncomfortable when discussing gender identity and not having knowledge of commonly used terms. Practical supports could be removing barriers to accessing and affirming healthcare such as ensuring travel needs are met to get to specific doctors (Clark et al., 2018). This could also include supporting whānau meetings to ensure parents and other family members understand the importance of this healthcare, and/or facilitating referrals to parent support groups for more information. It could also be referring to organisations such as OutLine who are Aotearoa specialists in supporting TNB people, including peer support services and advice on where to get gender-affirming healthcare.

Conclusion

Despite conversion therapy and access to gender-affirming healthcare being a relatively new and under-researched area, a significant amount of literature could be found internationally pertaining to the multiple different political, legal, ethical and religious aspects. This literature was largely sourced from other health professions and there is a very obvious lack of literature produced in this area from the social work field, especially in Aotearoa New Zealand. To inform best practice for social workers in supporting TNB people to access gender-affirming healthcare and improve its overall accessibility, a concerted effort must be made to undertake further research to create these models and provide training for new and existing social worker. For TNB people to gain equitable access to healthcare and the gender-affirming healthcare they deserve, the social work field must upskill in supporting this access and playing an active role in systemic health changes such as policy creation and implementation and organisation advocacy required to do so.

Submitted 14 February 2022

Accepted 27 March 2022

Published 13 May 2022

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Social licence and norm violation

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It has become increasingly common to refer to "social licence" or "the social licence to operate"; roughly, to the idea that the legitimacy of some activity depends upon its ongoing approval or acceptance by affected communities (Thomson & Boutilier, 2011). The increase in references is striking: "social licence" and "social license" appeared in less than a dozen news media articles a year between 1995 and 2000; by 2014 they were appearing 2000 times a year, and, by 2017, 3000 times a year.[1] Although we will see that social licence has earlier roots, this recent surge in use is widely thought to have begun in the mining sector in the 1990s, when the term was used describe the need to address local opposition which could otherwise impose massive costs on legally licensed projects, (Cooney, 2017) and to have been rapidly taken up in other industries and areas—from agriculture, to forestry, to tourism, and social policy and government (Moffat et al., 2016). As this list of applications suggests, social licence is significant, not simply because of the number of references, but also because of the work to which the idea has been put. Social licence is used to test or establish the legitimacy of a range of activities that have, or have the potential to have, profound effects on the lives of large populations—mining, oil exploration, the use of advanced analytics, intensification of agriculture, fisheries, and tourism, medical research, and so on. It is not, then, merely that social licence has "become … mainstream" (Clark-Hall, 2018, p. 6) or that "the concept of social licence has … become ubiquitous in recent years" (Jenkins, 2018, p. 27); social licence is an idea that has profoundly important practical consequences. While there was, in the early stages of this surge, relatively little academic attention to social licence, there is now increasing theoretical and empirical research being directed towards understanding the nature and use of social licence (See Moffat et al., 2016, and references gathered there).

This brief commentary is prompted by a recent article in this journal which contributes to both practical and academic interest in social licence. In "Qualitative research: Surveys, social licence and the integrated data infrastructure", Pauline Gulliver and her co-authors explore the social licence to include data in New Zealand's Integrated Data Infrastructure.[2] In the course of doing so, they advance (and rely upon) a specific definition of social licence. Social licence, they say, is:

> Societal acceptance that a practice that lies outside general norms may be performed by a certain agent, on certain terms [which] means that the practice can be performed by that agent without incurring social sanction. (Gulliver et al., 2018, p. 4)

They are quite specific about this definition and their commitment to it. "Our definition", they write, "makes explicit that the practice under consideration lies outside general norms" (Gulliver et al., 2018, p. 4). I will argue that this cannot be an adequate definition of social licence. It faces conceptual difficulties and would exclude many apparently uncontroversial appeals to the notion. Although I will make these points with reference to Gulliver et al., they are also relevant to an influential account of social licence and one which pre-dates the recent revival in interest in the idea.

Writing in 1815, Reverend John Cunningham, Vicar of Harrow on the Hill,

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remarked upon women who cut short the sabbath to gather in city parks on Sunday evenings: "At the hour of dinner, by a social license, not indeed strictly protestant, the Sunday seems to finish and they assemble in large conventions to discuss and supply the wants of the body" (Cunningham, 1832, pp. 62–63). The Reverend disapproves: "[B]y forcing horses and servants upon unnecessary employments", the women "… defraud two beasts of their lawful rest, and shut two souls from heaven" (Cunningham, 1832, pp. 62–63). Here "license" refers to excessive freedom or "licentiousness"; an insufficient regard for social conventions.[3] There is a non-pejorative version of this sense of licence too. Anthropologist Pierre van den Berghe suggests, for instance, that what he calls "institutionalized licence"—"well-defined, cyclical periods of institutionalized (and often ritualized) departure from the normative system of a given society"—helps to preserve the background normative systems from which they are departures, releasing tension and allowing expression of other norms, otherwise held in check: "The very contrast between the two phases of the cycle [a long 'normal' phase and a short 'licentious' phase] maintains the cohesion of the normative system" (Van den Berghe, 1963, p. 415). We find this non-pejorative sense of social licence as permission in modern discussions. Penny Clark-Hall uses the idea of "poetic licence"—a permission to depart from normal rules of language use—to frame her discussion of social licence for agriculture (Clark-Hall, 2018, p. 8). Gulliver et al.'s (2018) use is a more explicit example, which makes the requirement that the practice under consideration lies outside general norms part of the very definition of social licence. I have said that Gulliver et al.'s (2018) definition cannot be adequate, that it faces conceptual difficulties and would exclude many apparently uncontroversial appeals to the notion.

First the conceptual point. It is important to see at the outset that the general norms to which the definition refers—the norms outside of which the practice under consideration must lie—cannot themselves be the norms of licensing. The general norm with which a practice in question conflicts, that is to say, cannot be the norm according to which all conduct for which one needs a licence is wrong if one does not have a licence. Such an understanding of social licence would be problematically circular, since it would require us already to possess and understand a practice of social licensing, including a norm requiring the licensing of some activity, which would allow us to determine whether that activity lay outside the licensing norm. The norms with which a practice conflicts, then, must be norms which bear upon the contemplated practice itself. It must be the case that some contemplated activity—mining, or intensified agriculture, or the use of data by governments, or some aspect of medical research, or including data in a data set—is *itself* contrary to accepted or general norms, not merely that there is a licensing requirement in place which makes it wrong to carry out that activity without first obtaining a licence. This understanding is more plausible than the problematically circular alternative but, it too, is problematic, for it raises the second concern: it would exclude many—perhaps most—actual appeals to the idea of social licence.

Consider New Zealand's official statistics agency's 2018 measurement of their social licence, which they defined as "the permission it has to make decisions about management and use of the public's data without sanction" (Neilsen Co., 2018, p.3). Stats NZ commissioned a survey that discovered that most New Zealanders who knew about the agency trusted it and approved of the way it collected and managed information. Most New Zealanders who knew about Stats NZ, it turned out, thought it was a good thing there was an official Government statistics agency, and most approved of the job that agency does. Stats NZ took this survey to show that the agency *had* social licence for its activities. However, on the assumption that is part of the *definition* of social licence that the licensed practice is contrary to general norms, that conclusion would have been a mistake of some sort. At best, according to the licentiousness view, they should have concluded that they did not *need* social licence (since they discovered that most people who knew about the agency did *not* think that that agency's conduct was contrary to general norms), or even that they could not have it, since they were not doing anything which conflicted with general norms. That surely cannot be right, and it certainly does not describe what Stats NZ—social licence enthusiasts—appear to have taken themselves to be doing: namely establishing whether and to what extent they had social licence for their activities, or "permission … to make decisions about management and use of the public's data" (Neilsen Co., 2018, p.3).[4]

I think that many organisations (tourist operators, agricultural industries, and so on) seeking social licence take themselves to be roughly in Stats NZ's position. They think they should satisfy themselves, and potential critics, that their practices have ongoing approval and acceptance by the communities within which they operate. They may have noticed that new norms are emerging around their practices—communities might have new and more stringent environmental expectations, for instance—and they seek to discover how their practices stand, or are perceived to stand, relative to those new norms. They may be preparing programmes to convince communities that their practices *should* have ongoing acceptance and approval, i.e., that those practices do not conflict with general norms. If they succeed, they may conclude that they have social licence. All these activities, and the attitudes to social licence they reveal, look problematic under a definition under which the practice under consideration must lie outside general norms. If such an agency discovers that their conduct is not thought to conflict with general norms, then, by the lights of the definition which makes the requirement that a practice under consideration lies outside general norms part of the very definition of social licence, they could not have social licence.

At the very least, widespread and accepted uses of social licence (might we say the sense of social licence which has social licence?) are such that a definition must leave open the question of whether the practice in question is contrary to general norms, and must make it conceptually possible to seek and acquire social licence for activities which are not contrary to such norms. The point here is not to defend these widespread views of social licence—I argue elsewhere that they suffer problems of their own (Dare, forthcoming)—but, unless we are engaged in a quite dramatic revisionist project (which, as an aside, would dramatically narrow the scope of social licence), a plausible definition must I think preserve at least the core of those views of social licence.

Acknowledgement

I am grateful to an anonymous reviewer whose thoughtful comments improved this item.

Submitted: 15.11.21

Accepted: 05.02.22

Published: 13 May 2022

Notes

1 Factiva, "social license" OR "social licence". Google Scholar references follow a similar trend: 160 articles used the terms between 1995 and 2000, 6500 between 2011 and 2015, and just under 11,000 between 2016 and 2020.

2 The Integrated Data Infrastructure (IDI) is a large research database containing data about specific people and households in New Zealand, data gathered from government agencies, official statistical surveys, and non-government organisations, almost always without consent.

3 'Licentious' is now most used mainly to describe a lack of regard for conservative sexual mores, but while the Reverend does portray the woman as "assembl[ing] in large conventions to discuss and supply the wants of the *body'* (his emphasis), (Cunningham, 1832, p. 63) thereby shutting themselves and their servants from heaven, it seems that they were intent on walking and socialising, supplying wants for exercise and sociability.

4 Interestingly, the 2020 survey commissioned from the same firm by Stats NZ defines social licence in precisely the problematic way favoured by Gulliver et al. (2018): The surveyors report that Stats NZ describes the social licence concept as an "unwritten acceptance by the public that a practice that lies outside general norms may be performed on certain terms" (Nielsen Co., 2020, p.5).

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Community Connections—A wellbeing response to supporting staff during the pandemic 2020-2022 in Aotearoa New Zealand

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A note about Community Connections

Community Connections is a community based disability support provider which primarily offers a Supported Living, Te Pou Hononga, Supported Employment, and Network Support services. In any given week, 263 Community Connections Support Workers provide support to over 500 people in their homes and their communities. Our teams operate across the North Island of Aotearoa New Zealand, with offices based in Wellington City, Kapiti, The Hutt Valley, Palmerston North, New Plymouth, Napier and Whakatane.

Community Connections has a strong commitment to a person-directed approach so people can live the life they choose within their own community and has a vision of a society where people with disabilities are embraced as fully participating citizens. A majority of the people Community Connections support have an intellectual disability. This article offers an overview an organisational response to support staff through the Covid-19 pandemic 2020.

The impact of the Covid-19 lockdown in 2020

In March 2020, the New Zealand government implemented a 4-level alert system in response to the detection of Covid-19 cases in New Zealand. At various levels, disability support responses by Community Connections were adjusted to comply with the alert system and to meet the needs of the people supported. Community Connections was defined as an essential service, and some staff were required to work directly with people we support. It was decided by Community Connections management to set up a “well-being“ call system to support all staff until New Zealand went back to level 2. (The disease is contained, but the risk of community transmission remains.) This system was not to replace ongoing team and coordinator support of frontline staff, but as an additional support.

This practice note comprises a brief timeline of how and why the Welfare team was formed and the purpose of making wellbeing calls to our staff in the context of Covid- 19, the impact we sought to achieve and how what we learnt through this experience can influence workplace culture and support in an ongoing way.

The Staff Welfare team for Community Connections was established over the week of 21 March 2020 when our government made the choice to move to Level 2 in preparation for Level 3. This was at the emergent stage of the pandemic. With closer analysis of what seemed to be quite a natural development process, we used a task-centred social work model evolved from psychodynamic practice using a simple problem-solving approach to help support staff resolve presenting problems.

An anonymous survey for all staff in the organisation was sent out at Level 2 to elicit feedback around the helpfulness of the calls.

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Purpose of the welfare team development

The senior leadership of Community Connections wanted to make sure that staff were connected and coping with what was being asked of them over this stressful time. The calls would also serve as a mechanism to alert senior leadership to any unmet staff needs, unresolved issues, and good practice examples that could be disseminated throughout the organisation.

There was a desire to incorporate our organisational values by using a "strengths based" approach to our conversations, that included legitimising people's experiences and listening to staff concerns and worries. Community Connections wanted to ensure we were triaging any staff who we considered might require extra support, and also helped people to identify their natural supports.

There was a quick turnaround, with a member of the senior leadership team and a behaviour specialist tasked with setting up the response and identifying team members. A script was developed to guide team members in their communication and a database of staff with a correlating record-keeping line so the conversation could flow smoothly. This is shown in an example from the spreadsheet (Figure 1).

There were initially four members of the team, and it was identified that it was important for them to receive group supervision to discuss their experience. This was to ensure that no members of the team were adversely emotionally affected by hearing repeated stories of others' experiences.

The team spoke with their own teams about their engagement in the welfare team and made sure to clearly communicate the purpose and boundaries of the calls—this allowed for a dialogue between the senior leadership team and the co-ordinators that promoted the trust relationship. Initially, communication was effective, so we were able to check that the process that had been developed organisationally was in line with the government response.

There was soon a need to add more people to the team, when it became clear that with the shifting workload it was not manageable for us to make 260 calls between four people once per week. Due to not being able to meet this demand, we moved to one call every two weeks and sent a letter out to all staff via the Executive Director (ED) to let staff know what they could expect from our team.

Team members came from a variety of roles within the organisation: employment support, senior management, behaviour support, and support workers. All team members were chosen because they had demonstrated the skills of quickly building rapport with people and were good listeners and mature practitioners.

Findings

- Broadly, we noticed that the transition periods were the most challenging for our teams, with people being stressed about how the support they provide, and their personal experience would change depending on the government alert level.

- We also noticed these periods had the potential to impact the people we support; here the clear communication from leadership helped people to remain calm and the team to stay on message.

Person spoken to/ message left?	How are they physically?	How are they emotionally?	Any concerns they have (work)?	Key issues they are facing	Ideas they have	Region	Information elevated to management Yes /No	Emergent issues

Figure 1. Prompts for Structured Conversations Reflective of the Mana Wairoa Framework

- People are adaptive, particularly support workers.
- Our staff have good ideas and are receptive to innovation.
- Practising what we preach; this calling system was appreciated as a support tool, people appreciated the calls and recognised that it was in line with our organisation's mission statement. Modelling the importance of checking in with people and community and culture as a part of our mission statement.
- It was noted that some staff, because of the complexity of their role, or their own personal circumstances, required additional support. These people were allocated one person on the team to talk with and received a weekly scheduled call.
- The survey of staff had a low response rate of 26%. Of those responses 79% found the calls *somewhat helpful* to *very helpful*, and 19% found the calls *unhelpful*.

Impact on the Welfare team

We found that there was a cumulative effect on the people making the calls, hearing other people's experience as well as processing their own, unique situation. Recipients have a choice as to whether to share information or not; whereas the wellbeing team has had a lot of information and people's collective stresses to process. This information has now informed future practice for the Wellbeing team, the people assembled to do the work are selected for their level of maturity, their competency with reflective practice and ability to effectively utilise supervision.

There were also reputational impacts. We learned from a number of staff members who had worked for other organisations during various other crises; they commented on the response, including one person who spoke externally about the quality of the support and communication response from our organisation. This was primarily anecdotal; however, if we could transition to this being an ongoing feature of our organisation this could have positive impacts on staff retention.

Unintended consequences were not just picking up any "slack" but also mitigating health and safety risks and supporting people to feel valued. The team noticed that they felt proud of the work we had done and what had been accomplished in a short time frame.

Discussion

The team have discussed how the practice knowledge gained could be replicated to respond to a natural disaster and reflected how that might work due to everyone experiencing the trauma collectively during these events. The outcome was a recommendation that regional wellbeing leaders be incorporated into the Health and Safety teams.

Without limits on call time, we found practically there was a maximum number of total hours or people that each caller deal with to achieve quality or helpful outcomes.

Supervision from senior leadership is necessary for the team to reassess what is going on in their personal lives and how that can impact on calls. This was a relatively informal, facilitated catch-up or sharing circle that sought to develop team strategies, explore emotional load, form a cohesive response and adapt changing needs with the ebb and flow of government/societal changes. It was important, however, to have an experienced social worker to facilitate these sessions.

The script was helpful in the beginning to make sure, as a team, were on message and introducing ourselves in a neutral way. Making sure to outline key points, for example: "we are here as additional support, not taking the place of a co-ordinator or team leader", and "you should still use all of the usual channels for discussing particular workplace issues with your manager colleagues." Doing this meant we were able to take records of how people were coping more broadly and follow up where necessary.

Health and safety challenges in future might require scenario-based scripts for identified heightened risk factors. For example, someone in our organisation having Covid-19; what messages do we need to affirm to the team? what information needs to be gathered and who will synthesise that information? The script used was developed initially by leading team members and adapted situationally by the team depending on conversations and needs of staff.

We modelled the importance of checking in with people, being kind and building fellowship and resilience with teams. The Wellbeing team all thought that incorporating more peer support within the organisation would be another good outcome from what has occurred—we are currently developing a mental health training module as part of our onboarding and lessons from this will be incorporated into the way we deliver this training.

There was also a clear process identified within the well-being team that all coordinators were contacted if there was an identified need for support. All staff were informed of this process.

Reflections

Community Connections aims to support people with a disability and/or health conditions to develop the natural supports necessary to enable them to live in their own home, to connect with their community and to enjoy an independent, fulfilling life. It was noted that this aim was mirrored in the support calls from the Wellbeing team when we talked with people about how they could utilise their natural supports to promote their own wellbeing, and also assist people to connect with additional community support if required.

It was also noted that support workers felt "less isolated" in their practice by having the opportunity to connect with others in the organisation outside of their team through the Wellbeing calls, but also by sharing practice examples that had been successful when supporting people during the Covid -19 lockdown.

Wellbeing calls were not limited to frontline support workers but included all people in the organisation from support workers to the Executive Director, including auxiliary staff. Feedback from staff was that people developed a feeling that they were part of an organisation that responded to the Covid-19 lockdown together.

The 2021 lockdown 17 August 2021–31 August 2021 Actions and reflection

Aotearoa New Zealand went into another Level 4[1] lockdown on 17 August 2021, for two weeks. The Wellbeing team went into action and within two days we began making calls to essential frontline support workers. We inducted two new members to the team, including a Kaiārahi[2] who has been working with teams to develop a self-managing approach to their work and develop understanding around our new Mana Wai Ora[3] framework.

We used the same script and created a new spreadsheet for calls, we recorded data in the same way—we were able to connect the team with the appropriate support from their coordinators where there was uncertainty.

We decided also to prioritise contact to Support Workers providing essential support. In the interim period between lockdowns, we had made individualised plans for each person we support. We identified that people in Te Rito o Rehua[4] and Te Pou Hononga[5],were also prioritised due to the intensive and frequent support needed by individuals in these services.

As an organisation, we had already developed strict protocols as many of these team members work in a number of homes and the risk of cross-infection was high; therefore, we knew the stress levels from some people would likely be higher, particularly those with family members and others to support in their own lives.

Once we completed these calls, we found that many people did not answer the calls or were not too worried about the lockdown, they were understandably prepared for a "short sharp" lockdown- although as it turned out the Auckland area ended up being in level 3 for a total of nine weeks.

Some key takeaways (it is worth noting that these points were taken from the brief notes captured by our team so they should be taken as indicators of the broader response):

- Of 318 employees, we managed to speak directly with or texted 211
- One staff member had passed away since we last used the spreadsheet (not Covid related)
- Physical health—we had one person with a serious reaction to the PPE-7
- Of the 211 direct contacts with staff, three calls had information that needed to be elevated to Coordinators, the implication from this being that staff felt well prepared and communicated with
- 56 people of the 211 we had direct contact with had ideas for things we could do to improve services
- Of the 211 people we spoke with, we recorded 13 people struggling emotionally, feeling overwhelmed or worried about the community spread of the virus and five people specifically mentioned feeling isolated
- Three people commented on poor communication from the organisation
- Five people made a general complaint
- Three people made a specific compliment about the organisation
- Five people specifically mentioned completing training modules
- By far the biggest stressor for our staff was managing family obligations whilst doing their job, particularly those with children also at home.

Overall, staff were comfortable with the individualised plans and protocols that had been developed since our last lockdown and seemed more relaxed and able to handle the challenges presented by the lockdown. They also reported feeling (largely) happy with the communication they had received from the organisation. It was unknown at the start of this lockdown how long it would last, we knew it would be reviewed after two weeks, so many people initially reported enjoying the lockdown.

Community Connections' work during this period would have been much more challenging if we have been operating in the city of Auckland, although as an organisation we have had periods where we have had regions in different Level stages—providing an added element of complexity for communication with teams. Due to our Hawkes Bay Kaiārahi coming onboard to the Wellbeing team in the first two months of their job, they reported experiencing a great opportunity to develop relationships with many staff members in a short period of time.

This lockdown was less stressful for people; they broadly reported knowing what they had to do and completed tasks efficiently and with confidence. This Wellbeing kaupapa has been fully integrated into the Community Connections' dynamic response to health and safety challenges and significant events; it has also become part of our everyday practice.

Notes

1 https://covid19.govt.nz/about-our-covid-19-response/history-of-the-covid-19-alert-system/#alert-levels

2 Coach

3 Empowerment through Wellbeing

4 Teams delivering personal care supports

5 Teams delivering 24/7 supports

The Routledge international handbook of social work supervision

Kieran O'Donoghue and Lambert Engelbrecht (Eds.)
Routledge, London, 2021
ISBN 978-0-367250867, pp.702, Hardback, NZD447

Supervision is one of the core pillars of sound and humane social work practice and leadership. I'm sure we can all recall rewarding, stimulating and challenging sessions, contrasted with task-driven "KPI-drenched" meetings with our supervisor. Given its centrality to just and ethical practice, this volume is a welcome reference toolkit. This book is part of a wider handbook series of note—The Routledge International Handbook social work series is a splendid collection and something every library needs.

Opening chapters focus on a range of jurisdictions, with the USA a notable exception. I am always drawn to Scandinavian practice debates, and the German chapter is equally interesting given the pedological emphasis in Western Europe social work. Following sections cover supervisor settings, roles and responsibilities, models and approaches, interpersonal issues, leading and managing supervision and close with a focus on emerging areas. I started at the emerging areas section—excited to see what new debates are on offer. Chapter 50 stands out for me—the role of service user voice in supervision. Like the fourth-wall method of Brechtian theatre, the people we work with and for can be rendered present in the supervision process (an empty chair is sufficient to represent whānau and families). I was left pondering the possibility of families supervising my practice. What might this offer? Peer-based models are also a big area of interest for me (Chapter 22).

The book is large and comprehensive, and I found myself heading to chapters of interest rather than moving through the text. This is a real strength of the book. Each chapter stands alone yet is located within a wider context of debate nationally, culturally, institutionally, and discursively.

Several contributions from Aotearoa are included—I've always enjoyed Liz Beddoe and Kieran O'Donoghue's work. *Indigenous Eyes Over Supervision in Aotearoa* was beautifully written by Moana Eruera and Leland Ruwhiu in Chapter 17. A follow-up chapter might consider tauiwi practitioner needs in Kaupapa Māori supervision models. How might we build this into everyday practice and resist it becoming codified through managerial or KPI-drenched demands?

David Wilkins (Chapter 13) is a splendid practitioner-scholar, a rare mix of lived child protection practice experience with accessible scholarship and his chapter on child and family settings stood out for me. I work in this field, so was drawn to the chapters where child welfare was in sharp focus. David's argument that we need more supervision focus on the *how* and *why* of practice influenced my own work on the new practice framework for Oranga Tamariki. Further editions of the book would benefit from a local debate about supervision inside Aotearoa statutory child protection and forensic mental health because the stakes are so very high in these practice settings. The workplace significantly shapes how supervision takes place and this is explained well in Chapter 45: Organisational Culture.

I was pleased to see isomorphism covered, albeit briefly (Chapter 20), and organisational leadership in focus. Isomorphism is a theory

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of *acting up and acting down*—thus, how the supervisor is supervised will influence the supervision they facilitate and then flow on to the work and social work practice with families. The way supervisors are supervised has been a fascination for me and an area I think underdelivered in many practice settings. Anxiety and emotion management was another useful focus—helping practitioners to raise feelings and be able to *be present* with uncertainty and ambiguity is a practice reality and offers us reflective illustration to grow and stretch. This is particularly the case for child protection social workers.

There are several supervision models introduced in the book in Section 4. This is helpful for busy or anxious workplaces that will need to grasp effective models of supervision that the supervisee and supervisor can employ and participate in. The models covered required quite a bit of experience, and I pondered how we get the levels of experience needed. I think models need to be flexible and agile, perhaps less prescriptive.

Being part of rigorous and challenging supervision is a clear goal in the book and the case is well made. Less convincing were the arguments made for trauma-informed supervision. *Trauma* is one of the most overused terms in practice today, perhaps a modern-day catch-all, and I was looking for a more critical treatment of this term (Chapter 33).

Several chapters made the case for external supervision—with the risk of decision-making analysis and our emotions being outsourced, in my view. This is an alive debate now and warrants more exploration. I'm not convinced that external supervision offers the gains for all practice areas argued for (Beddoe, Chapter 21)—does it let internal supervisors off the hook? Does it let the organisation off the hook to develop the very best supervisors? How might we excite them to become the best reflexive leaders and supervisors they can be? Where is accountability for decision making located in external supervision? This is a particularly important debate for statutory child protection and forensic mental health services.

Practice frameworks are surprisingly absent. Practice theories, models and skills are covered, yet not located or housed within a comprehensive framework. Doing so would help to drive supervision to focus on the theoretical and methodological aspects of practice—helping to explore the "how and why" of practice that David Wilkins (Chapter 13) reminds us to focus on (see Stanley et al., 2021).

The editors left it up to me to think though what works, what's best, and what I might like to draw on. This may be intentional. I would have liked a bit more of a steer—do the editors think group supervision is a better investment than the dominant dyad model? Is peer-to-peer learning and feedback offering benefits in some contexts more than others? What might teaching hospitals show us about peer-based learning and, while the role of coaching is explained from the German context, what might it offer us here in Aotearoa? Coaching and supervision seem a sound complement.

Wow—what a book! Chapters are brief and clearly written, so easy to read. It's a large, and expensive hardback volume. Probably too expensive for most practitioners. This is a comprehensive book explaining what supervision is, the core aims and purpose, how to participate, to lead, to evaluate, and so on. Perhaps a few less chapters with more analysis of the core debates would enhance the book. I do hope a paperback edition is released, and a suggestion is a brief summary note that offers core ideas and leadership access to these important debates. Borrow this from your library and read on. Practice can only gain when supervision is sound.

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The Aotearoa handbook of criminology

Elizabeth Stanley, Trevor Bradley, and Sarah Monod de Froideville (Eds.)
Auckland: Auckland University Press, 2021
ISBN 978-1-869409395, pp.431, Paperback, NZD89.99

Social work and criminology coalesce in many practice settings. My work in the HIV AIDS sector in the 1990s witnessed the arrests and detention of HIV+ men under what I argued then was a draconian application of public health legislation. At the time, I struggled to argue back to the power of such draconian applications; the ideas in this text would have most definitely helped my advocacy. I was pleased to read and review this new handbook covering contemporary debates and practice areas that are relevant to social work in Aotearoa today.

This is a comprehensive and accessible volume, taking a critical, decolonising and feminist view of the issues covered. I liked the approach as those involved in crime, those who work in the field, those arguing for reform and importantly those affected by crime are all in sight. Social workers take an ecological approach to social and interpersonal issues and a focus on both those affecting with those affected by crime is an important focus for our work.

Four sections house 32 chapters, with topics you would expect: Section one introduces crime and sets out clear theoretical understandings of crime and criminology. Section two provides a range of illustrations to bring the theory to life. Environmental crime was particularly interesting (Chapter 10). Sections three and four will be of particular interest to social workers—covering criminal justice and differential experiences respectively. Contemporary areas of police racism and reform, youth justice, neuro-disabilities, gangs and mental health are included chapters. Social work students and practitioners have placements in a couple of practice areas—the gift in this book is insight into a significant array of experiences and issues.

The chapters are small, 10–12 pages, making this an easy-to-access set of debates. Study questions are always helpful to engage the thinking. A local text for a local audience may limit the book's wider international appeal; nevertheless we need local research and theoretical debates for our people in our place. While children feature in many chapters, a dedicated chapter on child abuse and child welfare would have enhanced the book. Youth justice gets a fuller treatment and, given Aotearoa has such a problem with child abuse, this seemed a curious omission to me.

The closing chapter, "Deportations: Sorting citizens across borders", sensitively and importantly covers the dawn raids from the 1970s and the legacy that is alive today. This chapter and others draw on Australia/Aotearoa-specific differences to highlight how national context and cultural histories so significantly shape both policy and state responses. We are, indeed, very different nations.

Social work students study the courts, legal and justice issues, and section three offers quite an in-depth discussion about the court system, sentencing, restorative justice and rehabilitation theories and methods. I found it refreshing to be updated in these areas; areas of practice I engage in because I work in statutory child protection.

I really like this book. I could dip in and out of areas I was drawn to. I've been a fan of Jan Jordan's work for years (Chapter 6—sexual violence). I have used the Good

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Lives Model (GLM) in radicalisation and extremism casework while in the UK (Chapter 22—Rehabilitations), and I enjoyed the comparison of GLM to the "risk needs responsibility" model. I welcome new and more debates about risk and risk-work. Social work is so often right there.

The application of the ideas to practice settings was underdelivered in the book, perhaps this is not quite the forum to attend to that task. That being said, social work students and practitioners could easily make connections between the ideas and practice responses. A couple of big-ticket items would have benefited from a more critical eye: *trauma* being one; such an overused term in social work today, something we need to take a more critical eye to. What does trauma actually mean, and to whom? Algorithms is another topic I was looking for a more critical treatment of. Like trauma, algorithms feature heavily in social work today, something we do need to be critical of, and question. Given the human rights and justice implications this may be our contribution to make.

Social work is so often in the risk business. Risk-work and making sense of risk and harm are not straightforward. So, we need to keep up to date with criminology ideas and practice debates and this book is a helpful friend for social workers. Libraries should stock this. Undergraduate study in social policy and sociology would also gain from this text being recommended reading. The easy-to-read chapters provide overviews of the institutions, polices and methods of theorising criminality and penal policy—useful for social workers. I was expecting to see a chapter on pre-colonial Māori society, and while mentioned in Chapter 19 this is an area where I think more could be presented and learned from.

Social work gains from drawing on new knowledge and debate from a range of social sciences. Social work in Aotearoa New Zealand needs contemporary research and debate about criminology and how we come to understand and respond to it, in the most humane of ways, toward the greatest effect. Our ethic of care is enhanced through current knowledge debates about how we come to understand these issues. This book offers a range of critical and helpful chapters to help us do just that. Short and pithy chapters are supported by study questions that invite application of the ideas in theoretical and practical ways. This is a contemporary Aotearoa text that will support social work study, research and practice.

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