COUNSELLING AUSTRALIA

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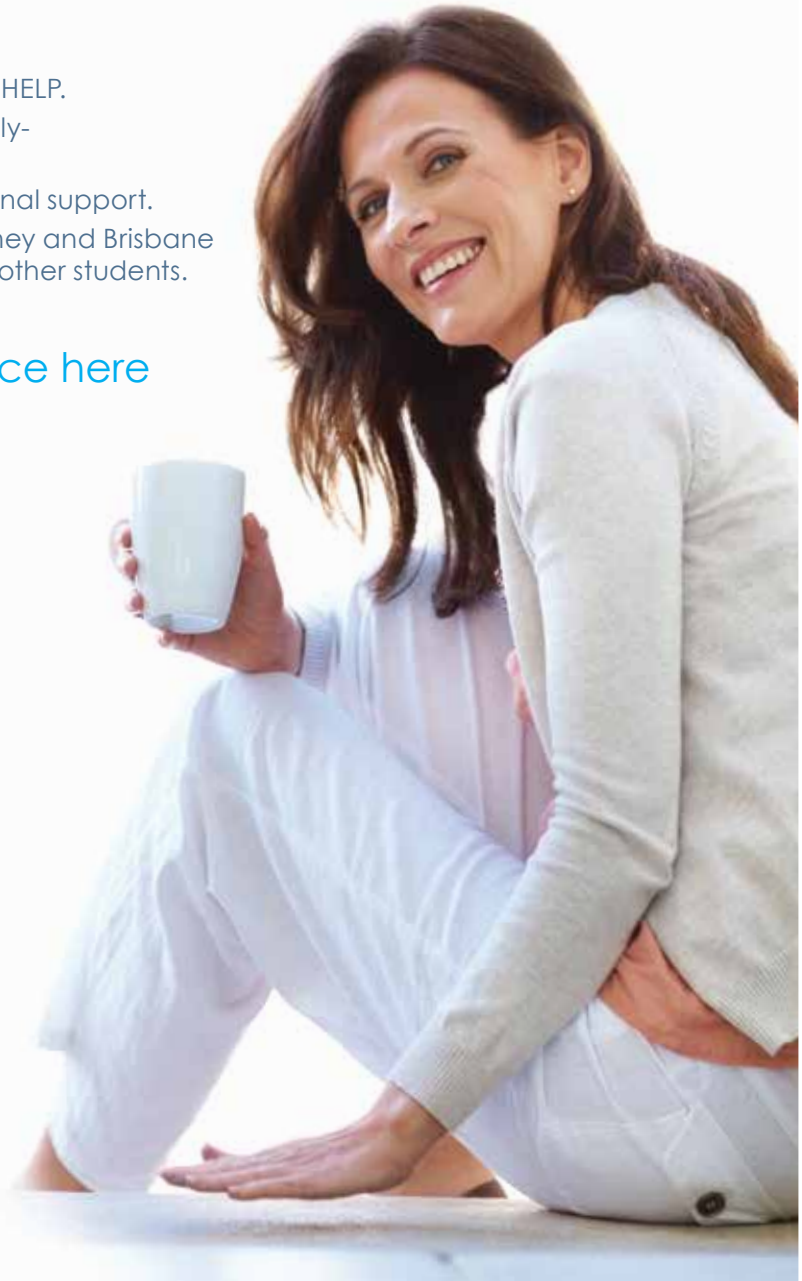

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See page 68 for peer-reviewed article submission guidelines.
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Crisis, what crisis?

By Philip Armstrong

Crisis, what crisis? The title of this special editorial may ring a bell for some of our mature aged readers. "Crisis, what crisis?" was the title of the rock band Supertramps bestselling album in 1975. What bought this memory to mind was the continual reference I hear within the counselling industry to us being in crisis. My first response is crisis what crisis? The definition of crisis being: *a time of intense difficulty*. The basis I hear people using the descriptor crisis is usually based on criticism in relation to issues such as: no jobs, peak bodies are not doing their jobs, the future is bleak and so on.

I am a positive person and always look for the positive in everything however I also like to remain balanced and ensure I keep those rose coloured glasses tucked away to make sure my vision is not clouded. So as a positive person who remains grounded I believe it is time we looked at the reality of counselling in Australia now in comparison to where it was in the mid 1990's to determine are we really in a crisis. Or are we simply not appreciating where we are at compared to where we were and simply feeding our darker emotive side.

Now please don't misconstrue what I am saying to mean I don't believe Mental Health services in Australia are not in crisis because they are. What I am going to discuss is the actual counselling industry not mental health services which are largely dependent on Federal government funding. This article is not about the delivery of mental health services or government policy. It is about the counselling industry and where it is today compared to yesterday to determine are we in "crisis".

To be in crisis you must be in a time of immense difficulty which in essence means worse off today than you have been in the recent past. If you remain in difficulty for a prolonged period of time this actually becomes the "norm" not a crisis. I have been in the industry for over two decades and I can say unequivocally counsellors are far better off now than ever before in my experience. So I don't believe the industry is in the norm or crisis. I personally believe counsellors today are better trained and I determine that through my 15 years of experience sitting on curriculum development boards and course advisory committees in both higher education and vocational education.

There have been significant efforts to continually raise the bar over the last 15 years and in particular the last 10 years to improve curriculums and assessment processes. This has led to what I believe to be greater employment opportunities for counsellors with counselling qualifications as opposed to education, psychology or social work. These being the traditional pre 2000 era qualification pathways into counselling.

Looking back to the early to mid-1990's when I first came into the industry things were not so good. A counsellor in private practice was paying over $800 per annum for Professional Indemnity and Public Liability insurance policies. Jobs hardly existed for counsellors outside private practice and the job market for counsellors was monopolised by psychologists. I got my first job in 1995 not because of my counselling qualifications but because of my Army background.

Most counselling graduate courses required you to pay upfront that is if you could find any. Besides the University of New England where I graduated with my degree in counselling in 1999 there were few options to train at the degree or graduate level in "counselling" within the higher education sector if you weren't a social worker or psychologist. In fact many of my colleagues actually went overseas, primarily to the USA, for graduate and specialist training. Qualifications within the vocational sector were also scarce. I remember there only being two choices in Brisbane when I first started studying a Diploma in 1993.

There were no organised national associations fighting to improve or indeed create employment opportunities, raise the profile of counselling let alone lobby at the Federal level and carry out representative duties to stimulate employment and training opportunities. Counselling was not on the political radar at all. The majority of professional associations were predominantly state based and largely driven by well-meaning psychologists which meant little was done to advance the cause of counsellors.

Or they were for all intents and purposes alumni's as membership was dependant on the completion of a specific modality or alignment to a training provider. I remember going to one meeting of a local state based association in Queensland that I joined and the majority of the members totally ignored me with one even refusing to shake my hand as he felt I didn't belong there. The majority of the members were either academics or psychologists so I didn't feel part of the organisation in any case.

You were pretty much on your own with no support outside of your immediate network, we didn't even have professional supervisors to turn to. I actually wasn't even aware of supervision as we know it now as there were no counselling supervisors and there was no requirement for association membership. You either consulted with your peers or hoped for the best.

Relevant professional education/development was not available specifically for counsellors and what was, was either ad hoc or irrelevant to counselling and if you did come across some decent OPD it was too expensive to undertake. To top all of this of there was little if any accountability to the public or client. There were no National complaint mechanisms and no national registers so

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the consumer only had the legal system to work through if they had any issues which explains why insurance premiums were so expensive. It was not till the advent of the National peaks bodies which took several years to actually become established did things start to turn around.

Thanks largely to ACA now in 2015 counsellors have many opportunities for employment and for those in private practice there are many benefits available. Just to name a few:

- contracting with NDIS on a decent hourly rate to deliver services to the disabled,
- in NSW counsellors can contract to WorkCover for private work at a good hourly rate,
- in South Australia a "Counsellor" is a professional titled position within the SA government,
- there are significantly more jobs available for "counsellors" now than ever before in this country
- insurance is less than $180 per annum (2015 rate), there have been consistent drops in ACA premiums over the last eight years (counselling is one of the few professions to experience a consistent drop in premiums.
- Advocacy for the industry such as:
- recognition for Medicare rebates
- recognition by private health funds
- recognition within other government departments such as Veterans Affairs
- higher profile within Mental Health

These are only a few examples, one recent win was recognition of ACA members for contract work with Australia's leading EAP provider, Converge International, with others due to come online next year. ACA is also creating opportunities through its own strategies such as the Walking Support Program and Mind Your Head website.

ACA has also instituted standards and qualification requirements for professional supervisors to ensure all counsellors have professional support by appropriately qualified specialists. OPD can now be sourced through "moocs" online for free or through very cost effective providers such as the Mental Health Academy not to mention the bevvy of short courses and workshops available throughout the country.

Students can now get commonwealth funded seats for grad qualifications with nearly 80% of Australian university's now delivering a Masters in Counselling, we also now have counsellors completing PhDs and lecturing in Bachelor and Masters programs instead of just psychologists and vocational qualifications can be completed on federal and state funding through fee help.

In relation to client reach, in 1994 your client group was generally restricted to your immediate geographical location as was your marketing. Social media and websites were not commonly used in the mid 90's. Therefore your potential client reach through marketing was restricted due to a lack of technical support. Just the advances in technology alone have significantly increased our ability to reach out to more potential clients at very little cost. This has led to a positive impact on the industry in regards to individual counsellors now being able to offer services all around Australia as well as enabling them to market their services more effectively. So counsellors are certainly better off now in comparison to the past in this regard.

As far as employment is concerned for many years there were few if any jobs advertised for counsellors that did not go onto read "psychologist or social worker". Large NGO's etc would only hire psychologists/social workers and would rarely consider counsellors. Again that picture has changed with many organisations now looking for registered counsellors with counsellor qualifications. Just in November of this year alone ACA advertised over 100 jobs to its registered counsellors that had been generated through the ACA employment scheme. Again more work needs doing to generate even more jobs but the current situation is certainly far better now than it's ever been. I don't think I know of any other counselling membership organisation in Australia working to raise employability for its members to this effect.

I would certainly not interpret today's climate for counsellors as being in crisis particularly in comparison from where we have come from to where we are at now. If I compare where we are now to where we were in 1994 "crisis" would the last word I would use to describe todays situation. Counselling is at an exciting and vibrant point in its history in Australia at this time. Comparative to the history of Psychology and Social Work in Australia we are certainly ahead in our milestones. There is still some way to go and battles to be fought but I think on balance counsellors in Australia are far better off now than they have ever been. I am afraid I need to go back to my open statement "crisis, what crisis?"

Notice:

ACA would like to apologize to Zali O'Dea (nee Crosbie) for not including her name in her Peer Reviewed article titled 'Ethical considerations for facially distinctive counsellors' which was published in Counselling Australia Vol. 15, No 3 2015. Zali O'Dea's is Founding Director of Karibu Anawim Pty Ltd and she holds a Masters in Counselling MACCA, Bachelor of Education, Diploma of Professional Writing & Editing, Certificate IV Teaching English as a Second or Other Language (TESOL) & Workplace Assessor Training.

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FEATURE
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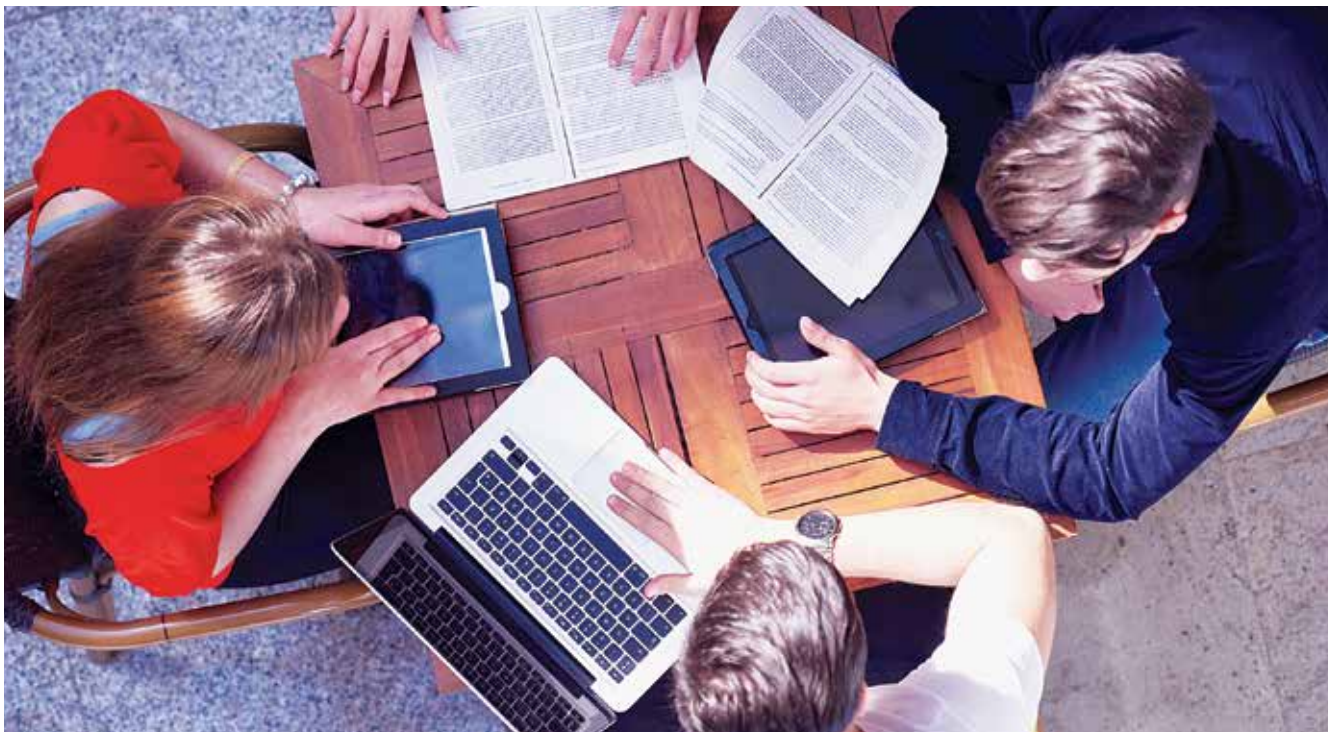
ARTICLE

Sources of Stress for School Counsellors: Challenges and implications for counselling

By Lynn Woods and Dr Ann Moir-Bussy



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The word 'stress' is a highly subjective phenomena which has been used widely in present times to describe distress in varying intensity. Eutress is a positive phenomenon that can motivate and energise. Through a subjective approach using phenomenology, this Qualitative Study used semi-structured interviews with five school counsellors working in Southeast Queensland Schools, to explore their lived experience of stress and response to stress. School counsellors work in an environment that is constantly changing, partly due to the influence of 'globalisation'. Such constant change and development provides challenges for students, families and staff, and to the counsellor's role. The finding of this small study are supported by previous research in this area. Stress e.g. role ambiguity and conflict, case load, case notes, isolation etc., were all mentioned by participants. However, the findings from this small sample also highlighted that response to stress initiated a process of positive and sustained change in both personal and work self-care, and the pivotal part this plays in sustaining the unique role of the school counsellor within the demands of an 'outcomes orientated' educational system.

Keywords: stress, eustress, school counsellor, balance, globalisation

Introduction

The understanding of how school counsellors in Australia experience and deal with stress, appears to be covered in a limited body of past research. Stress has been defined as 'the non-specific response of the body to any demand for change' (Sears & Navin, 1983). Understanding the phenomenological experience of stress is highly subjective in nature, and is generally understood to be interpreted with negative connotations e.g. trauma and burnout (Kirk□Brown & Wallace, 2004) , however stress that motivates to achieve, known as eustress, can be a positive phenomenon (Sears & Navin, 1983). A study exploring the relationship between stress and coping (Rowe, 2000), showed that problem focused coping is generally used when there is an expectation of being able to change a situation, and emotional-focused coping strategies when participants felt they had no control over changing the situation.

Background

Rapid growth in technology, and increasing internet access to knowledge and social media, along with the expansion of multicultural connection, brings many challenges to school counsellors. Schools are required to educate a diverse student population to a standard, higher than ever before (Darling-Hammond, 2008). School counsellors provide support within the daily demands of school life,

the increasing mental health issues that accompany life's challenges, along with multifaceted issues and expectations from all the major stakeholders – students, staff, administration, parents and professional bodies (Moran, 2002).

Previous studies on school counsellors and stress, identify underlying issues that cause tension, including the factors and conflicts that arise from role incongruence, and the ambiguity that places pressure on role expectations, time management, and the contribution of ego development (Culbreth, Scarborough, Banks Johnson, & Solomon, 2005), (Esters & Castellanos, 1998). Studies, mostly conducted overseas, have examined how school counsellors describe and experience their role, affirming a diversity in role description, as opposed to role base, as well as identifying the degree and sources of that stress (Kok, 2014; Sears & Navin, 1983). The difference between initial perceptions of the job description and the counsellor's practical experience of it, is a factor affecting role stress, along with the need to understand the changing and expanding role that school counsellors encounter (Culbreth et al., 2005), (l-Washington, 2007).

Incongruence and ambiguity of role, appears to be identified as a major causality of school counsellor stress in many of the previous studies, showing that multiple demands from a diverse population and need base, can lead to burnout, and an ensuing low sense of self adequacy (Wilkerson, 2009).

Aims and Objectives

This current research aimed to build on past research into school counsellors and stress The research used a qualitative methodology to understand the phenomena of stress and eustress, contained within the lived experience of a small sample of school counsellors in Southern Queensland. It aimed to inform those in the helping professionas, and educators that seek to underpin the health of their school bodies, through the intervention and support of school counsellors. These counsellors respond daily to multifaceted issues and expectations from all major stakeholders – students, staff, administration, parents and professional bodies (Moran, 2002).

Method

It is important when choosing the research method, that the choice is considered the most functional in exploring the research question, and Qualitative Research provides several options with regard to methodology (Malterud, 2001). The theoretical approach of phenomenology, gains empirical insights through embodied experience, and the question of focus can be approached with 'astonishment' rather than preconceived knowledge and theory. This intentional analysis system unfolds understanding through the shared experience of the participants, using open ended and semi structured questions (Aspers, 2004).

Researcher position

Based on a subjective ontological assumption, research in the field of counselling, examines experience within the phenomenon of focus, as the way to discover knowledge. It is therefore not possible for this researcher to function as external observer, simply measuring what is observed, but instead must explore the 'how and why' school counsellors feel about stress, by in-depth emersion within the data.

My epistemological position in relation to this research can be formulated as – 'the perspectives and experience of the school counsellors who were interviewed, contain data that can illuminate the experience of stress in a changing world, therefore I used school counsellors in the collection of this data.' Thus this study sought to intentionally describe the school counsellors experience of stress, rather than simply explain the source of these tensions. Using the method of phenomenology brings perceptions and experiences to the fore, and seeks to be free of perception and hypothesis (Lester, 1999).

Participants

Participants for this study were sourced using purposive sampling, recruiting five counsellors whose experience is in South Queensland Schools and used taped interviews in the collection of data. Participants were initially sent a Research Participation Invitation by email, and counsellors who expressed interest were then sent the Research Project Information Form. The study utilised maximum variation, using both male and female participants, from both public and private school sectors and from different geographical locations i.e. coastal, rural and metropolitan. There was also a spectrum of experience ranging from a counsellor in their first year, to two who have operated in this role for between twenty and thirty years. The researcher acknowledges the limitation of this small sample size in generalising the findings, however it also recognises that allowing quality time to unpack the data through rich description is sufficient to convey the essence of the phenomena investigated (Starks & Trinidad, 2007), (Miller & Salkind, 2002).

Interview schedule

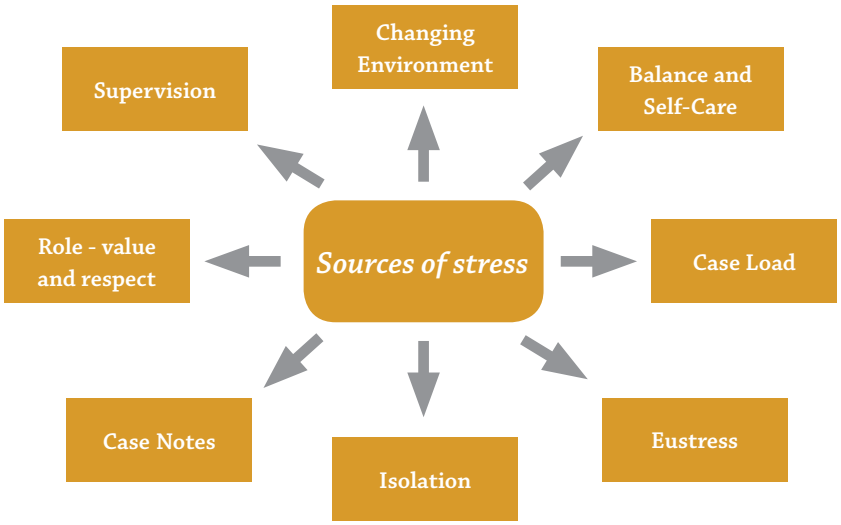
The researcher acknowledges that in these interviews, that the meaning of the participants feedback came through language, and that the formation of a positive alliance was central to collecting data. These indepth interviews followed the guidelines of confidentiality, and invited reflective responses from the participants. An initial general question established connection and rapport, and all participants were then asked the same set of questions. Flexibility was included in this semi-structured interview, using probing questions to further explore genuine experiential feedback from participants.

Transcript and analysis

Personal and professional experience in school counselling and stress was acknowledged by the researcher, in order to be transparent around any perceived bias. Bracketing also included inviting the participants to set aside their ideas about the issues that cause stress, and be open to their subjective experience of this phenomena in the interview. Interviews were recorded on audio tape and unchanged transcripts of the interviews were typed, with sensitivity to non-verbal cues e.g. silence etc. The researcher then listened again to the tapes, becoming immersed in the data and beginning to note perceived initial themes. Proper names were deidentified and participants were given a pseudonym and code. Meaningful units from each transcript were collated into codes, broader categories and then identified and developed into themes that represent the findings of this study.

SOURCES OF STRESS

Results



Case load

Four of the participants identified the demands that come from an escalating case load/management, as a primary source of stress. Participants stated that they are often expected to see an increasing number of students, within the limited time of a school day. One participant referred to a *'revolving door of children that have serious issues'*, and how the impact of their story, and the circumstances of students and families, can have a strong influence on the emotional and physical welfare of the counsellor.

Robert noted -

... then things that happen through the day, could be things that pop up without any warning, and they might be a critical incident it might be something that needs to be seen to straight away, and you've got to push other things back, and you can't talk about it, so you've got to be in control of it. As soon as you feel like you're losing control of your day, or you're losing, ... people trusting you to be in control of your day, then the stress starts to build

Joanne stated -

I think that in whatever role you are performing, there's organisational stress, and the stress from the role and the breadth of the role, and the number of hours in the week that you've got to do it in, and when other expectations are placed upon you, are they reasonable or do they create a stress internally for you that you in fact have to deal with by confronting it?. And in terms of role expectations, I have found as unpopular as it is, the best way is to confront it, and confront it early. Ah! so that everybody is on the same page.

Sarah's reflection was –

There's always drama so there's something happening every day, there's either some sort of fight, there's problems at home, the level of abuse and reportable incidents are probably higher as the kids are disclosing more and more about their home lives or past experiences ... yeah! so it is quite demanding

Another participant, Jake said –

The top challenge was having too many children to see and once I got the referral, and I read the story and the need for counselling it was virtually impossible for me to say no.

Rick added…

... because some days – like there's four periods in a day and sometimes I'll see – I'll have eight different sessions in that, you know dividing them in half and then plus lunch times, so it gets a bit, by the end of the day – how am I going to remember everything that was said sort of thing, so I guess, yeah!

Although participants spoke of spending more personal hours on their professional demands, the number of hours in a school day in which children can access the school counsellor is limited. Three participants spoke of spending all of this time, including lunch hours with students and how initially this was leading to a burnout situation. Exploring this with a trusted supervisor initiated a change that was ongoing and more balanced both in number and case type, as well as initiating more positive psychology intervention.

When reflecting on the high level of demand on a school counsellor and time involved, Joanne reflected:

'Classic is the Friday afternoon situation where someone comes in on a Friday afternoon because they are going to get beaten the hell out of on Saturday and Sunday. So they're in your office 12.30, 1.00 o'clock and so you're dealing with that and then you're thinking through the safety options for the weekend for them. Are Child Safety going to get to them in time, are they going to make the arrangements, is it expected of me to make some or all interim arrangements if they can't get out in time – that is high demand, high stress work.'

This high demand for counsellor time, also appears to impact on the effective recording of case notes. Participants spoke of seeing students without being able to have a break, or having the chance to recoup from each session, when case notes should be immediately recorded. One of the participants who is beginning work in this field, spoke of their stress when having to report to authorities around an alleged incident of assault on a student. There was a significant time lapse between the initial counsellor/client contact, and when the report was required. The alleged abusive circumstances were not presented initially by the student, and they spoke of their subsequent awareness for the need to be specific with information in case notes, and the stress of not having this skill taught, or adequate accountability and follow up, around the recording of case notes.

Rick stated –

That whole experience of going to the police for that statement, made it clear how important it was to be very specific with the information that I get and what I write down which I hadn't previously done, because no one really taught me

When talking about an escalating case load, Rick also verbalised experiencing a sense of dread at times, when hearing someone knock at the door, and a feeling of 'being pushed beyond my limits.' Accessing support under a heavy case load, also introduces confidentiality as a contributing factor to stress. Processing how long information is withheld before

action is taken, or the stress of disclosing it under a mandatory approach which the legislation demands from schools, puts the counsellor at risk of losing the client in the process.

Isolation

Robert remarked –

In the school counselling, unless you have a good rapport with someone in your workplace, then you really don't have anyone to bounce it off, because you are supposed to be competent all the time….. Most of the time we have people who have no idea what we are talking about. I think the attrition rate amongst counsellors is because they spend so much time trying to justify to other people that they're actually worthwhile.

Sarah commented -

Within this role, people just assume that you know what you're doing – off you go, get it done, show us the results and it can have the expectation of results…

While Joanne added

I don't really believe that administrators understand totally what we do. They're outcomes driven they want to see results and in counselling and therapy and school counselling often times the results we don't see and won't see until the fruit may bear in that student's life in their 20's because we're on about life long learning; we're not about immediate outcomes necessarily, we're on about managing the best way possible with that family, a situation, but often times the school has its own… what I call…, 'back ground conversations, or back ground expectations of what they want from the counsellor. It doesn't necessarily get articulated doesn't necessarily get expressed but you run up against it.

In response to feeling misunderstood and isolated, some participants spoke of feeling that the whole counselling/ psychology support model doesn't fit with the expectation of specific behaviours and outcomes. This resulted with some participants acknowledging that they spend significantly more personal hours on their professional role, and acknowledged that the process of this interview helped them to reflect on the need to revisit boundaries as a sustainable factor in their future working life. Making connections through the counselling network appears to counteract the feeling of 'floating by myself', along with maintaining and nurturing professional identity and relationship. A different perspective that comes with talking objectively with another counsellor in a different situation, was identified as providing a space for process that alleviates the burden of feeling isolated and taking the stress home. Robert said,

It's very hard … building a friendship or contact is far more relaxing, just someone, you don't want someone to fix something, you just want to make sure that at least you can actually articulate what you are feeling, because if you can't, then the feeling just stays with you and it builds…… you need someone, they don't have to fix it, they just have to tell you it's wrong or it's right, or 'yes I understand' that's all so you don't take it home.

Role – value and respect for the role

Role incongruence and ambiguity was identified in previous research as a source of stress for school counsellors (Wilkerson & Bellini, 2006). It can be inferred from information gathered during these current interviews that, unless there are clear policies and procedures in place for the counsellor role at the school in which they are working, role description and role expectations remains a fluid and interpretive factor around the expectations of school counsellors. Two participants highlighted the significant challenges that come with management and systemic stress when undertaking counselling intervention within an educational system. For example, being asked to take classes, or deal with disciplinary situations can be stressful, in that, a role encompassing a disciplinary aspect, can be at odds with the nature of the counselling role. Being asked to intervene at a point in a behavioural issue, without being included in the whole process that deals with underlying student issues, may contribute to a school counsellor feeling devalued, and misunderstood as to the purpose of their role.

So a devaluating – rather than allow me to share the whole process to recognise that it is something extreme or quite aside from reality, and no, it's not just a behaviour problem, there is something more underneath it not enough analysis of what's there (Robert).

Sarah noted

my role within the school was quite different and it's taken the young people a little while to realise exactly what I do and open up enough to sort of want to talk to me, because many of them have had experiences of counsellors before and it hasn't always been positive and many of them are from… they're already in the high risk category, so there is a lot of distrust there because of that.

This building up of trust for the counsellor and the counselling role, may impact on the possible future counsellor/ student relationship, and affect the time taken to open up and want to talk, perhaps at a later phase. The need for 'unseen time' such as writing case notes, thinking around assessments, and sometimes research time, can present a challenge to the counsellor who struggles with perception of needing to justify their existence and availability within the school system.

The role of advocacy for students has changed through a political shift in Australia under the Goss government in the 1980's (Slee, 1995), giving control of guidance officers to school principals in the state system. This accountability can create an internal stress for counsellors if the school agenda is perceived to be at odds with the counsellor's understanding of the process and support of a student. If a guidance officer counsellor feels that they do not have the support of the Principal and staff, then it was identified by participants that this may cause a continuum of stress. Joanne reflected -

The role has changed…. the government at the time which was the public service management committee in the late 1980's under Goss dismantled district guidance officers, they put them directly under Principal's control, and that meant that you didn't have support often times when you went in to advocate

The need for 'unseen time' such as writing case notes, thinking around assessments, and sometimes research time, can present a challenge…

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for students, because the school itself has its own agenda's with regard to that student. It then became a question of, in a state system, I do my role, and I have, on a continuum I guess of stress, I have less stress if I have a good relationship with the principal, to, if I don't have a good relationship with the principal, well, then it could be a constant source of stress.

In contrast, it was also stated that the support and trust of Principal and staff towards the Counsellor to determine the needs of a student and act appropriately, added to job satisfaction, and validated the value and respect for the role.

Jake noted

I loved it, absolutely love it…. know the principals of the schools where I worked, were very supportive and trusted, you know, my judgement… and trusted that I could determine the need for how often the child needed to see me, and the teachers were very accommodating to that.

Meeting with and advocating for students, dealing with presenting issues involving high risk demands, can mean that the core nature of the counselling role can be seen to be at odds at times, with expectations placed on other staff e.g. extra duties. These expectations may come from a lack of understanding, or lack of value, for the specialist aspect of the counselling role, or as was expressed by one participant, may also come from the financial pressures that some schools find themselves challenged with. It was also identified, that for a counsellor to refuse a directive regarding extra duties etc., it may place them with the added stress of being dismissed. Students often access the counsellor at times that are convenient to them, including lunch breaks, and it can be a source of continuous stress and misunderstanding for counsellor, students, and staff, if sessions are disrupted or postponed because of agency expectations.

Two of the participants acknowledged that previous experience in teaching provided an understanding of the constraints the classroom teacher has in terms of students exiting lessons, and that this experience enabled them to work closer with teachers, reducing the stress factor of class interruption. Jake commented,

I think that having been a teacher, you know of primary schoo,l was really helpful because I was understanding of what their constraints were and how difficult it was for them to have children coming and going and so I always tried to work very closely with the teacher to make that as easy

Case notes and access and ownership of information

The stress of balancing information shared with school and family, against confidentiality, can produce conflict around the extent and purpose of information shared or stored on a school data system. As Joanne noted,

types of documents do you share and balancing that with confidentiality so the school may have a system or technology or a data base system that they want to lock you into, but the difficulty with that is, um what do they want from you in relation to a student, what do they want you to input into that. Balancing that against confidentiality that's a source of stress, um because some schools want more detail than you're prepared to give.

One participant acknowledged that a defining factor in sharing information was – did that person need to 'action' it. Professional understanding between work colleagues, and the understanding that in Queensland, reports belong to the school, however the information belongs to families, helps to reduce the stress and confusion around ownership of recorded material. New school counsellors may experience stress if there is no support, feedback or clarification as to their appropriateness in keeping case notes. Rick said that

…the unknown, and not really having – like there's sort of been guidelines but not having someone I directly report to is new for me. So no-one is really checking on my work, so there's like a … I guess a sense of uneasiness … am I doing the right thing as well.

Unpredictability and a changing environment

In the interview, Joanne observed that one of the 'classic selection criteria for jobs these days, states the need to be able to manage competing demands in a rapidly changing world'.

That is a classic selection criteria that comes up, your ability to actually manage multiple challenges or multiple changes coming at you at once, which does happen. You can have changes coming in the field of counselling where you've got to adapt because of new research, or new approaches, at the same time that suddenly, politically, there's an imperative that's comes through educationally that schools have to respond to (Joanne)

New research and new approaches bring changes to the field of counselling intervention, along with a climate of budgets. The need to see results for money spent, is not always compatible with a counselling role that operates in mostly unseen intervention, and often initiates long term changes, not always immediately seen in short term circumstances.

We're in a climate of budgets that are, have been trimmed here and there and counsellors often are targets, because they aren't in front of a class, and schools recognise that their first priority is we pay

teachers to teachers in front of a class but if we're paying a counsellor x amount of dollars and they're not in front of a class then, we want to see what's happening for that (Joanne)

Technology

The rapid development in technology was identified as one of the major sources of stress in the changing school environment by a majority of participants. This evolution causes stress for counsellors and staff, particularly if the counsellor works, or has worked at more than one school e.g. is the school a 'mac' school or a 'P.C.' school. Data bases are often shared in schools, and the issue of confidentiality for the school counsellor is a concern, when information is required outside of what they perceive is appropriate, and this causes stress. As Robert said

And they're not prepared for it and the changes that come about, the parents don't understand technology. And the kids don't understand even though they use it – they DON'T understand and underlying all of that, is the social side of things that they don't understand, the social repercussions and the normal 'tooing and frowing' of social and emotional things….. they put in a new data base….and one of the struggles is bringing in new systems without allowing any time or human resource to help you put it in place. So you're running parallel with your workload all the time trying to put your system in place, trying to remember to put it on that.

Joanne commented

So technology up front, in your face is a stress. And the thing that I'm finding is that it's affecting all staff.

Changes in technology and the escalating bullying issue was discussed in this research by one participant. The amount of time taken up to deal with this challenge, and the ongoing extent of it, was identified as source of diminishing job enjoyment at times, particularly when this issue dominated the case load.

Emails and other conversational media is increasingly replacing face to face communication, resulting at times in miscommunication or messages being misinterpreted, and participants identified that stress and conflict arises, when the meaning in a message is misunderstood from what was intended.

One of the things that I'm finding in my current administration is that face-to-face communication is losing out and um miscommunication, or messages are being misinterpreted um when in fact, you don't want a meeting for a meeting sake, but there are places for meetings to clarify things and sometimes I think we're using technology and emails as a substitute for face-to-face communication. But also avoiding conflict….(Joanne).

A world connected instantly through technology enables media to bring critical and often graphic images and incidents into the home or school environment.

And what I found, like some of the interventions that I did in the classrooms, I realised as I progressed with that, that there was this great need that I hadn't really anticipated, um, around anxiety, even in really young children, because what I found was, I started going in and saying 'Who has nightmares?', now these would be seven and eight year olds and ninety-nine percent of them have nightmares so I came to realise, yea, you know they're kind of privy to information and fears and movies and things that we

weren't when we were young..(Jake)

Enmeshed in this, is the situation where children have access to watching horror movies etc., including those that contain material where it is difficult for children to separate reality from fiction. Children can sit in their bedroom and access graphic images emanating from global sources, and this stress invites a shift in thinking for the counsellor, as to how to approach the stress that comes from these effects on children, who do not have the understanding to process the reality of what they are watching. One participant spoke of a heightened sense of anxiety built up due to the television repeatedly showing the same footage of 911 over and over, and small children thinking that each of these footages was a separate and ongoing attack.

Sexuality and drugs

Personal confusion, and a global political agenda around sexuality, also permeates into school relationships and experience. The school counsellor can experience stress and dissonance when navigating support of students who are working through their sexuality, while being sensitive to the ethos of the school in which they are employed. This also includes the area of students taking and experimenting with drugs.

Sarah reflected

Some things that are happening in the community do automatically come into the school. There's the different kinds of drugs, it's what might be the preference of drugs at the time, and I know just recently there's been a lot of glue sniffing, paint sniffing and ice we've got problems in those areas so that certainly comes to the school and I think that within the community and some of the families, that are involved in the school, some drug taking is acceptable so it's something that we need to struggle with, sort of go well, how do you actually try to get a clear message to the young people, when they're getting a distorted message not only the community, but sometimes the family, so that can sometimes be challenging.

The challenge is for the school counsellor to reflect clearly on how they stand on certain issues personally, and in their counselling role, while remaining open and non-judgemental to the journey of those that they counsel.

When you make a decision you need to consider all of those you know, what all of those different sections might comprehend your decision to mean, or might, or whether they are actually going to be on board with some of those decisions, or whether more likely to complain about something that I might have said or done. All of that has to be considered…(Sarah)

One of the current global messages that influence health workers is a holistic approach to intervention. Participants identified that schools may believe in remedial learning, and enrol students with needs in particular areas, however they are not necessarily employing the resources necessary to adequately support the challenges of these students. This may add stress and confusion around the boundaries and role of the school counsellor.

Strengths from challenges

Each of the participants spoke of a time when they were personally aware of heading for stress and burnout, however they also reflected on the positive long term changes and strategies that evolved from this experience. Self-doubt, systemic mistrust and unhealthy coping behaviours, are not always easy to identify when working under stress in the school counselling role.

I guess one of the big questions that I had to answer was actually asked by a friend one time and they said, well why do you do it? You know because I was so stressed and um and then of course, getting to that point of burnout…(Jake)

I recognised that I had to deal with stress differently, and it was really clear to me when I did professional development training they say at the end of one of the days "What are you going to do after this to look after yourself….. Just recognising that I have to look after myself before I can look after anyone else. (Rick)

I've been so wound up with this role as well as other, you know, other pressures you know with other areas, that I hadn't started considering what this stress might look like in the long term, so I think it's good, it's valuable to start recognising that when someone is asking those right questions…..(Sarah)

I think the older you get, the more you actually have to recognise your psychological resources and the limitations of that. You also have to recognise, for want of a better word, your mortality, your health and you know, the old saying, you know, you pick your battle, becomes more of a thing to be conscious of. (Joanne)

I am not sure that you can separate what is stressful and what is a challenge, because if it is stressful then it's a challenge. (Robert)

Letting go of issues that may be handled in a different way, or not stressing out over confrontation, strengthened a perspective that built trust in working together with other administration and staff. Being aware also of past personal mental health issues, and how these were experienced and dealt with, allowed the counsellor to be alert and add to their thinking around self-awareness and eustress. Presenting issues within the cases dealt with by the counsellor, may trigger unresolved emotions that encourage the counsellor to seek personal counselling and support, and consequently strengthen their self-awareness and coping strategies.

Jake noted

I have to say you know there was a time when I really burnt out because, for some reason at that particular time, I was getting children who had, or were coming in with issues you know that had to do with an issue that I hadn't fully resolved for myself, my own personal um issues…… and so these children just seemed to have one after the other….. and I kept thinking 'I can do this' 'I can do this' (laughs) and there came a point where I couldn't do it. So for me then, how did I cope, I had to, you know I had to go and get help - I had to seek my own counselling on top of the supervision of course and get the help of colleagues.

Managing their environment, both physically and emotionally was a positive theme of the participants of this research.

Sarah said

When I walked into the office that I got, it was so cluttered…. and the walls were stark and really old ancient posters from probably ten years prior, so I actually gutted the room and made curtains and tissue box covers and cushions and threw some really bright rugs over the lounges, orange carpets, like everything really bright, I've got some of the art work of the kids and their names all over the walls and I've got some Tibetan meditation music and that plays through my office and there's plants and a fish tank, so it's a really calming room to be in and the kids have sort of expressed that as well, so I suppose I get a little bit of stress relief through the day.

I know that when also I'm stressed I – my environment around me reflects that (Rick)

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After experiencing periods of stress, two participants spoke of deliberately choosing to renew their focus in part, on the positive psychology aspect of their role that improves student functioning and helps them to thrive. They spoke of how a work load that primarily deals with high risk, high demand cases, can produce feelings of hopelessness and more of just helping students to cope, whereas a balance of proactive, positive interventions along with the other more demanding aspects of school counselling, restores a sense of job satisfaction and joy to the role. Participants verbalised a recognition of how a reduction of counsellor stress, and recognition of balance, flowed on to benefit clients.

Technology was identified as a stress that comes with a growing global digital age, however Joanne also stated that some of the changes did work in her favour. Being able to email students with information, rather than having to chase them up personally, was an advantage, along with emails to and from administration and teachers. This participant however also identified that personal emails in the same arena can be misinterpreted, and cannot always replace face to face communication.

Supervision, support, mentoring

All participants verbalised a need for supervision, however presenting factors within such a relationship can also contribute significantly to school counsellor stress, especially in times of a critical incident, where clarification of process needs to happen immediately.

It's knowing the consistency of who to turn to or who to trust, it's as if everyone's got a different agenda and it's difficult because anyone who is assigned to you as a supervisor or anything like that is doing a job, and you can recognise what they're doing, so in a way I guess you don't trust them, it's very hard, actually building a friendship or contact is far more relaxing….(Robert)

Participants identified that an internal supervision structure e.g. line management, deals mainly with case management, and that the advice from a supervisor within the system, can in some cases, push the counsellor past the limits of what they can handle in the school day. This raises the issue of trust and respect in relation to all parties navigating the demands and expectations of the system, within the supervisory relationship. It was reflected by one of the participants in terms of the counsellor needing to be consistently aware of who to turn to, or who to trust, especially in times of a critical incident, where clarification of process needs to happen immediately.

I think that every counsellor should have an external supervisor even if they have an internal supervisory structure that exists within the state system, because the issue of trust comes up between, if you're being supervised by someone of the system what remains confidential in the system, and I came to the conclusion very early on that it's better, you know it's mandated that you get supervision, but the type of supervision is basically case supervision, not personal supervision, and that's why I think you need to have personal supervision for your own management of stress.(Joanne)

Being immersed in a highly demanding and confidential role, can mask the emotional and physical drain that comes from constant student needs. Effective supervision provides 'another set of eyes' to look at the situation objectively for the care of both counsellor and client. Four of the participants also identified the need to access outside supervision and counselling for their own personal management of stress. Sharing with friends or co-workers, while navigating the boundaries of confidentiality, can allow the counsellor to vent and then move on, and this was seen by participants as a viable parallel process at times, to formal supervision sessions.

Balance and self-care

Sarah spoke of being aware that the counsellor themselves can systematically 'raise the bar', and therefore the school's expectations of what the counsellor will deliver within the role. Spending more personal outside hours to accomplish the work adds to the stress, and one participant observed that this is not sustainable, and would inevitably lead to burnout. Recognising and addressing high self-expectations as school counsellors, helps to provide a sustainable work/life balance. Counsellors, often go home still emotionally connected to stressful issues of the day. Situations of high risk, that involve the immediate safety of a student or a case of high level intensity, can produce a high level of adrenalin that may still be present in the body when returning home.

If you've dealt with a child abuse case or potential child abuse case between the hours of 12 and 3.00 your adrenalin is really flowing through your body, and is still flowing through your body because of the high demand of the situation, the at risk situation, the immediate safety of a person, you could still at 6.00 at night have this incredible amount of adrenalin and somewhere you have to turn into a

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partner and parent and relate to them. I think you can tune out to a certain degree but I've had the experience where I'm actually physically present, but mind and emotions are still with the case I was dealing with between 12 and 3. Um and that's because of the high level intensity nature of the case. (Joanne)

All participants identified that these situations of high intensity reflect in their home environment, and spoke of the need to deliberately take steps to compensate and restore calm to their bodies, preferably before re-entering their personal space.

I think the big point is knowing that the expectations of the organisation I need to find a balance between their expectations and my own expectations, and then come to some sort of, I suppose, a level that I'm happy to be able to say, that is going to have to do, and be able to walk away from work, so that I can maintain the balance throughout life not just the work environment.(Sarah)

One participant spoke of counsellors who are also parents, and their belief that it is important to give themselves space to *'get your head right to face your kids and give them what they deserve'*. They believe counsellors need to be able to recognise these signs of stress for themselves and take appropriate measures. These participants spoke of a change of their role when returning home, and each of the participants in this research, have thought about and identified strategies that they use when experiencing heightened stress. These include, understanding that, although there is an element of vocation to the role of school counsellor, it is a job, being able to let go of, and walk away from situations, and understanding boundaries of role responsibility and control. Accessing regular personal supervision, or meeting regularly with other counsellors, helps to offload personal baggage from cases, and means this is not taken home. Several participants spoke of attending to proper diet and targeted exercise, including meditation and mindfulness as a way to release stress from the body. Journaling, watching a good movie, camping and fishing, organising their environment, creating a measure of distance either by deliberate holidays away, or purposefully enjoying travel time to and from work, becoming grounded and in a better head space and attending professional development were some of the strategies these participants use in management of self-care.

Supervision that supports reflection on the bigger picture in the journey of a school counsellor, helps the counsellor to develop a clear understanding of the warning signs of their potential stress and burnout. Counsellors can then structure their work to maintain self-awareness and opportunity to reflect on the big questions in life that gives meaning to their choice of work as a school counsellor.

Discussion

This research, investigated the experience of stress and school counsellors in a rapidly changing environment. It identified and explored their coping or adaptive response to tension, recognising that this response can be reflected on as impacting personally and professionally in a negative way, or alternatively, as positive change in perception and behaviour. While the effect of these factors cannot be measured in numerical data by this small qualitative phenomenological study, participants expressed a conscious awareness of the significant shifts in their emotional, physical and spiritual resilience that produced ongoing and long term changes to themselves, their work and their clients.

Past research in the area of stress and school counsellors has primarily used Quantitative Research to gain an understanding into the relationship between variables such as ego development and the degree of burnout (Lambie, 2007), coping strategies and rising levels of stress (Wilkerson, 2009), collective professional self-esteem and burnout (Butler & Constantine, 2005) The various dynamics underlying the causes of stress for school counsellors appears to be consistently identified in these and present studies, supporting such factors as role ambiguity and conflict (Kirk, Brown & Wallace, 2004), ego development (Lambie, 2007), intrapersonal and organisational factors (Wilkerson & Bellini, 2006), supervision (McMahon & Patton, 2000) etc. This research, however, built on these past studies, to uncover the essence of the experience of the participants to the phenomena of stress, using in depth face to face interviews.

This research acknowledged the rapidly changing environment that school counsellors operate in, and participants identified a system that is increasingly affected by outcomes, budgets, political imperatives, and changes in the Australian Educational Curriculum. The parallel process of supporting students, families and staff navigating the social and emotional challenges of living in a digital age of expanding communication, while dealing with growing social and relationship issues that come with being a citizen of this digital age, creates stress for school counsellors. This may contribute to an increasing rift between expectations and definition of role by administration, and school counsellors

maintaining the essence of the core of the nature of their role, compassion v performance. Past studies have looked at the growing diversity of demands on the role of the school counsellor and the pressure this puts on them to prioritise and best perform their tasks (Wilkerson & Bellini, 2006). This research identified that the challenge of understanding the role of school counsellor remains at times, misunderstood, and a source of systemic stress for the counsellor. Perhaps future research may explore how counsellors working in a school agency, can maintain the uniqueness of their intervention, which seeks to elicit lifelong learnings as opposed to immediate tangible results as measured by a school system. Research may also explore how finding a fit or cultural match, between counsellor and the school's culture and ethos, contributes to the possible success of this experience.

Supervision featured strongly in the reflection of participants in this research, however different facets and effectiveness of this support were also a major reflection in feedback. Participants identified that there were sometimes negative aspects to a supervisory relationship, such as lack of trust or respect, duel responsibilities of an agency supervisor, or even 'bad advice' that exasperated an already overwhelming situation. Conversely good supervision continues to be identified as beneficial, both in past studies (McMahon & Patton, 2000), (Vallance, 2004), (Edwards et al., 2005), and in this present research. The school counsellors in this study highlighted the importance of finding different areas in a support base e.g. clinical supervision, personal counselling, friends and colleagues, and understanding their needs and appropriate accountability for themselves, their families and their clients.

One of the major outcomes from this study was the need for life/work balance and self-care. Participants reflected on and explored the high demand, high stress nature of their role, along with the unpredictability of the nature or severity of a case, or case load. This research found that stepping back to view the larger picture, most often in positive supervision, facilitated a process in which self-awareness 'meaning of life', reconsolidated personal and professional values and boundaries for the participants. In this limited study, all participants identified times of escalating stress as agents of deliberate and positive change, while recognising that this change is also a process.

Conclusion

Operating in an environment of constant change, the school counsellor is stretched and challenged to respond to new and varied demands. There are numerous stakeholders that compete for counsellor time and intervention, however it appears that for these participants, their response to job stress in a world of escalating knowledge, communication, change and crises, is to implement and practice balance in both their personal and professional life. Perhaps it is the ability of school counsellors to understand and maintain the nature of the core of who they are, that will preserve their valuable and unique role within an evolving educational structure.

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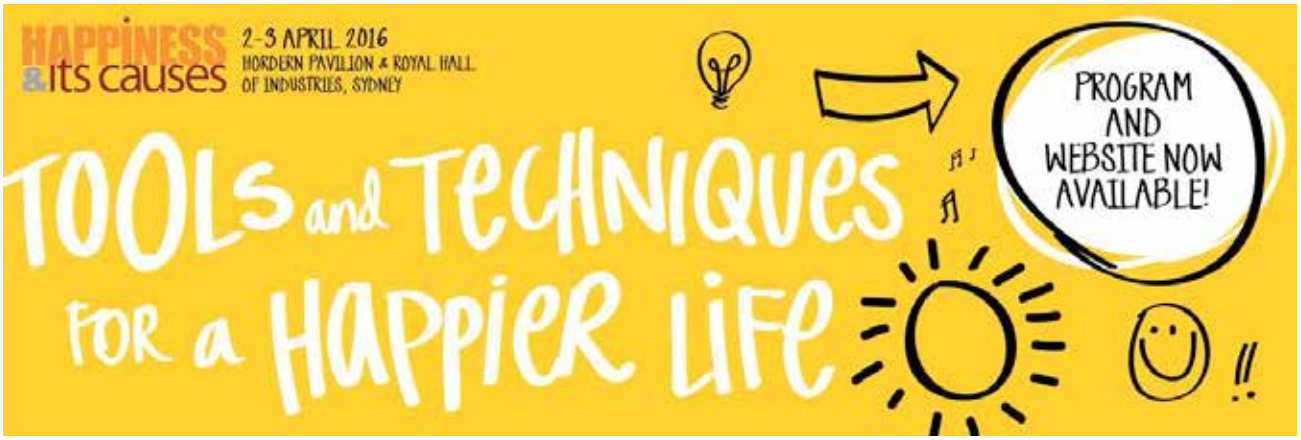

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PEER REVIEWED ARTICLE

Expectations during pregnancy: The Influence of Antenatal Education and Social Support on the First Weeks of Motherhood

By Francesca Tondi and Dr Ann Moir-Bussy

Abstract

The transition into motherhood is a magical, delicate time in the life of a woman. In particular, expectations can help to prepare for childbirth and the postpartum period, but they can also be source of sufferance when they are not met. This study focuses on some of the social processes involving the first months of motherhood, by looking at mothers' expectations, how they are formed, as well as the role of social support and antenatal education. While attention is usually focused on the consequences of distress symptoms during the postpartum period, not much is known about the causes of these symptoms. A qualitative study addressing this gap using a small pilot study was carried out. Semi-structured audio-taped interviews were transcribed and analysed. Themes were identified in order to expand the knowledge and to assist health care professionals designing or improving antenatal education programs, as well as providing support for parents to-be and new mothers.

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Introduction

The substantive area of this study focuses on a few social processes concerning the first months of motherhood. The research concentrates on women's expectations, and on how they may impact positively or negatively on the actual experience of becoming mothers for the first time. The study looks at how expectations are shaped and influenced by external sources, such as media, social support, and antenatal education. In particular, the research looks at the way social support during pregnancy and antenatal education influence expectations of first-time mothers. The study considers antenatal education, social support, and expectations as social structures that interact with each other and influence the overall experience of the first months of parenthood. This study aims to expand knowledge about the role of mothers' expectations, how these expectations are formed, and their impact on motherhood. The central questions will examine :

- How social support during pregnancy and immediately after birth impact on the experience of motherhood
- How information from antenatal education, advices, and media impact on the creation of expectations and on the experience of motherhood.
- What happens when expectations are met or when, contrarily, they are not met.

Background

Pregnancy and the transition to motherhood have a huge impact on women's health, social roles, and psychological wellbeing (Hendrick, Altshuler, Strouse, & Grosser, 2000). While this transition is generally a time of great joy, it can also be a great source of stress, as in addition to labour and delivery, new mothers deal with unfamiliar demands and expectations (Britton, 2005). The passage to motherhood is a gradual and complicated transition that lasts far beyond childbirth (Woollett & Parr, 1997). First-time mothers, in particular, seem to be mostly affected by distress symptoms such as anxiety, depression, and stress during the first 24 months postpartum. Compared to multiparous women, first time mother tend to score significantly higher in symptoms of distress, suggesting that socio-cultural and contextual factors have a stronger influence than biological ones on the appearance of negative symptomatology linked to the first months of motherhood (Dipietro, Costigan, & Sipsma, 2008). Expectations about becoming a mother for the first time play an important role on the actual experience of motherhood (Wardrop & Popadiuk, 2013), and depending on whether they are optimistic or pessimistic, realistic or not, they are predictive of postnatal outcomes for both mother and child (Bravo & Noya, 2014). Forming expectations helps one prepare physically or mentally for the experience (Martin, Bulmer, & Pettker, 2013), but when the experience does not match the expectations, the discord can leave a mother feeling confused, angry, upset, or even traumatized (Baker, Choi, Henshaw, & Tree, 2005). For this reason it is important for women to base their anticipation on accurate information (Martin, Bulmer, & Pettker, 2013). Nowadays, a large number of sources of information is available to women, such as societal beliefs, media, support people, and antenatal education (Wardrop & Popadiuk, 2013), so it may be hard for women to discern what could be useful advice from potentially harmful tips (Martin, Bulmer, & Pettker, 2013). Antenatal classes provide information and techniques for managing labour and delivery, and attendance to childbirth preparation is usually linked to positive effects and feelings of satisfaction about the childbirth (Quine, Rutter, & Gowen, 1993). Some antenatal classes provide women with information about the first weeks after giving birth (Gray, 2013), otherwise women generally tend to be informed and base their expectations on the basis of what their support people suggest or refer to them (Wardrop & Popadiuk, 2013). For these reason it seems that attending antenatal education as well as having the opportunity to discuss any concerns and doubts with someone trusted, are important factors for women when creating expectations. However, many women do not attend antenatal classes due to a variety of reasons; in remote areas of Australia, for example, only limited resources are available to pregnant women, and they all seem to target practical aspects of pregnancy and immediate after-birth, rather than focusing on psychological factors (Glover, 1986). In addition, some women lack of social support both during pregnancy and once the baby is born; it is the case of women who have recently migrated to Australia, and/or asylum seekers who do not speak the language (McCarthy & Haith-Cooper, 2013). Unfortunately, even if women who do not have a strong support system are probably the ones who would most benefit from attending antenatal classes, researchers have pointed out how they are most likely not to enrol in prenatal education (Bravo & Noya, 2014).

Literature Review

Becoming mothers for the first time: Expectations

Becoming parents for the first time can be a magical time, as well as a challenging period for both mothers and fathers. A Canadian study investigating the transition into parenthood characterized the responses of mothers and fathers-to be as fearful, prepared, and competent; While men focused on distal goals, women were significantly more fearful than their partners, voicing concerns about delivery, postpartum stress, and being adequate parents (Delmore-Ko, Pancer, Hunsberger, & Pratt, 2000). Creating expectations can help prepare mentally for the experience (Martin, Bulmer, & Pettker, 2013) but as pointed out by many studies, while having positive expectations during pregnancy predicts better outcomes of delivery and after-childbirth, negative expectations tend to result into maternal symptoms of depression and child behavioural problems (Christiaens, Verhaeghe, & Brake, 2008; Dipietro, Costigan, & Sipsma, 2008; Luoma, et al., 2004). On the basis of these results it seems appropriate to assume that while forming expectation is inevitable as it is a natural human process, it is preferable for women to hold positive expectations. Another factor that needs to be clarified is the importance of holding realistic expectations during pregnancy; the dissonance between anticipation and actual experience can in fact be source of distress, shame, and anger for women (Baker, Choi, Henshaw, & Tree, 2005; Martin, Bulmer, & Pettker,

2013; Mozingo, Davis, Thomas, & Droppleman, 2002). In addition, clinically normal experiences could be perceived as traumatic to the new mother who does not have a realistic idea of what will happen (Baker, Choi, Henshaw, & Tree, 2005). Pessimistic, unrealistic expectations seem to be cause of negative symptoms among mothers, but even if a huge amount of research has studied the impact of stress, anxiety, and depression on the postpartum period (Shwu-Ru, Panchalli, & Ching-Yu, 2013; Guardino, Dunkel Schettera, Bower, Lu, & Smalley, 2014; Vieten & Astin, 2008), not much is known about the causes of these symptoms. However, a study by Dipietro, Costigan, and Sipsma (2008), has underlined a major incidence of distress symptoms among first time mothers, suggesting that stress, anxiety, and depression have a strong socio-cultural and contextual influence. It seems realistic to assume that first time mothers 'expectation are based on external influences, such as media, family, friends, books, and childbirth classes (Ayers & Pickering, 2001), while multiparous women know what to expect on the basis of their personal experience. First time mothers appear to be more likely to be influenced by external sources, with the risk of forming uninformed childbirth and postparum expectations that may lead to harmful symptoms and/or experiences (Martin, Bulmer, & Pettker, 2013). On the basis of these findings it is essential to underline the importance, especially for first time mothers, of forming positive, realistic expectations in order to prevent negative psychological symptoms. While much is known about the undesirability of postpartum distress symptoms, there is still a lot to investigate in regards to what causes these negative manifestations. It seems realistic to believe that having positive, realistic expectations can prepare to childbirth and to the subsequent period of time, and can represent a protective factor against distress, in order to fully enjoy the experience of motherhood. Resources should be implied in order to understand and prevent postpartum distress, rather than just trying to cure it.

The audience for this study may include clinicians, professionals, and researchers who may be interested in planning interventions in order to support individuals involved in the social processes illustrated by the theory. Also some researchers may be interested in testing some information into practice (Starks & Brown Trinidad, 2007). The study aims to add to the existent knowledge in order to help build and/or improve antenatal education programs, and assist health care professionals, including counsellors, and parents to-be by providing a focus lens on some of the common expectations among women. In addition it aims to shed light on the processes preceding the formation of these beliefs. Professionals could target common expectations that women hold during pregnancy and focus on what happens when they are met or not. First time parents or expecting mothers could also benefit from this study by reading the experiences of others in similar situations. Finally, this study could enlighten the importance of support and prenatal information for first time mothers

and parents in general, that could lead to the creation of more specific and more accessible antenatal classes.

Moral Support

Moral support has often been linked to favourable pregnancy and postpartum outcomes. On the contrary, social deprivation is considered a crucial element in undesirable perinatal outcomes (Poeran, et al., 2013). Women who lack social support are more likely to experience mental health issues and poor wellbeing during their pregnancy (Poeran, et al., 2013). It is often the case of immigrants or women that have recently moved away from their families and friends. Pregnant asylum seekers and refugee women are also part of this "at-risk" category of people who lack of social and moral support (McCarthy & Haith-Cooper, 2013). However, even women having sufficient amount of support, often find that the type of support received is inadequate or inappropriate; new mothers, in fact, may feel burdened, judged and "bombarded" with advice and opinions, rather than supported (Wardrop & Popadiuk, 2013). In terms of forming expectations, having no support people to share concerns and doubts with, or being given inaccurate information, seem to lead to the same negative consequences (Bravo & Noya, 2014; Martin, Bulmer, & Pettker, 2013). Many mothers, when discussing their own experiences, pointed out how having the chance to meet other women in a similar situation and to share experiences, feelings, and worries related to pregnancy was a great way to alleviate symptoms of inadequacy, distress, and apprehension that troubled them (McCarthy & Haith-Cooper, 2013). Having the opportunity to meet other women in the same position can be a source of relief (Gray, 2013) both for women who have no social support and for those that believe they are not satisfied with the quality of the support they are getting.

Antenatal Education

Although the overall objective of antenatal classes is well meaning, research suggests that often, the information they offer can be unrealistic and contrasting in nature, which may depend on the way the information is presented (Lavendre, Moffat, & Rixon, 2000). A Scottish study found that there was a huge variation in the quality of antenatal education across the nation (Hardie, Horsburg, & Key, 2014). In a review of qualitative studies it was noted that generally midwives receive limited training in leading groups; because of their training as clinicians rather than as teachers, they may encounter difficulties when they are asked to assume the role of educators (Nolan, 2009). Furthermore, the same study, pointed out how women tend to adapt their manner in an effort to please their midwife, indicating the influence of midwives who provide antenatal classes (Nolan, 2009). In general it appears that, similarly to social support, antenatal education can be very useful as it provides women with helpful information, but it can also be source of inaccurate information; it appears that the teacher's point of view may have a strong impact on the creation of expectation among women who attend classes (Hardie, Horsburg, & Key, 2014). An Australian study on breastfeeding pointed out that a common social problem emerged for women with their breastfeeding when personal expectations were found to contrast the expectations of midwives, family, and friends, which led to confusion, self-doubt and sense of guilt (Hauck & Irurita, 2002). Another concern regarding antenatal education classes is their accessibility; women living in remote areas of Australia have very limited options in regards to antenatal education (Glover, 1986). An American study pointed out that immigrants who had recently relocated to the USA were less likely to attend prenatal education due to a number of reasons such as difficulty with the language, and lack of information about the new health system (Bravo & Noya, 2014). It seems plausible that these results could be generalized also to the Australian setting; pregnant asylum seekers and refugee women, for example, are less likely to seek timely maternity care (McCarthy & Haith-Cooper, 2013). In conclusion, while antenatal education provides women with useful, "monitored" information, this information could be inconsistent and/or biased by the educator's personal views. Another issue is the availability of antenatal classes for some vulnerable groups in society. Once again, while resourced are utilized to cure negative symptoms during the postpartum period, it would be essential to increase the attention on prevention and on those periods preceding birth.

Method

Research Design

The research was a small scale pilot study. The qualitative approach aimed to give some explanation for partially unexplained phenomena through in-depth semi-structured interviews.. An outcome of this study has been to expose a set of processes experienced by the participants involved, in order to deepen the understanding around some factors such as the impact of moral support, antenatal education, and the forming of expectations among first time mums.

Participants

Participants of this study were mothers who had their first child in the previous twelve months. Because this was a small pilot study, the sample size consisted of five women. The participants were personally contacted by the researcher, who invited them to share their story. The researcher had met the participants during the previous months and was introduced to one of them by a friend. The research recruited women aged from 23 to 30 years old who had attended various types of antenatal education; three of them attended the Expecting and Connecting antenatal care group at the University of the Sunshine Coast (Gray, 2013) during different times of the year. This program consisted of monthly two hours sessions incorporating antenatal assessment, education, as well as socialisation with other mothers-to-be. One participant of this study attended one-day course with her partner in preparation of labour, and one of them did not attended any specific antenatal courses but was followed through her pregnancies by her GP. Every participant attended a two-hours breastfeeding class. Participants also had different levels and types of social support during their pregnancies; some of them had only just moved to the Sunshine Coast and had restricted or "distant" support, while others had the complete support of family and friends. The role of partners' moral support was also partially investigated in this study.

Qualitative research frequently utilises interviews as the primary data collection strategy (Starks & Brown Trinidad, 2007). In this research a semi-structured interview format was utilised. Conversation is an important tool in qualitative research as it

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promotes the participation of all parties to look at their understanding of the subject through discourse, guiding to a mutual increase in knowledge (Thomas, 1999).

The researcher began with a list of set questions about the type of antenatal education attended during pregnancy, and the level of social support available during their pregnancies. Participants were then invited to freely talk about their expectations and whether these expectations had been met or not. The researcher asked for particulars in order to gain clarity and to stay close to their life experience. It was implicit for both the participants and the researcher that their words would be understood and would speak for themselves (Starks & Brown Trinidad, 2007). Most interviews lasted for around forty minutes. The researcher recorded the conversations, transcribed them, and provided a copy of the transcriptions to the participants.

Data Analysis

In this research, the method of interpretation consisted of a constant, inductive process of decontextualization and recontextualization (Starks & Brown Trinidad, 2007). During the phase of decontextualization the researcher divided data from the original framework of singular cases and allocated codes to parts of meanings in the text. During the phase of recontextualization, the codes were considered for configurations. Finally, the data was reordered around core subjects and relations, drawn across all the narrations.

It is important to specify that qualitative analysis is subjective. The researcher was conscious of the influence of her own perspective, and pre-existent beliefs, and tried to be as open and considerate as possible while dealing with the data and attending to the participants. The development of new ideas should stem from the data only, and not from preconceived theoretical concepts (Urquhart, Lehmann, & Myers, 2010).

Outcomes

Following the analysis central categories emerged from the data. Secondary analysis of the categories revealed key processes and themes.

Moral Support

Moral support was one of the most important themes that emerged from the conversations with the participants. Each participant discussed and underlined the importance of having support people around during pregnancy, labour and the weeks after birth. In particular, it appeared that it was the quality of moral support, not the number of support persons, that impacted positively or negatively on participants' experiences.

Partner support

Participants who felt supported during their pregnancy particularly appreciated their partners' patience and empathy throughout, what they described as a 'delicate time'.

"well I have got my husband, who was absolutely amazing for the entire pregnancy... I have heard horror stories from other people because...you don't look like there is anything wrong with you, and there is nothing wrong with you but everything about you feels different...you feel like you are in somebody else's body. And especially toward the end, when I was starting to get a lot of back pain I just couldn't do much at all, go to the shops or anything, and he really looked after me, he did lots for me"(Participant J)

Participants underlined how their partners had found it difficult to understand mood swings and strong emotions that characterize the first weeks of pregnancy. Women admitted it was hard for the fathers-to-be to understand their feelings as they had never experienced such important physical and hormonal changes. Looking back at their experiences, women expressed gratitude for their partners' support:

..he was good. But… mmm... he kept telling me I was really annoying... maybe I didn't realize but he kept telling me that when I was pregnant I was like... crazy... maybe he was right. –laughs-(Participant I)

"I would say I was really emotional at first. J said I had extreme mood swings in the first few weeks since we found out. I just had really strong emotion. I think I mainly got really angry for little things. J was great, he didn't take it personally. (Participant C)

Participants were generally happy with the amount of support they received from their partners during labour. On the other hand, they admitted that there was not much the fathers could do to help except for being kind and present.

I tried to pass on all the information I learnt from the classes but I don't think he comprehended that much because I think he didn't feel like he needed to know that much. He was just there, he knew he couldn't do much except staying there and be my support, saying kind words. He did really well actually. (Participant K)

And A was very good too. At first he just sat there looking terrified. He wasn't moving. But when it was time to push he was very encouraging and we hugged a lot. I definitely felt his presence. I thought I was going to yell at him for saying something wrong.-laughs-(Participant M)

When talking about after-birth, mothers listed as important factors their partner's availability and their willingness to share responsibilities.

..He is great, he spends heaps of time with him. Being mainly just the two of us, no grandparents around, we pretty much share responsibilities fifty-fifty.(M)

Even though all participants had indicated their partner as main source of moral support, they also voiced some difficult times, especially at the beginning of their adventure as parents. Lack of sleep and management of free time was mentioned more than once as a cause of discord for the couple.

...There was also a hard time, when N was a few months old and you know...you are doing everything for the baby, you are at home with him all day, and then your husband comes home from work and you are still doing everything for the baby... you feel like you never get a break from it, it's full on, it's 24 hours, especially when they are up all night. And I felt I wasn't getting enough support from him and I would still clean the house, cooking dinner, I felt like a single mum at times...

But I then realised he didn't really know what to do, either. It doesn't really come natural for a man as it does for a mum and he does shifts work so when he comes home he needs to relax before he goes back to work, which it's hard when it feels like I am also working all day even if I am at home. So that was definitely challenging. (K)

We did have some really difficult times when B was a couple of months old. We did not like each other at all. We used to argue all the time...

... I think it was the lack of sleep. B had bad reflux and it used to take ages to get him back to sleep when he woke up at night. We were both very sleep-deprived. I expressed milk so J could do one feed, the one at 4 am and he always seemed very resentful about it. As if I was the one meant to do it. (C)

"I think he gets it now. He gets how exhausted I am because one night we both stayed up as H was sick and he said to me "so this is what you do every night?" he was shocked and since then he is the one who wakes up in the morning.

...And I am glad he got it because I was on the edge of a nervous breakdown. I felt really misunderstood. Then he eventually got what I meant. But he had to experience it first. I guess that is the key. It's hard to understand things until they happen to you in first person. (M)

A common idea that participants shared was the fact that fathers took longer to adjust to their new role as parents. Participants suggested that mothers had the chance to familiarise to their new status all through pregnancy; therefore they had felt ready for it, while their partners had required more time to gain confidence around their babies and around their new position as carers. Also as babies become more independent and more interactive, fathers find it easier to look after them, leaving the mothers feeling more supported than during the first weeks.

Others' moral support

While partner's support was listed as the most important source of moral help, participants indicated family and friends as other significant influences in their life as new parents. What surfaced from the conversations was that women really valued the importance of knowing they had someone to turn to in order to obtain validation and advice. While practical help was appreciated, what participants had found really vital especially once the babies were born, it had been the opportunity to check with others if what they were doing was "right".

Participants indicated their mums as the first person they would call to ask for information, followed by friends who had recently had babies. Women who lived far from their family of origin or had recently relocated, explained how at times it had been difficult to communicate and ask for support, due to time difference and distance.

Distance from family and close friends had been a small challenge for the participants who had recently moved to the Sunshine Coast, however, they still found different strategies to overcome the physical remoteness from important support people such as frequent phone calls or relying on new support people. Distance was generally not perceived as lack of support. Participants explained that their family attitude, their willingness to listen and their useful advice had been more important than physical closeness.

Lack of support was generally linked to other factors; even participants who lived close to their family and close friends had, at times, felt not supported enough. Some of the reasons why participants had not felt supported involved not feeling listened, not feeling validated, having their own feelings not understood or undermined, and receiving unhelpful advices. Advice from others was a key theme that emerged from conversation and will be further explored.

Finally, midwives were generally praised for their important role of support. Home visits had been indicated as particularly useful as they had helped participants feeling validated and on the "right track" within their own home environment.

And also with the midwives...it's almost like a motherly advice. Someone that had gone through it as well and also knew what she was talking about on a professional level.(K)

And the midwives were all very nice and they came and visit us at home for a couple of weeks twice a week. It was helpful because they told me the baby was good so I was relieved.(I)

Information Received and the Forming of Expectations

Participants described how they had informed themselves during their pregnancy in order to feel prepared once they would have met their babies for the first time. Participants listed as main sources of information the Expecting and Connecting antenatal group organised at the University of The Sunshine Coast, one-day classes which prepared them for labour and/or breastfeeding, advice from family and friends, and information they found in books or on the internet. Gathering information in order to form expectation was an important process that started during pregnancy and continued after the babies were born.

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Antenatal education

All three participants who attended the Expecting and Connecting group expressed satisfaction for the amount of information they received, as well as for the chance to meet and connect with other women going though the exact same stages of pregnancy as well as stages of their lives. In terms of outcomes they all underlined how they had felt prepared for each stage they had been informed about.

I think before I went to those classes I had no idea about what to expect, really. And it was good learning and then knowing what it was going to happen, especially when giving birth. It was important for me to know what to expect.(K)

The participant who attended the day course about labour with her partner explained how she had received enough information but, due to the short length of the course, she did not believe she had had the time to form realistic expectations.

The woman who was followed exclusively by her GP explained that while she was being reassured about her pregnancy being healthy, she wished she had more time to talk about general information around pregnancy. Every participant to the study attended one-day breastfeeding classes and were highly encouraged to breastfeed their babies, but they also stated that the class was only partially useful as the best way to learn is to actually practice with the baby once he or she is born.

Generally, at different degrees, participants indicated that the information they had received had been truthful and had helped them to form realistic expectations. A difference that emerged was that the three participants who attended the Expecting and Connecting group had the chance to exchange opinions with other mums in an environment perceived as safe, while the other participants expressed the desire to connect more with women in the same situation.

I think it would be just so nice if women were able to share what is it that they actual feel and what is going on for them, you know, being really honest about it. Because I think you end up finding out that a lot of people are having the same experience but when it doesn't fit the idea of this magical time of life then sometimes it feels like something is wrong with you and yeah... accept as much help as you can.(J)

Books, the Internet, and general Media

In order to feel prepared, women also looked at information in books, websites, web forums, or mobile apps. While they were satisfied with the amount of information available to pregnant women or new-mums, they shared the common concern that at times they had to block some of the information in order not to feel overwhelmed or too scared. Also some common themes portrayed in the media around labour, or giving birth, had been indicated as the reason behind the creation of false expectations.

When you are home by yourself you read on the internet what people have chosen to share and you think "oh, my baby is not doing that, he should be sleeping three hours at the time in the middle of the day and that sort of things..." so I was getting really frustrated...and it impacts on other areas I guess. I think I stopped doing that so much now, and it's getting a little bit easier.(J)

I think we both expected that J would hold my hand and breathe with me, the sort of thing you see in movies, but I didn't want him to touch me and I couldn't talk to him. I even got to a point where I asked for epidural but they said no because it was too late to do it.(C)

Advice from others

While it would be simplistic to subdivide advice as "good" or "bad", participants indicated some of their feelings in relation to the quality of advice they received from people around them. The following table represent in short form some of the themes that emerged from the conversations.

Unobtrusive, positive, and correct advice was perceived as helpful. Midwives were the source of advice that was most appreciated by women. Also mothers' advice had been mostly described as helpful, probably because perceived as completely benevolent. Women who felt encouraged, optimistic and prepared approached pregnancy, labour, and after birth with enthusiasm.

"Horror stories" was a term used by participants to describe obtrusive, negative advice, which was definitely indicated as the most frustrating type of recommendation. Many conversations touched upon the fact that negative, scary advice had either caused very pessimistic feelings and fears, or had prevented the participants to form expectations; they had blocked out some of the thoughts regarding certain subjects, leading them to feel unprepared once they had to face some of the stages involving those topics.

Expectations VS Reality

Participants widely discussed about their experiences, relating them to what they had expected and contemplating on the effects of having their expectations met or not. The tables represent in short some of the contents that emerged, and will be proposed to follow.

Participants who approached each stage feeling optimistic and found their expectations to be met, described their experiences as positive. They felt mostly satisfied and in control. Labour was a crucial stage discussed by the mothers interviewed in this study.

Women interviewed who had their negative expectations met, were probably the ones who described the most unfavourable experiences. They indicated feelings of depression and discouragement. Participants who held positive expectations but found them not to be met in reality, also described their feelings of guilt, disappointment and shock.

I really wasn't expecting it to be the way that it was. I spent a lot of time last year, I was going to prenatal yoga and reading up on things, I was feeling really confident about the birth but I ended up being overdue, I went to 42 weeks and I had to be induced, I wasn't really happy about that..it ended up being yeah...it was quite an unsettling experience (J)

Even if forming expectations is considered a natural process, some women indicated how, at times, they had not formed any at all for different reasons. The motives behind these choices were different: some participants just wanted to be flexible and relaxed and not to plan, while others involuntarily stopped thinking about certain subjects after hearing information which had made them feel fearful.

Discussion

The focus of this study was to uncover more about the role of expectations among expecting women and to understand some processes behind the creations of such expectations. It has also been the intention to uncover how advice from

support people as well as by antenatal educators impacted on the creations of expectations. It appeared that forming realistic expectations was a key factor for the well being of expecting mothers. For this reason attending antenatal programs or gathering information was indicated as necessary in order to feel prepared for pregnancy, birth, and after-birth. Unrealistic expectations were often the result of incorrect advice provided by other people as well as information read on the internet. Books, midwives, or mothers' advices had been generally described as helpful in the process of forming realistic expectation.

Another interesting factor that emerged from the study was the tendency of women to block out negative information. Women who felt "bombarded" by obtrusive, pessimistic advice indicated how, in order not to feel fearful, had blocked out thoughts regarding certain areas, resulting in no expectations around specific subjects. Having no expectations could result in women feeling relaxed and positive, or guilty and confused, depending on the outcome of their lived experience. For this reason, while having no expectations was certainly better than having negative expectations, looking back women who did not have expectations described themselves as "naive" and not prepared enough.

Partner support was investigated and widely discussed and a common theme that emerged was that, while partners had been perceived as supportive, they also had taken time to become familiar with their new role, leaving women feeling overwhelmed by responsibilities during the first weeks after birth. Participants admitted they believed it had to do with the fact that they had had time to familiarise in first person with their new conditions as parents during pregnancy, while for their partner it had not been the case. During the first few weeks after birth breastfed babies are particularly depended from their mums, leaving them to feel like they are doing most of the work, and their partners unsure about how to help. The first few weeks were described as the most difficult in terms of adjustment for the couple. All women agreed that once babies were older partners had found it easy to interact and had been more collaborative. Sleep deprivation and tiredness was another factor discussed and was described as unexpected as well as one of the main reason of discord within the couple.

TABLE 1: Different types of moral support discussed

	Enough support perceived	Not enough support perceived
Partner support	Understanding, cooperative	Misunderstanding, underestimating, dismissive, not involved
Family support	Availability, useful unobtrusive advice, validation	Unavailable, distant, insistent and obtrusive advice, judgemental
Others' support	Understanding of the situation, similar situation, connected, useful unobtrusive advice, willingness to share information	Judgmental, dismissive, disconnected, sharing of "horror stories", obtrusive or incorrect advice

The implications of this study are mainly two. Firstly it appeared that being prepared and receiving truthful, encouraging advice had been perceived as essential in order to form realistic, positive expectations in order to approach each phase of the new adventure with a constructive attitude. The chance of sharing opinions and concerns with other women in the same situation had also been indicated as a good influence for expecting women.

Finally, when discussing the role of support people and their importance, conversations indicate that the "best" support a woman could ask for was a kind, patient, available and unobtrusive help. Feeling connected and validated was in fact underlined as more important than practical help.

Pregnancy support and antenatal support is an area where counsellors can bring positive encouragement to expecting mothers and their partners. Also psychoeducational groups for both partners could help them to prepare for their first child as a couple and enable them to achieve the outcomes that strengthen their relationship and their marriage.

Conclusion

A number of themes have emerged as a result of the research, in particular, what is perceived as most helpful by new mothers in need of moral support. It is also important to understand about what is perceived as "good" support and may apply that in real life with family or friends who are expecting or have recently become parents. Distance was not as important factor as had been expected. It could in fact be overcome by connecting with other people or with the use of technology. Connecting with others in similar situation, appeared crucial. The findings of this study seem to point out once again, the importance of antenatal education as well as forming connections, suggesting that women who live in remote areas or do not speak the language may miss out , leaving them feeling isolated and experience unpleasant feelings.

Because of the small scale of this study the main limitation involved the number of participants who took part in this study. A larger, more diverse sample may have shed light on other processes that were not analysed in this study.

Future research could investigate more deeply the experience of partners in order to help them feel prepared for the new chapter of their life. Because partners were indicated as main support people, but were also described as not prepared for the first few weeks of their babies' lives, it may be worthwhile to develop programs which exclusively target men in order to allow them to feel in control and prepared. Men and women live differently the experience of becoming parents. It would seem there is a lack of information around male perceptions and challenges of becoming fathers for the first time. In order for fathers to be adequate support they may need appropriate, tailored information, as they live their experience very differently from their partners.

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Francesca Tondi has completed her research as part of her Masters of Counselling through University of the Sunshine Coast and she is looking forward

to working in the Counselling field and furthering research.

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TABLE 2: Quality of information received and consequent feelings

Advice Received	Feelings
Positive	Encouraged, optimistic
Negative	Fearful, pessimistic, upset
Sufficient	Prepared, worried, excited
insufficient	Worried and confused
Correct	Satisfied, supported
incorrect	Upset, bombarded
Unobtrusive	In control
Obtrusive	Not in control, annoyed

TABLE 3: Interaction between type of expectations and whether they were met or not

	Positive Expectations-Feeling Optimistic	Negative Expectations-Feeling Fearful
Expectations met	Positive experience: Feeling satisfied, positive, powerful, in control	Negative experience: Feeling depressed, discouraged
Expectations not met	Negative experience: Feeling guilty, feeling depressed	Feeling relieved, feeling confused

TABLE 4: The role of "no expectations"

	No expectations
Positive experience	Feeling relaxed, feeling satisfied
Negative experience	Feeling confused, feeling unprepared, feeling guilty.

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PEER REVIEWED ARTICLE

Differences Between Individual-based and Collective-based Systems of Culture

By Paula Davis

Abstract

Models of culture provide a framework to examine, explain and classify cultures according to their cultural differences in value systems. This article explores Hofstede's (1984) model of culture as it applies to cross-cultural counselling, particularly the post-war cultures of Uganda and Sri Lanka. Australia has a high representation of these cultures due to refugees and asylum seekers fleeing the respective protracted wars. Hofstede's model affords an easily understood explanatory model of cultural dimensions that informs the diverse ways people in Anglo-Australia, Uganda and Sri Lanka think, feel and behave. The dimensions are: power-distance, uncertainty-avoidance, masculinity-femininity, individualism-collectivism, long term-short term orientation and indulgence-restraint. These dimensions essentially depict values that are expressed in cultural practices evident on three levels: 1) symbols; 2) rituals; and, 3) heroes/heroines. This article explains and discusses each of Hofstede's dimensions of culture and how they are represented in the three levels of culture. An application to counselling practice for Ugandans and Sri Lankan will be provided for each cultural dimension and level.

Uganda and Sri Lanka are collective-based value systems that have experienced profound, protracted political and war violence. As a cross-cultural counsellor and educator in these countries the author has discovered that they embrace a different cultural value system to the Anglo-Australian individual-based value system. Whereas ideals of personal independence tend to predominate the Anglo-Australian culture, ideals of interdependence and social harmony appear to predominate the Ugandan and Sri Lankan cultures. Thus, a model of culture is needed that assists Anglo-Australian counsellors to understand and work sensitively within these cultures and with refuges and asylum seekers in Australia who represent these cultures.

There are several explanatory, evidence-based models of culture generate insight into cross-cultural differences. Initiated by House in 1991, the evidence-based GLOBE model, an acronym for Global Leadership and Organizational Behavior Effectiveness, contains a Nine Dimensional Model of culture (Hofstede, 2011). From 1994 to 1997, House, Hanges, Javidan, Dorfman and Gupta (2004) built upon Hofstede's (1980) research findings and others to collect data from approximately 17,000 managers in approximately 1,000 multi-national organisations from food processing, financial services and telecommunication services in approximately 60 countries worldwide.

Anthropologist and cross-cultural researcher, Edward Hall (1976) formulated an evidence-based model based the concept of high-context and low-context cultures. In his model key factors such as context, time, space and information inform communication and word choice in routine communication in different cultures (Hall, 1985). Thus, in high-context close-knit groups, very few words are needed to communicate a complex message even though this might be less effective with outsiders, whereas in low-context cultures the individual might problem solve alone but communicate more explicitly when needed (such as needing more information). Anglo-Australia would constitute a low-context culture while Uganda and Sri Lanka would represent high-context cultures. Thus, according to Hall's (1976, 1985) model it would be advantageous for me to gain the support of the group by building relationships in order to communicate well. Even though these models have merit, Hofstede's (1984, 1990) Five Dimensional Model of Culture is chosen for further consideration because it is evidenced-based, straightforward and insightful.

Hofstede's (1984) model of culture is based on a prototype introduced in 1980 that since has acquired normal science status. In 1980, Hofstede collected data from 116,000 employees working in IBM, a large multinational corporation situated in forty different countries. He focused on the importance of fundamental established patterns of thinking, feeling, and behaving ingrained by late childhood and his model is regarded as a paradigm in the field of cross-cultural research. Through his empirical data analysis Hofstede concluded that, "organizations are cultural-bounded" (p. 252) and he encapsulated cultural differences into four dimensions. His four dimensions of culture are: power distance, uncertainty avoidance, masculinity-femininity, and individualism-collectivism. Hofstede's original framework has been replicated by six major studies (Hofstede, Hofstede & Minkov, 2010). Minkov (2007, as cited by Hofstede et al, 2010) developed the World Values Survey and added a fifth and sixth dimension that are Long Term versus Short Term Orientation and Indulgence versus Restraint. The current VSM 08 (Values Survey Module) includes revisions of VSM 80, 82, and 94 (Hofstede, Hofstede, Minkov & Vinken, 2008). It consists of 28 items, 20 questions using 5-point ratings and 6 demographic questions and 7 sub-scales. In essence, Hofstede's dimensions reflect "broad tendencies to prefer certain states of affairs over others" (1994, p. 8). The six dimensions Hofstede's (2011) model will be discussed and presented in binary form.

Power-Distance Dimension

Explanation of cultural construct.

The power-distance dimension in Hofstede's (2011) model of culture reflects the degree to which a culture deals with power inequalities (Hofstede et al., 2010). These are described as "the extent to which the less powerful members of institutions and organisations within a country expect and accept that power is distributed unequally" (Hofstede, 1994, p. 28). Anglo-Australian culture is more attuned to smaller power distances between those in authority or those holding privileged positions (such as the Prime Minister, doctors, lawyers, et cetera) than the ordinary person. Equality is valued and professional distance minimised.

Application to counselling.

Collective countries such as Uganda and Sri Lanka prefer a large status differential. They function with larger power-distances and tend to view the counsellor as an expert. For example, in Ugandan culture, age, respect and the consulting of elders about community decisions are crucial. However, in cultures such as Anglo-Australia with a smaller power-distance, the individual expects to be consulted and have a say in the outcome. Indeed, in Sri Lanka family inequality is endorsed by society. Even adult children are expected to be obedient to their elders.

Moreover, Western counsellors are primarily trained in a collaborative approach as opposed to expert-subordinate. Western clinicians are generally trained to be careful of assuming excessive power and to minimise client-counsellor distance. However, in large power-distance societies such as Uganda and Sri Lanka, the counsellor's "expert" status is valued, applauded and respected for superiority and title.

Thus, an Anglo-Australian trained counsellor may attempt to close the power-distance between them and their client/s. Negotiating this cultural dilemma is necessary early in counselling so that both parties understand and work with it in ways that support the client.

See Table 1.

TABLE 1 Hofstede's (2011) power-distance dimension

Small Power Distance	Large Power Distance
Use of power should be legitimate and is subject to criteria of good and evil	Power is a basic fact of society antedating good or evil: its legitimacy is irrelevant
Parents treat children as equals	Parents teach children obedience
Older people are neither respected nor feared	Older people are both respected and feared
Student-centered education	Teacher-centered education
Hierarchy means inequality of roles, established for convenience	Hierarchy means existential inequality
Subordinates expect to be consulted	Subordinates expect to be told what to do
Pluralist governments based on majority vote and changed peacefully	Autocratic governments based on co-optation and changed by revolution
Corruption rare; scandals end political careers	Corruption frequent; scandals are covered up
Income distribution in society rather even	Income distribution in society very uneven
Religions stressing equality of believers	Religions with a hierarchy of priests

** Power-Distance Societies (Hofstede, 2011, p. 9).*

Uncertainty-Avoidance Dimension

Explanation of cultural construct.

Hofstede (2011) observed that culture exists on an uncertainty-avoidance continuum with regard to levels of comfort with structure and ambiguity. He observed that scores tend to be higher "in East and Central European countries, in Latin countries, in Japan and in German speaking countries, lower in English speaking, Nordic and Chinese culture countries" (Hofstede, 2011, p. 11). The weak uncertainty-avoidance cultures prefer situations and discourses where uncertainty and ambiguity prevail.

Application to counselling.

Strong uncertainty-avoidance cultures such as Uganda and Sri Lanka try to minimise threat by enforcing socially sanctioned strict laws, rules and codes of behaviour. Dissenting opinions and uncertainty are discouraged and certainty resides in legislation, religion, community rituals, oral traditions, or relationships (such as family elders). Social harmony is a primary goal. An Anglo-Australian trained counsellor may not appreciate or consider the priority of social harmony engendered by these strong uncertainty-avoidance cultures. Alternately, weak uncertainty-avoidance cultures such as Anglo-Australia prefer novelty and risk-taking. Dissenting opinions are encouraged and tolerance for the unknown is not uncomfortable as it would be in strong uncertainty-avoidance cultures. Thus, the Anglo-Australian counsellor may encourage their Ugandan and Sri Lankan client/s to move into unknown areas and take risks too early into the counselling process and thereby cause considerable discomfort to their client/s. Again, this needs to be named as it occurs and negotiated within the context of the counselling relationship.

See Table 2

Individualism-Collectivism Dimension

Explanation of cultural construct.

The individualism-collectivism dimension in Hofstede's (2011) model refers to the degree to which societal members focus their allegiance on the self or the group. Despite an increase in globalisation over the past century these differences still appear to be significant and this is a significant consideration in counselling. Hofstede (2011) noted that wealthy cultures (such as Australia and the United States of America) tend to be individualistic, whereas developing countries (such as Uganda and Sri Lanka) tend to be collectivistic. Individualistic cultures such as Anglo-Australia tend to experience looser ties between individuals and exhibit

greater independence, whereas collective cultures such as Uganda and Sri Lanka tend to form strong, cohesive ties between group members such as family and extended family (parents, aunts, uncles and cousins) (Hofstede, 2011). They contain values "in which people from birth onward are integrated into strong, cohesive in-groups; often their extended families (with uncles, aunts, and grandparents) continue protecting them in exchange for unquestioning loyalty" (Hofstede & Bond, 1988, pp. 10-11). Greater psychological distance exists between the in-group and out-groups and fierce loyalty is demanded of those in the in-group in return for security and protection (Hofstede, 2011).

Conversely, individualistic cultures tend to concentrate on the "nuclear" family where it is considered healthy to be self-sufficient. This is described as, "societies in which the ties between individuals are loose: Everyone is expected to look after himself or herself and the immediate family" (Hofstede & Bond, 1991, as cited by Kim, 1995, p. 4).

Whereas individualism tends to focus on individual goals, ambitions, aspirations and needs as primary over those of the group, collectivism tends to view needs, achievements, survival, quality of life, and wellbeing as the same as those of the group (Muhammad, 2011). Likewise, individualism tends to promote self-actualisation over group cohesion whereas collectivism tends to promote group harmony at the cost of the individual.

Application to counselling.

Cultures high on the collectivism dimension consider relationships to be primary and confidentiality is not a consideration. A counsellor from Anglo-Australia that is high on the individualistic dimension may find this attribute confusing, as privacy and confidentiality are valued. Moreover, in conflict situations Ugandan and Sri Lankan collective-based cultures tend to value "saving face", avoidance and the use of mediators to intervene (Hofstede, 2011).

TABLE 2 Hofstede's (2011) uncertainty-avoidance dimension

Weak Uncertainty Avoidance	Strong Uncertainty Avoidance
The uncertainty inherent in life is accepted and each day is taken as it comes	The uncertainty inherent in life is felt as a continuous threat that must be fought
Ease, lower stress, self-control, low anxiety	Higher stress, emotionality, anxiety, neuroticism
Higher scores on subjective health and wellbeing	Lower scores on subjective health and wellbeing
Tolerance of deviant persons and ideas: what is different is curious	Intolerance of deviant persons and ideas: what is different is dangerous
Comfortable with ambiguity and chaos	Need for clarity and structure
Teachers may say 'I don't know'	Teachers supposed to have all the answers
Changing jobs no problem	Staying in jobs even if disliked
Dislike of rules - written or unwritten	Emotional need for rules – even if not obeyed
In politics, citizens feel and are seen as competent towards authorities	In politics, citizens feel and are seen as incompetent towards authorities
In religion, philosophy and science: relativism and empiricism	In religion, philosophy and science: belief in ultimate truths and grand theories

** Uncertainty-Avoidance Societies (Hofstede, 2011, p. 10).*

TABLE 3 Hofstede's (2011) individualism-collectivism dimension

Individualism	Collectivism
Everyone is supposed to take care of him- or herself and his or her immediate family only	People are born into extended families or clans which protect them in exchange for loyalty
"I" – consciousness	"We" –consciousness
Right of privacy	Stress on belonging
Speaking one's mind is healthy	Harmony should always be maintained
Others classified as individuals	Others classified as in-group or out-group
Personal opinion expected: one person one vote	Opinions and votes predetermined by in-group
Transgression of norms leads to guilt feelings	Transgression of norms leads to shame feelings
Languages in which the word "I" is indispensable	Languages in which the word "I" is avoided
Purpose of education is learning how to learn	Purpose of education is learning how to do
Task prevails over relationship	Relationship prevails over task

** Individuality-Collectivism Societies (Hofstede, 2011, p. 11).*

Conversely, counsellors from individualistic cultures such as Anglo-Australia tend to value self-expression, assertive strategies and speaking out as ways of resolving conflict (Hofstede, 2011). As a result, the Anglo-Australian counsellor may inadvertently experience "cultural bias" in the way they conduct the counselling process and conceptualise their client's difficulties. To avoid this cultural awareness is necessary.

See Table 3.

Masculinity-Femininity Dimension

Explanation of cultural construct.

According to Hofstede (2011), high masculinity cultures such as Uganda and Sri Lanka tend to value behaviours such as assertiveness, ambition, achievement, competition, and the procurement of wealth, whereas high femininity cultures such as Anglo-Australia tend to value nurturing and supporting others, relational qualities, and quality of life seeking. High masculinity cultures tend to display well-defined expectations of male/female societal roles and behaviours and "there is often a taboo around this dimension" (Hofstede et al., 1998, as cited by Hofstede, 2011, p. 12). Sexual inequality is valued as a means of maintaining social harmony in high masculinity cultures such as Uganda and Sri Lanka. Conversely, in high femininity cultures like Anglo-Australia there is a tendency to be less prescriptive and gender expectations are more indistinct and sometimes blurred.

Application to counselling.

There are several applications of the masculinity-femininity to counselling. Firstly, cross-gender counselling tends to be refuted in high masculinity cultures and even in moderate masculinity cultures such as Uganda and Sri Lanka that allow mixed groups, the expectation is that men speak first and often speak for the women. In relationship counselling the counsellor needs to monitor the tendency for the male to speak for the woman during sessions.

Secondly, some high masculinity cultures demand certain protocols in areas such as dress codes and mixed gender groups. Protecting female modesty and chastity is viewed as paramount with some Islamic cultures requiring female covering for the entire body. Ugandans and Sri Lankans value modesty and women dress accordingly. An Anglo-Australian counsellor needs to be aware and sensitive to these cultural issues.

An Anglo-Australian counsellor tends to value gender equality and abhor sex discrimination. Gender equality and anti-discrimination is written into Australian laws through the Commonwealth Acts of 1986, Affirmative Action (Equal Employment Opportunity for Women and 1999, Equal Opportunity for Women in the Workplace. Formerly high on the masculinity dimension, Australian traditional patriarchal gender roles and expectations have shifted markedly during the last century. Women entered traditional male occupations and men began to perform domestic duties previously believed to be the exclusive domain of women. This has not yet occurred in the moderate masculinity cultures of Uganda and Sri Lanka. Thus, the Anglo-Australian counsellor needs to grapple with whether the shift in values towards more equality is an outcome of cultural evolution and whether the role of counsellor one of a cultural change agent in terms of structural inequality.

See Table 4.

Short-Term and Long-Term Orientation Dimension

Explanation of cultural construct.

Hofstede's (2011) short-term and long-term orientation dimension refers to whether the culture is focused on the present or the future. Using a questionnaire designed by Chinese scholars, Bond (Hofstede & Bond, 1988) studied 23 countries with a history of Confucianism and Confucian Work Dynamism was added as a fifth dimension (Hofstede et al., 2010) ranging from long term to orientation to short term orientation that explains the rapid economic growth experienced by many Asian countries. Confucian ethics tend to value, promote and foster primary attributes such as frugality, a shame motivation, perseverance, and respect for hierarchal chain of command, followed by lesser valued but important attributes of tradition and saving face (Hofstede et al., 2010). It was found that long-term oriented cultures are East Asian countries (including Sri Lanka), followed by Eastern and Central Europe, whereas medium-term orientated cultures are found in South Asian and North-European countries. Short-term oriented cultures are United States of America, Australia, Latin American, African (including Uganda) and Muslim countries (Hofstede et al., 2010).

TABLE 4 Hofstede's (2011) masculinity-femininity dimension

Femininity	Masculinity
Minimum emotional and social role differentiation between the genders	Maximum emotional and social role differentiation between the genders
Men and women should be modest and caring	Men should be and women may be assertive and ambitious
Balance between family and work	Work prevails over family
Sympathy for the weak	Admiration for the strong
Both fathers and mothers deal with facts and feelings	Fathers deal with facts, mothers with feelings
Both boys and girls may cry but neither should fight	Girls cry, boys don't; boys should fight back, girls shouldn't fight
Mothers decide on number of children	Fathers decide on family size
Many women in elected political positions	Few women in elected political positions
Religion focuses on fellow human beings	Religion focuses on God or gods
Matter-of-fact attitudes about sexuality; sex is a way of relating	Moralistic attitudes about sexuality; sex is a way of performing

** Masculinity-Femininity Societies (Hofstede, 2011, p. 12).*

Application to counselling.

There are several implications of short-term and long-term orientations. According to Minkov (Hofstede et al., 2010) Uganda falls into short-term time orientation culture. Anglo-Australian counsellors who economically value time may be irritated by a seeming lack of focus on time in their client/s. They may see this as irresponsible, demonstrating lack of care and concern. Lateness may be assumed to be disinterest, unconcern or rudeness.

An Anglo-Australian counsellor may also have clear boundaries around session times and begin to bring the session to a close as the traditional hour looms on the horizon. However, a Ugandan client may presume that leaving or closing down a personal encounter when the issue under discussion is unfinished indicates that time is more important than relationships. Clearly, tolerance, flexibility and adaptability are required to work cross-culturally between the different time-oriented cultures of Anglo-Australia and Uganda.

TABLE 5 Hofstede's (2011) short-term and long-term orientation dimension

Short-Term Orientation	Long-Term Orientation
Most important events in life occurred in the past or take place now	Most important events in life will occur in the future
Personal steadiness and stability: a good person is always the same	A good person adapts to the circumstances
There are universal guidelines about what is good and evil	What is good and evil depends upon the circumstances
Traditions are sacrosanct	Traditions are adaptable to changed circumstances
Family life guided by imperatives	Family life guided by shared tasks
Supposed to be proud of one's country	Trying to learn from other countries
Service to others is an important goal	Thrift and perseverance are important goals
Social spending and consumption	Large savings quote, funds available for investment
Students attribute success and failure to luck	Students attribute success to effort and failure to lack of effort
Slow or no economic growth of poor countries	Fast economic growth of countries up till a level of prosperity

** Short-Term Orientation-Long-Term Orientation Societies (Hofstede, 2011, p. 15).*

TABLE 6 Hofstede's (2011) indulgence-restrained dimension:

Indulgence	Restrained
Higher percentage of people declaring themselves very happy	Fewer very happy people
A perception of personal life control	A perception of helplessness: what happens to me is not my own doing
Freedom of speech seen as important	Freedom of speech is not a primary concern
Higher importance of leisure	Lower importance of leisure
More likely to remember positive emotions	Less likely to remember positive emotions
In countries with educated populations, higher birthrates	In countries with educated populations, lower birthrates
More people actively involved in sports	Fewer people actively involved in sports
In countries with enough food, higher percentages of obese people	In countries with enough food, fewer obese people
In wealthy countries, lenient sexual norms	In wealthy countries, stricter sexual norms
Maintaining order in the nation is not given a high priority	Higher number of police officers per 100,000 population

** Indulgence-Restrained Societies (Hofstede, 2011, p. 16).*

Conversely, Sri Lanka falls into medium-term time orientation where time, punctuality, and planning are valued along with socialisation, relationships and spirituality. As Anglo-Australia inclines towards short-term orientation, the cultures tend to be more in sync in this area.

See Table 5.

Indulgence-Restrained Dimension

Explanation of cultural construct.

Indulgence-restrained cultures was added to the model as a sixth dimension by Minkov in 2010 (as cited by Hofstede et al., 2010). Based on World Survey items indulgence cultures such as Anglo-Australia allow for personal gratification and freedom to enjoy life, experience fun and focus more on individual control of happiness and wellbeing. Leisure time is highly valued. Conversely, restraint cultures such as Sri Lanka socially control these desires "by means of strict social norms" (Hofstede, 2011, p. 16). Positive emotions, personal freedom and personal happiness are less important than group wellbeing. Indulgence cultures tend to exist in South and North America, Western Europe and parts of Sub-Sahara Africa. Restraint cultures tend to predominate in Eastern Europe, Asia and the Muslim world (Hofstede, 2011). Medium indulgence-restraint cultures tend to be found in Mediterranean Europe (Hofstede, 2011).

Application to counselling.

There are several applications to counselling. In high indulgent cultures such as Uganda, children are allowed much freedom and lack of restrictions. However, as adults they appear to become more restrained and see the value of leisure as a foreign Western concept. This implies that relaxation and stress management tools are viewed as indulgent.

In high restraint cultures such as Sri Lanka, love or marital happiness is not considered important. The immediate family and the extended family system choose their child's life partner, career and lifestyle. There is little self-determination. An Anglo-Australian counsellor from an indulgence culture may view this as oppressive and unmerited and speak against it, failing to understand that the primary goal of Sri Lankan society is social harmony rather than individual autonomy. Thus, an Anglo-Australian counsellor must be aware and sensitive to these cultural disparities.

See Table 6.

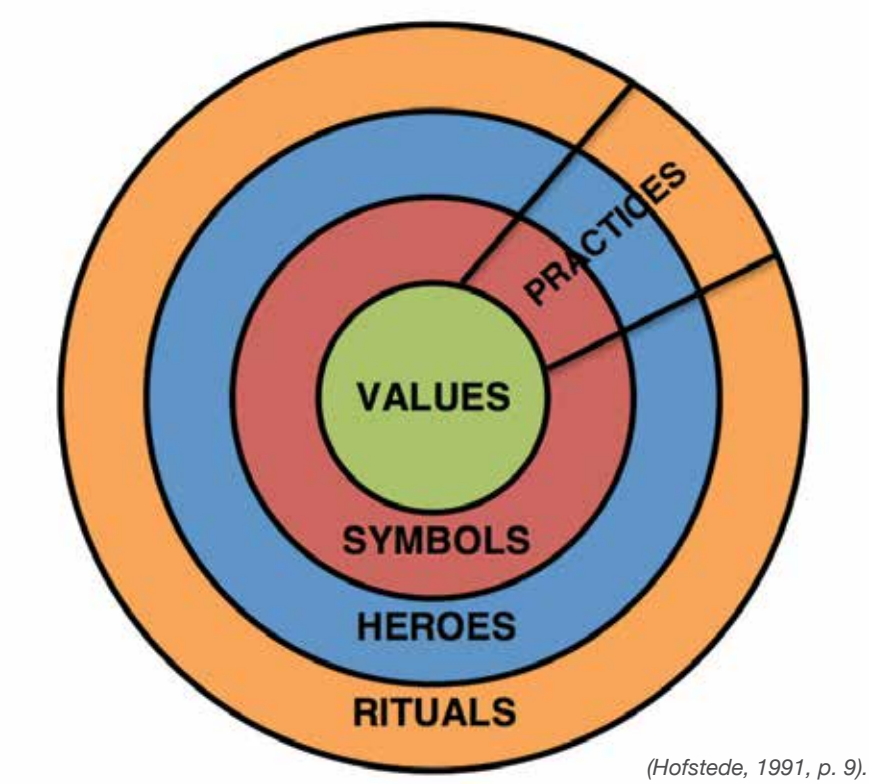
Levels of Culture

According to Hofstede (1991), the previous six dimensions depict cultural values that are expressed in cultural practices. They are evident on three levels as "manifestations of culture at different levels of depth" (p. 9). These are: 1) symbols; 2) rituals; and, 3) heroes/heroines. These will be explained as follows:

1) **Symbols** – "words, gestures, pictures or objects that carry a particular meaning which is only recognized by those who share the culture" (p. 7).
2) **Rituals** – "are collective activities… which, within a culture, are considered as socially essential: they are therefore carried out for their own sake" (p. 7). An example is the way people greet each other.
3) **Heroes** – those who serve as models for actions and behaviour (p. 7-8).

Hofstede's (1991, p. 9) "onion diagram" is diagrammatically illustrated in Figure 2.4.

FIGURE 2.4 The "Onion Diagram"



(Hofstede, 1991, p. 9).

There are three applications of these three levels to counselling.

1) **Symbols.** A useful tool in cross-cultural counselling is a cultural artefact or symbol that holds "more than its obvious and immediate meaning" (Jung et al., 1978, p. 4). A Ugandan or Sri Lankan client may be invited to bring an artifact that represents the presenting problem. Thus, the counsellor may learn about the client's culturally formed constructs.
2) **Rituals.** The client will come with previous cultural rituals that sustain and preserve social cohesion in their society. For example, in Uganda communal sacrifices are offered to invoke blessings upon social activities, such as rites of passage (for example, initiation, marriage, and death). Rites of passage are important because they are accompanied by a change in social status (for example, boy to man, to wife, living person to dead). Distinctive and exclusive tribal dances always accompany these ritualistic transitions. The culturally aware counsellor may invite the client to access culturally healing rituals in therapy.
3) **Heroes.** *The Heroes Journey*, by the American scholar, Joseph Campbell (1968) identifies an ancient wisdom narrative pattern where the hero or heroine embarks

on an adventure and leaves the familiar realm, learns to navigate an unfamiliar and sometimes hostile environment, achieves great deeds on behalf of the group, tribe, or society, and returns to his/her familiar setting a changed person. Campbell (1968, as cited by Louie, 2007) states:

The usual hero adventure begins with someone from whom something has been taken, or who feels there is something lacking in the normal experience available or permitted to the members of society. The person then takes off on a series of adventures beyond the ordinary, either to recover what has been lost or to discover some life-giving elixir. It's usually a cycle, a coming and a returning (p. 23).

The Heroes Journey and similar narratives resonate with universal ideals in the desire to impact one's inner and outer worlds, construct meaning from adverse circumstances and repair the world. Hence, symbols, rituals and heroes are utillised by Ugandan and Sri Lankan cultures in order to reintegrate individuals, families and the group back into internal and external stability. Healing for clients from these cultures may involve connecting them to cultural strategies that assisted them to manage adversity and promoted spiritual wellness.

Conclusion

Regarded as a paradigm in the field of cross-cultural research, Hofstede's (2011) model of culture attempts to explain six dimensions of culture that describe the way people think, feel and behave in Anglo-Australian, Ugandan and Sri Lankan cultures. This article has presented the clinician with an evidence-based framework to highlight cultural differences in these societies. It has also provided a framework for awareness and sensitivity in cross-cultural counselling, particularly for counselling clients from the cultures of Uganda and Sri Lanka. The counselling clinician has been provided with practical applications of the model and specific interventions. In addition, Hofstede's dimensions of culture has been discussed as representing values that are expressed in cultural practices evident on three levels: 1) symbols; 2) rituals; and, 3) heroes/heroines. Each level has been applied to counselling practice and possible interventions have been provided for counselling practice.

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Paula has worked as Senior Lecturer in counselling for 13 years and is currently an adjunct lecturer at Morling College. She holds a Bachelor of Education, a Graduate Diploma in Counselling and a Masters in Counselling. Her doctoral candidature in cross-cultural trauma education/counselling is nearly completed. She is also an accredited counselling supervisor, an international marriage educator, and she regularly travels to Africa and Sri Lanka to train and support personnel and survivors of political violence and trauma. She is an honorary guest lecturer at Uganda Christian University.

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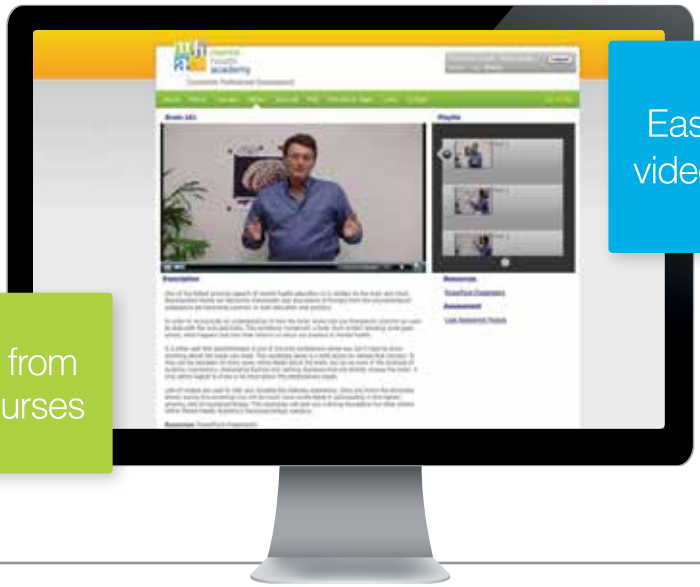

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Will is a central concept in the psychology of Psychosynthesis founder, Roberto Assagioli, who described will as operative on personal, transpersonal, and universal levels. This course is particularly oriented to those in the helping professions who may be seeing clients in the throes of transformational and other crises

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This video is the place to begin instruction in play therapy - it is upbeat and entertaining with great visuals, but also includes the critical basics for students with many live demonstrations. The presenter uses puppets to help communicate the rationale, principles, and basic skills of play therapy. Each skill is demonstrated through video clips of play therapy sessions with culturally diverse children.

Brief Counseling: The Basic Skills

In this video John Littrell (Colorado State University) shows how to teach brief counselling from a microskills framework. You will learn how to search out positives and solutions early in the session; how to structure a five-stage brief interview; how to ask questions that make a difference; and how to manage difficult clients.

Attachment and the Therapeutic Relationship

When a child is referred for therapy it is common to discover that the child has experienced disruption to a significant attachment relationship which has impacted that child in serious ways. This presentation draws upon a number of actual cases, and shows experiential techniques to explore the topic.

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This workshop uses real-life stories to describe how the school counsellor uses the Undercover Team Approach in a strategic way to disrupt a story of bullying relations in a secondary school classroom and rewrite an alternative story of support for the victim.

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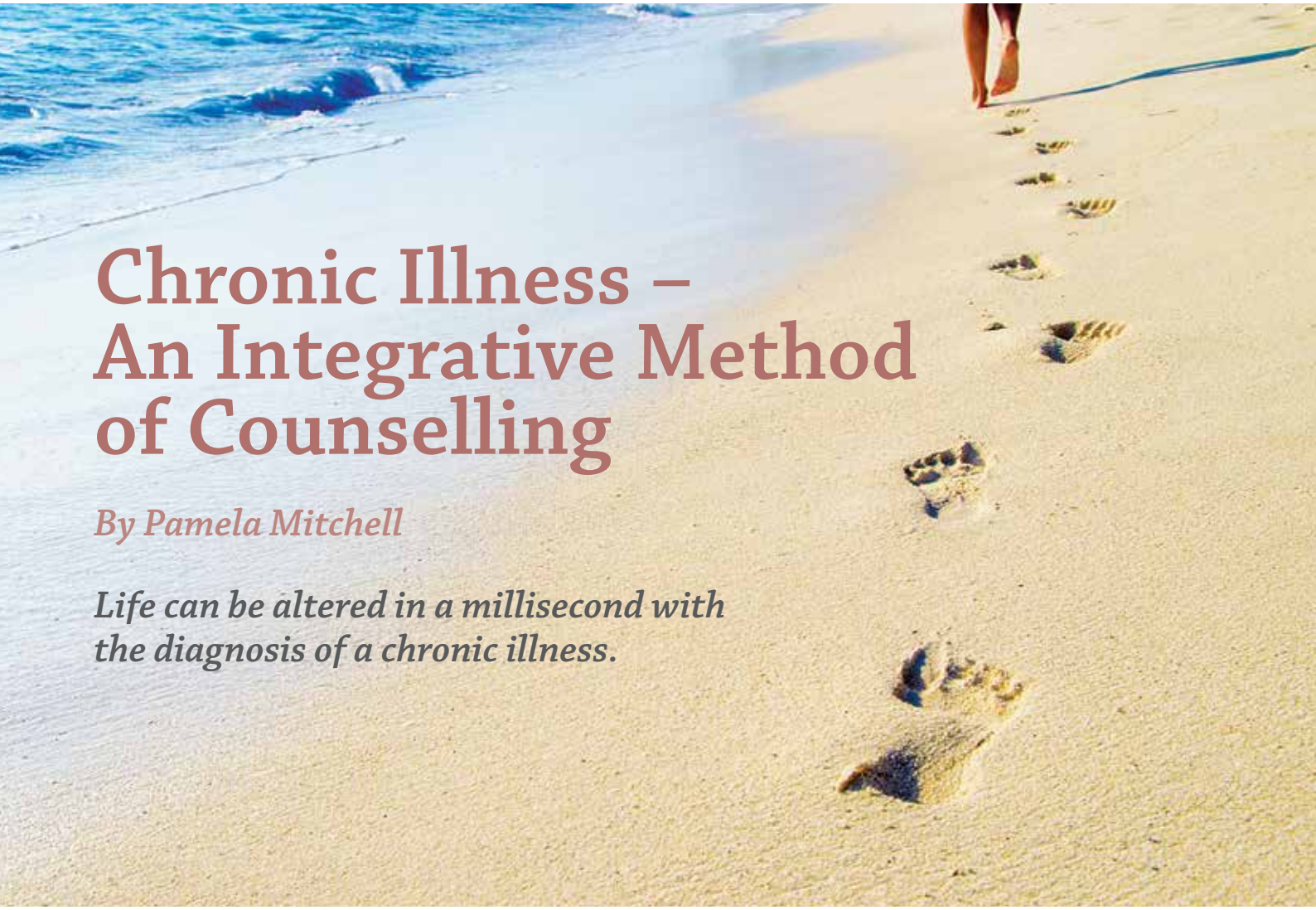

Chronic Illness – An Integrative Method of Counselling

By Pamela Mitchell

Life can be altered in a millisecond with the diagnosis of a chronic illness.

PHOTO: 123RF.COM

So what exactly is 'chronic illness'?

Chronic Illness is a state of health or wellbeing, which is debilitating to the extent, that there is a block to normal recovery. The body may often be slow or non-responsive to conventional medical treatment and in many circumstances, only pain and symptom relief, can be offered. With medical advances, the likelihood of chronic illness, and at any age, is increasing. Emerging psychological models demonstrate an awareness of these issues. It does not necessarily mean that the condition is life threatening, or cancer or tumour related.

For some people, there will have been a gradual onset of symptoms or health deterioration over months – even years, where pain and discomfort have been endured, often hidden from loved ones, and where a personal decision has been made to stay in denial, rather than to seek medical intervention.

For others, the awareness of something not right in their bodies has brought swift action to determine the cause, often with extensive tests and second medical opinions, only to be told there is no clinical evidence of any disease. As powerlessness and frustration grow and symptoms worsen, finally a diagnosis confirms what they have suspected from the start – a chronic illness, often debilitating, progressive, incurable, or even classified as… terminal.

And then there are those who have no symptoms whatsoever, where during a routine medical check, there is considerable shock when they learn a chronic condition has been silently developing.

The ability to adapt and to cope will of course differ from one person to another, but regardless, there will always be an impact. Shontz,(1975) describes the person's initial reaction to news of having a chronic illness, firstly as 'shock', then 'encounter', leading to 'retreat'. This latter stage he explains as "Using retreat as a 'base of operation' patients tend to contact reality a little at a time until they reach some form of adjustment to the health problem and its implications".

Similarly Cohen and Lazarus (1979) describe the impact effect as "…being healthy, able, and having a normal physique is central to most people's image and evaluation; becoming ill can be a shock to a person's sense of security and to his or her self image" and …"As a result, adjustment to an illness or injury which is life threatening or potentially disabling may require considerable coping effort".

When these clients are able to cross our doorsteps, there is so much counsellors can provide, and so much fulfillment to be gained. It is akin to creating footprints together on an unknown route where change, need, priority, and challenge overtake each other from one moment, one day, one month to the next, and sometimes, end.

One where the counsellor's tool kit of skills and techniques, experience and knowledge, resources, modalities, support, empathy, unconditional regard, silence, stillness, presence, have a place, a relevance, from the client's time of diagnosis or whenever they allow us to enter the core of their world and wound.

However, for many people with chronic illness, counselling has not been on their priority list. Specialist care and associated treatment plans have taken precedence and have cost a lot of money. The purse, has only so much in it. In Australia the limited access to rebate puts restrictions on the client's means, to include counseling as part of their health regime.

The importance of the role of the counselor in helping the client to adapt and cope with chronic illness is born out by the extensive works of Cohen and Lazarus (1979), Moos & Tsu (1977), Corr (1992), Doka (1996), Corr, Nabe & Corr (2003), and Samson & Clark (2007).

Each of these Authors identify that beyond medical issues, the real support needs to come from a task-oriented approach with emphasis on addressing the psychosocial implications: physical, psychological, social, and spiritual needs, and more recently the inclusion of … vocational. (Samson,2006).

Their theories are summarized and reviewed in a Paper entitled "Psychosocial adaptation to chronic illness: description and illustration on an integrated task-based model" co-authored by Samson, A., Siam, H., and Lavigne, R., and published in The Magazine of Professional Social Workers, Quebec, Canada.

The Authors of this paper put forward their own recommendations for an Integrated Model incorporating aspects from these past theories. It is both well illustrated and outlined. Their overall premise is that their Integrated model "… attempts to take into consideration the complexity and the individual aspect of the process of adaptation", (Samson et al, 2007).

Samson et al make reference to the considerable scientific progress over the past two decades, wherein the tag 'terminal' disease is in many cases now being defined as 'chronic illness'. Their suggestion is that models and tasks need to be geared toward encouraging individuals (and loved ones) to learn more about their conditions and ways to adapt and cope throughout what might potentially be much longer periods of life.

They base their recommendations and integrated model on five key assumptions:

1. that it is a 'highly individual process'
2. that there is no 'uniform way'
3. that there is an innate drive to regain social and psychological homeostasis
4. that the individual using task based models can re-assess issues, take control, and be better equipped to make quality choices
5. that positive or negative outcomes will manifest

In alignment with this psychosocial stance of adaptation and coping, a number of counselling modalities, either singularly or integrated, can be effective in working with clients with chronic illness and these include but are not limited to:

Transpersonal - to consider the 'felt-sense', spiritual context, meaning.

"Transpersonal Psychology…focuses on the study of transpersonal experiences and related phenomena. These phenomena include the causes, effects and correlates of transpersonal experiences and development, as well as the discussions and practices inspired by them". (Walsh & Vaughan)

"That life itself is bigger than illness, diagnosis, treatment, or disease mechanism. A moment of laughter, a walk in the country, simple touching, or tears, can reorganize biology in a way that drugs cannot." Budd, M. 1993)

Acceptance and Commitment Therapy – combining objectivity and acceptance with changes to behavioural approaches for greater ability to cope .

"getting to know unpleasant feelings, then learning not to act upon them, and not to avoid situations where they are invoked……"a positive spiral where feeling better leads to a better understanding of the truth" (Shpancer, N.)

" ACT teaches ways to undermine struggle, avoidance, and loss of the moment." (Hayes, S.)

"..life involves pain. Sooner or later we all experience it – physically, emotionally and psychologically. But in every painful life circumstance there is an opportunity for us to grow." (Harris, R.)

Person Centered - a therapeutic environment with genuine regard, respect, caring, empathy, leading to the client's increased level of accurate insight , self-expression of feelings, and self-responsibility.

"A relationship in which at least one of the parties has the intent of promoting growth, development, maturity, improved functioning, improved coping, with the life of the other..." and " more appreciation of, more expression of, more functional use of the latent inner resources of the individual" (Rogers, C. 1958)

Gestalt – helping the client to be consciously present, to gain clarity without over-theorising or thinking, to work on removing blocks and patterns, to take responsibility.

" 1. Valuation of actuality (temporal present vs. past or future), spatial (present vs. absent), and substantial (act vs. symbol)

2. Valuation of awareness and the acceptance of experience

3. Valuation of wholeness or responsibility." (Naranjo, C.)

Mindfulness – a method for paying attention to our troubled world – mentally, physically, emotionally, spiritually, and then through simple practices, invoke our own preferred state of peace, and wellbeing.

"What is mindfulness? Perhaps the simplest way to describe it is to say that mindfulness is the practice of paying attention: knowing where our attention is and being able to choose where to direct it. A slightly more technical definition would be 'attention training' or 'attention regulation'" and.. "Mindfulness can give us back what we might think we have lost – ourselves." (Hassed, C., McKenzie, S.)

"Mindfulness has the real potential to generate inner peace, foster physical and psychological healing and lead to a heightened sense of wellbeing and connectedness." (Gawler, I.)

Narrative –A therapeutic process where the **counsellor** adapts a 'not knowing' stance and the client is identified as the 'expert' of their story. Working together to externalize the client from their problems and to help the client construct a preferred and unique story for living their life, with their new choice of options.

"To facilitate an emerging dialogic process in which 'newness' can occur" and

"where nothing is fixed". (Anderson & Goolishian)

Emotional Freedom Technique (EFT) – Incorporating a dialogue and a tapping technique on specific acupuncture points enabling negative thoughts and feeling states to be disengaged and replaced with a new program.

"EFT's foundation comes from a common sense blend of Acupuncture and Mind-Body Medicine, both of which have decades of scientific studies supporting them. Their effectiveness has been so profound that prestigious institutions such as Stanford, Harvard and many other universities, clinics and hospitals have chosen to use and/or study them. Just do an internet search for terms such as "Mind Body Research" and "Acupuncture Research" and you will be exposed to the huge warehouse of scientific studies that validate the EFT Tapping underpinnings." (Craig, G., Craig, T.)

Meditation and Relaxation – Progressive Muscle Relaxation, Somatic Relaxation, Guided Imagery and Visualisation, Mindfulness, as well as other forms of Meditation and Relaxation, can assist significantly in regaining perspective and clarity. Likewise, these practices are immensely effective for the reduction of chronic or acute pain, associated symptoms, side effects from chemotherapy and radiotherapy, anxiety, fear, stress, worry, insomnia. With regular use there is imminent potential to increase health and wellbeing.

"In meditation
There comes a calm,
A clarity,
Which enlightens
The inner depths of our being,
Brought to us
By the harmonious function
Of nerve and endocrine cells
Which mastermind
The healing powers of the body."
(Meares, A (1985)

The following is an excerpt from a case study where many of the above modalities, formed a valuable part of this counsellor/client relationship.

Case Study

Ruby had breast cancer.

Living alone with her three treasured cats, working as a public servant, reliant on the public health system, public transport, and public housing, her visits were not frequent.

She came for counselling support in the latter stages of her life, not ,she made clear, for herself, but to seek help in mending the estrangement in her family. She had not seen her daughter or her mother for many years. Nor did they speak or meet, to the best of her knowledge, independently from her.

In sessions over the months that were left, Ruby was able to express her feelings, talk about her life; sometimes sit in silence, whilst on other occasions laugh or swear out loud. On some days her pain was harsh, initially described by her as her just desserts in terms of the guilt she carried for the unresolved rift in her family.

As she began to self –actualize and prioritise what was most important in her time left, two letters were carefully composed, handwritten and posted by her to her mother and to her daughter. Dialogue of what she might actually say if she ever heard from them, also became clearer in her mind. She would visualize and rehearse this, both in our sessions together, and then to her cats at home.

Ruby learned to meditate and was buoyed by the reduction in pain and the improvement in her sleep as she implemented this new ritual into her daily life. She spoke often of her new found awareness of beautiful colours during her meditations, especially her favourite, purple.

Admitted once more to hospital for pain management, her mother and daughter came to visit. They came together. There was no private room, just a barouche in a corridor, the only space available. There were many tears, many hugs.

And most importantly for Ruby, her rehearsed dialogue had an opportunity, at last, to be shared. Ruby felt that after so long, so many missed years, she was able to take care of them from her bed, reconnect each of them with the other, give them a sense of family and belonging to go on beyond her death. It left her feeling like she had not 'copped out' .

Some days later, Ruby was transferred to a hospice. She spent her last days with minimal pain, re-living and sharing the story of her mother' and daughter's visit.

Sleeping more, she still meditated, focusing on her colour purple, and experiencing her own inner peace, free of guilt and fear.

Ruby died in a room alone – just as she had spent so many of her years.

Summary

As statistics reveal longer life spans and a re-labelling from 'terminal' to 'chronic' illness occurs, there is a valid place for Counsellors to work in this field.

By working in the psychosocial framework which looks beyond the medical diagnosis itself, there is much that can be achieved to help clients adapt and to cope with their illness or disease physically, psychologically, socially, spiritually, and vocationally. It could be said that through the mindful integration of each of these parts, the value is far richer than the sum of the parts.

As Counsellors we recognize the benefits of clinical supervision and this is never more evident than when we work in this field. Not only for our own self – care, but to be mindful of those issues of attachment, dependency, burnout, blurred boundaries, letting go, and our continual growth.

"the development of a therapist's self-awareness must carry at least as much weight in his or her professional education and training as the accumulation of knowledge about theories and methodologies established by the leaders of the profession." (Edwards & Bess).

Pam Mitchell has been in private practice as a Counsellor since 1991. Most of her clients come with chronic illness, anxiety, grief, loss and trauma. She incorporates meditation and relaxation into her work both for individuals and in group settings. As a qualified Supervisor, she works with individuals and with groups in this regard.

Pam Mitchell

Pam has a Masters of Counselling, and is a Level 4 Member (ACA). She is an accredited Supervisor, College of Supervisors(ACA),) and a Level 2 Member, Clinical Counsellors College (ACA).

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Complementing meaning reconstruction with bereaved parents: Three case reports using multiple intelligences.

By Dr Mark Pearson and Fran Hamilton

Abstract

Three case reports illustrate the therapeutic and extra-therapeutic outcomes from the application of Gardner's (2006) theory of multiple intelligences (MI) in bereavement counselling with adults. As a qualitative, phenomenological study, the experiences of a senior counsellor were gathered, through a semi-structured interview. The resulting transcript, in which the case reports were embedded, was analysed using interpretative phenomenological analysis. Five major themes emerged and indicated that for the participant and her clients an MI approach supported meaning reconstruction, was a useful basis for selecting treatment options, challenged counsellor assumptions about client abilities, supported a focus on client strengths and enhanced the level of exploration in sessions. Relevant areas for future counselling research are discussed.

Introduction

This study analysed three case reports within an interview that explored the experiences and observations of a senior counsellor who specialises in supporting clients working through traumatic bereavement. The three case reports illuminate some possibilities for using multiple intelligences theory (MI; Gardner, 2006) in bereavement counselling. The participating counsellor had volunteered in a larger study designed to explore the impact of introducing Gardner's (1983, 2006) theory of multiple intelligences (MI) into counselling with adult clients (Pearson, 2011; Pearson & O'Brien, 2012; Pearson, O'Brien & Bulsara, 2015), and had engaged in a MI training intervention designed for counsellors. The counsellor's voice is preserved in communicating these experiences through the use of extended extracts from her interview, as well as phenomenological analysis of the transcript.

Literature review

Multiple intelligences theory

Multiple intelligences theory (MI) (Gardner, 1983, 2006) regards intelligence as having a number of separate components, rather than being based on a singularly calculated intelligence quotient. Gardner's theory delineates eight intelligences or cognitive styles, each representing a different ability through which people can communicate, process their difficulties, and learn. While there is to date little research on MI in relation to counselling, the implications for MI theory applied to counselling have been considered by Booth and O'Brien (2008), O'Brien and Burnett (2000a, 2000b), Pearson (2011), Pearson & O'Brien (2012) and Pearson, O'Brien and Bulsara (2015).

Gardner's eight intelligences can be summarized as verbal linguistic (strong ability to use words), mathematical logical (ability with deductive reasoning), visual spatial (ability to use images and graphic designs), musical rhythmic (ability to express through music and rhythm), bodily kinaesthetic (ability with movement and awareness of the body), intrapersonal (awareness of internal moods and thoughts - also termed "emotional intelligence" [Mayer & Salovey, 1995, p. 197]), interpersonal (ability to learn and express through relating to others), and naturalist environmental (affinity with nature and living things) (Nolen, 2003).

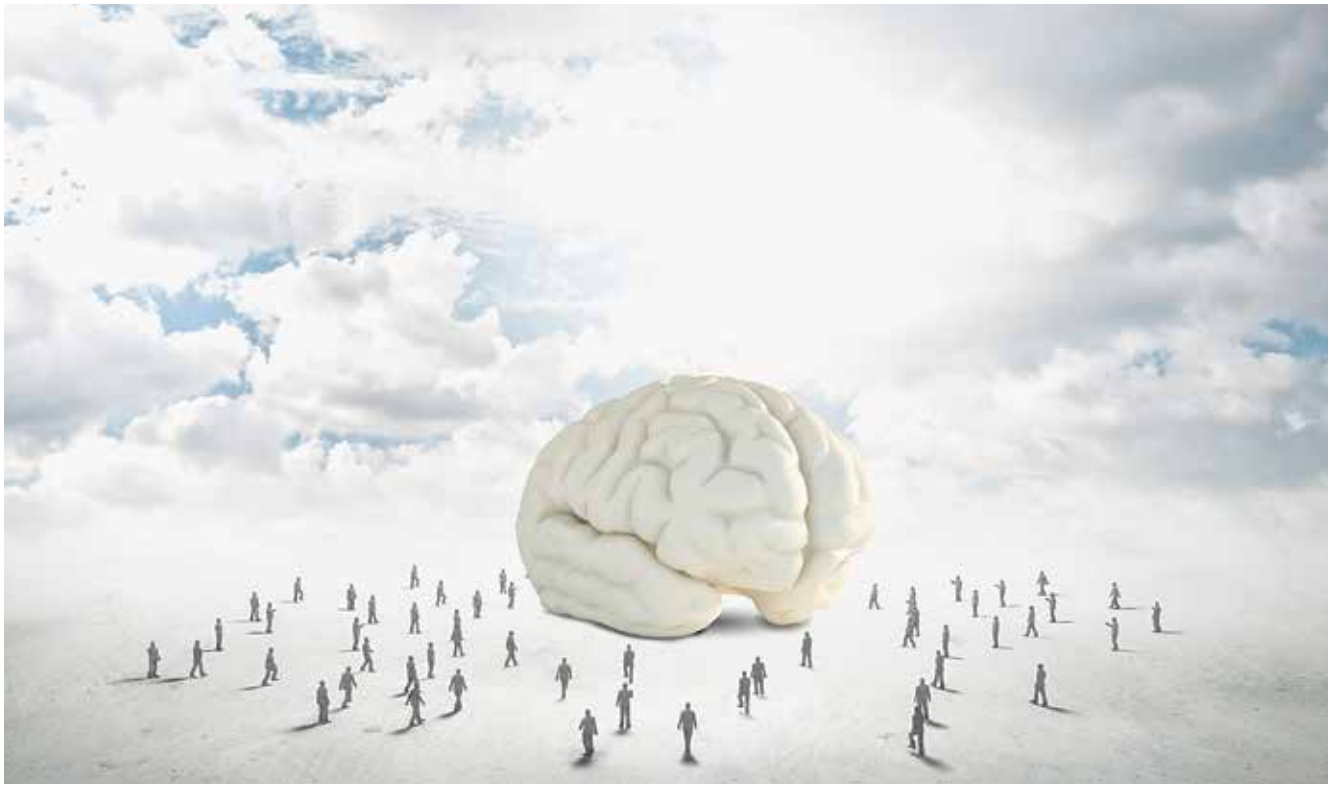
Counselling clients draw on a range of largely separate information-processing devices, memory and intelligence-specific language systems in order to make meaning of the world around them, and to participate in therapy (O'Brien & Burnett, 2000a, 2000b). Using a MI approach to counselling may be more effective and lead to more positive outcomes for those clients whose preferred intelligences during counselling differ from the traditional focus on verbal linguistic and logical mathematical intelligences (Booth & O'Brien, 2008).

Over many years, pre-school to tertiary educators have found improvements in learning when MI methods have been introduced (cf, Gardner, 2006; Greenhawk, 1997; Hopper & Hurry, 2000; Kezar, 2001; Vialle, 1997), and within the field of education curriculum planning and new methods of teaching have been developed based on MI theory (cf, Clarke & Cripps, 2012 [fine art curriculum]; Emerick - Brown, 2013 [adult education]). MI interventions, where students have been enabled to identify their own dominant intelligences, have been shown to have a positive impact on their study skills and habits, and attitudes towards educators (John, Rajalakshmi & Suresh, 2011).

Several intelligences may operate at the same time and usually complement each other (Brualdi, 1996). Each person is different, "we have here a distinctive, and possibly changing, profile of intelligences, and there can never be a formula for reaching each individual" (Gardner, 1997, p. 21). In other words, while counselling theory, methods and research is usually based on data extrapolated from groups, clients present for counselling with an individual sense of self, meaning systems, language and intelligences.

The theory of MI can be used to understand both a client's and a counsellor's preferred communication style, and this understanding can guide the way counselling is applied, and enhance creativity within counselling (Keteyian, 2011). As counsellors are likely to be able to more clearly understand their own style and discern client abilities or preferences, they are likely to make fewer assumptions about others (Keteyian, 2011).

There have been some critiques of Gardner's work, with Morgan (1996) suggesting that what Gardner labelled as



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intelligences are more accurately seen as "cognitive styles". Eysenck (1998) criticized the lack of empirical research behind Gardner's formulation of MI theory. White (2004, 2008) presented several challenges to the way Gardner originally identified the various intelligences. Nonetheless, White also acknowledged that the implementation of MI theory in educational settings may have increased students' self-esteem and motivation for learning.

These criticisms have been strongly rebuffed by Kornhaber (2004), describing the solid sources of Gardner's data in cognitive developmental psychology. In responding to critics, Gardner (2006) has outlined his own criticisms of the methods used in an attempt to empirically test his theory, and has expressed willingness to change terminology if necessary and adapt to new research outcomes emerging in the future.

Counselling in western countries has focused primarily on the use of verbal / linguistic and logical / mathematical intelligences and many writers have advocated that the field move beyond its talking emphasis (e.g., Jordan, 2000; McNamee, 2004; Straus, 1999; Wiener, 1999).With the exception of creative arts-based approaches and somatic therapies, western counselling and counselling education appears to have been conducted on the assumption that clients communicate and process information in narrow and similar ways.

Seeing clients' abilities, or intelligence preferences, as beyond being hierarchical, and hence beyond judgment, may have a liberating and esteem-building impact on clients (as it does within education, for example Mettetal, Jordan and Harper, 1997). In parallel with research in the field of education (e.g., Hoerr, 1992; Kelly & Tangney, 2006; Quiñones & Cornwell, 1999; Smagorinsky, 1995), it is reasonable to theorize that helping counselling clients find a range of ways that enable them to communicate and understand their challenges more effectively through use of their intelligence strengths, may enhance self-esteem, build confidence, and may strengthen the connection between counsellor and client.

Bereavement counselling

Contemporary grief theories and models mainly focus on such dynamics as movement between attending to loss and attending to restoration of life (e.g., the Dual Process Model [Stroebe & Schut, 2010]), meaning making, (e.g., Attig, 2001; Neimeyer, 2001), helping clients feel they can maintain a connection with the deceased (Heidtke & Winslade, 2004; Silverman & Klass, 1996; White, 1988), and post-traumatic growth (Tedeschi & Calhoun, 2004). These approaches are particularly suited to work with bereaved parents who instinctively reject notions of severing attachments and seemingly linear prescriptions for their grieving which are often contrary to their lived experiences. The death of a child is considered to be the worst loss of all, confronting parents with the most difficult form of bereavement (cf, Klass, 1996; Neimeyer, 2006; Talbot, 2002). The experience of this loss is likely to lead to a profound existential crisis (Bugental, in Yalom, 1980).

In addition to the loss itself, parents find that previously constructed ways of coping no longer apply to the new situation (Attig, 2001; Neimeyer, 2001). It is evident that there are many dimensions involved in grieving for a child: parents have to adjust to the absence of their child, and they also lose a much-anticipated future life, including their dreams and hopes for the family (Talbot, 2002). It is not surprising then, that bereaved parents feel as though they have not only lost their parental role, but they have lost their very identity (Attig, 2001; Klass, 1996; Talbot, 2002).

Multi-modal grief therapy techniques

There are many useful techniques and multi-modal activities that have been employed to assist clients to work through grief and to eventually rebuild a sense of self. These have included using evocative language, using symbols (e.g., photos, letters, DVDs of the deceased, personal belongings),

writing, drawing, role-playing, creating memory books, using directed imagery and metaphor (Worden, 2009), as well as a broad range of 'creative' approaches, such as visualisation (Neimeyer, 2012).

Many writers have recommended the use of creative arts as being useful in grief work (cf, Gunn, 2012; Rogers, 1993; Seftel, 2006) and music listening and music-making in particular as effective in the recovery from grief (cf, Bright, 1999; Gladding, Newsome, Binkley & Henderson, 2008; McFerran, 2011; Magill, 2011; Popkin, et al., 2011). The range of techniques recommended as useful by a number of writers suggests that various intelligences can be utilized in the grieving process; however the selection and application of techniques has seemingly not had the benefit of an integrating framework.

Meaning reconstruction after loss

There is a range of ways people grieve. Among the variables in the way grieving takes place, it is conceivable that the client's intelligence strengths or preferences may be active, even if they are unaware of these. Martin and Doka (2000) conceptualized adaptive grieving styles, which are reflections of individuals' idiosyncratic uses of cognitive, behavioural and affective strategies in adapting to loss. These strategies have been regarded as flowing from diverse variables including personality and culture.

The Dual Process Model of bereavement (Stroebe & Schut, 2010), which charts the journey of oscillation between a focus on loss and a focus on restoration, has been described as being highly effective (Neimeyer & Currier, 2009). This model has a focus on better detailing coping, and predicting what might contribute to "good versus poor adaptation" to the stress of loss (Stroebe & Schut, 2010, p. 274). This model encompasses processes of "orientation to the loss" and also of "restoration of contact with a changed world (as through re-engaging relationships and work and experimenting with new life roles)" (Neimeyer & Currier, 2009, p. 335).

The case reports presented here involve three parents who have achieved, for the most part, a balance of attention to loss-oriented coping and attention to restoration-oriented coping. This balance is considered appropriate for each client in the Dual Process Model (Stroebe & Schut, 2010), in light of the time since their loss. The clients are continuing or reconnecting with therapy to build on meaning reconstruction and support for post-traumatic growth.

Method

This study used a qualitative approach, which recognizes individual experiences and seeks to gain the unique perspective of those studied (Langdridge & Hagger-Johnson, 2009). The three cases reported here by an experienced, highly articulate counsellor-participant are both the "objects of study" as well as "the product of inquiry" (Creswell, 2007). The reports are based on the counsellor's experiences and reflections with, and observations of, three clients and their artefacts created within counselling sessions. The reports describe therapy sessions that took place in an agency setting, in the weeks after the counsellor-participant took part in pilot training in the application of Gardner's MI theory to counselling.

The participant is a senior counsellor with post-graduate counselling qualifications, with over twenty years in practice, who is also engaged as a tertiary counselling educator. She specializes in the support of clients dealing with traumatic bereavement. The clients, whose stories are reported, were all adult volunteers in a trial of an MI approach to counselling, who gave consent for their de-identified stories to be used for research.

The semi-structured interview of the counsellor-participant took place three months after the training intervention. The transcript from the recorded interview became the raw data that contained the three case reports. Interpretive phenomenological analysis (IPA) was used as the data analysis method, a qualitative approach that explores how people make sense of

The MI theory and questionnaire has provided a further, creative way of continuing work with bereaved clients beyond their trauma and into their reconstructing self in their 'new world.'

their lived experience (Smith, Flowers & Larkin, 2009). From the counsellor's overall experiences within her practice, and in particular with the three clients, several major themes emerged, as will be detailed.

Case studies generally include a description of a problem to be studied, the context, the main issues, and the lessons learned (Lincoln & Guba, 1985). The three cases reported here all involved adult counselling clients who were recovering from traumatic loss of a child.

During a 60 minute semi-structured interview the participant was invited to report both observations of any general impacts from including MI theory within counselling sessions and to describe several cases where a MI approach was used. She was also invited to complete a short questionnaire that sought reflections on her experience and the subsequent application, of the MI training intervention. The high level of articulation in the responses, from a specialist counsellor, and the rich data presented, formed a rationale to present these findings in a single cohesive article.

Making sense of the stories

Analysis of the interview transcript was conducted using interpretive phenomenological analysis (IPA) (Smith, 2003). IPA provides a means to understand the perceptions and reflections of participants and the themes that emerge from their experience. Interpretation of data illuminated themes across cases within the interview. As IPA is concerned with what the participant thinks or believes about the topic under discussion, transcripts were returned to the participant with an invitation to expand, clarify and correct the text as deemed appropriate or necessary.

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The MI training intervention

The one-day MI training intervention attended by the counsellor, developed and presented by the first author, introduced four main areas: (1) MI theory, (2) means for assessing counsellors' and clients' preferred intelligences, (3) practical counselling activities that utilize each of the intelligences, and (4) session-planning in the light of clients' intelligence profiles.

The practical counselling activities presented during the MI training were drawn from expressive therapies and have been tested and published (cf, Pearson, 2003; Pearson & Nolan, 2004; Pearson & Wilson, 2001, 2009). The intervention included use of a MI survey (Chislett & Chapman, 2005) to inform counsellors about their own preferred intelligences and to use with clients. Counsellors attending the training were encouraged to include the MI framework and activities in their future counselling, in the light of their own assessment of client needs.

Findings

The counsellor's learning experiences

Application of MI theory, and the discerning of clients' intelligence preferences, seemed to have had a positive effect on therapy in that it was reported as enhancing the therapeutic alliance, and contributing to therapeutic renewal:

> The information helped identify [for me] approaches I was trying that weren't working, and steered me into finding more suitable interventions. I was aware of my own preference for language and to counteract that I have used art, drawing or painting to open other pathways for the client. I think MI added to the work that I already do … sort of adding more to the toolbox… but in a way that is tailored to client strengths, not my preferences.

The participant described the context of the cases as a second phase of therapy for three adult clients, after working through traumatic bereavement (they had each lost a child), when they appeared ready to focus more on "exploration of their way of being" and the resolution of "historical issues". The participant reported that previously over the years she had adapted her approach to integrate the encouragement of continuing bonds, as recommended by Klass (1996), and used Neimeyer's meaning reconstruction, (Neimeyer, 2001), narrative therapy (White & Epston, 1990), and the dual process model (Stroebe & Schut, 2010). She reported further:

> Most of my clients come to me after a traumatic bereavement. The MI theory and questionnaire has provided a further, creative way of continuing work with bereaved clients beyond their trauma and into their reconstructing self in their 'new world.' Using the MI survey gave a clear sense of therapeutic mode shift from the traumatic loss toward ongoing making sense of historical life events and family of origin issues, towards further development of meaning reconstruction and recognition and integration of post traumatic growth into the present and new sense of self [identity].

> Before using the MI preference questionnaire, my tendency was to introduce to my clients activities that I had experienced myself in the MI training workshop. In other words, I introduced the ways of working that were most comfortable for me. Having the MI preference questionnaire to work through with my clients really brought my awareness to how to tailor therapy around their unique combinations of strengths.

> I feel that the MI theory and activities have enabled me to work with my clients in a different way; a way that feels innovative for them as well. It's brought a new energy to their therapy and a sense of purpose.

> Finding out the client's intelligence profile, can override or correct the assumptions that we develop about clients based on our observations and assessment interview. For all three clients, that's really been a theme that has emerged for me, it's about exploring more with the client what it is that interests them, what their strengths are; rather than making assumptions based on their occupation or educational background.

> Integrating MI findings with meaning reconstruction exercises brings clarity that helps individualize therapy, in other words, the therapeutic ingredients are adapted to suit the present moment with the present client.

Extracts from case reports

Client One - Noelle

Noelle is a former professional athlete who now works as an accountant. It is 20 months since her loss. Her third daughter died unexpectedly at the age of 13 months.

As Noelle is a former professional athlete, in thinking about working with her, I was sure that everything would be about the body and movements – the bodily/kinaesthetic intelligence. In fact, when she completed the MI questionnaire, it came out that she scored well on the verbal/linguistic and logical/mathematical intelligences. I had thought more of her athletic abilities and didn't fully recognize other aspects of her that were also her strengths. She's also very visual/spatial. I would have picked out activities relating to body/kinaesthetic and art therapies if she hadn't done the MI questionnaire. Interestingly, Noelle is aware people think of her primarily as an athlete, she has a belief that people think she 'isn't very clever,' [so] she felt validated by the MI results.

So I was quite pleased to have the results, because we worked through the Life Review Map exercise [an extended time-line activity that incorporates images and words and depends on logical/mathematical ability] and she found it the most powerful way of working. Noelle embraced the imagery of the exercise and found it opened up a vocabulary for writing about life. This exercise also helped her in expressing aspects of restoration such as 'I'll always have two girls on earth and one in heaven'. Other future-oriented work covered her decision to return to study an arts degree, and remain in accounting to help with the bills. The activity brought forward rich material that we have identified as being important to work on in an ongoing way.

Client Two – Clare

Clare is a teacher, it is 18 months since her loss. Clare became pregnant after ten rounds of IVF treatment; however, her baby girl died in utero at 29 weeks gestation. Following delivery Clare had a post-partum haemorrhage and a life-saving hysterectomy was performed.

I felt the reason I wanted to introduce the MI work with Clare was that I have tried quite a few approaches with her in the past and believe she very much wants to please me. I have tried a lot of visual activities, such as whiteboard work and drawing. I've even tried, in the past, to play throw-catch with her and just try to get her more into movement, to bring some energy into the room and take her out of a sense of being stuck.

When we did the MI questionnaire, her bodily/kinaesthetic intelligence and visual/spatial intelligence registered as a low preference. I was confronted [by the awareness] that I hadn't picked this up. Clare's inter- and intra-personal and linguistic intelligences were stronger. So I offered the Emotional Mapping activity to her [identifying and illustrating internal experiences on a large body outline drawing]. This made sense and was familiar to Clare, as we often use a physical slowing down relaxation exercise. Clare found many emotions and expressed space within for the deep loss of her fertility, [and] this built on earlier work using metaphor. Being fully aware of the 'body holding emotions' provided a richer way of expression for her in subsequent therapy sessions.

The Sentence Starters [reflection and writing activity] worked for her (and I wonder if it's because she's a teacher), and she liked that activity. It's hard to tell, except that she wrote a bit, and brought her focus back into the session and she talked about some of the writing that came up - it was deeper than what we had done before.

In the session I felt that her involvement may have been more like a classroom exercise. It felt - to me - as if she was trying to perform or do the right thing. But when she was at home and she had the space, her writing showed more insight and honesty with herself, especially around the realization she had choices. There is now more of a relatedness between what goes on in the counselling room and how Clare is processing her issues at home.

She is now gradually being more self-directed with a stronger sense of self-advocacy. There seems to be more knowledge that she has some control over her life and the ability to live the life that she really wants.

On earlier assessment, Clare had previously lacked oscillation and was more loss-oriented in her coping. The MI work helped her into that deeper space, in a way that my attempts at working with her before – that may have been more superficial or more interventionist – did not achieve. Using the MI approach enabled Clare to more fully engage with the therapist.

Client Three – Michael

Michael is the manager of an accountancy practice; it is 14 months since his loss. His son was born prematurely at 27 weeks and had an inoperable heart condition, and died when six hours old. Michael and his wife have had a subsequent, healthy child.

Michael's MI scores were high across the board except for intrapersonal; that was his lowest score. He has a very strong personality and a strong sense of self. He is very articulate and creative. He comes from a family of all boys; he played rugby – he is a 'real man'. He is also very articulate in terms of his ability to communicate and his ability to do the therapeutic work.

Michael came to me knowing what he calls his weaknesses. His 'weaknesses' are being able to explore his emotions. In my view he is not really weak in that area compared to many clients. His ability to reflect and his insight are quite powerful.

When I started some MI work with him I wanted to offer the Life Review Map with him, but he didn't want to do it. He said he wanted to focus on the problems he has in the present and he

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wanted to really focus on just those. He had a strong sense that the past is the past and he couldn't change it. His present problems related mostly to a sense of meaninglessness in his work. The death of his baby had highlighted the preciousness of life, and he didn't want to waste time in a job that wasn't reflecting his 'true self.'

Michael scored highly on the musical/rhythmic intelligence, and this strength developed as we used the Feelings in Music activity [a worksheet for recording responses to tracks of music, using colour and images, and writing down feeling and memory responses]. During his engagement with the activity he spoke at times, and communicated what he felt and what he was doing.

It appeared to be safe for him to explore the way music could be a thread from his loss and grief into his newly evolving self. Afterwards he shared his love of music, and how this changed at different times of his life. He remembered how powerful music had been following the death of his son. Although we had worked with music before, this activity was building on that experience – for both of us.

After the first music activity session, he started emailing me lyrics that were meaningful to him, that went with his experience of the grieving process. He also sent 'YouTube' links, and invited me to watch and listen to them. It's another doorway for him to work with his feelings and to communicate them. Significantly, his attention to music has developed and he is connecting songs and lyrics to his growing sense of self, his new identity evolves along with his musicality.

Michael's need for more purposeful work is being partly satisfied by his newly found capacity for supporting other bereaved families. He shares song lyrics with other parents (via a newsletter) and connects with others, encouraging them to share their stories and songs together. Michael's long-term aim is to support other fathers in their grieving. As his therapist, I am in awe of his capacity to grow through grief into this strengthened man with willingness to help others.

I think this MI way of working was effective to help create that connection in the therapy session, especially around the music. It made his everyday life more relevant to me, and hopefully what we did in the session, more relevant to him.

TABLE 1: Summary of Themes

	Dominant themes	Minor themes
1	Using the MI approach supported meaning reconstruction	Increased restoration-focus in clients' extra-therapeutic activities
2	MI as a basis for selecting treatment options	Supports increased use of client abilities as a basis for choice in modalities used
3	Counsellor assumptions about client abilities can limit treatment options	Mi survey helps counsellors challenge / correct their assumptions
4	MI can support a focus on client strengths	Treatment can be tailored to client strengths Client ability with their strengths can develop
5	MI-based activities "took clients deeper"	

Discussion

Five dominant themes, and five closely associated sub-dominant these, emerged from analysis of the interview and case reports. The themes are summarized in Table 1.

Central to the first theme is the indication that the use of an MI approach to understanding client strengths and making treatment choices, did indeed support meaning reconstruction. It also appears that clients' healthy oscillation between a loss-oriented focus and a restoration-oriented focus - that is at the heart of the Dual Process Model (Stroebe & Shut, 2010) - was supported. A closely linked, minor theme indicated that clients displayed a readiness to increase a restoration-focus and consolidate their process of meaning reconstruction through life (extra-therapeutic) activities that used their identified MI strengths. In addition to the support from MI, the use of life activities may be partly due to the natural emergence of reciprocity some clients develop in ways of giving back, and gaining something positive from a significant loss (Calhoun & Tedeschi, 2004).

The second major theme to emerge from the case reports was the way an MI approach seemed to increase a focus on client abilities, as a basis for considering treatment options. The MI approach appeared to increase the counsellor's effectiveness in selecting session activities with which the client had an affinity and ability.

The third theme clustered around the counsellor's observation that her previous assumptions about client abilities, even though carefully considered, may have limited treatment. The MI survey tool provided a helpful challenge to these assumptions and a basis for correcting them and offering clients alternative routes to explore and process their issues.

Use of the MI framework to assist the counsellor to focus on client strengths was the fourth theme. The MI framework also helped to guide implementation of treatment options in line with client strengths. It is assumed from the transcript that a strengths-focused orientation was important to the counsellor. Such a focus is a foundation in narrative practice (Payne, 2006; White, 2007), which was identified as one of the approaches integrated into the counsellor's style of working. It was also noted that when the in-session activities chosen used client strengths, those strengths seemed able to develop.

The counsellor reported a few times that her perception that the appropriate choice of MI activities "took clients deeper", meaning that her clients seemed more able to process emotions effectively. This fifth theme is closely linked to the fourth, that of using client strengths, in that helping clients find the best means for reflection and communication, appeared to enhance client willingness or ability to explore their narratives more fully with the counsellor.

An additional minor theme to emerge was that the counsellor made treatment choices, or changed treatment choices, as a direct result of clients' responses on the MI survey. This suggests that the client's MI survey results became a useful tool and a reference point for the counsellor.

Major themes indicated that a MI approach appeared to support meaning reconstruction, was a useful basis for selecting treatment options, challenged counsellor assumptions about client abilities, supported a focus on client strengths, and enhanced the level of psychological and emotional exploration in sessions.

Limitations and Future Research

Drawing on the experiences of one counsellor and reporting on her work with three clients does not constitute research that is generalisable. However, the aim of this paper was to explore areas on using MI in counselling for further research, and to indicate some ways that counsellors might enhance bereavement work using MI theory and practice. A larger study that can incorporate both counsellor and client perspectives is recommended.

Conclusion

MI theory has been applied and found to be effective in many areas of education and more recently in counselling with young clients (cf, Booth & O'Brien, 2008; Gardner, 1999, 2006; Longo, 2004; O'Brien & Burnett, 2000a, 2000b; Pearson & Wilson, 2009; Waterhouse, 2006). A large number of counselling activities that utilize MI theory have been trialled and described as part of expressive therapies (Pearson, 2003; Pearson, 2004; Pearson & Nolan, 2004; Pearson & Wilson, 2001, 2009). Expressive therapies and the wider field of creative arts therapies offer a large number of practical ways to respond to clients' MI preferences.

Analysis of the experiences of one counsellor indicates that a MI approach can support bereavement counselling, in that it is highly flexible and can support clients' individual patterns of both working through grief and achieving meaning and identity reconstruction. MI activities also appeared in this case to support exploration of existential challenges, and provide therapeutic freedom for post-traumatic growth. The choice of modalities in a MI approach allows treatment to be based more on the client's interests and abilities.

In the light of the themes emerging from these three case reports, counselling educators may be interested to conduct further research and to consider implementing training in MI theory; provision of an overview of therapeutic approaches that use specific intelligences (e.g. O'Brien & Burnett, 2000b); use MI survey instruments to help identify counselling interns' natural or preferred intelligences (e.g. Chislett & Chapman, 2005) and any associated biases.

The study of MI theory and practice within the counselling profession may provide several contributions. It may identify new ways to understand and enhance the early therapeutic alliance, it could provide a model for extending counsellors' understanding of eclectic practice, it could provide a framework for counsellors to be more flexible and accurate in the delivery of service to clients, and to utilize new ways of matching treatment and extra-therapeutic activity recommendations to client preferences, abilities and strengths.

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PEER REVIEWED ARTICLE

Adult-Male Children As End-Of-Life Care Decision-Makers: A case study

By Trish Smith[1] and Dr Ann Moir-Bussy[2]

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Abstract

This qualitative study investigated the lived experience of male adult-children as end-of-life care decision-makers for parental, and/or adult siblings' (including -in-laws') end-of-life care. Results suggest that male adult-children participate as decision-makers in end-of-life care decision-making more frequently than previous research indicates, and that sibling infrastructure influences acquisition of the role of primary and/or shared decision-maker. Results further indicate that male adult-children with female siblings appear to enact more decisional and delegatory roles, while female siblings appear to undertake more carer-specific roles. This study's subjectivity and small n size limit its generalizability and cross-cultural merit. Further research may improve service provision to adult-child surrogate end-of-life care decision-makers, enabling targeted and tailored support for their individual, circumstantial needs.

Introduction

While adult-children appear to comprise the largest group of surrogate end-of-life care decision-makers for parental end-of-life care decision-making, male adult-children appear to gain the role of primary surrogate decision-maker far less often than do female adult-children. Research indicates that female adult-children assume this role more often as an automatic extension of their gender-driven tendency to develop nurturing carer roles for their parents. However, there is very little specific research regarding the nature of male adult-child involvement in end-of-life care decision-making, and how their involvement differs to that of female adult-children. Additionally, decisional roles among siblings and how they relate to performance of carer role distribution are unknown.

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Increasing reliance upon non-spousal end-of-life care decision-makers reflects the changing, complex nature of aging in the Western World. Historic assumptions that surrogate end-of-life care decision-making for parental/sibling/-in-law relatives is predominantly performed by female adult-children may not accurately reflect present-day socio/-familial surrogate decisional dynamics, nor gender-specific differences relating to end-of-life care decisional roles and supportive carer roles.

This Sunshine Coast, Queensland-based study aimed to investigate the lived experience of twelve male adult-children who participated as end-of-life care decision-makers for parental and/or siblings (including -in-laws) end-of-life care, in order to verify that male adult-children actively assume the role of primary and/or shared surrogate decision-makers more-often than existing research reflects, and that certain features within their circumstantial personal decisional environments may predict the nature of the role they will undertake. Additionally, this study sought to investigate whether personal interview methods of research participation are reportedly more appealing to male adult-child than online survey methods.

Literature Review

While adult-children appear to comprise the largest group of surrogate decision-makers for parental and/or other siblings end-of-life care, male adult-children appear to assume decisional roles approximately seven times less than female adult-children (Brody, 1990; Horowitz, 1985; Lovell, Smith, & Kannis-Dymand, 2013). Empirical investigations specifically considering adult-children are minimal (Checkovich & Stern, 2002; Horowitz, 1985; Noël-Miller, 2010; Pezzin, Pollack, & Schone, 2007; Pezzin & Schone, 1987; Parks et al., 2011; Strawbridge & Wallhagen, 1991; Wolf, Freedman, & Soldo, 1997), and suggest that female adult-children transition into the primary carer role as an automatic extension of their gender-driven tendency to develop nurturing carer roles for their parents (Brody, 1990; Horowitz, 1985; Noël-Miller, 2010; Pezzin & Schone, 1999). Furthermore, within the existing research pool, familial surrogate end-of-life care-givers are frequently referred to collectively, without differentiation between spouses, adult-children, other relatives, or friends (Bowman, 2000; Caron, Griffith, & Arcand, 2005; Lovell et al.). The term 'carer' appears to have been used when referring specifically to carer roles and carer tasks/duties while also implying their relationship with end-of-life care decisional-making. This contributes to the lack of specific data on end-of-life care decisional roles (Checkovich & Stern, 2002; Lovell et al.), which are themselves distinct from most carer duties, are highly variable over time, are highly circumstantial, and are influenced by sibling features and gender-based differences in decision-making (Berger, DeRenzo, & Schwartz, 2008; Bowman, 2000; Checkovich & Stern, 2002; Parks et al.; Pillemar & Suitor, 2006; Sanz de Acedo Lizarraga, Sanz de Acedo Baquedano, & Cardelle-Elawar, 2007; Tilden, Tolle, Nelson & Fields, 2001; Zettel Watson, Ditto, Danks, & Smucker, 2008). Historic rationale for the lack of male adult-child presence in surrogate end-of-life decision-making includes male pre-occupation with employment compared to domesticized females having greater time availability (Checkovich & Stern, 2002), disadvantageous geographic proximity, lack of nurturing instinct, and poor technical skills associated with mental health (Noël-Miller, 2010).

Lovell et al.'s (2013) study (n=93) of familial/friend surrogate decision-makers' post-death grief and guilt after prioritising comfort or longevity for loved-ones' end-of-life care identified a dis-proportionate anomaly (7:1) of female respondents/

decision-makers (86%) to male respondents (13%) within their Participant pool. They found that adult-children comprised the largest non-genderised surrogate decisional group (52.7%), of whom 47.3% were adult daughters, compared to 5.7% being adult sons. The distinct gender imbalance in their Participant pool suggested that male adult-children do not participate in end-of-life care decision-making as much as female adult-children (Chekovich & Stern, 2002), and/or that their Participant recruitment method failed to attract the interest of potential male adult-child Participants as much as it did for females.

Surrogate End-of-Life Care decisions are made by approved proxies for someone who is unable to manage decision-making themselves, for indeterminable periods of time – years, months, days, or hours – and being decisional, are separate from carer tasks (Berger et al., 2008; End of Life Care Network, 2011). Factors influencing surrogate decisions may include inter-personal knowledge (Elliot, Gessert, & Peden-McAlpine, 2009), religious beliefs (Caron et al., 2005; Phelps et al., 2009; Spilka, Minton, Sizemore, & Stout, 1977), and medical professional advice (Cherlin et al., 2005; Rabow, Hauser, & Adams, 2004).

The context in which adult-child surrogate decision-making occurs varies, and may be while the decisionally-reliant person remains living semi-independently at home, living with carer adult-children, or living within care facilities (Checkovich & Stern, 2002; Pezin & Schone, 1987; Pezzin et al., 2007; Wolf et al., 1997). As physical and cognitive loss increases dependence (Checkovich & Stern, 2002; Commonwealth Home and Community Care Program, 2014; Pezzin & Schone, 1999), the capacity to autonomously navigate decisional roles decreases, and decisional responsibilities commonly become deferred to adult-children (Checkovich & Stern, 2002; Hines et al, 2001; Lang & Quill, 2004; Pezzin et al., 2007). Noël-Miller found that the tendency for female adult-children to assume nurturing/motherly carer roles towards parents/mothers results from gender-role expectation and from parent preference for same-sex/female-child carers for personal cares (2010). Conversely, Wolf et al. (1997) found that while daughters apparently dominate as carers, male adult-children tend to occupy predominantly decisional roles, spending less time attending to carer functions, especially when female adult-child siblings are available (Checkovich & Stern, 2002). This is supported by Horowitz (1985), who found that male adult-children typically provide care support in the absence of female siblings. Findings in Sanz de Lizárraga et al. (2007)'s study of gender and age effects upon general decision-making (female decision-making is emotional, lengthy, and prone to uncertainty/doubt, while male decision-making is analytical and expedient) indicate that gender-typical decisional differences could contribute to differences in male and female adult-child surrogates' decision-making, decisional roles, and inter-sibling decisional conflict (Smets et al., 2012).

Palliation – an enduring state of end-stage health for which there is no foreseeable opportunity for cure regardless of the potentially indeterminable duration of remaining life (Sepúlveda, Marlin, Yoshida, & Ullrich, 2002; Truog et al., 2008; Weissman, 2004) – is directly associated with decision-making for end-of-life care, and although complex, is underlain by two basic decisional care options – prioritising longevity or prioritising comfort (Berger et al., 2008; Lovell et al., 2013; Truog et al.; Weissman, 2004). Prioritising longevity focusses on treatment continuation, whether passive-/aggressively, optimistically, and/or desperately, and often at critical end-stages of life when certain treatment features deemed potentially futile and exacerbating patient discomfort are associated with low/no quality of life (Caron et al., 2005; Dreyer, Førde, & Nortvedt, 2010; Lang & Quill, 2004; Weissman, 2004). Prioritising comfort optimises opportunities for gentle death through beneficent pain/anxiety management (Kaldjian, Shinkunas, Bern-Klug, & Schulz, 2010; Rothchild, 1994; Steinhauser et al, 2000). Caron et al. (2005) found that when immediate care needs transcend the scope of advanced care directives/anticipated-patient-wishes, surrogates base end-of-life care decisions on their perception of the patients' best interests relative to immediate health needs, with comfort being the most commonly favoured mode of care (Berger et al.; Weissman, 2004; Zickmund-Fisher, Lacey, & Fagerlin, 2008; Zweibel & Cassel, 1989). They also found that familial decision-makers are often unaware of the terms 'for comfort' and 'for longevity', and of how their decisions reflect either of these options. For example, they found that Participant 'Son-02' deferred medical decisions to doctors provided that their decisions did not prolong his wife's suffering, evidencing a decision for comfort rather than longevity (Caron, et al.).

Palliation can trigger pre-death grief – a complex, evolving emotional experience of indeterminable duration prior to the death of a loved-one (Sanders, Ott, Kelber, & Noonan, 2008; Tilden et al., 2001). Despite its early onset, it has the circumstantial potential to manifest ongoing difficulties post-death beyond the range of 'normal' grief, so is of biopsychosocial and therefore economic concern (Peisah, Brodaty, & Quadrio, 2006; Sanders et al., 2008). Palliation can also manifest complex inter-personal stressors on adult-child siblings, especially in relation to differences between perceived role functions and decisional choices.

Sibling conflict associated with end-of-life care decision-making was found by Strawbridge and Wallhagen (1991), and Peisah et al. (2006) to occur at rates of 40% and 25%, respectively (Howe, 2007; Wolf et al., 1997). Major themes of conflict include unequal distribution of care (Pezzin & Schone, 1987; Wolf et al.), financial distrust/exploitation (Peisah et al., 2006), and/or disputes about whether to prioritise comfort or longevity (Breen, Abernathy, Abbott, & Tulsky, 2001; Caron et al., 2005; Dreyer et al., 2010; Marks & Arkes, 2008; Tilden et al., 2001). Dysfunctions in family dynamics impose less readily-evident features (Parks et al, 2011; Peisah et al., 2006; Phelps et al., 2009) which diminish when external/neutral representatives provide a decisional buffer (Dreyer et al., 2010; Khodyakov & Carr, 2009; Nolan et al, 2005). Effective communications between medical professionals and decision-makers facilitate post-death reductions in depression, anxiety, and complicated grief (Lang & Quill, 2004; McGee, Shigemitsu, Henig, & Raffin, 2001; Sahlberg-Blom, Ternestedt, & Johansson, 2000; Weiner and Roth, 2006).

The legal/bioethical parameters of familial/friend surrogate decision-making for end-of-life care are governed by the law of double-effect, and guided by theories of beneficence and non-maleficence (Dreyer, et al., 2010; Quill, Dresser, & Brock, 1994; White, Willmott, & Ashby, 2010). They are based on end-of-life care ethics that require surrogates to unite legally vague/specific, medically-diverse, -changeable, -demanding, and emotionally-demanding determinants with their subjective concerns (Berger et al., 2008; Buchanan & Brock, 1998; High & Turner, 1987; Solomon et al., 1993; Zweibel & Cassel, 1989).

Understanding and identifying adult-child decision-makers' needs may lead to beneficial strategies for prevention, identification, and management of dysfunctional processes, and so contribute to psycho-socioeconomic and legal/bioethical burden reduction (Khodyakov & Carr, 2009).

Methodology

Ethics Approval

Following the submission of a Low Risk Ethics Application Form, Human Research Ethics, University of the Sunshine Coast approval S/14/667 was granted on the 30th February 2015.

Research Design

Using the qualitative narrative interview method, Participants took part in individual in depth interviews. This method was chosen primarily for its ability to best capture individual Participants lived experience as end-of-life-care decision-makers (Hutchinson, Wilson, & Skodol Wilson, 1994; Opedenakker, 2006). Their factual recollections across themes relevant to this study were meaningfully and cathartically enhanced by the emotional expression that vocalised self-expression facilitated, thus enhancing the richness of data gathered (Hutchinson et al., 1994; Opdenakker, 2006).

Participants

Study details/advertisements were placed on social media site Facebook, on local aged care facility noticeboards, and through advertisement placement in the Sunshine Coast Seniors Newspaper, February/March editions. Twelve respondents emailed or texted their interest in participating, were contacted by email and/or phone/texts, and were screened and qualified as per the study's Research Project Information Sheet.

Data Collection Method

Narrative (recorded) interviews included discussion of the research project information sheet, confidentiality, gaining consent, and Participants' description of their lived experience as an end-of-life care decision-maker.

Data Analysis Procedure

Recorded interviews were transcribed onto Word documents via Surface notebook, saved to a USB, and stored securely. Each recorded interview was deleted once transcribed. Responses were collated according to twelve themes, using the process of thematic analysis.

Findings

Participant Demographics

Descriptive demographic data for the entire sample of male adult-child surrogate end-of-life care decision-makers (n=12) is presented in Table 1. Although Participants resided on the Sunshine Coast Qld at the time of being interviewed, their experiences occurred across the Eastern States of Australia (Queensland, New South Wales, Victoria). Participant ages were grouped 30-40, 40-50, 50-60, 60-70, and 70-80 years of age. There were 1, 1, 6, 3, and 1 participants in each group respectively, representing 8%, 8%, 50%, 25%, and 8% of the Participant population, respectively. Participants (P) are identified as P1, P2, through to P12. Siblings are denoted by B (Brothers) and S (Sisters), and are categorised numerically - B1/S1 (eldest), B2/S2 (second eldest), etc. The 12 Participants undertook 23 surrogate end-of-life care decisional-processes between them. Ten related to Participants' mothers, eight to fathers, one to a sister, one to a brother, and one each to a mother-, step-father, and brother-in-law. Three (25%) Participants (P3, P5, P8) had no female siblings. Two (16%) Participants' (P6, P9) only sibling was female. Seven (58%) Participants (P1, P2, P4, P7, P10, P11, P12) had male-female sibling combinations. Six Participants (P3, P6, P8, P9, P11, P12) were sole decision-makers, six Participants were shared decision-makers (P1, P2, P4, P5, P7,P10), and 3 (25%) of Participants experienced sibling conflict (P1, P5, P7). Results are presented as themes within the data, followed by Table 1. Participant data, and then individual Participant data summaries within each theme.

Themes

Theme 1: Participant-Sibling Infrastructure

Ten of the twelve Participants (83.3%) were either youngest (58.3%) siblings (P3, P4, P5, P9, P10, P11, P12) or near-youngest (25%) siblings (P1, P2, P7). Two Participants (16.6%) were eldest siblings (P6; P8). Individual Participant sibling profiles are presented in Table 1.

Theme 2: Nature of dependents' decline

Surrogate decision-making was due to the limiting effects of physical and/or cognitive decline.

Theme 3: Decisional Role

Primary decisional roles were held by a total of eight (66.6%) Participants who were comprised of four youngest siblings (P3, P9, P11; P12), two near-youngest siblings (P1, P7), and two eldest adult-children (P6, P8). Only Primary decision-making Participants whose siblings included female siblings reported co-residing with their dependent relative. Participants P1, P7, and P12 periodically combined primary decisional-roles with live-in-carer roles. Participants P1 and P7 also shared some decision-making/discussions with some siblings while maintaining overall decisional capacity within their family group. Loss of siblings potentially influenced decisional roles. Participants who experienced sibling loss were P1 (B1/B2), P3 (B1), and P12 (S1).

Shared-only decisional roles were held by four Participants (P2; P4; P5; P10). Participants' siblings either shared decisional roles (P2/B1/S1; P4/B1/B2/S1; P5/B1/B2; P10/B1/S1/S2), or avoided decisional roles (P11/B1; P12/B1).

Older female siblings (P1/S3/S2; P4/S1; P10/S1/S2; P11/S1), and younger female siblings shared decisional roles and also assumed carer tasks also (P2/S1; P7/S1), or undertook carer tasks only (P6/S1). Two (P6/S1; P9/S1) were generally excluded from decisional roles, and one abstained from decisional roles (P1/S1).

Theme 4: Family Demographics

Participant-family demographics varied. Some (younger) Participants (33.3%) had resided with the decisionally-dependent family member, either at their home or at the members' home, for varying lengths of time. Each of these Participants (P1, P7, P10, P12) had male and female siblings, with some siblings becoming deceased (P1; P12) during decisional times. P10 and siblings returned their decisionally-dependent relative to her home at the final end-stage and co-resided to share end-stage carer roles. All twelve Participants travelled as required to provide decisional care. 42% of Participants (P1, P4, P6, P10, and P12) actively travelled interstate and from overseas to contribute to both decisional processes and care. P5 travelled significant in-State distances to visit his father weekly, despite personal/family commitments, financial costs of constant travel, and parental factors which increased overall difficulties.

Theme 5: Bond Strength

Bond strength between Participants and reliant members ranged from low to high.

Theme 6 Following Wishes

Following the reliant persons' wishes was expressly very important to 11 out of 12 participants (P1-P5, P7-P12). Extenuating circumstances necessitated P6 to prioritise necessary care over wishes.

Theme 7 Sibling Conflict

Decisional sibling conflict occurred for 25% of the Participants (P1, P5, P6). P1 experienced mild decisional conflict with S3 which did not alter their long-term relationship, and experienced very stressful conflict with S2 which did alter their long-term relationship. P5 experienced stressful discussions (mild conflict) with brothers during end-stage decision-making. P6 experienced mild conflict with S1 resulting from his autonomous decision to transfer their parents to permanent care.

Theme 8 Decisional Guilt

75% of Participants (P1, P2, P3, P4, P7, P8, P9, P10, P12) reported decisional guilt despite their positive roles as primary/shared surrogate decision-maker for their family members end-of-life care.

Theme 9 Religious/Spiritual/Non-Believer

Participants reported being either religious, spiritual, or non-believer.

Theme 10 Literacy/Education/Family

All Participants were computer- and phone-literate, and were educated, employed/retired, and had their own families (indicated by Yes or No on individual Participant results).

Theme 11 Survey Participation versus Distortions in Data

All Participants reported being unlikely to participate in online surveys, and participated in this study after encouragement by spouses/friends, because of the use of a personal interview, and because of the relevance/merit of the content relevance (indicated by Yes or No on individual Participant results).

See Table 1

Discussion

This study found that its' male adult-child Participants actively participated in surrogate decision-making for parental and other-siblings (including -in-laws) end-of-life care. Rather than avoiding decisional responsibility, they actively undertook primary decisional roles, primary and shared decisional roles, or shared decisional roles. The type of role undertaken appeared to be related to the Participants sibling infrastructure and sibling gender infrastructure (Chekovich & Stern, 2002; Zettel-Watson et al., 2008).

Male adult-child Participants who were primary end-of-life care surrogate decision-makers were either the youngest or near-youngest adult-males within their sibling infrastructure, were an only/remaining child, were the only child capable of managing such decision-making, or whose only other sibling was a female. Younger/near-youngest Participants who had more than one other-sibling undertook the primary decisional role while also sharing some decisional responsibilities with other siblings. This appeared to occur as a result of the primary decision-maker being the most proactively involved decision-maker who respectfully led communication among siblings and delegated also. In families where a male adult-child was actively involved as the primary decision-maker, sisters seemed more likely to fulfil carer roles, including personal care tasks and delegated 'run-around-roles', while male adult-child Participants who performed decisional roles and undertook some carer functions performed less time-consuming/non-personal carer tasks (Horowitz, 1985; Noël-Miller, 2010; Wolf et al., 1997). Participants with greater than one other sibling seemed more likely to share decision-making (Wolf et al.). Only Participants who were near-youngest or youngest in their sibling structure and whose other siblings were comprised of male and female siblings co-resided with a decisionally-reliant family member (P1, P7, P10, P12). These Participants reported being primary decision-makers (P1, P7, P12).

Shared decision-making occurred between male adult-child Participants and siblings when two or more other siblings were present. Siblings who appeared to be least-likely to be involved in decision-making were eldest male or female other-siblings.

This study's findings for sibling conflict (25%) are supported by similar findings in previous research (Checkovich & Stern, 2002; Peisah et al., 2006). General categories of conflict were unfair financial gain (P7/B1/B2) (Peisah et al.), undermining primary decisional role (P1/S2, P7/B2), and sibling rivalry (P1/S2) (Parks et al., 2011; Peisah et al.; Phelps et al., 2009). A cause of serious disturbance occurring (P2) around poor quality of medical support/advice is also supported within the research (Dreyer et al., 2010;

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TABLE 1 – Participant data

Participant	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Age range	40-50	60-70	60-70	50-60	30-40	60-70	70-80	50-60	50-60	50-60	50-60	50-60
Siblings structure	S1	B1	B1	B1	B1	P6	B1	P8	S1	B1	B1	B1
	S2	P2	P3	B2	B2	S1	B2	B1	P9	S1	S1	S1
	S3	S1		S1	P5		P7			S2	P11	P12
	B1			P4		S1				P10		
	B2											
	P1											
	B4											
Decision for	Mum	Mother	Mother	Father	Father	Father	F.I.Law	Mother	Mother	Father	Father	Sister
		Brother	Father			Mother	Mother			Mother		Father
							M.I.Law					Mother
							B.I.Law					
							Father					
Family member experienced cognitive and/ or physical decline	✗/✓	✗/✓	✓/✗	✗/✓	✗/✓	✓/✓	✗/✓	✗/✓	✓/✓	✗/✓	✗/✓	
		✗/✓	✗/✓	✓/✓		✗/✓	✓/✗			✗/✓		
							✓/✗					✗/✓
							✓/✗					✓/✓
							✓/✗					✗/✓
							✗/✓					
Dependant co-resided	✓	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✓
Delegated to Female sibling/s	Yes	No	N/A	No	N/A	Yes	Yes	N/A	Yes	No	No	
Strength of bond with dependent family member	High	High	Moderate	Moderate	Moderate	Low	Moderate	Moderate	Moderate	Moderate	High	Moderate
		High					Moderate					
							Moderate					
							Moderate					
							Moderate					
Sibling conflict	Severe	✗	N/A	✗	Moderate	S1	Moderate	N/A	Mild	✗	✗	✗
Decisional Role	Primary & Shared	Shared	Primary	Shared	Shared	Primary	Primary & Shared	Primary	Primary	Shared	Primary	Primary
Female sibling carer	✓	✓	n/a	✓	n/a	✓	✓	n/a	✓	✓	✓	n/a
Undertook carer role	✓	✗	✗	✗	✗	✗	✓	✗	✗	✓	✗	✓
Religiousness	Spiritual	Spiritual	Religious	Spiritual	Religious at that time	Non-religious	Spiritual	Spiritual	Spiritual	Spiritual	Spiritual	Spiritual
Following wishes important	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
Decisional Guilt	Significant	Significant	Moderate	Moderate	Moderate	Low	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate
Fully literate	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

Khodyakov & Carr, 2009; Lang & Quill, 2004; Nolan et al., 2005; Sahlberg-Blom et al., 2000; Weiner and Roth, 2006). In this study, sibling conflict primarily originated from older, least-active siblings towards the younger, primary decisional Participant who willingly shared decisional opportunities among other siblings.

Living proximity to dependent family members did not prevent decisional participation. Participants (66%) whose demographic status varied during their decisional care (P1, P3, P4, P5, P6, P7, P10, P12) maintained involvement. In particular, 42% of Participants (P1, P4, P6, P10, and P12) actively travelled between states and from overseas as required to contribute to both care and decisional processes, demonstrating that demographics affected ease of, but did not prevent, decisional role function.

All Participants exhibited considerable bond strength, regardless of perceived bond strength, through depth of investment in ensuring that dependent members received best-possible decisional care. This appears to be inter-linked with all Participants' expressed intention to make decisions compliant with the dependents' wishes, including P6 who only for extenuating circumstances based decisions on need for safety and care provision. Decisional guilt appeared to be co-associated with bond strength and the ability for known wishes to be fulfilled. Post-death grief appeared to be greatest among those Participants who reported being very close with a decisionally-dependent relative, and whose ability to fulfil the relatives known wishes to the best of their ability had been impeded either through the actions of another sibling perceived to be less-genuinely invested (conflict) or as a result of pressure-based, sub-quality medical advice. Neither the decision-makers religious perspective nor the nature of the dependent persons decline were reported influences on the nature of Participants' decisional role.

All Participants in this study were high-functioning adults, being technologically (computer- and mobile-) literate, educated, working/retired, and having own families. This contradicts the stereotype of male adult-children as being non-participants in end-of-life care decision-making for reasons such as being pre-occupied with working schedules, lacking nurturing capacities, being of limited technical, literacy, and/or educational abilities, and/or for being potentially low-functioning adults co-dependent on decisionally-dependent relatives. Participants in this study reported being highly motivated to configure personal/family and work schedules to allow dedicated time for decisional involvement.

This study was generated out of curiosity relating to the 7:1 ratio of female adult-child Participants (86%) to male adult-child Participants (13%) via online survey participation used in research by Lovell et al. (2013). As a secondary area of investigation, it considered the possibility that male adult-child disinterest in online survey participation may contribute to differences in male:female Participant ratios in adult-child research. When asked whether they were inclined to participate in online surveys, and why they chose to participate in this study, all Participants in this study expressed disinterest in voluntarily online survey participation. Reasons given for participating in this study included pressure from female spouses/associates who had seen advertising seeking Participants, relevance and meaningfulness of the topic, the personal interview component, and recognition of the associations between personal interest in the topic, the anticipated importance to the wider community, and a wish to discuss the pressures within their experiences.

Conclusion

This study's findings suggest that adult-male child participation in end-of-life care decision-making may be greater than it has been assumed to be, with depth of emotional- and time-investment in performing decisional roles being notable.

Male adult-children's position within their sibling infrastructure and sibling gender (as applicable) appear to influence their participation and type of decisional role that they will undertake (primary, shared, or both), and whether they are more likely to undertake co-residency and/or task-oriented carer roles for their dependent family member. Sibling un/availability, sibling conflict, and quality of medical advice appear to influence decisional outcomes, and subsequent guilt/stress experienced by primary male adult-child decision-makers.

The consensus among this study's Participants that online research participation is of less interest to them than one-on-one interviews may reflect a gender-based difference in participant behaviour.

This study was limited by the small participant base (n = 12), subjectivity, and by its non-culturally diverse outcomes. Future research may contribute to greater knowledge regarding male adult-child end-of-life care decision-makers and their needs within this circumstantially complex situation.

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Dr Ann Moir-Bussy is Senior Lecturer and Program Leader in Counselling at the University of the Sunshine Coast and worked closely with Trish as Supervisor of her research project.

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Understanding loss: A guide for caring for those facing adversity

Review by Jude Boyland

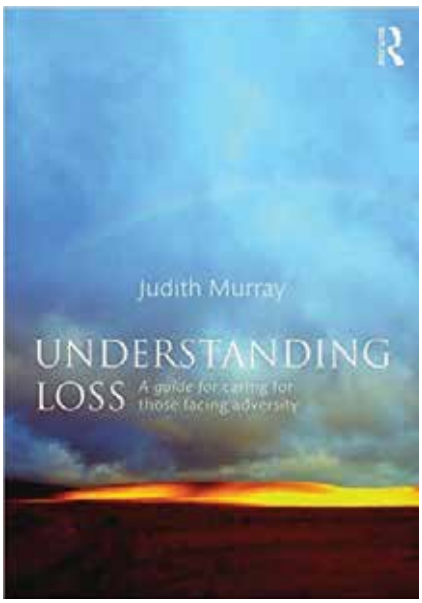
I deem it to be an honour and a privilege to be asked to write a review of this book authored by Associate Professor Judith Murray. Dr Murray's career path has seen her holding positions in secondary school teaching, psychology and nursing. Currently, Dr Murray is Associate Professor in Counselling and Counselling Psychology in the School of Psychology and the School of Nursing, Midwifery and Social Work at the University of Queensland. Dr Murray also holds a part-time position as a Registered Nurse in Haematology and Oncology at the Princess Alexander Hospital in Brisbane where, in the early 2000s, she headed a Loss and Grief Unit. It was during these years that I met, worked with and studied under the guidance of Dr Murray.

Understanding loss: A guide for caring for those facing adversity is compiled in three parts. Part 1, **Introduction**, addresses two key concepts – 'finding a place for a psychology of loss' and 'respect'. Part 2, **Understanding**, addresses six key concepts – 'grief and grieving'; 'making the picture of grieving three dimensional'; 'loss amongst loss'; 'the integration of loss'; 'the individuality of loss' and 'taking our knowledge into practice'. Part 3 draws all the threads together in a context of **Enablement: taking our understanding into practice** and addresses four key concepts – 'moving into practice: safety is the key'; 'let's move to enablement': 'thinking more formally about care: principles to guide care' and 'thinking about enablement using the *Ten Questions of Loss framework*'.

Each chapter addresses the focussed concept in a logical progression of information that is easy to read and free of jargon. Each chapter concludes with a chapter summary. Figures and tables are interspersed throughout the text and provide opportunity for the reader to reflect, summarise and consolidate what has been read.

It is in Chapter eight – Taking our knowledge into practice – that Dr Murray makes initial reference to concepts developed by her in the early 2000s and first published in 2005. Since their inception into the language of loss and grieving, these concepts have underpinned any work I have done that embraces life transitions. They are embodied in the notions of the world 'that was', the world 'that is', 'roads to healing' and barriers that might be presenting as 'blocks to healing'. These key concepts are subsequently addressed in a variety of ways throughout Part 3 of the reader's journey into *Understanding loss: A guide for caring for those facing adversity* – Enablement: taking our understanding into practice.

It is also in Chapter eight – Taking our knowledge into practice – that the *Ten Questions of Loss* are introduced. As Dr Murray notes, when considering how to take our understanding into practice, it is helpful to have a framework that can be used in a practical way, irrespective of the level of care, as we listen to the stories of those who are confronted with the experience of loss. Dr Murray also notes that while she has organised the information in the form of questions to consider, this does not mean that our discussions with the person affected by loss should occur using a strict question-answer format. Rather, the *Ten Questions of Loss* simply reflect the science of loss and give direction for discussion. As Dr Murray explains, "they provide a framework for hearing the story of loss, not a mechanism to gain a diagnosis" (p. 138).



Understanding loss: A guide for caring for those facing adversity is a must have for any clinician working in the field of loss and grieving and is available on line through some of the most popular suppliers, both local and international.

Jude R Boyland

(Clinical Counsellor, Professional Supervisor, Behaviour Consultant, Life Coach)

(PhD Candidate, Master Education, Diploma Professional Counselling, Certification Professional Supervision, Certification Choice Theory Reality Therapy, Certification Solution-Oriented Hypnotherapy)

Murray, J. (2016). *Understanding loss: A guide for caring for those facing adversity.* New York. NY: Routledge.

***Available at https://www.openleaves.com.au* Price: $68.00**

Neuropsychotherapy: Theoretical underpinnings and clinical applications.

Rossouw, P. J. (Ed). (2014). St Lucia, QLD: Mediros PtyLtd. Review by Jude Boyland

In the preface of Neuropsychotherapy: Theoretical underpinnings and clinical applications, Dr Rossouw describes his work as being "the culmination of a significant interest in and a passion for engaging with people suffering from a range of mental challenges" (p. i). The foreword of Neuropsychotherapy: Theoretical underpinnings and clinical applications is written by Associate Professor, Dr Judith Murray, who acknowledges "the interactive approach to the psychosocial care of others" (p. v) espoused in the multiple papers presented in Dr Rossouw's book. Dr Murray also acknowledges the overarching theme that recognises the power of the human mind to heal and to grow, within the sanctuary of a safe and supportive therapeutic environment.

The structure of Neuropsychotherapy: Theoretical underpinnings and clinical applications comprises two sections. The papers in section A address theoretical underpinnings and the papers in section B address clinical applications.

In section A, Dr Rossouw presents three papers that trace the initial development towards a theory of brain-based therapy, followed by further development towards a refined perspective and culminating in the presentation of an integrated theoretical model.

In section B, the reader is taken on a therapeutic journey through minds that are dealing with a diverse array of human challenges. There is the adolescent and the young woman, each presenting with a social anxiety disorder and there is the young woman with a fear of abandonment. There is the anxious and psychologically abused athlete, the woman with anorexia nervosa and the women and men with post-traumatic stress disorder. Contextual scenarios embrace bullying in the playground, bullying in the workplace, panic disorder and separation anxiety in children.

Therapeutic approaches are also diverse and are eclectic in their focus on the individuality of the challenge confronting each human being and each human mind.

From the perspective of a practising clinician and a professional supervisor, I highly recommend Neuropsychotherapy: Theoretical underpinnings and clinical applications as a worthwhile addition to any clinician's professional library.

Neuropsychotherapy: Theoretical underpinnings and clinical applications is available on line through some of the most popular suppliers, both local and international.

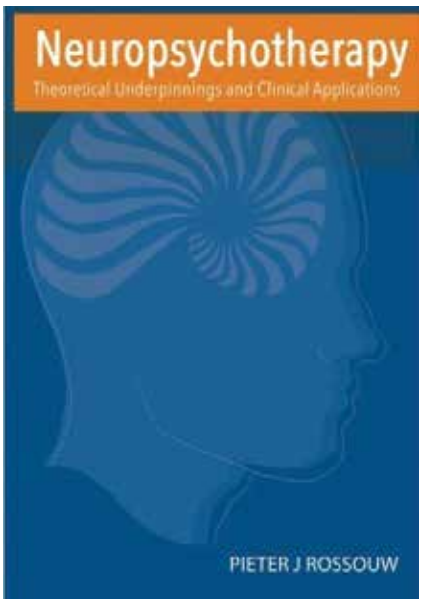
Jude R Boyland

(Clinical Counsellor, Professional Supervisor, Behaviour Consultant, Life Coach)

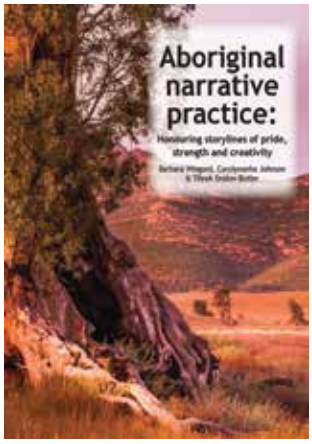
(PhD Candidate, Master Education, Diploma Professional Counselling, Certification Professional Supervision, Certification Choice Theory Reality Therapy, Certification Solution-Oriented Hypnotherapy)

Neuropsychotherapy: Theoretical Underpinnings and Clinical Applications By Pieter J Rossouw

Available at: http://www.mediros.com.au/ Price: $55.00



Aboriginal Narrative Practise: Honouring storylines of pride, strength and creativity



For those of you that are intrigued by the concept of Narrative Therapy, this is a fantastic book to educate and illuminate indigenous issues, and how best to appropriately face them with clients. This book shares different instances in which creative interventions by Aboriginal narrative therapists were most effective & the common goals that clients will strive towards. This book gives a clear and concise definition of Narrative Therapy and the approaches that it takes on; highlighting that each individual is the expert in their own life. Within this book, there is a distinct delineation from western bio-medical approaches to mental health & significant input from Aboriginal Elders. The topics covered include historical context, lateral violence, political practise, re-membering, sex, the aboriginal intervention and linking communities. This book is a great resource that can be used in a number of ways, and allows the reader a greater understanding of how to be a therapeutic support by using Narrative Therapy.

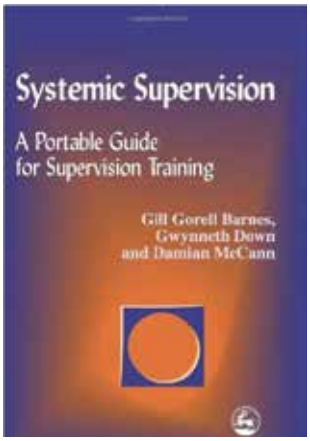
If you are interested, the book can be purchased from the Narrative Therapy Library (http://www.narrativetherapylibrary.com/) in conjunction with The Dulwich Centre.

***Aboriginal narrative practice: Honouring storylines of price, strength and creativity* By Barbara Wingard, Carolynanha Johnson and Tileah Drahm-Butler**

Available at: www.narrativetherapylibrary.com
Price: $27.50

Systemic Supervision: A Portable Guide for Supervision Training

Review by Catherine Dodemont



Systemic Supervision is a publication from the United Kingdom that evaluates the practical and theoretical issues in implementing and upholding professional supervision for Family Therapy in training and workplace arenas under the professional guidelines of The Association of Family Therapy, United Kingdom.

The text examines supervision within family therapy settings including theoretical and practical implications by respected consultants, professional therapists and supervisors in the field of family Therapy. Valuable insights into how research and practice in family therapy have developed through the decades are also included.

Key areas discussed in the supervisory relationship include important topics for the therapist and supervisor such as power, gender, ethnicity and sexuality issues and ethical and moral dilemmas that may be overtly or covertly present.

Although Systemic Supervision is based on United Kingdom professional family therapy training guidelines, the issues that are raised in the supervisory relationship are very much relevant to all therapists and supervisors.

Catherine Dodemont. Master Counselling, Bachelor Social Science, Member College of Clinical Counsellors (ACA Inc), Member College Professional Counsellors (ACA Inc).

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Systemic Supervision: A Portable Guide for Supervision Training (2009) By Gill Gorell Barnes, Gwynneth Down and Damian McCannJessica Kingsley Publishers London and Philadelphia

Available at: www.amazon.com
Price: Kindle $28.94 Paperback $36.95

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Brenda Searle	CANBERRA REGION	0406 376 302	$100 to $130	FTF/PH/GRP/WEB
Mijin Seo - Kim	DOWNER	02 6255 4597	Upon Enquiry	FTF
NEW SOUTH WALES				
Elizabeth Allmand	QUEANBEYAN	0488 363 129	$120	FTF/WEB/PH
Penny Bell	CUMBI UMBI	0416 043 884	Upon Enquiry	FTF/GRP/PH/WEB
Sandra Bowden	BATEAU BAY/ CENTRAL COAST	0438 291 874	$70	FTF
Patriciah Catley	NARELLAN	02 9606 4390	Upon Enquiry	FTF
Patricia Cheetham	KENSINGTON	1300 552 659	Upon Enquiry	FTF
Michael Morris Cohn	NORTH BONDI	0413 947 582	$120	FTF/GRP/PH/WEB
Leon Cowen	LINDFIELD	02 9415 6500	Upon Enquiry	FTF/GRP/PH/WEB
Lorraine Dailey	MAROOTA	0416 081 882	Upon Enquiry	FTF/PH/GRP/WEB
Karen Daniel	TURRAMURRA	02 9449 7121 or 0403 773 757	$125 1hr; $145 1.5hrs	FTF/WEB
Brian Edwards	FORRESTERS BEACH	0412 912 288	Upon Enquiry	FTF
Aaron Elliott	CARDIFF	0408 615 155	Upon Enquiry (flexible)	FTF/PH/WEB
Linda Elsey	WYEE	02 4359 1976	Upon Enquiry	FTF/GRP/PH/WEB
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David Gotlieb	SYDNEY/BOWRAL	0421 762 236	$40 Grp, $80 Indiv	FTF/PH/GRP/SKYPE
Kim Michelle Hansen	PUTNEY	02 9809 5989 or 0412 606 727	Upon Enquiry	FTF
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Margaret Hutchings	YAMBA GRAFTON	0417 046 562	Upon Enquiry	FTF/PH/GRP/WEB
Vicki Johnston	EASTLAKES	02 9667 4664	Upon Enquiry	FTF
Joy Ruth Kennedy	OAKDALE	0437 571 424	Available upon enquiry	FTF/PH/GRP/WEB
Brian Lamb	NEWCASTLE/ LAKE MACQUARIE	0412 736 240	$120 (contact for sliding scales)	FTF/GRP/PH
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Danny D. Lewis	FORRESTERS BEACH	0412 468 867	Upon Enquiry	FTF
Dr Dawn Macintyre	CLUNES	0417 633 977	Upon Enquiry	FTF/PH/WEB
Moira McCabe	HAMILTON	0416 038 026	Upon Enquiry	FTF
Rod McClure	BONDI JUNCTION	0412 777 303	Upon Enquiry	FTF
Heide McConkey	BONDI JUNCTION	02 9386 5656	Upon Enquiry	FTF
Karen Morris	NEWCASTLE/ HUNTER VALLEY	0417 233 752	$100	FTF/GRP/PH/WEB

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Deborah Rollings	SUTHERLAND	0427 584 554	Upon Enquiry	FTF/PH
Hanna Salib	LUDDENHAM	0401 171 506	Upon Enquiry	FTF
Grahame Smith	SINGLETON	0428 218 808	$66	FTF/GRP/PH/WEB
Kirilly Smitheram	NEWTOWN	0411 550 980	Upon Enquiry	FTF
Carol Stuart	BONDI JUNCTION	0293 877 752	$80 pp - % rate $50 for early graduates	FTF/GRP/PH/WEB
David Edwin Warner	PEAKHURST	0418 283 519	Upon Enquiry	FTF/PH/GRP
Shane Warren	DARLINGHURST	0418 726 880	Upon Enquiry	FTF
David Robert Watkins	ELANORA HEIGHTS	0404 084 706	Upon Enquiry	FTF
Michella Wherrett	LAKE MACQUARIE/ NEWCASTLE	0414 624 513	$80	FTF/PH
Jennifer Blundell	AUSTINMER	0416 291 760	Upon Enquiry	FTF/PH/GRP/WEB
Katrina Christou	NEWTOWN	0412 246 416	Upon Enquiry	FTF
Lyndall Briggs	KINGSGROVE	02 9024 5182	Upon Enquiry	FTF
Josephine Luna	ELDERSLIE	0412 263 088	Upon Enquiry	FTF
NORTHERN TERRITORY				
Margaret Lambert	DARWIN	08 8945 9588 or 0414 459 585	Upon Enquiry	FTF/GRP/PH/WEB
Rian Rombouts	MILLNER	0439 768 648	Upon Enquiry	FTF
QUEENSLAND				
Lynette Baird	MAROOCHYDORE/ SUNSHINE COAST	07 5451 0555	Grp $30 or Indiv $90	FTF/GRP
Laura Banks	BROADBEACH	0431 713 732	Upon Enquiry	FTF
Tanya-Lee M Barich	WONDUNNA	0458 567 861	Upon Enquiry	FTF
Ligia Barnett	EMERALD	0419 954 984	Upon Enquiry	FTF/PH/WEB
Maartje (Boyo) Barter	WAKERLEY	0421 575 446	Upon Enquiry	FTF
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Iain Bowman	ASHGROVE	0402 446 947	Upon Enquiry	FTF/PH/GRP/WEB
Judy Boyland	SPRINGWOOD	0413 358 234	$100	FTF/GRP/PH/WEB
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Erin Annie Delaney	BEENLEIGH	0477 431 173	Upon Enquiry	FTF
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Patricia Fernandes	EMERALD/ SUNSHINE COAST	0421 545 994	$30-$60	FTF/PH
Aisling Fry	LOTA	0412 460 104	Upon Enquiry	FTF
Rev Peter Gee	EASTERN HEIGHTS/ IPSWICH	0403 563 467	$65	FTF/GRP/PH/WEB

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Anne-Marie Houston	BUNDABERG	0467 900 224	Upon Enquiry	FTF
Beverley Howarth	PADDINGTON	0420 403 102	Upon Enquiry	FTF/PH/WEB
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Jodie Logovik	HERVEY BAY	0434 060 877	Upon Enquiry	FTF/PH
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Maggie Maylin	WEST END	0434 575 610	Upon Enquiry	FTF/PH/GRP/WEB
Neil Roger Mellor	PELICAN WATERS	0409 338 427	Upon Enquiry	FTF
Ann Moir-Bussy	SIPPY DOWNS	07 5476 9625 or 0400 474 425	Upon Enquiry	FTF/GRP/PH/WEB
Menny Monahan	KIPPA-RING	0419 750 539	$100.00	FTF/PH/WEB
Judith Morgan	TOOWOOMBA	07 4635 1303 or 0412 372 431	$100	FTF/PH
Diane Newman	BUNDABERG WEST	0410 397 816	Upon Enquiry	FTF/PH
Margaret Newport	SARINA	0414 562 455	On enquiry	FTF/PH/GRP/WEB
Gary Noble	LOGANHOLME DC	0439 909 434	Upon Enquiry	FTF
Steven Josef Novak	BUDERIM	0431 925 771	Upon Enquiry	FTF
Colin Palmer	KALLANGUR	0423 928 955	Upon Enquiry	FTF
Christine Perry	BUNDABERG	0412 604 701	$70	FTF/WEB
Penelope Richards	CHAPEL HILL	0409 284 904	Upon Enquiry	FTF
Natalie Scott	TARRAGINDI	0410 417 527	0410 417 527	FTF
Yildiz Sethi	WAKERLEY	07 3390 8039	Indiv $90, Grp $45	FTF/GRP/PH/WEB
William James Sidney	LOGANHOLME	0411 821 755 or 07 3388 0197	Upon Enquiry	FTF/PH/GRP
Deborah Stevens	KINGAROY	0411 661 098	Upon Enquiry	FTF
Frances Taylor	REDLAND BAY	0415 959 267 or 07 3206 7855	Upon Enquiry	FTF
Pamela Thiel-Paul	BUNDALL/GOLD COAST	0401 205 536	$90	FTF
David Hamilton	BEENLEIGH	07 3807 7355 or 0430 512 060	Indiv $80, Students $60	FTF/PH/GRP/WEB
Christine Castro	ALGESTER	0478 507 991	Upon Enquiry	FTF
Tracey Milson	ARUNDEL	0408 614 062	Upon Enquiry	FTF
Lyn Patman	BROWNS PLAINS	0415 385 064	Upon Enquiry	FTF
Brian Ruhle	URANGAN	0401 602 601	Upon Enquiry	FTF
SOUTH AUSTRALIA				
Leeanne D'arville	SALISBURY DOWNS	0404 476 530	Upon Enquiry	FTF
Richard Hughes	WILLUNGA	0409 282 211	Negotiable	FTF/PH/WEB
Adrienne Jeffries	STONYFELL	08 8332 5407	Upon Enquiry	FTF/PH/WEB

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Pamela Mitchell	WATERFALL GULLY	0418 835 767	Upon Enquiry	FTF
Carol Moore	OLD REYNELLA	08 8297 5111 bus or SMS 0419 859 844	Grp $35, Indiv $99	FTF/PH/GRP/WEB
Laura Wardleworth	ANGASTON	0417 087 696	Upon Enquiry	FTF
Ellen Turner	HACKHAM WEST	0411 556 593	Upon Enquiry	FTF
Kerry Turvey	TANUNDA	0423 329 823	Upon Enquiry	FTF
TASMANIA				
Pauline Mary Enright	SANDY BAY	0409 191 342	85 per session Group on App	FTF/PH/WEB
David Hayden	HOWRAH NORTH	0417 581 699	Upon Enquiry	FTF
Benjamin Donald Turale	HOBART	0409 777 026	Upon Enquiry	FTF/PH/WEB
VICTORIA				
Joanne Ablett	PHILLIP ISLAND/ MELBOURNE METRO	0417 078 792	$120	FTF/GRP/PH/WEB
Danielle Aitken	SOUTH GIPPSLAND/ MELBOURNE METRO	0409 332 052	Upon Enquiry	FTF/GRP/PH/WEB
Anna Atkin	CHETLENHAM	0403 174 390	Upon Enquiry	FTF
Nyrelle Bade	EAST MELBOURNE/ POINT COOK	0402 423 532	Upon Enquiry	FTF/GRP/WEB
Marie Bajada	BALLARAT	0409 954 703	Upon Enquiry	FTF
Judith Beaumont	MORNINGTON	0412 925 700	Upon Enquiry	FTF/PH/GRP/WEB
Zohar Berchik	SOUTH YARRA	0425 851 188	Upon Enquiry	FTF
Kathleen (Kathy) Brennan	NARRE WARREN	0417 038 983	$35 Grp, $60 Indiv	FTF/GRP/PH/WEB
Zoe Broomhead	RINGWOOD	0402 475 333	Upon Enquiry	FTF
Sheryl Brosnan	CARLTON NORTH/ MELBOURNE	03 8319 0975 or 0419 884 793	Upon Enquiry	FTF/GRP/PH/WEB
Sandra Brown	FRANKSTON/ MOUNT ELIZA	03 9787 5494 or 0414 545 218	$90	FTF/GRP/PH/WEB
Molly Carlile	INVERLOCH	0419 579 960	Upon Enquiry	FTF
Lehi Cerna	HALLAM	0423 557 478	Upon Enquiry	FTF/PH/GRP/WEB
Lindy Chaleyer	BRIGHTON EAST	0438 013 414	Upon Enquiry	FTF
Tim Connelly	HEALESVILLE	0418 336 522	Upon Enquiry	FTF
Roselyn (Lyn) Ruth Crooks	BENDIGO	0406 500 410 or 03 4444 2511	$60	FTF
Debra Darbyshire	BERWICK	0437 735 807	Upon Enquiry	FTF
Linda Davis	LEONGATHA/GIPPSLAND	0432 448 503	Upon Enquiry	FTF/PH/GRP/WEB
Patricia Dawson	CARLTON NORTH	0424 515 124	Grp $60 1 1/2 to 2 hrs, Indiv $80	FTF/GRP/PH/WEB
Lisa Derham	CAMBERWELL	0402 759 286	Upon Enquiry	FTF/WEB
Sara Edwards	DINGLEY	0407 774 663	Upon Enquiry	FTF/WEB
Karen Efron	NORTHCOTE	0432 391 887	Upon Enquiry	FTF
Mihajlo Glamcevski	ARDEER	0412 847 228	Upon Enquiry	FTF
Matt Glover	CROYDON HILLS, EAST DONCASTER	0478 651 951	Conc: $70, Full: $90 Group: $30/hour	FTF/PH/GRP/WEB
Maurice Grant-Drew	ELWOOD	0412 331 301	Upon Enquiry	FTF

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Melissa Harte	PAKENHAM SOUTH YARRA	0407 427 172	$132 to $143	FTF
Belinda Hulstrom	WILLIAMSTOWN	04714 331 457	Upon Enquiry	FTF
Beverley Kuster	NARRE WARREN	0488 477 566	Upon Enquiry	FTF
Barbara Matheson	MELBOURNE	03 9703 2920	Upon Enquiry	FTF
Robert McInnes	GLEN WAVERLEY	0408 579 312	Indiv $70, Grp $40 (2 hours)	FTF
Marguerite Middling	NORTH BALARAT	0438 744 217	Upon Enquiry	FTF
Paul Montalto	THORNBURY	0415 315 431	Upon Enquiry	FTF
Andrew Reay	MOORABBIN	0433 273 799	Upon Enquiry	FTF
Patricia Reilly	MOUNT MARTHA/ GARDENVALE	0401 963 099	Upon Enquiry	FTF
Lynne Rolfe	BERWICK	03 9768 9902	Upon Enquiry	FTF
Claire Sargent	CANTERBURY	0409 438 514	Upon Enquiry	FTF
Kenneth Robert Scott	BUNYIP	03 5629 5775	Upon Enquiry	FTF
Karen Seinor	WODONGA	0409 777 116	Upon Enquiry	FTF
Gabrielle Skelsey	ELSTERNWICK	03 9018 9356	Upon Enquiry	FTF/PH/WEB
Cheryl Taylor	PORT MELBOURNE	0421 261 050	Upon Enquiry	FTF
Suzanne Vidler	NEWPORT	0411 576 573	$110	FTF/PH
Helen Wayland	ST KILDA	0412 443 899	$75 Indiv	FTF/PH/GRP/WEB
Natalie Wild	BORONIA	0415 544 325	Upon Enquiry	FTF
Cas Willow	WILLIAMSTOWN	03 9397 0010 or 0428 655 270	Upon Enquiry	FTF/PH/WEB/GRP
Rosslyn Wilson	KNOXFIELD	03 9763 0772 or 03 9763 0033	Grp $50 pr hr, Indiv $80	FTF/GRP/PH/WEB
Jacquie Wise	ALBERT PARK	03 9690 8159	Upon Enquiry	FTF
Michael Woolsey	SEAFORD/FRANKSTON	0419 545 260 or 03 9786 8006	Upon Enquiry	FTF
Joan Wray	(MOBILE SERVICE)	0418 574 098	Upon Enquiry	FTF
Sheryl Judith Brett	GLEN WAVERLEY	0421 559 412	Upon Enquiry	FTF
Brian Johnson	NEERIM SOUTH	0418 946 604	Upon Enquiry	FTF
Snezana Klimovski	THOMASTOWN	0402 697 450	Upon Enquiry	FTF
Robert Lower	BEVERIDGE	0425 738 093	Upon Enquiry	FTF
John Dunn	COLAC SW AREA/ MT GAMBIER	03 5232 2918	By Negotiation	FTF/GRP/WEB
Deborah Cameron	BRIGHTON/HONG KONG	0447 262 130	Upon Enquiry	FTF/GRP/WEB
WESTERN AUSTRALIA				
Genevieve Armson	CARLISLE	0412 292 999	Upon Enquiry	FTF
Sharon Vivian Blake	FREMANTLE	0424 951 670	Indiv $100, Grp $60	FTF/PH/GRP/WEB
Marie-Josee Boulianne	BEACONSFIELD	0407 315 240	Upon Enquiry	FTF
Lynette Cannon	CAREY PARK	0429 876 525	Upon Enquiry	FTF
Karen Heather Civello	BRIDGETOWN	0419 493 649	Upon Enquiry	FTF
Cindy Cranswick	FREMANTLE	0408 656 300	Upon Enquiry	FTF
Alan Furlong	WINTHROP	0457 324 464	Upon Enquiry	FTF

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Merrilyn Hughes	CANNING VALE	08 9256 3663	Upon Enquiry	FTF/PH/GRP/WEB
Eva Lenz	SOUTH FREMANTLE/ COOGEE	08 9418 1439 or 0409 405 585	$85, concession $70	FTF/PH/GRP/WEB
Salome Mbenjele	TAPPING	0450 103 282	Upon Enquiry	FTF/PH/WEB
Carolyn Midwood	DUNCRAIG	08 9448 3210	Indiv $110, Grp $55	FTF/GRO/PH/WEB
Dr. Patricia Sherwood	PERTH/BUNBURY	0417 977 085 or 08 9731 5022	$120	FTF/PH/WEB
Phillipa Spibey	MUNDIJONG	0419 040 350	Upon Enquiry	FTF
David Peter Wall	MUNDARING	0417 939 784	Upon Enquiry	FTF
Lillian Wolfinger	YOKINE	08 9345 0387 or 0401 555 140	Upon Enquiry	FTF/PH/WEB
John Dallimore	FREMANTLE	0437 087 119	Upon Enquiry	FTF
INTERNATIONAL				
Deborah Cameron		+852 6779 8957	Upon Enquiry	FTF/GRP/WEB
Dina Chamberlain		+852 6028 9303	Upon Enquiry	FTF
Fiona Man Yan Chang		+852 9198 4363	Upon Enquiry	FTF
Pui Kuen Chang		+852 9142 3543	Upon Enquiry	FTF
Polina Cheng		+852 9760 8132	Upon Enquiry	FTF
Viviana Cheng		+852 9156 1810	Upon Enquiry	FTF
Eugnice Yiu Sum Chiu		+852 2116 3733	Upon Enquiry	FTF
Wing Wah Hui		+852 6028 5833	Upon Enquiry	FTF
Cary Hung		+852 2176 1451	Upon Enquiry	FTF
Giovanni Ka Wong Lam		+852 9200 0075	Upon Enquiry	FTF
Frank King Wai Leung		+852 3762 2255	Upon Enquiry	FTF
Lap Kwan Tse		+852 9089 3089	Upon Enquiry	FTF
Barbara Whitehead		+852 2813 4540	Upon Enquiry	FTF
Yat Chor Wun		+852 264 35347	Upon Enquiry	FTF
Eugene Chong		+65 6397 1547	Upon Enquiry	FTF
David Kan Kum Fatt		+65 9770 3568	Upon Enquiry	FTF
Gan Su Keng		+65 6289 6679	Upon Enquiry	FTF
Jeffrey Gim Tee Po		+65 9618 8153	$100.00	FTF/GRP/PH/WEB
Saik Hoong Tham		+65 8567 0508	Upon Enquiry	FTF

2016 Trauma Education

presented by
Dr Leah Giarratano

Leah is a Sydney based doctoral-level clinical psychologist with 20 years of clinical and teaching expertise in CBT and traumatology

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These workshops are endorsed by the, AASW, ACA and ACMHN

Clinical skills for treating posttraumatic stress disorder (Treating PTSD)

This two-day (8:30am-4:30pm) program presents a highly practical and interactive workshop (case-based) for treating traumatised clients; the content is applicable to both adult and adolescent populations. The techniques are cognitive behavioural, evidence-based, and will be immediately useful and effective for your clinical practice. The emphasis is upon imparting immediately practical skills and up-to-date research in this area.

12-13 May 2016, Brisbane CBD
19-20 May 2016, Melbourne CBD
26-27 May 2016, Sydney CBD
2-3 June 2016, Cairns CBD
9-10 June 2016, Perth CBD
16-17 June 2016, Adelaide CBD
23-24 June 2016, Auckland CBD

Clinical skills for treating complex traumatisation (Treating Complex Trauma)

This two-day (8:30am-4:30pm) program focuses upon phase-based treatment for adult survivors of child abuse and neglect. In order to attend, participants must have first completed the 'Treating PTSD' program. This workshop completes Leah's four-day trauma-focused training. The content is applicable to both adult and adolescent populations. The program incorporates practical, current experiential techniques showing promising results with this population; techniques are drawn from EFTT, Metacognitive Therapy, Schema Therapy, attachment pathology treatment, ACT, CBT, and DBT.

10-11 March 2016 Singapore CBD*
7-8 July 2016, Brisbane CBD
14-15 July 2016, Melbourne CBD
21-22 July 2016, Sydney CBD
28-29 July 2016, Perth CBD
4-5 August 2016, Adelaide CBD
11-12 August 2016, Auckland CBD

Program fee for each activity

* You need to be registered by 31/12/15 to attend Singapore otherwise it will be cancelled

Early Bird $690 or $600 each if you register to both (or with a colleague) more than three months prior using this form

Normal Fee $780 or $690 each if you register to both (or with a colleague) less than three months prior using this form

Program fee includes GST, program materials, lunches, morning and afternoon teas on both workshop days

For more details about these offerings and books by Leah Giarratano refer to www.talominbooks.com

Please direct your enquiries to Joshua George on **mail@talominbooks.com**

2016 Trauma Education Registration Form for ACA

Please circle the workshop/s you wish to attend above and return a copy of this completed page or register at our website

Name:			
Address:			
Phone:		Email (*essential*):	
Mobile:		Special dietary requirements:	
Method of payment (circle one)	Visa	MasterCard	Electronic Funds Transfer (EFT)
Name of cardholder:			Expiry Date:
Card Number:			Card Verification Number:
Signature of card holder:			Debit amount: $

EFT or credit card payment is preferred. Simply complete the information above, scan and email this page mail@talominbooks.com

A receipt will be emailed to you upon processing. Note: Attendee withdrawals and transfers attract a processing fee of $55.

No withdrawals are permitted in the seven days prior to the workshop; however positions are transferable to anyone you nominate.

WANT TO BE PUBLISHED?

Submitting your articles to *Counselling Australia*

About *Counselling Australia*

Why submit to *Counselling Australia*? To get publishing points on the board!

Being published is part of most career advancements for professional counsellors and psychotherapists, particularly those who wish to advance in academia.

All peer reviewed articles are eligible for OPD points and publishers can claim on their CVs to have been formally published. *Counselling Australia,* a peer reviewed professional journal that is registered and indexed with the National Library (ISSN 1445-5285), is now calling for articles and papers for publication.

Counselling Australia is designed to inform and discuss relevant industry issues for practicing counsellors, students and members of the Australian Counselling Association. It has an editorial board of experienced practitioners, trainers and specialists. Articles are invited to be peer reviewed and refereed or assessed for appropriateness by the editor for publishing. Non-editorial staff may assess articles if the subject is of a nature as to require a specialist's opinion.

The quarterly journal is published every March, June, September and December.

Editorial policy

Counselling Australia is committed to valuing the different theories and practices of counsellors. We hope to encourage readers to submit articles and papers to encourage discussion and debate within the industry. Through their contributions, we hope to give contributors an opportunity to be published, to foster Australian content and to provide information to readers that will help them to improve their own professional development and practice. We wish to promote to readers the Australian Counselling Association and its commitment to raising the professional profile and status of counsellors in Australia.

Previously published articles

Articles that have been previously published can be submitted as long as permission for reprint accompanies the article.

Articles for peer review (refereed)

- Articles are to be submitted in MS Word format via email.
- Articles are to be single-spaced and with minimal formatting.
- Articles must be submitted with a covering page requesting a peer review.
- Attach a separate page noting your name experience, qualifications and contact details.
- The body of the paper must not identify the author.
- Articles are to contain between 1500 and 5000 words in length.
- Two assessors, who will advise the editor on the appropriateness of the article for publication, will read refereed articles.
- Articles may be returned for rewording or clarification and correcting prior to being accepted.

Conditions

- References are required to support both arguments and personal opinions and should be listed alphabetically.
- Case studies must have a signed agreement by the client attached to the article for permission for publication.
- Clients must not be identifiable in the article.
- The author must seek permission to quote from, or reproduce, copyright material from other sources and acknowledge this in the article.
- All articles are subject to our editing process and all authors will be advised of any necessary changes and sent a copy prior to the proofing of the journal for publication.
- Authors are to notify the editor if their article has been published prior to submission to *Counselling Australia*.
- Only original articles that have not been published elsewhere will be peer reviewed.
- *Counselling Australia* accepts no responsibility for the content of articles, manuscripts, photographs, artwork, or illustrations for unsolicited articles.

Deadline

Deadline for articles and reviewed articles is the 7th of February, May, August and November. The sooner articles and papers are submitted, the more likely they are to be published in the next cycle.

ACA Recognised PROFESSIONAL DEVELOPMENT

SPECIALTY COURSES (Continued.)

Case Studies in Narcissism

Over this course you will have the opportunity to explore the NPD cases of a man, a woman, and a couple. You will be able to see the symptoms "in action" in the case study subjects' lives, and the huge impact the disorder has had on significant others in their lives.

Fostering Resilience in Clients

The purpose of this course is to help you enhance the emotional resilience of your clients. To do that, you will want to understand what resilience is and which skills or responses to circumstances tend to increase it.

Principles of Psychosynthesis

The purpose of this course is to acquaint you with the basic principles of Psychosynthesis: its assumptions, core constructs, and understandings about what makes a being human, and what, therefore, may be the best means of facilitating that being's growth toward its fullest potentials.

Understanding Will

Will is a central concept in the psychology of Psychosynthesis founder, Roberto Assagioli, who described will as operative on personal, transpersonal, and universal levels. This course is particularly oriented to those in the helping professions who may be seeing clients in the throes of transformational and other crises

Overview of the Principal Personality Tests

This course aims to give you an overview of the most common personality test types used today, the applications of their usage, and a sample of the types of questions they ask. The discussion of each test includes a short section outlining some of the major criticisms or limitations of the test.

Plus many, many more!

WORKSHOP VIDEOS (Continued.)

Play Therapy: Basics for Beginning Students

This video is the place to begin instruction in play therapy - it is upbeat and entertaining with great visuals, but also includes the critical basics for students with many live demonstrations. The presenter uses puppets to help communicate the rationale, principles, and basic skills of play therapy. Each skill is demonstrated through video clips of play therapy sessions with culturally diverse children.

Brief Counseling: The Basic Skills

In this video John Littrell (Colorado State University) shows how to teach brief counselling from a microskills framework. You will learn how to search out positives and solutions early in the session; how to structure a five-stage brief interview; how to ask questions that make a difference; and how to manage difficult clients.

Attachment and the Therapeutic Relationship

When a child is referred for therapy it is common to discover that the child has experienced disruption to a significant attachment relationship which has impacted that child in serious ways. This presentation draws upon a number of actual cases, and shows experiential techniques to explore the topic.

Using Undercover Teams to Re-story Bullying

This workshop uses real-life stories to describe how the school counsellor uses the Undercover Team Approach in a strategic way to disrupt a story of bullying relations in a secondary school classroom and rewrite an alternative story of support for the victim.

Plus many, many more!

Learn more and join MHA today:

www.mentalhealthacademy.com.au/aca

mental health academy