COUNSELLING AUSTRALIA JOURNAL

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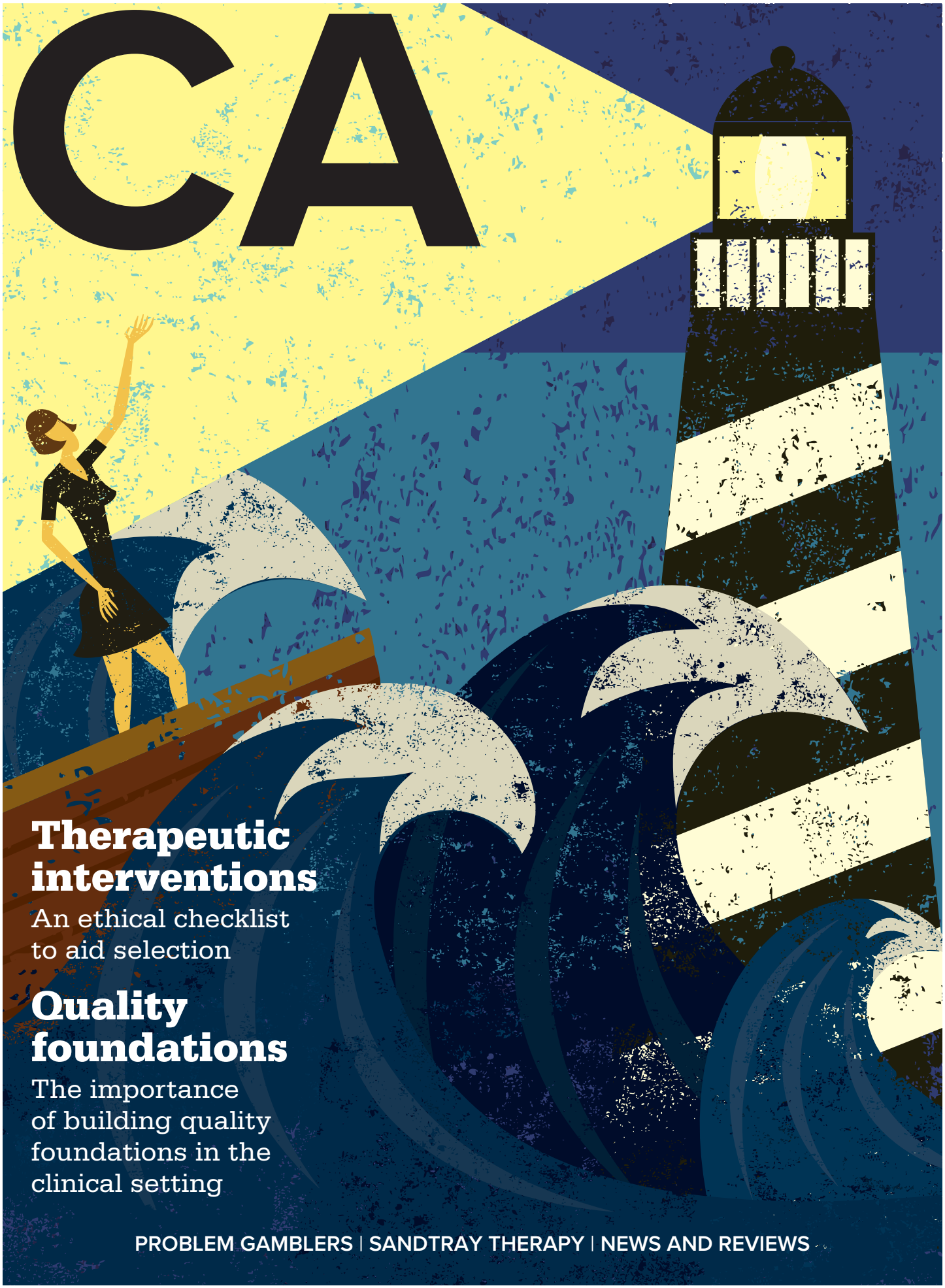

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Quality foundations

The importance of building quality foundations in the clinical setting

PROBLEM GAMBLERS | SANDTRAY THERAPY | NEWS AND REVIEWS

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Letters to the editor should be clearly marked and be a maximum of 250 words. Submissions and letters may be addressed to:
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See page 63 for peer-reviewed article submission guidelines.

Editorial

Welcome to the winter edition of your *Counselling Australia* journal, which has undergone a design and content makeover; subtle, but still exciting because it reflects the keen interest and support shown by members.

It is in response to last year's member survey that we have given the journal a lighter, more contemporary feel, and taken on board the suggestions and ideas on topics of professional interest to members.

There has also been an enthusiastic response by members keen to contribute articles and this marries with our efforts to enliven the whole journal with more 'grass roots' writing to complement the crucial reporting of research and academic studies.

An example in this edition is St Kilda counsellor Helen Wayland's article on some of the practicalities of client interaction and the influence of a training session with co-founder of the International Centre for Clinical Excellence, Scott Miller on her approach to therapy and client relationships after. Similarly, Dr Judith Boyland draws on the wisdom of noted American psychiatrist, Milton Erickson, to elucidate "tips for successful sessions".

And on a subject close to home for many in all walks of life, we report on the research into online engagement and internet safety from Dr Ebinepre Cocodia of the University of Notre Dame in Sydney. These are forefront issues today for children and young people and Dr Cocodia's paper explores current safety themes associated with young people's internet experiences and the propensity for psychological distress and risky behaviour.

Looking ahead, topics that members have raised as subjects they are keen to see explored in this journal include: working with children and counselling in schools, member/supervisor profiles, coaching articles, couple and family therapy, and every day issues in the counselling room such as tiredness, pressures and business management.

In fact, practical advice and case studies on how to establish a successful counselling practice was a popular request. A 'tools' page offering specific strategies for common or uncommon situations has also been suggested.

The survey revealed a high level of professional engagement among members, which the Counselling Australia journal editors are keen to support. We are anticipating already a rich trove of insightful, instructive and generally fascinating reading in the many editions to come.

Philip Armstrong
Co-editor

UPCOMING EVENTS

6th Asia Pacific Rim Confederation of Counsellors Conference

27–29 September 2019, Brisbane

Join top academics, practitioners and speakers from around the world to share their work through presentations, workshops and research papers. This year's Conference Theme: Insight and Learnings from around the Pacific Rim; meeting your community's mental health needs. For full details, visit: **www.theaca.net.au/conference-2019/index.php**.

Healthworks 2019 Calendar of Health Awareness Events

The Healthworks 2019 Calendar of Health Awareness Events gives you hundreds of ideas to inject fresh energy and enthusiasm into your wellness program. Healthworks gathered every published health day, week and month that they could find, to give the most relevant and useful health-related events in Australia in 2019, including Stress Down Day and Mental Health Week. To find out more information and access free resources, visit: **www.healthworks.com.au/2019-calendar-health-awareness/**.

Supervisors Register

The ACA College of Supervisors Register has grown significantly and as such needs to be made more accessible for those looking for a Supervisor. By placing the register on the ACA webpage members and non-members will be able to access the register and find an ACA-registered supervisor. ACA have moved the register from the *Counselling Australia* journal to the 'Publications and Resources' page on the ACA website. The register of supervisors will be refreshed and uploaded monthly onto the ACA website under the tab, 'Publications and Resources', 'Download Documents', 'Supervision'. A tab has been placed on the homepage to ensure the register can easily be found by all.

Executive summary

Taken from the Australian Register of Counsellors and Psychotherapists Productivity Commission Submission, April 2019

Our submission aims to provide the Commission with relevant information based on research and evidence. We discuss outcomes being achieved, what works and what doesn't, identify gaps and strengths in current mental health services, provide suggested strategies for improvement, and discuss whether taxpayers are receiving value for money on investment in mental health services.

Our key recommendation relates to the utilisation of Registered Counsellors and Psychotherapists, and how such utilisation will strengthen the mental health system through the delivery of cost-effective, accountable, efficacious mental health services.

We propose that providing Registered Counsellors and Psychotherapists access to the Medicare Benefits Scheme (MBS) through the Better Access Initiative (BAI) will reduce expenditure for mental health services while simultaneously improving the quality of service delivered. Inclusion would also contribute to resolving workforce shortages and waiting times, issues which are presently costing consumers and the nation significantly.

We provide an overview of the counselling and psychotherapy industry; research literature on the efficacy of counselling and psychotherapy services; and the cost-effective nature of counselling and psychotherapy within the broader context of mental health services. In doing so, we have established the proposition that Registered Counsellors and Psychotherapists can be included in government programs with no reduction in the quality of service; no increase in the risk of harm; rigorous practitioner accountability; whilst delivering substantial budgetary savings.

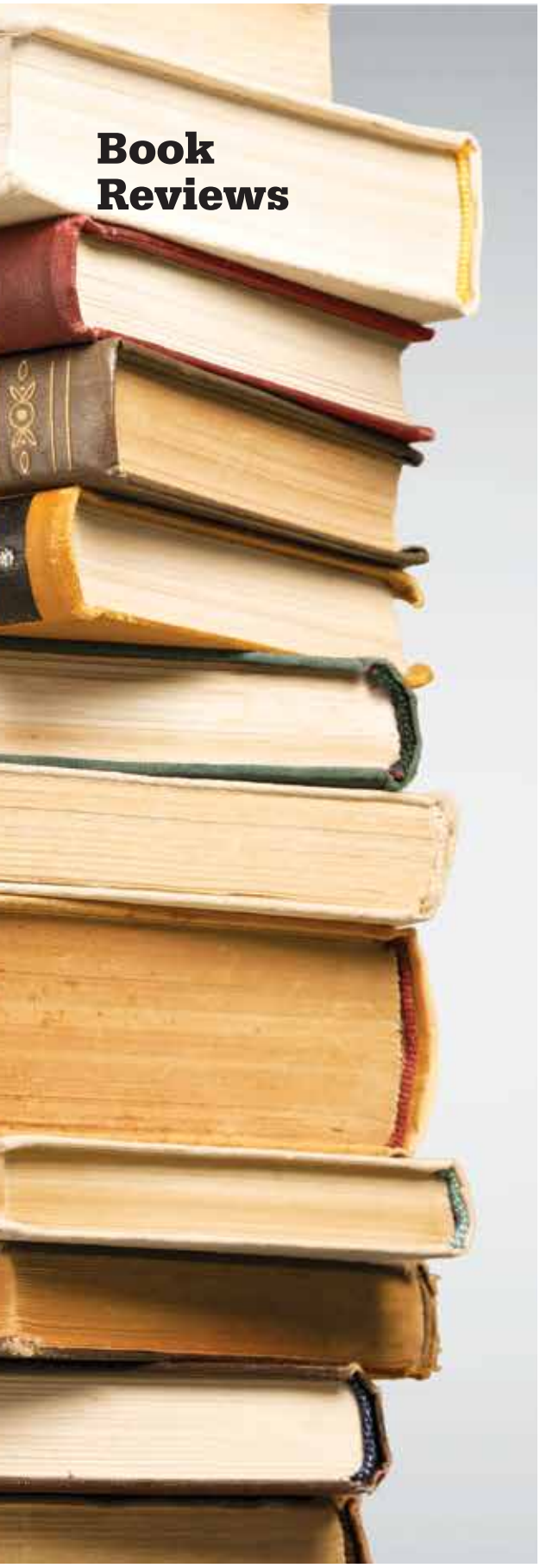
Currently, Registered Counsellors and Psychotherapists meet the needs of consumers of mental health services by providing a range of evidence-based psychological strategies. Registered Counsellors and Psychotherapists can work seamlessly in existing mental health services within MBS, NDIS, NGOs, hospitals and the wider health system.

They currently deliver psychological therapies in multidisciplinary teams within a range of settings, including state-based work cover programs and Employee Assistance Programs.

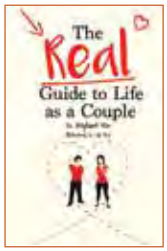
Registered Counsellors and Psychotherapists present the opportunity for cost-savings, a bolstered workforce to increase access to treatment for people that have mild or moderate mental illness and disadvantaged groups, but counsellors and psychotherapists are currently under-utilised in the health system.

In a stepped model of care, counsellors and psychotherapists can provide a range of evidence-based psychological strategies, and bolster support in the existing teamwork approaches to client management shared between GPs, psychologists, psychiatrists and other allied health practitioners. There is opportunity to achieve social and economic productivity gains and improving consumer choice by maximising the available workforce potential of Registered Counsellors and Psychotherapists.

Our key recommendation relates to the utilisation of Registered Counsellors and Psychotherapists, and how such utilisation will strengthen the mental health system through the delivery of cost-effective, accountable, efficacious mental health services.



Book Reviews



The real guide to life as a couple
By Dr Stephanie Azri
Review by Lyn Baird

The real guide to life as a couple by Dr Stephanie Azri is an easy-to-read, down-to-earth and very practical book for clients to read as it addresses many of the issues that are covered in relationship counselling. It would be a very useful book for clinicians to have available for their clients to purchase as a resource to help consolidate the learning and guidance they have received throughout the sessions. The 12 chapters address the most common issues in relationship counselling and at the end of each chapter there is a 'Truth and Dare' exercise, which would be valuable to incorporate as it has practical exercises to help strengthen relationships.
Dr Azri references and includes practical insights from Dr Gottman as well as Dr Gary Chapman. I highly recommend this book as a resource for relationship counselling. ACA members can download the first chapter for free from Dr Stephanie Azri's website: **www.stephanieazri.com**.

Solution-focused brief therapy with clients managing trauma
Edited by Froerer et al
Review by Dr Susan Miller

Solution-focused brief therapy with clients managing trauma, edited by Froerer et al., is a rich resource that includes contributions from international clinician authors. Published in 2018, this remarkable book inspires hopeful ways of working with trauma. The book reflects a departure from a traditional focus on pathology and diagnosis, towards a focus on strength, coping and courage in trauma treatment. The breadth of the work is ambitious, incorporating the theory, philosophy, research and application of solution-focused brief therapy (SFBT) to trauma work. Readers who are new to the approach will appreciate the applied sections, particularly the clarity with which SFBT is illustrated across a broad range of survivor populations. Commendably, the book positions SFBT as evidence-based practice. An early section is dedicated to relevant research into SFBT and trauma. A fascinating overview of the interface of SFBT, positive psychology and neuropsychology findings further substantiates the approach. Readers are also invited to consider the constructivist foundation of the approach, particularly the critical role of therapist language, solution-focused questioning and client meaning. Against this backdrop, the clinician authors detail their work, frequently in challenging and time-pressured contexts. This book is so much more than a 'how to'. Practitioners will benefit from the diversity of the clinical case illustrations, many of which reflect internationally poignant issues. Readers will appreciate the opportunity to gain insight into demanding clinical work in areas such as war trauma, sex trafficking and violent crime. Session transcripts bring alive the voices of the clinicians and their clients and illustrate the ways in which a solution-focused lens facilitates resilience and agency. The authors' respect for the psycho-cultural narratives and inner resources of their clients is evident. Readers will be engaged by the candour of the authors and the way in which their front-line experiences are brought to bear on a spectrum of hope challenged cases. Those experienced in SFBT will be reminded how the elegant simplicity of the approach can provide light and direction in the darkest client presentations. *Solution-focused brief therapy with clients managing trauma* is about clinical optimism regarding the human capacity for vision and change in the face of the unimaginable adversity. This inspiring book shows us how trauma and hope can indeed exist in tandem.

Angel
By Karen Keavy
Review by Simone Potter

Angel by Karen Keavy is a children's book about a girl called Angel who has been sexually abused by her grandfather. Although Angel has told her mother, as in so many real-life cases, her mother does not initially believe her. It takes us though her feelings about the abuse. Although her mum tells her that she is imagining it, Angel knows in her heart that it is real and that it is not right as it is making her sad. Angel talks to a trusted teacher at her school, who believes her. In the end, Angel and her mum talk about the importance of listening to your heart. Angel's mum also discloses that the same thing happened to her when she was a child. Highlighting the fact that child sexual abuse can be generational and that often children are not believed when they first tell someone about it, the book attempts to make sense of the mother's dismissal of Angel's allegations by pointing out that Mum has lost trust in her feelings. The fact that Mum believed her in the end might encourage a child to disclose if something like this is happening to them. I liked that it showed Mum's initial response of disbelief and encouraged the child to tell and keep telling until someone believes them. The use of sensory language in this book could help children to connect with their own senses and learn to trust their feelings.

As a book to use with children in counselling, it would not be the first book to reach for as it is about the abuse of a child specifically by her grandfather. But where there is proven sexual abuse by a close family member or strong suspicions, it could be used during the course of therapy to help the child feel safer and more confident that they will be believed, or to aid in therapeutic conversations.

This book also has a lot of potential for use with adult survivors of child abuse. It may assist with normalising the experience of not being believed and open conversation about how generational child sexual abuse is often allowed to occur, as well as triggering general therapeutic conversation.

Angel covers a difficult topic with sensitivity. The author includes a guide to using the book, which is informative and based on research and best practise, and contact details of Kids Helpline and the **author's website: www.karenkeavy.com.**

COMPLEMENTARY MEDICINE AND EDUCATION

School counsellor referral practices: the emerging partnership between complementary medicine and education

When people think about school counsellors, they often think about school personnel who help teenagers with personal or family challenges and offer career guidance. However, there is much more to school guidance.

By Robbie Spence

I recall one of my university counselling lecturers telling me to remember that when I gained employment as a developmental guidance counsellor in a primary school, I would be like the school GP – always refer on when children require specialist intervention or allied health support. This has stuck with me for the past 10 years, and as an advocate for complementary medicine, I continue to contemplate how I can best promote and work with practitioners such as naturopaths, homeopaths and holistic counsellors in order to maximise a child's learning and development.

When people think about school counsellors, they often think about school personnel who help teenagers with personal or family challenges. Images of career tests and career guidance sessions often remain one of the few memories of one's own experience at school,

however, there is more to school guidance. Most primary schools across Australia also employ school guidance counsellors. These counsellors might also be known as developmental guidance officers, school psychologists or educational psychologists. While qualifications differ from state to state, these practitioners in primary schools perform many of the same functions. In the developmental or primary school sector, guidance counsellors serve a critical role in supporting the emotional, psychological, developmental and educational needs of an often diverse group of students. The role of a guidance counsellor primarily involves child and parent counselling, advice and advocacy for child development and disability, and psycho-educational assessment. In a school context, the core focus of a guidance counsellor's work is to investigate and provide relevant assessment and interventions to promote learning and development. However, what happens when issues arise that are out of scope of the school guidance counsellor's practice? It's simple. They refer on to general practitioners, allied health practitioners, and medical specialists.

Current referral practices

Referral to support services and practitioners external to the school is a frequent practice that is often necessary to get the right treatment and intervention for students. More often than not, guidance officers in developmental settings refer to psychologists, occupational therapists, speech pathologists, physiotherapists, optometrists, audiologists, paediatricians (via GP referral) and community support programs. These practitioners provide schools and teachers with a greater understanding of the child, which can inform the way in which teaching is targeted to maximise learning. For example, occupational therapists might support children to participate in their learning environment by assessing their ability to function in the classroom by assessing executive function, sensory needs or posture. Speech pathologists support language and literacy development and recommend intervention or strategies that might build a child's ability to communicate and engage with the classroom curriculum program. Optometrists can assess vision and prescribe corrective lenses or vision exercises to support learning engagement. Allied health practitioners such as these are big players in the referral process when guidance counsellors make suggestions for further investigation or support, and they do an amazing job that will always remain vitally important. However, as the community embraces complementary health more and more, there appears to be anecdotal increase in the frequency at which parents are turning to other types of practitioners such as homeopaths, naturopaths and holistic counselling practitioners to help in their children's learning and development. What does this mean for the future of developmental guidance counsellors, schools, and

In the developmental or primary school sector, guidance counsellors serve a critical role in supporting the emotional, psychological, developmental and educational needs of an often diverse group of students.

the way they refer? To help answer this, an understanding of the current community and emerging academic landscape is necessary.

The emerging partnership between complementary medicine and education

Recent tightening and attempts to increase self-regulation of the complementary medicine industry has led to a greater acceptance of natural approaches to wellbeing throughout the community. Government accreditation of natural medicine programs within the higher education sector have paved the way for a new generation of complementary medicine practitioners with in-depth medical knowledge and clinical experience in providing evidence-based therapies to the public. The field of natural medicine has made significant moves away from the alternative, towards the complementary, and indeed has been accepted by many allopathic trained medical doctors (Kemper, 2008). Complementary medicine has become an academic field in which significantly more research is being conducted. In line with these changes and subsequent public acceptance, there has been an increase in the public's use of complementary therapies, particularly in relation to children's health and wellbeing, and to support learning and development (Friedman, Slayton, Allen, & Mehta, 2014; Revuelta-Iniesta et al., 2014; Salomone, Charman, McConachie, & Warreyn, 2015; Wray et al., 2014; Gottschling et al., 2014).

Complementary medicine has been used to support children with behavioural and learning difficulties and developmental disabilities for some time, although research is catching up to provide evidence as to its efficacy (Arnold, Hurt, & Lofthouse, 2013; Akins, Krakowiak, Angkustsiri, Hertz- Picciotto, & Hansen, 2014; Brown & Patel, 2005; Sarris, Kean, Schweitzer, & Lake, 2011). A number of treatments and approaches to behavioural and learning development have emerged through the complementary medicine fields of herbal medicine, homeopathy, nutritional medicine and holistic counselling.

Parent preferences in the referral process: considerations for the future

Parents are often concerned about the development of their children and as such they seek to assist, where they can, to maximise their child's participation in school and learning experiences. Increasingly, parents are seeking the advice of naturopathic practitioners (practitioners of herbal and nutritional medicine) and homeopaths to support their children with behavioural and learning difficulties (Bull, 2009; Harrington, Rosen, Garnecho, & Patrick, 2006). Parents are often excited to explore a number of treatment options that have been found to benefit children's and young adults' learning behaviour, particularly in the areas of attention, memory and hyperactivity (Arnold, Hurt, & Lofthouse, 2013; Stonehouse et al., 2013; Pipingas, Camfield, et al., 2014; Chan, 2002; Sinn & Bryan, 2007).

Due to the perceived significant increase in the number of children being treated by complementary interventions such as in homoeopathy, naturopathy and holistic counselling practitioners, schools and developmental guidance officers will no doubt benefit by expanding their knowledge and skills in being able to advocate for parents, their children, and be able to confidently and competently refer on to appropriately qualified natural health practitioners within the Australian context. As an important current practice, school specialists like guidance officers often refer children to traditional allied health services; however, referral to complementary health practitioners is an area to be considered and formally explored both in policy and practice.

As the body of research increases and as complementary health practitioners advance in academia, schools will be better positioned to develop policies around referral to and liaison with such practitioners. This will ensure the development of strong relationships between the complementary medicine sector and school education, thus working towards the ultimate school and parental goal of maximising student learning outcomes. ■

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Robbie is a clinical counsellor and registered teacher who works in developmental guidance and counselling, supporting families, parents, children, teachers and education professionals. He holds a Master's degree majoring in Guidance and Counselling from the University of Southern Queensland, and has completed further studies in contemporary educational research. He is a qualified professional supervisor, an experienced special educator, and specialist in school-based psycho-educational assessment, learning and development. He is also a qualified sandplay therapist and registered creative arts therapist.


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Problem gamblers

Family attitude navigating (FAN) model: role of concerned significant others in prognosis of problem gamblers

Concerned significant others can have positive or negative influence on the prognosis of gambling addiction for problem gamblers.

By Bernard Fan

Abstract

The proposed family attitude navigating (FAN) model suggests that the concerned significant others (CSOs), including family members and friends, are important in the recovery of problem gamblers. Key family relatives and CSOs can express negative attitude towards their gambling family members, which can increase the risk of gamblers' relapse and heavy gambling. On the other hand, the CSOs who are more prone to express positive attitudes towards problem gamblers can contribute to gamblers seeking treatment and encourage them to successfully restrain from gambling.

Introduction

Gambling is a common social and relatively low-risk activity for most people. There are a few terms used to describe people with gambling problems, including problem gambling, compulsive gambling, pathological gambling and gambling disorders (*Diagnostic and statistical manual of mental disorders*, American Psychiatric Association, 2013). In Australia, problem gambling has been defined as a lack of control by the gambler over his or her gambling behaviour, which results in adverse personal, economic and social consequences in gamblers' and their families' lives (Productivity Commission 1999, p.17). In the pathway to their gambling problem, there are a number of factors contributing to their gambling disorder, including ecological, sociological, biological, cognitive, behavioural and personality (Welte et al 2015, Rantala & Sulkunen 2012, Ibanez et al 2002, Vanes et al 2014, Zhuang et al 2018). Despite different models that explain pathways of development and maintenance of problem gambling, they do not explain why some gamblers are motivated to quit while some gamblers relapse after abstaining for an extended period of time. This paper fills the gap of current theories that cannot explain why the same situations can be triggers to gamble or motivation to quit. The proposed model will provide an explanatory mechanism to elucidate how the internal and external factors function as triggers to relapse and as motivation to quit. It is speculated that the concerned significant others' (CSO) or family's attitudes will navigate those factors to be either a risk factor of relapse or to be a protective factor as motivation to quit their gambling addiction.

Background and rationale

A literature review has been done to summarise theoretical models of problem gambling in explaining pathological gambling (Lesieur & Rosenthal 1991, Sharpe and Tarrier 1993, Griffiths & Delfabbro 2001, Blaszczynski & Nower 2002,

Raylu & Oei 2002, Sharpe 2002, Rickwood et al 2010, Upfold 2017, Menchon et al 2018). Lesieur (1979) developed a grounded theory of the compulsive gambler's spiral of options and involvement model. Rosenthal and Lesieur (1996) hypothesised that there are two characteristics of gamblers: escape seeker and action seeker. Jacob (1986) proposed a general theory of addiction to explain various addictive behaviours including gambling. Griffiths and Delfabbro (2001) argued that gambling is a multifaceted behaviour that involves biological, psychological and sociological components that interact together to contribute to the gambling behaviour. Therefore, no single theory can explain the etiology and maintenance of gambling behaviour. Griffiths and Delfabbro (2001) have proposed a comprehensive biopsychosocial approach to explain gambling addiction. Blaszczynski and Nower (2002) have further elaborated on the biopsychosocial approach of gambling and identified different gamblers in their 'Pathways model of problem and pathological gambling' (Blaszczynski 2000, Blaszczynski & Nower 2002).

Despite different models explaining the development and maintenance of problem gambling, they do not explain why some gamblers relapse after abstaining for an extended period of time. Some researchers have postulated models to explain the process of relapse (Brown 1987, Marlatt & Witkkiewitz 2005). Brown (1987) postulated that gambling is very exciting and is a form of arousal that becomes cognitive expectancy that reinforces gambling behaviour for the abstained gambler. Despite the reinforcement schedule of gambling that has been broken after an extended period of abstinence, the abstaining gambler is triggered by internal mood states and cognitive expectancy of former patterns of gambling experience, in addition to external environmental situations and playmates of former gambling. All these internal and external stimuli will be relapse-provoking situations, which produce pleasant arousal and relief from boredom (Brown 1987). Marlatt proposed relapse is the result of an interaction between internal factors and external factors. Internal factors include affect, coping, self-efficacy and outcome-expectancy, while external factors consist of social influence, access to substance and cue exposure. Marlatt assumed that if a gambler attributes to internal, global and uncontrollable factors, risk of relapse increases. If the individual attributes to external, unstable and controllable factors, risk of relapse reduces (Marlatt & Witkiewitz 2005). It is assumed that the individual will be influenced by stimuli from relapse-provoking situations and drive them to meet their cognitive expectancies of former patterns of gambling behaviour. Stimuli and relapse-provoking situations are built up over a period of time during their abstinence and drive the gamblers to relapse.

Chantal et al (1995) reported motivation is a key determinant of gambling involvement. Motivation for change reflects the readiness for change alongside the stages of change. Motivations for change are driven by both internal and external elements. Internal or intrinsic factors include cognitive, attitude and awareness of negative consequence of the addiction behaviour, while external factors cover the influence of other people and life crisis on the gamblers (Evans & Delfabbro 2005). According to the Self-Determination Theory (SDT), studies showed that high autonomous motivation for quitting, such as awareness of problems of gambling addiction, improved self-image and a desire for a new life, predicted higher readiness for change, while high external motivation for change, such as family's pressure, reflected a lower stage of change. Intrinsic and autonomous forms of motivation are significantly associated with

According to the Self-Determination Theory (SDT), study showed that high autonomous motivation for quitting, such as awareness of problems of gambling addiction, improved self image and a desire for a new life, predicted higher readiness for change, while high external motivation for change, such as family's pressure, reflected a lower stage of change.

treatment success (Kushnir et al. 2016). However, there is also research which has reported contradictory results that external factors are more associated with higher motivation for change.

Evans and Delfabbro (2005) reported that external factors such as physical and mental health, financial pressure, effects of gambling on relationships or losing one's home that put them in life crisis were the important reasons for seeking help. While internal elements of feeling shame and denying their gambling problem, and doubt of their own self-control without professional assistance caused their resistance to quit gambling and were their main barriers to seeking help. Help-seeking more likely occurs in response to external factors of gambling related harms such as financial problems, relationship issues and psychological distress (Suurvali et al 2010, Gainsbury et al 2014).

Gambling studies have reported inconsistent findings on the influence of internal and external factors on the prognosis of problem gamblers. It shows that internal factors interact with external factors of gambling, causing the gambler to either gamble more intensely or motivating them to quit. Internal and external situations can be triggers for more gambling, as reflected on the problem gambler's higher score on IGS (Turner et al. 2013). However, internal and external situations can also be motivation for gamblers to change their habitual gambling behaviour and quit (Kushnir et al 2016, Evans & Delfabbro 2005).

Therefore, there may be some elements in influencing the role of internal and external factors in contributing to the maintenance and relapse of gambling or motivating them to quit their gambling. This paper postulates a grounded theory that explains a mechanism in navigating the internal and external elements to be either motivation to quit or trigger situations for gamblers to relapse.

Role of family

Besides the problem gamblers themselves, family members of problem gamblers are the most common people directly experiencing the negative impact of the gambler's addiction problem. It is estimated that one problem gambler affects on average 10 to 15 other people (Productivity Commission Report, 1999). Impact of problem gambling on spouses and families is devastating and traumatic. The discovery of a family member's gambling problem is overwhelming, shocking and traumatic for families, especially spouses or parents who are living with the gambler. It is because the consequences of gambling such as debt, loss of property, legal issues, ruin of future life, stress and shame are too huge and devastating to be fixed (McComb et al 2009). These damaging impacts on families also damage the relationship with families who have lost trust in gamblers. The spouses of gamblers report experiencing betrayal and deceit because of the shock of disclosure of the hidden gambling problem. These impacts on couple relationships are influential. Lee (2002) reported that couple interactions of problem gamblers were characteristic of unproductive communication and negative cycle of blame, placating, avoidance

and withdrawal, which resulted in interpersonal disjunction, intrapsychic disconnection and limited awareness of their problems (as cited in McComb 2009). McComb (2009) has hypothesised that there is a reciprocal cycle of negative impacts of gambling on couple relationships and the negative relationship dynamics on the development of problem gambling. It is difficult for the couples to break through this vicious cycle.

Little research has been done on the role of family and the attribution of CSOs on the dysfunction of family members with gambling problems (Orford et al 2010). In a literature review of addictions, Kourgiantakis and Ashcroft (2018) reported that few studies have been done on family involvement in both substance abuse and problem gambling treatment for adults, despite improvement in entry and engagement in treatment of people with addictions.

Moreover, few studies have examined the importance of family involvement in the treatment of gambling addiction. One study reported that involving CSOs has been associated with significant improvement in treatment outcome including compliance with therapy guidelines, reduced drop-out from the treatment and reduced relapse (Jimenez-Murcia et al 2017). However, it is assumed that the positive outcome of involving CSOs is due to the effect of disorder – specific interventions that focus on specific ways in which CSOs manage the situations to prevent gamblers relapsing (Jimenez-Murcia et al 2017). The role of CSOs in supporting gamblers focus more on their coping strategies and on the impacts of gambling rather than on improving their interpersonal interactions. This hypothesis is similar to Ciarrocchi's report on the involvement of couples in the treatment of problem gamblers. Ciarrocchi reported that involvement of couples in the treatment of problem gamblers, according to the Integrative Behavioral Couple Therapy, showed improvement of treatment outcomes on gamblers (as cited in McComb et al 2009). Despite Ciarrocchi's notice in the role of family in remedying the couple relationship, focus of amending the relationship is placed on achieving goals on environmental control, financial recovery and legal issues. This solution-focused approach to fix the consequences of gambling may not help improve dysfunctional communication and negative interaction for couples, but instead further imposes tension on their relationship.

In a literature review study, McComb et al (2009) reported that problem gamblers sought help for issues such as marital conflict and communication problems. On the other hand, Bertrand et al (2008) also reported that problem gamblers had difficulty in coping with negative emotion. They were reluctant to stay in treatment after quarrels with families because gamblers did not feel support but felt resent and distrust from their families (as cited in Jimenez-Murcia et al 2017). Conflict with others and quarrels are triggers for relapse to gamble (Littman-Sharp et al 2009). These findings show the importance of interpersonal relationships and emotional interactions between families and problem gamblers in the prognosis of gambling addiction.

The role of family is important in the development and maintenance of addictions. It is speculated that interpersonal dynamics of family members play an important role in the recovery of people with addictions. There are studies on the relationship between family interaction and relapse of alcoholism. O'Farrell et al (1998) reported that alcoholic patients with high expressed emotion (EE) spouses were more likely to relapse and had a shorter time to relapse compared with alcoholic patients with low EE spouses. Atadokht et al (2015) also reported a positive relationship between negative attitude of family and the frequency of relapse, and a significant negative relationship between perceived social support and the frequency of relapse of substance addiction. Githae (2016) reported that there was a significant association between families' expressed emotion and relapse of individuals with alcoholic addiction. It is suggested that interactional patterns among family members play an important role in maintaining maladaptive behaviours, such as alcoholism (Githae 2016). However, there are few studies explaining the role of family interaction in the maintenance and relapse of gambling among problem gamblers. These findings shed light on understanding the prognosis of gambling addiction.

Concerned significant others

The people surrounding those with gambling problems are identified

as 'concerned significant others'. CSOs are not confined to family members such as parents, partners, siblings and children of problem gamblers but also include friends, colleagues, workers and others in the general community who have close contact with problem gamblers.

In conceptualising the experience of CSOs of family members with addiction problems, there are two models commonly described in the literature: the co-dependency (CD) model and the stress-coping model. Co-dependency is described as an unhealthy relationship between family members and people with addiction. Co-dependency contributes to the family members suppressing their own emotions, focusing externally, self-sacrificing and attempting to control the family member's addiction behaviour (Dear et al 2005). Co-dependency is described as being causally related to the addictive behaviour, such as alcoholism. The family's tolerance of unacceptable behaviour and loss of control over emotion increases parallel to the drinker's tolerance for alcohol and loss control over drinking (Miller 1994).

In other words, co-dependency contributes to the deterioration of the addictive behaviour. However, the concept that co-dependency is based on speculation and impression to describe the behaviours of CSOs is criticised. Moreover, there is a lack of empirical evidence to support and consensus about a definition of co-dependency (Miller 1994, Calderwood & Rajesparam 2014). The other model describes CSOs as the stress-coping model.

The stress-coping model, or stress-strain-coping-support (SSCS) model, assumes that a family member with an addiction problem including substance abuse or gambling constitutes stressful life circumstances, which causes other family members to experience negative impacts in the form of physical health and psychological distress. Different people may respond to stressful conditions in different ways. Stress-coping model assumes that CSOs have the strength to cope with the adversity and stressful circumstances. CSOs still have the capacity to determine their own destiny and they are not powerless (Orford et al 2010).

There are a number of studies done on CSOs (Salonen et al. 2015, Svensson et al 2013, Wenzel et al 2008, Jimenez-Murcia et al 2017). Most studies mainly focused on the impact of problem gamblers on CSOs. Negative impacts on CSOs included financial burden, physical health, psychological distress, marriage and relationship breakdown and career influence (Lorenz & Yaffee 1989, Hodgins et al 2007, Chan et al 2016). It is proposed that there is a reciprocal role of family on recovery and dysfunction for family members with gambling problems.

A proposed family attitude navigating model on the prognosis of a gambling problem

In the past few decades, it has been speculated that environmental factors have influenced patients with mental health disorders. Family environment is one of the important variables in determining the prognosis of patients. The construct of EE is an important measure of the family environment. EE theory hypothesises the effect of family environment on patients with mental issues. The nature of EE is described as family attitude and feeling towards the patient.

The EE theory hypothesises that patients living in a family environment that is characterised by critical, hostile or emotionally over-involved or intrusive attitudes, that is high-EE relatives, will have higher relapse rates than those living with low-EE relatives (Leff & Vaughn 1985). The predictive validity of EE has also been found in relapse of substance abuse (O'Farrell et al 1998, Atadokht et al 2015, Githae 2016). Therefore, it is assumed that EE theory is appropriate to analyse the impact of CSOs on the prognosis of problem gamblers' family members.

A qualitative study has reported the impact of CSOs during their description of family members with gambling problems. The study applied EE theory to analyse the attitude of the CSOs towards their family

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members with problem gambling. It reported that family members were classified as high-EE during the period when their problem gambling family members were at their peak in their gambling and had relapsed to gamble. On the other hand, the CSOs were low-EE and expressed positive attitude of warmth or positive remarks in describing the recovery of their gambling family members whom restrained from gambling (Fan 2017).

Therefore, it is hypothesised that key family relatives and CSOs expressing negative attitude towards their gambling family members can contribute to the problem gamblers relapse. On the other hand, the CSOs who are more prone to express a positive attitude towards problem gamblers can contribute to gamblers seeking treatment and encourage them to restrain from gambling. The vulnerability–stress model explains that relatives who expressed negative attitudes are more emotionally-arousing to the patients, while relatives expressing a more positive attitude tend to have a calming effect on their family members. Stressful life events as well as social environmental stress can interact with pre-existing vulnerability characteristics of the patient and produce psychotic episodes (Nuechterlein & Dawson 1984). Therefore, it postulates that when the CSOs are critical and hostile towards problem gamblers, their negative attitudes may be stressful to problem gamblers. A stressful family environment may trigger problem gamblers to relapse. Centre for Addiction and Mental Health (CAMH) Inventory of Gambling Situations (IGS) has identified that "conflict with others" is one of the triggers for problem gambling (Littman-Sharp et al 2009). Rosenthal and Lesieur (1996) hypothesise that some problem gamblers are "escape seekers" and they resort to gambling as a way to escape to numbing or oblivion. Negative attitude of CSOs towards problem gamblers may unintentionally contribute to their relapse. CSOs' negative attitude could be a trigger for problem gamblers to relapse in order to escape the adversity of family environmental stress. Therefore, it supports co-dependency theory that family's loss of control over emotion will associate with the drinker's loss control over drinking. Moreover, when CSOs are too emotional, over-involved or over-protective towards the problem gambler, for example helping them to pay their gambling debt continuously, their emotional over-involvement (EOI) also contributes to maintenance and relapse of their family members' gambling behaviour. The CSOs' over-protective attitude associated with relapse of problem gamblers explains co-dependency theory, the family's tolerance of unacceptable behaviour associated with the drinker's substance abuse.

On the other hand, when the problem gamblers are able to be abstinent, it is encouraging for the CSOs who may respond with a positive attitude towards problem gamblers. The CSOs positive attitude is rewarding for the gamblers in return. Moreover, CSOs' positive attitude enhances the gamblers' emotional wellbeing and provides them social support as a buffer against relapse. These positive attitudes explain the variation of the prognosis of gamblers. Therefore, it is the family attitude navigating the triggering situations of both internal and external factors into the direction of either relapse of gambling or motivation to quit their gambling addiction. The emergent FAN model of CSOs on the prognosis of problem gamblers is shown in Figure 1. The EE theory does not indicate a unidirectional relationship between relatives' attitudes and the gamblers' relapse. There exists an interaction between the patients and relatives. The rating of EE is not necessarily static over time (Vaughn 1989). It explains the possibility of the CSOs being able to change from a negative attitude to a positive attitude towards problem gamblers when problem gamblers show progress in abstinence. It is proposed that there is a reciprocal role of family on recovery, and dysfunction on family members with gambling problems.

The CSOs who are more prone to express positive attitude towards problem gamblers can contribute to gamblers seeking treatment and encourage them to restrain from gambling.

Figure 1
FAN model in the prognosis of problem gamblers.

Problem gamblers begin their gambling at family or social gatherings with gambling activities. Family members and peers are important role models in shaping children's gambling behaviour. Problem gamblers learn gambling from their family members or CSOs and develop a positive attitude towards gambling that results in higher levels of gambling involvement. Besides positive gambling attitudes, adolescents also learned gambling as a coping strategies for stressful situations, which further put the adolescents at risk of developing gambling problems. However, positive gambling attitudes alone are not enough for people to develop gambling problems. One study reported that attitudes and beliefs towards gambling did not directly influence the severity of the participants' gambling problem. Attitudes and beliefs were linked more to their triggers to gamble and these triggers carried more weight on the severity of their gambling problem (Fan 2014). Therefore, positive attitudes and beliefs towards gambling may spur the interaction with trigger situations. Trigger situations can be both internal and external factors such as negative emotion, positive arousal, self-image, awareness of problems, feeling shame, conflict in relationships, facing legal issues and financial crisis, which can be stressful to problem gamblers. However, the prognosis of gamblers depends on the interaction between the trigger situations and the interpersonal dynamics of family. This interpersonal dynamic element is the role of families' or CSOs' attitudes towards the problem gamblers. If CSOs express criticism, hostility and emotional over-involvement towards their problem gamblers, their negative attitudes will put extra tension on the vulnerable gamblers who may resort to gambling as a way to cope with the stress, which results in their relapse. On the other hand, if CSOs express positive attitudes of warmth and positive remarks, their positive attitudes will be supportive towards gamblers for recognising their efforts in abstinence and encourage problem gamblers to abstain and quit from gambling.

Therefore, despite the same internal or external factors, CSOs and family members can have different effects on the prognosis of the problem gamblers depending on their attitude towards the problem gamblers – for example, as the problem gambler faces external stressors of crisis such as financial pressure and the family members or CSOs express a negative attitude such as criticism and hostility. A stressful family environment will become a risk factor that can further deteriorate the relationship and impose pressure on the vulnerable problem gambler, who may relapse to gamble in order to seek emotional escape from the crisis. In this situation, internal elements of feeling shame and belief of their own strategies to solve their financial problem by gambling can be barriers for the gamblers to seek help. Although gamblers feel shame, guilt and remorse, they disconnect these emotions and defend or deny these feelings in response to the blame from their spouses (Lee 2002). Therefore, CSOs' negative attitude navigates the gambler's internal feeling and external stress of life crisis towards the pathway of relapse.

On the other hand, if the family member or CSOs express positive attitude such as warmth and positive remarks, they can provide encouragement and calming effect

towards the problem gambler to abstain from gambling. In this situation, external factors of life crisis and internal factors such as awareness of the consequences of gambling and improving self-image, can motivate problem gamblers to quit gambling and sustain behavioural change. Moreover, CSOs' positive attitude can become protective factors such as family cohesion and family connectedness, to buffer the influence of risk factors and protect against high-risk behaviours. This FAN model postulates a mechanism of family's attitude in navigating the situations to a different path of prognosis of the gambler either in relapse or recovery.

Implication

The proposed FAN model suggests that the CSOs, including family members and friends, are also important in the recovery of problem gamblers. Their attitudes towards problem gamblers can have either positive or negative influence on the prognosis of the problem gamblers. CSOs are in frequent contact with the family members with addictive problems. CSOs tend to be emotionally invested and are crucial in helping their family members seek treatment and to change their addictive behaviour. Therefore, it is important to provide counselling services to families and CSOs as well. Neglect of the influence of families and CSOs can hinder the rehabilitation of the problem gamblers.

Conclusion

This FAN model hypothesises that the role of family members or CSOs of problem gamblers may not be only passive victims bearing the negative impact of the issues created by the problem gamblers. Family members can also contribute to the prognosis of the problem gamblers. The attribution of CSOs can be both negative and positive depending on their expressed emotion towards the family members with gambling problem. This FAN model provides an alternative hypothesis in explaining the prognosis of the problem gamblers. It will be ideal to do a longitudinal and prospective study of family attitude towards the problem gamblers over a period of time. ■

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Therapeutic interventions

An ethical checklist for selecting therapeutic interventions

One of the most important considerations for counsellors is evidence-based practice. This consideration is achieved by reviewing relevant literature, practicing wisdom and observing the Australian Counselling Association (ACA) and other applicable standards.

By Dr Milê Glamcevski

The review

Much of the literature in the counselling field talks about the conditions for intervention (Hardina, 2013) and how these interventions should be conducted (Trevithick, 2005; Lishman, 2004). There are numerous models available to manage interventions and the risks of the intervention (Hardina, 2013). Following on from key recommendations in influential text such as Moore, Randall and Barton (2009), Sudbery (2002), Trevithick (2005) and Harms (2007) counsellors need to able to change/adapt treatment plans (interventions), in order to adjust the conditions and context of the intervention. It is repeatedly covered in the literature, that change/adaption needs to be considered for the intervention to be ethically valid. For this reason, counsellors require ethical decision-making models and ethic frameworks for selecting new interventions.

A review of the extensive range of ethical decision-making models is beyond the scope of this article, however, it does cover ethical considerations at key points in the selection of new therapeutic interventions.

Pre-client work

In the stage of 'pre-meeting the client', there are multiple considerations regarding the potential new intervention and its ethical considerations. One of the most important considerations for counsellors is evidence-based practice. This consideration is achieved by reviewing relevant literature, practicing wisdom and observing the Australian Counselling Association (ACA) and other applicable standards.

The key consideration is that counsellors need to 'do no harm' (non-maleficence). It is the 'golden rule' of any intervention (ACA, AASW, 2010; AASW, 2014; APS, 2010). Boyle and Gamble (2014) highlight the needs to consider issues that can make the intervention problematic. Issues that can be viewed as harmful or potentially harmful include, but are not limited to, lack of evidence, physical risk, intimate contact and levels of competence for the new interventions (Department of Health and Human Services, 2011). In addition, to advance ethical validity of an intervention, counsellors need to explore their own values about the client, client group, intervention's value, intervention's effectiveness etc. (Ivey, 2010; Bunker & Alban, 2012).

Initially meeting the client

At the initial meeting with the client, significant information is required to be provided to meet the requirements of informed consent.

The informed consent provides an environment for clients to make self-determinations. Key documents and texts (ACA, AASW, 2010; AASW, 2014; APS, 2007; APS, 2010; APS, 2015) discuss in detail the requirement of informed consent. However, as pointed out in Koocher and Keith-Spiegal's (2016) work, despite the significant information available, there are minimal standards and few enforced benchmarks for informed consent.

As highlighted in the literature, some key components of commencing an ethical intervention are to explain the rationale of procedure, the evidence available for it, its process, any potential risks, and the counsellor's experience and training with the intervention.

For the proposed intervention the counsellor needs to obtain the client's treatment goals and assess the suitability of the intervention for the client. To meet the requirement of suitability, an examination of the client's environment, characteristics and circumstances, this includes emotional and psychological vulnerabilities, social supports and networks, finances, insight, behaviours of concern or risk etc., needs to be conducted. To act in an ethical way (in accordance with current codes of ethics), the client needs to be informed about their right to decline the treatment or withdraw from the treatment. They need to explain the circumstances under which termination of the treatment may occur and the limits of confidentiality. To be ethical, discussion about the options for treatment needs to occur; especially about more conventional, more available and more evidence-supported treatments.

Beginning and conducting the intervention

The information on commencing a therapeutic intervention is considerable (Geldard, 2011; Ivey, 2010; Bunker & Alban, 2012). A brief meta-analysis of literature recommends that once commenced the counsellor should monitor the same aspects as those at the initial meeting of the client, namely the interventions and its various aspects are evidence-based, potentially controversial or problematic issues are monitored, the counsellor continues to explore and reflect on their own values, and they have suitable competencies. Well-captured in works such as Barnett and Johnson (2008), the Mental Health Council of Australia (2010) and the Community Mental Health Guiding Principles, is that ethical interventions have procedures in place to continually discuss the intervention with the client and monitor the effectiveness of the intervention as it progresses.

A point often absent from the mental health literature is the Occupational Health and Safety (OH&S) requirement to ensure a physically and emotionally safe environment for all. This seems to be left up to organisation's guidelines and insurance requirements to outline the OH&S.

Terminating the intervention

Counsellors have a requirement to have articulate and clear methods of gauging when and how it is appropriate to terminate an intervention (Barnett, & Johnson, 2008). Key texts talk about appropriate termination when the intervention has met the treatment plan goals, i.e. when to end the therapeutic activity as it has been completed (Ivey, 2010).

However, on occasions, due to a wide variety of reasons the counsellor will be required to terminate the sessions before the therapeutic activity has reached a successful conclusion. Some conditions and situations for considering termination include when the client is making poor progress and a different or more demanding service is required, i.e. a referral out is necessary because the client is not benefiting from the current service. The counsellor is attempting (presented with) an intervention for an issue they are not competent to deal with, i.e. during monitoring or assessing the intervention the client presents with a situation or condition of significant risk, which cannot be managed appropriately and a referral out is necessary.

For a termination to be done ethically within the intervention,

As highlighted in the literature, some key components of commencing an ethical interventions is to explain the rationale of procedure, the evidence available for it, its process, any potential risks, and the counsellor's experience and training with the intervention.

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it is recommended to seek guidance from a senior colleague and or engage in professional supervision. It is also recommended that the client be advised of the reasons for termination, while ensuring an active referral and handover to another appropriate professional occurs.

Summation

This paper used the literature to synthesise a conceptual framework to ethically consider new therapeutic interventions. The literature was critically analysed to look at the ethical guidelines for considering the intervention pre-meeting the client, initial meetings with the client, performing the intervention and terminating the intervention. The basic framework can be presented in the checklist following:

Checklist

Before meeting the client

- Evidence informed (evidence-based practice)
- Potentially controversial or problematic issues identified
- Explore/reflect on your own values
- Have suitable competencies to deliver therapy

Initially meeting the client

- Client's goals for obtaining treatment
- Is the proposed intervention suitable for the client?
- Sufficient details of the proposed treatment provided to the client
- Consider broader characteristics/circumstances
- Client aware of their choice to participate, decline and withdraw

- Explain that alternative, more conventional treatments are available
- Conditions under which to terminate treatment explained
- Confidentiality and its limits explained

During the intervention

- Safety and does it meet the OH&S requirement?
- Measure the effectiveness/ monitor progress
- Check in regularly – own values and informed consent

Termination

- Know and agree when to terminate
- Review work with colleagues and supervisor

On critical review, the literature was consistent and repetitive on a number of guiding considerations for ethical decision making with new interventions. The overriding principle was 'do no harm' (non-maleficence). It is rather simple but poignant that no harm through the intervention should befall the client. The logical follow-on was that the intervention should improve the welfare of the client while doing no harm. The ethical framework for selecting new interventions should lead to the best possible (or at least an improved) outcome for the client by addressing the difficulties in their current situation.

Best practice is the comprehensive and systematic appraisal of evidence from the literature, in particular professional bodies' guidelines and published research studies, in an effort to use interventions that provide maximum benefit and minimal risk to the client. Professional bodies such as ACA, AASW and APS provide lists of therapies with established practices that they have considered. The valuable evidence supports ethical decisions for the use of new interventions.

In concluding, to be ethical and select new interventions, a framework is required. At all times counsellors should use interventions they are competent to employ while maintaining the rights of the client. Counsellors are competent by basing interventions on firm theoretical underpinning, supported by empirical evidence and ethically reviewed for benefit to the client. There must be ethical consideration including innovation and development strategies for the selection of a new intervention. ■

About the author

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In summary, Dr Milê Glamcevski has the following experience:

- 19 years of providing mental health therapy to clients
- Worked as an educator and mental health professional in five countries
- Lectured for eight years on Undergraduate and Post Graduate programs in Australia, South-East Asia and Europe
- Designed course syllabuses and training curriculum for universities, multinationals, local NGOs, international NGOs, youth etc.
- Research leading to publications in peer journals and international conferences

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TO DO OR NOT TO DO

The gift of providing space in a counselling session

Being aware of the pacing of sessions and providing space has become more important than ever.

By Sophie Lea

This week I set an exercise for my Master of Counselling students to guess how long a minute takes to pass. Inviting them to close their eyes, I then asked them to raise their hands when they felt a minute had elapsed, encouraging them not to count in their heads. Interestingly the average time all my students had raised their hands was 32 seconds. Every single student raised their hand before 45 seconds had passed. Why did I set this task?

When I was training to be a counsellor, keeping focus and allowing for space and sometimes silence in my counselling sessions was a significant challenge for me. I described to my students the experience I had when first working as a counsellor. The analogy that I think best describes this is, it was like having two worlds in my mind. These worlds I named the 'client brain' and the 'therapist brain'. My 'client brain' was focused on absorbing everything the client was telling me, how they were sitting, what the client might be feeling, what their verbal and non-verbal cues were etc. Meanwhile my 'therapy brain' was formulating the next line of questioning, thinking about an approach or resource that might be helpful, forming an empathetic statement, grappling with my professional insecurity by trying to look the part of a wise, trustworthy professional.

The problem was that I was either focused on my client, which meant I lost my therapeutic train of thought, or I was in 'therapy brain' and then I often misheard and frequently tuned out from what my client was saying and doing. It was becoming problematic. I hadn't yet developed what I call the 'counsellor superpower', being able to utilise effectively both the 'client and therapist brain' simultaneously. My students and therapists that I supervise comment frequently on the trouble they have allowing for space in their sessions, and I have a few thoughts as to why this might be the case.

Firstly, as professional therapists we are usually very aware that we are being paid to provide a service and pay equates to performance, performance can be linked to doing something, so we 'do!'. A a counsellor new to the profession once told me, she felt "like a performing monkey". She felt that she had to keep providing her clients with resources and techniques, as much as she could give, each moment of every session. When I enquired as to why she felt compelled to do this, she swiftly answered, "Because they are paying me to help them!" OK, so does this mean 'doing' also equates to being professionally valued by our clients? Maybe.

The fear of not being good enough, that you are not a competent counsellor and you will be found out as a phoney, I think runs deep for a lot of us in the helping professions. Feeling compelled to fill up client session time and not allow for space might be a symptom of this fear. I believe professional counsellors are acutely aware of the responsibility of their work and the fragility of the space they sometimes hold.

However, as counsellors, I believe we need to aim to find a balance here. By allowing for moments of reflection, taking a

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breath and actively facilitating a pause, this can assist our clients in truly connecting with what they are needing to tell us. Sometimes our clients are conscious of this and sometimes not. If we create pressure on ourselves to 'perform' throughout the whole session, are we effectively connecting with our clients and establishing a productive therapeutic relationship? I would think not. Providing opportunities for our clients to be active in their own counselling process and be able to develop their own self-efficacy is vital. Giving my clients a resource or a technique to practise can be an important contribution to provide, but the questions I reflect on first are: is this useful to the client? What is the timing of when this might take place? Is this action purposeful and not a time-filler, driven by my own professional insecurities? And which is more important, my agenda or the clients'?

Being aware of the pacing of our sessions and providing space in the session has, in my view, become more important than ever. The franticness of our society and the developing of instant gratification in our Western world may have impacted on our capacity and willingness to pause... just... wait... to... see... what... happens. If we can model this and allow our clients and ourselves to pause and reflect during our session, what may be revealed, heard and understood? In my experience, a lot.

The gift of pausing during a session allows for the counsellors 'client and therapy brain' worlds to integrate and facilitate an improved depth of understanding and purposeful action to support the clients' needs. The 'counsellor superpower' emerges!

However, facilitating space in session I believe is a skill, it takes awareness and practise, both in the context of therapy and outside of it. As counsellors I think we need to consciously practise being comfortable with providing space and embracing silence, both purposeful and occasionally awkward, because with it can come the gift of increased focus, clarity and connection for ourselves and, most importantly, our clients. ■

About the author

Sophie Lea is a professional counsellor and clinical supervisor with over 17 years' experience working in therapy education settings both in Australia, overseas and in private practice. She practises a person-centred approach with reference to CBT, ACT and narrative therapy modalities and specialises in adolescent and family counselling. Sophie is also a lecturer in the Master of Counselling and a PhD Candidate at Monash University. She presents workshops for healthcare professionals working in schools and community services fields. For further information please refer to her ACA/LinkedIn profiles.

Sandtray therapy

A cross-theoretical approach to counselling

By Fiona Werle

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Abstract

The role of sandtray therapy has always had a place in trauma-based interventions; however, it fell out of favour with the onset of more left-brained psychoanalytical theories taking hold of the psychological systems of the time, where Freud and his contemporary's held sway. Sandtray therapy as an expressive form of therapeutic healing during the 1920s did not have the research and theoretical framework to support this contemporary and cutting-edge method, and in an era of pure talk therapy, where therapy was usually therapist-led, seeing children as able to heal themselves from trauma using an expressive sandplay therapy must have seemed ludicrous indeed. As we will see today the expressive therapies have gained popularity amongst peers and researchers, supported by neuroscience and advances in mental health and wellbeing. We will explore sandtray therapy as a cross-theoretical approach to counselling and psychotherapy, supported by a summary of the 21 Blue Knot Foundation's Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. The guidelines sit alongside the sandtray framework, we have made no attempt to include them other than to highlight the cross-theoretical nature of sandtray therapy using guiding principles of sandtray therapy as a trauma informed practice. It was not possible to meet all of the 21 Blue Knot practice guidelines; however, that does not deter this writer from advocating for the method of sandtray therapy as a trauma-informed practice method.

Introduction

A young child witnessed a murder, four years later his carers and others wonder – does he remember? The room is set, the child plays, but when the inevitable question is asked, "Do you remember how your father killed your mother?", the child goes to the shelves, directly to the container that holds the guns, knives, swords, bows and arrows and other fighting equipment. Silently he finds the knife, walks over to the sandtray and buries the knife with the pointed end protruding from the sand, buried half in, half out. The intention of his actions and the focus on using the sandtray as the resting place was the beginning

of the much-needed release for this six-year-old, who at the age of 18 months witnessed the brutal stabbing murder of his mother at the hand of his biological father. The next phase in our treatment plan was for this child to build a trauma narrative so that when confronted by the questions from his peers at school he could simply state the facts that reflected his sense of being, and his place and belonging in the world with his new mum and dad.

Origins of sandtray therapy

The originator of the idea to work with children using a contained space with a tray filled with sand for therapeutic play originated with Dr Margaret Lowenfeld, who opened a clinic for 'nervous and difficult children' in 1928 in London. It was here that she developed sandtray therapy, which she initially called the 'World Technique'. Dr Margaret Lowenfeld explored ways to tap into the 'childhood' of children to help them explore their feelings. Her specialisation was working with children with complex trauma and intergenerational trauma inherited from their parents as a result of war. Lowenfeld worked specifically with children in her role as a child psychiatrist. Her insightful mind led her to think in new and exciting ways to work in a trauma-informed framework led by the children themselves, making this framework unconventional for the time when leading psychiatrists such as Freud were the flavour of the day. Sandtray therapy was novel even as an assessment tool; however, today we know that therapeutic models specifically designed to address the multiple dimensions of complex trauma lay in the sensorimotor and expressive fields, which specifically interact with right-brain modes to build a bridge to connect left and right brain. The 'World Technique' framework included comparison of world cultures, civilisations, the creativity of artists, poets and more, exhibited in the symbols and images of the sandtray miniatures. Her research and expressive work with children combined holistic understanding of the influence of the child's environment, socio-economic situation, education, family and society. There is not much that has changed today in the sandtray therapy framework, once again we are encouraged to advocate for the use of sandtray therapy as a trauma-informed method, supported by neuroscience, neurobiology and related theories.

Understanding of the aetiology and effective treatment of complex trauma is not widespread, including within the mental health sector. To the extent that complex trauma is misunderstood and misdiagnosed (i.e. fragmented into discrete classifications which fail to capture its underlying nature and comprehensive effects) this underlines the need for guidelines appropriate to its detection and treatment. Indigenous people, survivors of clergy and other institutional abuse, asylum seekers and the 'Forgotten Australians' are some of the diverse groups who have experienced complex trauma, which needs to be seen in these terms if it is to be adequately responded to. Dr Pam Stavropoulos, Consultant in Clinical Research, ASCA, May 2012 (Knot, 2018).

According to Dr Margaret Mead (1977) in the introduction, "The 'World Technique' was vital in the understanding of how children learn to relate to the real world, or became stunted, apathetic or distorted" (Lowenfeld, 2007). Her legacy is the understanding in the mental processes of traumatised children's (and adults') inability to often express emotions in words. Non-verbal trauma informs sandtray therapy as a method of communication that embraces many of today's research and evidence-based theories, including that of neuroscience and neurobiology. Today we have more of an understanding of the workings of the human mind, with advances in neuroscience confirming what Lowenfeld must have known, even if on an energetic level or felt sense, when she worked with her trauma-informed practice using expressive sandtray therapy. Lowenfeld introduced into her theoretical framework three modes of experiencing; these are physical, intellectual and emotional (Rae, 2013). When a child steps into the therapy room their first impulse is to go to the sandtray. Often they need little coaxing nor instruction on what to do, because play is their natural realm. If this does not occur, then it is important to recognise and be aware of complex trauma. This is true also for the adult sand player, their may be anxiety around using sandtray therapy if they themselves are unable to play due to their own childhood trauma. A child will often be silent yet physical in their sandplay building. If a child is talkative, they may be less able to be emotionally connected. In these instances, I place my fingers to my lips and say, "Let's be silent today."

Client and therapist engagement

Sandtray therapy can be a tool for clients to feel, see and experience the motives, facts and other aspects that can lead to self-change. The sand player creates a three-dimensional scene using diverse sandtray miniatures that reflect all aspects of life, from the natural to the supernatural. Any dialogue can be client-led or therapist-directed. Using cross-theoretical approaches, sandtray helps clients explore sensory image-thinking held within a framework of self, family, community or environment. We often call this a holistic approach, but it informs the therapist where a client finds themselves in the

Photo: Daniel Cheung / Unsplash

present moment and of the clients place in the world, their sense of purpose and meaning. This increases client engagement through a moment to moment connection, bringing up felt senses for both client and therapist as we engage with the images brought to life in the sandtray using sandtray miniatures. Watching this process unfold, the therapist is often caught feeling what the client feels, often termed advanced empathy (Corey, 2009). Holding this therapeutic space, a trained sandtray therapist needs to have done their own self-process using sandtray therapy to fully appreciate the beauty of what their clients will be exposed to. The therapist must understand that their clients have choice, they chose unconsciously what is revealed in the sandtray and in so doing this leads to change, awareness and growth.

The mother child bonding

A healthy child brought up in a healthy environment will experience normal growth and development. Safe and nurturing environments help children bond to their caregivers. This helps protect the child's developing brain from stress. This is called secure attachment (Bretherton, 1992). A child who experiences insecure attachment is at significant risk of abnormal development. Children who don't have a secure base learn that they can't rely on their caregiver for comfort and they may be unable to self soothe. If a child can't regulate their emotional states or rely on others to help them, their biological fight/flight/freeze response is repeatedly triggered (Knot, 2018). Gabor Maté (2003) highlights the importance of the mind-body connection and bringing our attention to our holistic connection with self, and how our thinking about self affects our body in different ways. Different personality types will experience stress differently. A pleaser, for example, suffering from early childhood trauma stress may be impacted by a combination of physical and biochemical responses to emotional stimuli, influencing their major organs and immune system. A pleaser may not ask for help and thus suffer in silence (Maté, 2003). Other studies suggest that childhood trauma triggers invoke "a strong graded relationship between the numbers of different adversities experienced in childhood and every health risk behaviour studied, including cigarette smoking, obesity, physical inactivity, alcoholism, drug abuse, depression, suicide attempts, sexual promiscuity and sexually transmitted diseases" (Banyard et al, p.141 as cited in Blue Knot, 2018). Sandtray therapy allows the traumatised sand player to enter their intrinsic world to explore past hurts, feel into the pain held within their physical bodies and release traumas. This process, in all truthfulness, is one that needs to be experienced in order to fully understand the complexities of all the facets that take place within the boundaries of the sandtray over a period. Here the child (or adult) explores their attachment bonds. Using the miniatures a child is able to re-imagine and re-configure their basic needs, secure attachment (Bretherton, 1992) and psychosocial stages of development (Erikson, 1981). The therapist uses these theoretical guidelines to 'see' the changes in real time. The work of Pat Ogden explores the sensorimotor psychotherapy as an intervention for trauma and attachment. "We remember the past not only in words, images and stories, but also through chronic habits of tension, movement and postures. Our bodies continually respond to what happens to us, how others treated us, and how we feel inside" (Ogden, 2015, p. 99).

The science in sandtray therapy

Sandtray therapy employs a 'bottom up' and 'top down' approach, the moment the client places their hands into the sand they experience a felt sense. The neurobiology of a relational approach to

trauma recovery is inspired by interpersonal neurobiology, of safety. This has evolved out of the work of Badenoch, Ogden, Briere, Levine, McFarlane, Orloff, Schore, Shapiro, Siegel, Perry, van der Kolk, James, Porges, Allan Schore, Dan Siegel and Iain McGilchrist. Bonnie Badendoch, as a sandtray therapist, addresses the consequences of experiences that remain unintegrated (Badendoch, 2008) and provides insight and practices for supporting integration during the therapeutic process. The transitional object, being in this case the sandtray miniature, figures as the first symbol, indicating the child's ability to symbolise the carer's presence when working on attachment issues, and mother and child bonding. A basic instinct of trust can be experienced as a "symbol of the union of the baby and the mother" (Winnicott, 1974, p. 130 as cited in Varga, 2011), helps the child preserve some sense of connectedness, while it simultaneously involves the awareness of the lack of identity. Psychotherapy determines that a polarity must be experienced in order to find balance.

The activity of playing with the transitional object simply allows for the continued presence of the "significant other" in her (mothers) absence (Varga, 2011). Sandtray is the safe space in which the child experiences re-attachment. Building sand worlds combines the activating factor to trigger the first sensory experience. We look at a client processing in the sandtray, watching the creation of a sand world, observing their whole body, movements and non-verbals. To the trained eye of a professional sandtray therapist these bodily movements speak volumes. When clients become aware of events from the past, often from early childhood, that have influenced their behaviour, thinking or actions, it increases their self-awareness.

Not only this but clients also become aware that they have choice to continue to recreate a new normal, increasing resilience as they become the narrators of their new story. An adult sand player may slump from exhaustion, having carried their trauma for many years, or they may sit up and feel light. Repression of emotions can emerge in the form of an 'aha' moment, tears, curiosity, more questions especially the 'why?'. Response to the release of repressed emotions is an individual experience and should always be guided by the therapist as such, using non-judgemental person-centred counselling (Corey, 2009).

Badendoch cautioned on applying scientific ideas to the field of psychotherapy. Though it feels that this is exactly what

is occurring here, a simplistic comparing and relating theories to complex conditions.

Therefore, when we are given the permission to talk about energy and information flow, this sets up the key foundations and a summary of sandtray therapy as a felt sense, an invisible realm where clients alike explore the depths of their intrinsic self, deplete of words and whose actions do not require conscious thought-out planning, but moment-to-moment, here-and-now spontaneous mindfulness.

The treatment plan for this scenario is allowing clients exploration into sand worlds, where they can continue to utilise one or more of the modes, to explore the self, their family, environment and a larger sense of meaning, within their chosen collective.

A verbal directive from the therapist may include asking the client to explore their whole self, asking the words 'Who am I?' This Socratic exploration uses a language based on curiosity (Werle, 2016) and the role of the therapist is not to answer these questions, but to walk beside the client as they step into empowerment as they find new aspects of themselves, including shadow or, as I often say, "get to know your inner bitch, she could come in handy". Our role as therapist in this treatment plan is to become the significant other, especially if the client has had avoidant attachment and requires a sense of security and unconditional love. I find to give a heartfelt love to clients is a basic necessity, it sets clients up to experience basic safety needs according to the model of Maslow's Hierarchy of Needs (Maslow, 1943). In doing a series of sandtrays, a client explores the complexities of their intrinsic world. Through dynamic expression, the sand player creates spontaneous expressions of their social reality, inner traumas, fears and complexes and all this can take place non-verbally.

The sandtray, sand and miniature objects are the vehicle or medium of expression (Kalff, 2003). Trauma is associated with a process that altered consciousness, which Piaget called 'disassociation' and Freud termed 'splitting of consciousness' (Cherry, 2018). In today's terms we understand trauma as single incident trauma (PTSD), complex trauma (childhood abuse) and intergenerational trauma (Knot, 2018). Though many place intergenerational trauma at the hand of minorities, I would suggest that if you are human you are integrated into the intergeneration trauma chain.

Nonverbal communication

In complex trauma, sandtray therapy can become an invaluable non-verbal means of communion, which extends the normal bounds of communication, having to use talk therapy, until the client (adult) has an awareness and understanding of the inner child process and where the trauma resides. The multisensory experience of seeing, touching and doing within the boundary and safety of the therapeutic alliance, allows the client to tap into the right-brain creative region. In turn the significant other, the therapist, is also holding a space of safety and mimicking the right-brain limbic connection. A strong therapeutic alliance has the therapist using advanced empathy, feeling deeply as they sit with their client.

Lowenfeld's modes may also be seen as representative of this neuro feedback loop, or limbic to limbic relationship. When a client is expressing emotions of grief and loss the attention or focus is towards the emotional modes – the physical body and intellectual thinking modes are decreased (Rae, 2013). In the unique relationship with the therapist, the sand player is held in a therapeutic alliance and the therapist in turn may experience the sand player's felt sense. If a therapist is spiritually oriented, they may take this support to another level. Ogden's sensorimotor presents this as orienting our focus consciously or unconsciously towards where our impulses take us. "Trauma, attachment and other significant life experiences have

In complex trauma sandtray therapy can become an invaluable non-verbal means of communion which extends the normal bounds of communication, having to use talk therapy, until the client (adult) has an awareness and understanding of the inner child process and where the trauma resides.

Photo: Markus Spiske / Unsplash

a powerful effect on how and what we orient toward" (Ogden, 2015, p. 116). During a sandtray therapy session clients connect with different modes, jumping from the emotional to the thinking to the physical. Neither is incorrect, all of these modes make up our holistic way of expressing ourselves as humans. In affect by alternating from mode to mode the client is building resilience by becoming aware of the impacts on their whole self, which the expression of emotion has released.

This state of awareness brings the client more choice. They can choose to work with mindfulness-based sandtray therapy to experience a deeper sense of their emotional wellbeing and how this affects their thinking and body sense, by being in a state of mindful awareness, reflecting on their sand worlds, looking at the metaphor and listening to their inner voice of wisdom. This is how it works in the sandtray as well; clients bring themselves into a state of focused awareness. Focused attention allows clients to orient in new ways, understanding how their behaviours and way of being in the world has kept them in a state of their conditioning. Conditioning, behaviour and ways of being were useful as coping mechanisms in a previous life, but perhaps now these ways serve to hinder health and wellbeing (Werle, 2016).

This strength-based approach opens a new dialogue, no longer 'I can't' but 'I can, I will'. Step-by-step clients build their internal strength, gaining a new perspective of themselves as creators of their own destiny.

Behaviours are often learned habits and patterns set up in the family environment. In this space our focus can stay in early childhood and parenting styles.

A young girl who was constantly told to be a 'good girl, people only like good girls', may grow up being a pleaser, where this was not her natural state.

Personality traits in the developmental stages is another area that can be explored through the sandtray, and if the personality theory that Gabor Maté speaks of holds true, early intervention could see certain personality types break their cycle and the pleaser find her inner bitch!

Traumas played out and resolved in the sandtray

Traumas are memories embedded into the emotional circuitry. In complex trauma the symptoms are signs of an over-aroused amygdala impelling the vivid memories of a traumatic moment to continue to intrude on awareness (Goleman, 1995), which affects clients' daily habits, thoughts and actions. Complex trauma is defined as betrayal at its core. For child victims of abuse the child is marinated in deception, left with a deep abiding sense of shame, feeling when something happens, they are automatically at fault.

Children and adults who have access to sandtray therapy for the treatment of complex trauma and attachment inadequacies will benefit from long-term therapy of up to and more than a year. In repeated sandplays clients relive the trauma safely, the memory of the trauma repeats in a context of low anxiety and desensitisation and it allows for a no traumatised set of responses.

In sandtray therapy clients use the elements, water being representative of deep emotions, sand the earth element. Used within the safe boundary of the sandtray a client is tapping into their own innate healing aspect, their emotional self is releasing unexpressed fear, anger or negativity.

The sandtray becomes the containment in the psychical sense, the therapeutic relationship provides the safety element (Turner, 2005) and a traumatic memory can be rearranged or changed, giving a client the choice to heal. Children can use the sandtray miniatures

Children can use the sandtray miniatures to create wonderful fantasy sand worlds to explore the trauma, giving the story different outcomes, such as killing the antagonist, calling in the guards, going into battle and defeating the enemy – think about all the fairytales and Disney stories. Accessing sandtray therapy is the step towards building resilience (Kalff, 2003) as the child changes the story of their trauma-focus to include a new trauma narrative.

to create wonderful fantasy sand worlds to explore the trauma, giving the story different outcomes, such as killing the antagonist, calling in the guards, going into battle and defeating the enemy – think about all the fairytales and Disney stories. Accessing sandtray therapy is the step towards building resilience (Kalff, 2003) as the child changes the story of their trauma-focus to include a new trauma narrative.

This is how our young boy processes his emotions and behaviour through sand worlds whose themes revolve around fighting, swords, knifes, killing and, like a phoenix, returning to do battle all over again. For a whole year his theme did not change, the soldiers he lined up were labelled good and bad. The bad guys always had to lose. By reinacting the murder of his mother, this child was gaining a sense of resilience, he controlled who held the knife, he controlled who lived and who died.

Over time this child stopped wetting his bed, he learned to call his carers 'mum' and 'dad' without hesitating, his language and academic skills were enhanced and those around him were also free to talk about what happened to this little boy without the whispers and corridor talk.

Similarly, clients have a remarkable ability for adaption, Ogden refers to this as "the wisdom of the body" (Ogden, 2015, p. 81). The body holds feelings, emotions or unexpressed trauma and attachment issues. Studies done on the Romanian orphan babies highlight the importance of early attachment – that of being held, having eye contact, hearing a lullaby. Absence of these healthy and normal early attachment bonds and actions led to the Romanian babies and young children suffering from psychological, physical and emotional symptoms, even death. Yet these babies received food, water, shelter, all the basic needs according to Maslow's Hierarchy of Needs (Maslow, 1943), but they did not receive love, safety, security, warmth, eye contact – all the basic human needs to enable healthy attachment leading to early attachment trauma.

"Trauma and attachment influence how we feel about our bodies. If we were not held safely, treated kindly, or given enough support, we may feel ashamed, disgusted, repulsed or angry toward our bodies" (Ogden, 2015, p. 82). On an emotional level emotions left unexpressed, according to Gabor Maté (2003), lead to disease and chronic illness, even death. Sandtray therapy guided by a well-trained sandtray therapist enables clients young and old, to connect back to find that felt sense of safety, security, and to rebuild a sense of trust that leads the client towards autonomy and further healthy psychological development.

Conclusion

In conclusion, sandtray therapy and the framework it encompasses holds a platform for most of the 21 Blue Knot Clinical Guidelines in the context of childhood trauma and trauma-informed care and service delivery. Although we were not able to address all of the areas of the practice guidelines for treatment of complex trauma using sandtray therapy, this means that there is scope within the sandtray therapy community for further research and practice to utilise these guidelines to promote this therapeutic method as a trauma-informed practice. Regular professional supervision for current and emerging sandtray therapists would ensure that these practice standards are followed. Although this is admittedly why this paper cannot address all of the Blue Knot practice guidelines, it is not always the case that those using sandtray therapy as a standalone method are professionally trained using high principles and standards along with an absence of professional sandtray therapy supervision. Though the key is working collaboratively with research institutes and driving the sandtray advocacy towards a unified practice method to deliver research and evidence-based trauma informed practice, in so doing sandtray therapy will become a well-recognised standalone practice method.

Clinical Supervision Services

'Critical reflection, continuous learning'

Clinical supervision is a collaborative process that supports the professional development of practitioners working in the helping professions; and promotes ethical practice to enhance client outcomes.

Charlene Pereira is an ACA registered supervisor and a member of the ACA Clinical Counsellors College. She has in excess of 15 years clinical experience.

Where is Charlene located? Ringwood North and Melbourne

What are my supervision options?

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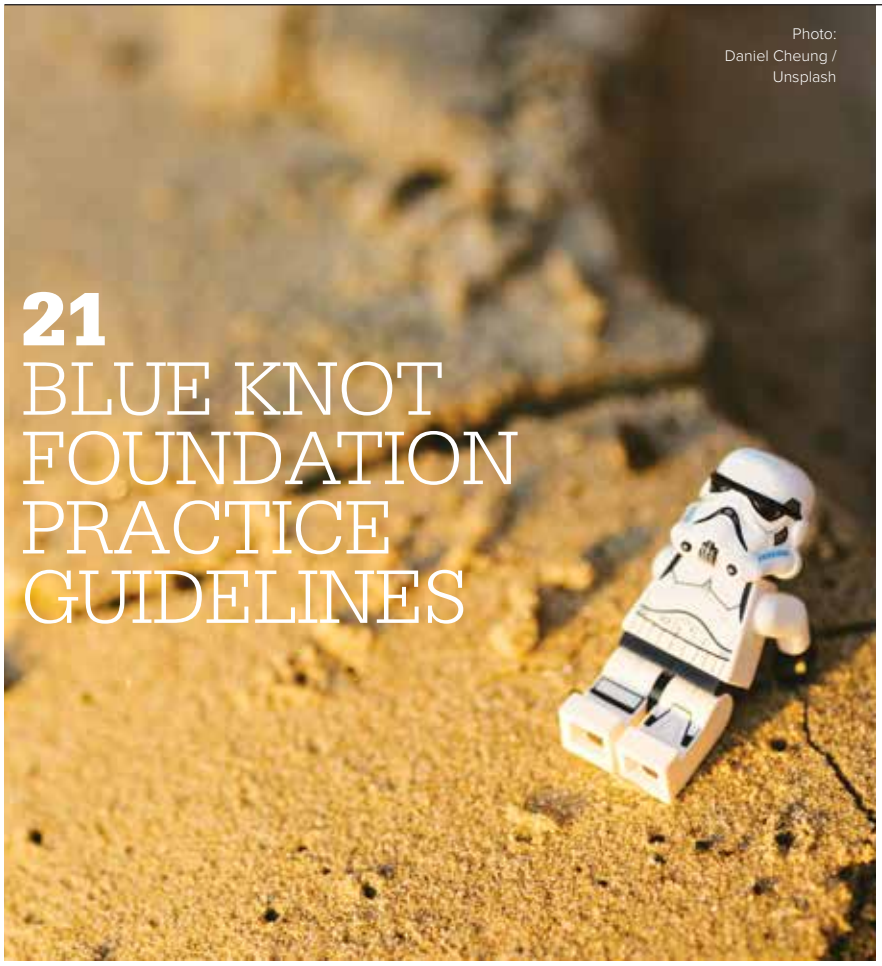

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21 BLUE KNOT FOUNDATION PRACTICE GUIDELINES

(1) Facilitate client safety. '[A] first order of treatment is to establish conditions of safety to the fullest extent possible. The client cannot progress if a relative degree of safety is not available or attainable'.

(2) Recognise the centrality of affect-regulation (emotional management; ability to self-soothe) as foundational to all treatment objectives and consistently foster this ability in the client. Facilitation of effective management of internal states is vital to a felt sense of safety, and as critical to experience outside the therapy session as to experience within it. Fostering of the ability to self-regulate should be a consistent task of therapy, involving, among other things, the teaching of strategies to self-monitor and self-intercept. Note that this task can be compounded in that existence of a coherent sense of self cannot be assumed (see Pt 3).

(3) Recognise the breadth of functioning impacted by complex trauma and that acquisition, not just restoration, of some modes of functioning may be necessary. Particularly if it dates to childhood, complex trauma can entail developmental deficits in self-organisation which do not apply in 'single-incident' PTSD (i.e. where there is no prior underlying trauma). 'As a group, clients with complex trauma disorders have developmental/attachment deficits that require additional treatment focus... treatment goals are more extensive than those directed at PTSD symptoms alone'.

(4) Regard symptoms as adaptive and work from a strengths-based approach which is empowering of the client's existing resources. A view of symptoms as 'expectable and adaptive' reactions to traumatic childhood experiences (i.e. as the outgrowth of normal responses to abnormal conditions) should inform clinical work.

(5) Understand how experience shapes the brain, the impacts of trauma on the brain (particularly the developing brain) and the physiology of trauma and its extensive effects. Key aspects of this information should be sensitively communicated to the client, with a view to normalising distressing/problematic internal experience and responses for which they may otherwise hold themselves solely responsible. The effects of trauma on the brain, body and subsequent functioning should form part of the psycho-education which is a significant component of effective trauma therapy. While self-blame is unlikely to dissolve in the wake of psycho-education alone, current insights into the physiology of trauma and its effects need to be communicated to the client.

(6) Encourage establishment/strengthening of support networks. Likely impairment of relational capacity may mean that supports are lacking or nonoptimal. The therapeutic relationship itself fosters relational capacity as healthy support networks are worked towards.

(7) Attune to attachment issues at all times and from the first contact point. While different in presentation and levels of functioning (including at different points in their lives) complex trauma clients have sustained assaults to their ability to connect with themselves and others. Attuning to attachment

issues is vital to the therapeutic alliance and to effective working within it. It also assists recognition of potential indicators of whether the client is experiencing complex or single-incident trauma. Thus there are significant reasons for therapist sensitivity, from the first contact point, to the relational style of the client (and thereby to the possibility of underlying trauma).

(8) Understand and attune to the prevalence and varied forms of dissociative responses, the differences between hyper and hypoarousal, and the need to stay within 'the window of tolerance'. Structural dissociation represents an extreme form of defence in the face of extreme (inescapable) threat, and is a frequent feature of complex trauma when abuse begins early in childhood. Yet there are many and milder forms of dissociative response of which the therapist needs to be aware ('The more you know about dissociation, the more you automatically watch for its markers'). As responses to the experience of extreme anxiety, hyperarousal is characterised by agitation, while hypoarousal manifests as passivity, 'shut down' and withdrawal. Therapy must always remain within 'the window of tolerance'; i.e. the threshold of feeling the client can accommodate without becoming either hyper or hypoarousal.

(9) Expect and be prepared to work with a variety of client responses, including a sense of shame which may not be readily apparent but which is frequently present and intense. Inability to self-regulate and to draw upon relationships to regain self-integrity engenders deep shame to which therapists should be attuned ('The feeling of shame is about our very selves – not about some bad thing we did or said but about what we are'; 'shame also expands the clinician's focus from fear or anxiety to the sense of a damaged self').

(10) Embed and apply understanding of complex trauma in all interventions. Recognising the limits of standard assessment tools and modalities in relation to complex trauma, but also the extent to which these can be redressed via incorporation of the new clinical and research insights (see Pt 11) ensure that all interventions stem from understanding of current clinical and research insights into complex trauma.

(11) Ensure the therapeutic model/approach promotes integration of functioning and contains the 'core elements' consistent with research findings in the neurobiology of attachment. These include activation of/engagement with right-brain processes, attentiveness to the role and effects of implicit memory, and engagement with physical as well as cognitive and emotional processes – 'we must attend to all three levels: cognitive processing... emotional processing... and sensorimotor processing (physical and sensory responses, sensations and movement'). While there are different ways of attending to these dimensions, current research elaborates the need for all three to be addressed therapeutically ('it is important to be able to engage the relevant neurobiological processes'). As Rothschild highlights, there is a frequent misconception that clients in 'the freeze state' are under-aroused, with the ensuing danger that the therapist may attempt to provoke an obvious response. 'Every trauma client, whether frozen, dissociated, or hypervigilant, is suffering with a nervous system that is in overdrive, already provoked to the highest level' (Rothschild, Trauma Essentials, New York: Norton, 2011, p.15; emphasis added). Thus '[r]educing pressure by removing provocation will relieve the nervous system and make mobility, calmness, and clear thinking more possible' (*ibid*).

(12) Recognise the extent to which the above requires adaptation of, and supplements to, 'traditional' psychotherapeutic

approaches (i.e. insight-based and cognitive behavioural). Research in the neurobiology of attachment establishes the limits, as well as benefits, of 'talk', and the need for active addressing of physical, sensorimotor, and experiential processes as well as cognitions and verbal expression of emotion ('bottom up' and 'top down').

(13) Phased treatment is the 'gold standard' for therapeutic addressing of complex trauma, where Phase I is safety/stabilisation, Phase II processing and Phase III integration. The ability to tolerate emotion (self-soothe, regulate affect) is a primary task of treatment, and accounts for the importance of Phase I. Attempts to 'process' trauma in the absence of ability to self-regulate can precipitate overwhelm and re-traumatisation. 'Processing' of complex trauma is a Stage II task and should not be encouraged in the absence of the two foundational self-regulatory work of Phase I. Hence the critical importance of Phase I to therapeutic outcomes – 'Overstatement of the importance of this step is not possible; it is vital if trauma recovery is to be realised'.

(14) Therapy should be tailored and individualised; 'one size does not fit all'. 'Adapt the therapy to the client rather than expecting the client to adapt to the therapy'.

(15) Therapists should be culturally competent and sensitive to gender, sexual orientation, ethnicity, age, and dimensions of 'difference'. Awareness of, and attunement to, the potential impacts of 'difference' in its various forms (age, ethnicity, socio-economic status, and so on) is important for all therapeutic work, including and especially that with complex trauma. To the extent that clients are themselves attuned to therapist ambivalence, it is imperative for therapists of complex trauma to be highly attuned to their own responses to perceptions of cultural, gender and other 'differences' in relation to their clients, and to be conversant with some of the valuable resources which can assist in this regard.

(16) Engage in regular professional supervision. 'The intensity and complexity of transference countertransference dynamics in complex trauma relationships are such that working without clinical consultation, at any level of helper experience, can pose great hazards for both clients and therapists.

(17) Attend to duration and frequency of sessions. Therapists should recognise that complex trauma treatment is generally longer than for many other presentations, and that while varying significantly according to the client, is 'rarely…meaningful if completed in less than 10-20 sessions. If economic or other constraints severely limit the number of available sessions, there are strong grounds to confine therapy to the 'stabilisation' (Phase I) stage. Therapy is recommended to occur on a once or twice-weekly basis, with sessions ranging between 50 and 75 minutes for individual therapy and between 75 and 120 minutes for group therapy. Therapy should not exceed these recommended standards of frequency in the absence of compelling grounds for doing so, or destabilisation and dependence may result.

(18) Recognise the importance of implementation of boundaries. 'Boundaries are particularly salient with clients who have been subjected to violations, exploitations, and dual relationships. Boundaries should be mutually negotiated, and care should be taken to ensure that the client understands their significance and does not experience them as punitive. Maintenance of boundaries is also important for therapist self-care; while this is always the case it is especially so in the demanding work of complex trauma.

(19) Engage in collaborative care as appropriate. This entails collaboration not only with the client, but with the other professionals and services (e.g. prescribing physician) with which they may be in contact.

(20) Facilitate continuity of care as appropriate. Histories of betrayal and abandonment render complex trauma clients vulnerable to feelings of rejection. The ending of therapy (for whatever reason) is itself a process which represents 'a critical opportunity to support and sustain the client's gains in relational, emotional, and behavioural self-regulation'. Courtois, Ford & Cloitre note that in the event of client engagement with a new therapist or treatment provider, interventions which encourage a sense of continuity should be integrated into the client's transition process.

(21) Diversity of clients means that recovery, too, is diverse. 'Therapists must be aware of differences in clients' capacities to engage in therapy and to resolve their symptoms and distress. There are as many degrees of self- and relational-impairment as there are of healing capacities and resources, resulting in different degrees and types of resolution and recovery'. ■

(Collated by Suzette Misrachi: 12/05/2017)
See: pp. 4–9 of Blue Knot Foundation's Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery, www.blueknot.org.au/guidelines.

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Fiona Werle is the CEO of Opengate Institute, which advocates for a united industry in learning, education and supervision. Its aim is to support all therapists, current and future,w to have access to good research-based and government-approved education in sandtray therapy. Fiona advocates for sandtray therapy in Australia and she has recently written a curriculum and Qualification as a graduate certificate in sandtray therapy, 10757NAT, of which she hopes to be able to train new and emerging sandtray therapists who have a passion in their own fields and industry, working within areas of their expertise. Fiona runs a successful training organisation and is currently developing Sandtray Play Work for academic learning and emotional social and behaviour skills. She has written two books on sandtray therapy, self-published, but hopes to have these reviewed and accepted by a publisher. She's also a professional supervisor of counselling and sandtray therapy. Fiona currently runs a private counselling and sandtray therapy practice. She is NDIS-registered to work with clients with disabilities and also runs a practice for clients who request counselling. Other clients include Challenge Foster Care and FACS.

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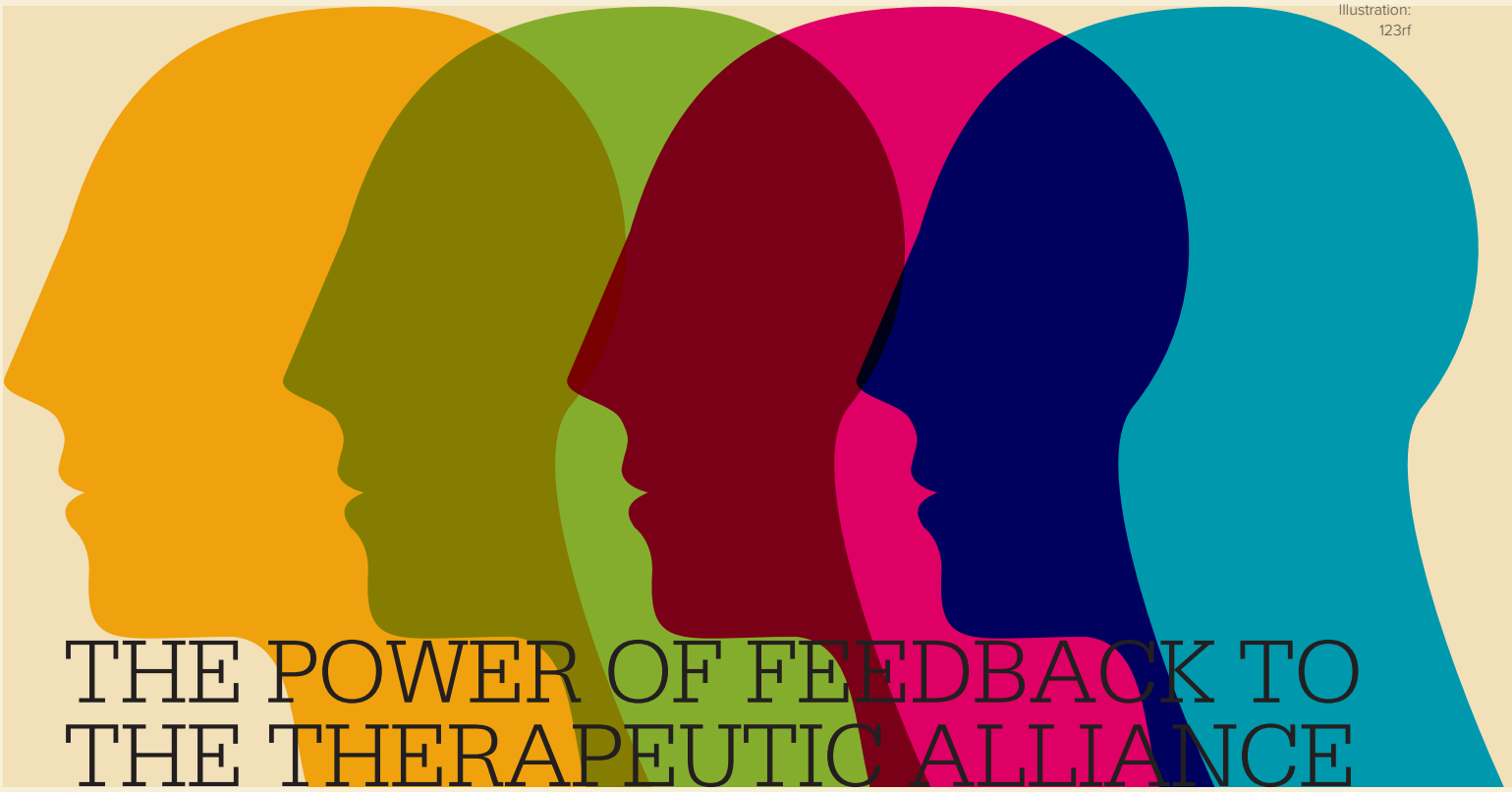


Illustration: 123rf

THE POWER OF FEEDBACK TO THE THERAPEUTIC ALLIANCE

Hearing client feedback can be difficult; however, it is important in creating strong therapeutic relationships.

By Helen Wayland

In terms of becoming a better therapist, perhaps the most influential training I ever attended was Scott Miller's 'Supershrinks'. I'll cut to the chase and tell you that Scott Miller is a researcher and he researches what works in therapy. And what works in therapy is the relationship.

We are all tied in to our own modalities and, like most therapists, I am very attached to my toolbox, which includes EDMR, hypnotherapy, art therapy, and a range of other (in my opinion) life-changing techniques. However, the rather uncomfortable truth that Miller reveals is that research shows, over and over again, that the therapeutic alliance results in a significant proportion of the positive change for our clients.

So, you ask, how can we make that alliance stronger, if all we need to do is create a strong client relationship? The answer to that question is: ask for feedback. Every session. In fact Miller recommends feedback at the beginning and the end of the session. Let's talk about the stuff you ask at the end of the session first, because it's the most uncomfortable for the therapist.

"Did you feel heard and understood today? Did we talk about what you wanted to talk about?" These two questions can be immensely powerful at the end of a session. Of course, you have to be prepared to hear the truth, which is why many therapists very seldom ask these basic questions. Miller points out that therapists routinely overestimate their own efficacy, and clients often say they weren't heard or understood. There is a genuine chasm between what the therapist thinks is happening and what the client experiences in a session.

That gap can be bridged by the strength of the alliance, and clients can be very forgiving of lapses, gaffes and misunderstandings if you allow them to freely voice their feelings about the session during the session. I've had a client say to me: "I can't believe you just said that to me!" Which only gave me a great opportunity to know that I'd inadvertently said something offensive to him. Most importantly, the client felt empowered to reveal his true reaction, knowing it would be heard.

So how do we get to a place where ruptures can be mended immediately, in the moment, by the client being able to state their feelings as they arise? By asking for their feedback regularly. "Have

we worked on what you wanted to work on today? Do you feel like the method I'm using is a good fit for you?" Ask this after the first session and continue to ask in subsequent sessions. Even clients who are not assertive to start with become more so if you keep asking.

As therapists we often have our own agendas for the treatment plan and the pace at which that moves. I recently had an eighteen-year-old client who just wanted to unpack, slowly, some things that were happening to him. Because he'd been referred by someone with whom I'd done very successful EMDR and hypnosis in the past, I launched in and pulled out all the tricks – bamboozling him in the process. When I asked, in a rather self-satisfied way, at the end: "How is it feeling as we come to the end of the session? Did we work on what you wanted to work on?" He replied honestly that we didn't talk about what he wanted to talk about and that he felt awful as we came to the end of the session, and that the session wasn't at all what he expected or wanted. Some sessions down the track we are now successfully using all of the processes I'd tried to introduce at the beginning – but we had to repair the rupture first, of my agenda running roughshod over his sensitivity.

The questions we ask at the beginning of the session are just as important. "How is it feeling, since we last met? Individually, interpersonally, socially? What was useful to you about the last session? Was there something that I missed that you would like to bring in today?"

The point of asking for feedback is to create a relationship where the client and the therapist are working together, to create an agreed-upon treatment plan and using a method that works for the client.

In Miller's 'Supershrinks' presentation, he shows a short film of a therapist whose results in the outcome scales (a way of keeping track of these feedback questions and tracking a client's improvement) outranked all other therapists from around the world in terms of both client mental health and therapeutic alliance. I happened to meet her, when I was sitting next to her at a conference in the US, and she asked me to visit her at her practice treating veterans in the UK. I spent a day sitting in on sessions as she collaborated closely with her clients on outcomes. There was a strong sense that she didn't see herself as an expert, but as someone with a set of skills that she could bring to help in the areas that the clients needed them. She is one of the most humble therapists I have ever met, as well as being one of the most successful.

The take-home message of this story is that you don't have to pretend to have the answers when you are working with clients. Ask them how you're doing: are they feeling supported and listened to? Ask them how they'd like to work with you, going forward. What methods would they like you to use? And listen to the answers without judging yourself or your client. ■

About the author

Helen Wayland is a counsellor, hypnotherapist, EMDR therapist and clinical supervisor working in St Kilda, Melbourne. Level 4 Member ACA, Member of the ACA College of Supervisors, Clinical member AHA, member EMDRAA.

Scott D. Miller is co-founder of the Centre for Clinical Excellence: **www.centerforclinicalexcellence.com**

Read an article on 'Supershrinks' here: **www.psychotherapy.com.au/fileadmin/site_files/pdfs/Supershrinks.pdf**

How Australian registered general nurses perceive their role in suicide prevention

By Marie Ward

Abstract

This qualitative study explored how registered general nurses in Australia perceived their role in suicide prevention. Through semi-structured interviews, seven Australian university-trained registered general nurses, each with at least six years of experience, spoke about their experience, knowledge, attitudes and opinions regarding suicide prevention. Interpretative phenomenological analysis (IPA) was used to analyse the interview transcripts.

Ten themes emerged from the analysis. Physical care comes first; nurses feel underconfident outside of physical care; there is no time for psychological care; nurses rely on personal experience to understand the importance and the need for psychological and holistic patient care; mental healthcare is hopeless; mental illness stigma still exists; nurses fear not being able to cope and burning out; nurses have a desire for more support; nurses want more relevant and accessible education; and certain nurses need suicide prevention training more than others. Clinical implications and suggestions for further research were discussed.

Introduction

3,027 people in Australia died by suicide in 2015 (Australian Bureau of Statistics, 2016). But suicide can be prevented, (Mann et al. 2005; Krysinska et al. 2016; Mishara and Martin 2012; Szekely et al. 2013; Matsubayashi, Ueda and Sawada 2014; Roscoat and Beck 2013) and the evidence shows that most people communicate their desire to suicide (Pompili et al. 2016; McPhedran and De Leo 2013) and most people who kill themselves have recently had contact with health professionals (Rahme et al. 2016; Luoma, Martin and Pearson 2002). The majority of those health professionals are nurses (Bramhall 2014; Valente 2010). This means that nurses are in the frontline of healthcare and in a prime position to help prevent suicide. The Australian Government is now making suicide prevention a health priority (Department of Health and Human Services, 2016). However, suicide prevention is not part of the standard training for nurses. Nurses feel underqualified to assess and take care of patients at risk of suicide and they prioritise physical care over psychological care (Oranye, Arumugam, Ahmad and Arumugam 2016; Coppens et al. 2014; Kishi et al. 2011; Puntil et al. 2013; Valente 2011; Hulatt 2017). Most nurses also hold negative and stigmatised attitudes about suicide and suicide prevention (Betz et al. 2013; Valente 2011; Neville and Roan 2013; Kishi et al. 2014). While it is known that education and skills training can help to improve this (Perboell, Hammer, Oestergaard and Konradsen 2015; Kishi et al. 2014; Egan, Sarma and O'Neill 2012; Coppens et al. 2014; Wu et al. 2014; Mahendran et al. 2015), there is still much unknown about whether nurses believe that suicide prevention is even part of their role. There are no Australian studies on how nurses perceive their role in suicide prevention and very little is known about nurses' priorities and attitudes on suicide prevention in Australia.

The objective of this research was to add to the current body of knowledge about how nurses perceive their role in suicide prevention in order to learn how to better support nurses and equip them with tailored suicide prevention skills in their role at the frontline of healthcare.

Participants

Participants in this study were all registered general nurses between the ages of 25 and 45 and were working in Australia. All participants were personally recruited by word of mouth by asking the researcher's nursing colleagues if they were interested in participating.

TABLE 1: PARTICIPANT INFORMATION

NAME	AGE	EXPERIENCE AS A NURSE	AREA OF SPECIALTY
Amanda	29	6 years	Trauma
Rebecca	35	11 years	Community/emergency
Claire	35	13 years	Acute surgical
Jim	38	17 years	Subacute medical/surgical
Anne	44	19 years	Acute surgical
Mary	38	16 years	Community
Jess	33	10 years	Post-anesthetic recovery

Design and method

This study employed an interpretative phenomenological analysis (IPA) approach using semi-structured interviews to help gain a greater understanding of nurses' professional experience, knowledge, attitudes and opinion on suicide prevention. IPA is a qualitative method of research specifically designed to examine how people make sense of their world, gain greater insight into people's perceptions and is sensitive in describing and exploring differences in experiences among a small sample of participants (Smith & Osborn, 2008). Ethics approval was granted from the Cairnmillar Human Research Ethics Committee (HREC) prior to collection of the data. The HREC approval number is 2017/01304-14. Semi-structured interviews of up to 60 to 90 minutes were held.

The interviews were conducted online using Vsee software. The interviews were digitally recorded and copied to a secure storage device. The audio recordings were transcribed verbatim. Information likely to identify the participant was removed from transcripts and participants were given pseudonyms.

Each transcript was read and summarised and meaningful passages from each interview were put in a separate file.

Meaningful descriptions of similar attitudes and experiences were placed in the same document to help uncover evidence of each theme and the existence of any subordinate themes. Five subordinate and five subthemes were identified.

Results and discussion

Physical care comes first

The nurses in this study tended to view their role as being physical. They spoke about physical care being their number one priority. This finding is consistent with the findings of other recent studies that found nurses prioritised physical care above psychological and psychosocial care (Jones et al., 2015; Oranye et al., 2016).

"The physical demands on nurses are very high. Does that mean that they are the best people to provide psychological care? It may not be a reality." (Jess)

Nurses feel underconfident outside of physical care

All of the nurses felt out of their depth, underconfident and incompetent in dealing with mental health and suicide prevention. They didn't know what questions to ask and were afraid of saying the wrong thing, offending their patients and ruining the rapport. They perceived mental illness as much harder to treat and they found working with mental illness as less rewarding so they tended to avoid it. This appeared to be a subtheme related to putting physical care first. This was influenced by the healthcare system and by nursing education, which emphasised physical care first. This thematic finding is in line with many other recent international studies which also found that nurses had a lack of education in suicide prevention and that they felt inadequately prepared to support patients with depression and suicidal ideation (Betz et al., 2013; Coppens et al., 2014; Hulatt, 2017; Oranye et al., 2016; Prince, 2011; Puntil et al., 2013; Valente 2011).

"You do feel out of your depth. You just hope that you're saying the right things, it's really intimidating knowing what to say. You don't know what to say." (Jess)

There is no time for psychological care

The nurses in this study were so busy providing the necessary physical care that they did not have time to also provide psychological care. They had so much physical care work that they often worked back late and frequently missed out on getting meal breaks. As a result,

the provision of psychological care, such as performing a suicide assessment, was seen as an extra burden. This supports the finding of a recent mixed method study, which also showed that time was a huge barrier for nurses discussing suicide with their patients (Hulatt, 2017).
"It's hard with time constraints, when you know that there's other people that you've got to see and other things to be doing." (Jim)

Nurses rely on personal experience to understand the importance and the need for psychological and holistic patient care

All of the nurses in this study believed that holistic care is important, and that practising psychological care and suicide prevention is part of holistic patient care. The nurses get a sense of fulfillment and meaning when they know they have provided good holistic care. In fact, the reason many of them became nurses in the first place was due to a desire to help others and make a difference in their patients' lives. Many of the nurses rely on their own professional and personal experiences to enable them to provide good holistic care. The nurses reflected on their previous experiences to help them decide the best course of action to take in order to help patients in psychological distress. This finding is important as it shows that nurses have a passion to provide holistic and psychological care and it also reveals that nurses learn from reflecting on their personal and professional experiences. This indicates that there could be potential for improving holistic care and suicide prevention if nurses had more time and support to prioritise psychological care. This also shows that nurses could benefit if they were given opportunities to reflect and learn from their experiences. This finding is in line with Wu et al's. study (2014) which showed reflective learning and group discussions helped to improve nurses' provision of psychological care and suicide prevention.
"The patient might not remember the surgeon who cut out the cancer but they'll remember the nurse who they felt a connection with and the nurse who went out of their way to look after their emotional needs. That's part of the reason why I got into nursing anyway, with Mum dying at a young age; I thought I could maybe help people who had gone through hard times." (Jim)

Mental healthcare is hopeless

Each of the nurses in this study revealed a sense of hopelessness around suicide prevention and the mental healthcare system in general. All of the nurses felt hopeless about adequate funding and support being provided for suicide prevention. Some of the nurses also had a negative view of being able to help patients with mental illness. The nurses perceived mental illness as being far harder to treat than physical illness. They found it less rewarding to care for psychiatric patients than to care for patients with physical illness, as they could not see psychiatric patients improve as easily as they could see physical ailments improve. This is similar to the findings of a quantitative study carried out by Betz et al., (2013) which revealed nurses felt hopeless and sceptical about suicide being preventable. This scepticism and sense of hopelessness in mental illness could affect nurses taking on a role in suicide prevention.
"My workplace would never, ever in a million years send us off for mental health training. The GPs', they're the huge gatekeepers of our healthcare system but they're under so much pressure." (Claire)

Mental illness stigma still exists

The nurses in this study talked about the mental illness stigma in our society as well as in the health care system. Some of the participants indicated that nurses' attitudes towards suicide prevention could be a potential obstacle in suicide prevention. This echoes the findings from several other studies that showed nurses as having a negative attitude and stigma towards psychiatric patients (Hodgson, 2016; Hulatt, 2017; Jones et al., 2015; Kishi et al., 2011; Neville & Roan, 2013; Valente, 2011). This is concerning, as it could deter suicidal patients from opening up and expressing their suicidal ideation to nurses and it could affect the care that the nurses provide for suicidal patients.
"It was hard sometimes, certainly when the patients were being really derogatory and nasty, to feel empathy for them because they might have nearly hurt one of my coworkers, or did something really nasty to myself as well." (Jim)

Nurses fear not being able to cope and burning out

Many participants in this study have significant concerns about working with patients in psychological distress. Some nurses believe that they won't gain a sense of personal accomplishment if they work with patients with mental health issues and suicidal ideation, and this appears to be related to their view of mental health as being hopeless to deal with. Some of the participants were concerned that working in mental health would be bad for their personal wellbeing. They feared that they would not be able to cope with the burden. This finding is particularly important as current research shows that all nurses have a particularly high risk of getting compassion fatigue (Boyle, 2011) and nurses are known

for reporting high levels of stress and burnout (Canades-De la Fuente et al., 2014; Milner, Maheen, Bismark, & Spittal, 2016; Silva et al., 2015; Spence, Laschinger, & Fida, 2014).
"On my mental health placement, I felt like a fish out of water, and I felt really useless. I just felt helpless." (Jim)

Nurses have a desire for more support

Most of the nurses expressed feeling great pressure and responsibility in their role. The nurses expressed a desire for greater support from doctors in regards to taking more responsibility for their patient's mental wellbeing. The nurses' desire for more support is related to their fear of not being able to cope and burning out. The nurses would like an opportunity to debrief in a safe space; however, time and resources are major barriers to this. Most of the nurses do not get opportunities to debrief at work unless a major event has occurred. Therefore, nurses tend to debrief informally outside of work with colleagues and friends. The nurses valued support offered within the multidisciplinary team. This is an important finding as it shows that nurses could be willing to receive clinical supervision and utilise support from a multidisciplinary team. Clinical supervision is known to serve as a form of peer support and it has been shown to provide stress relief for nurses (Koivu et al., 2012).
"I think debriefing is really important because you can reflect on how people responded well to a situation and on maybe what could have been done better, and learn for next time." (Rebecca)

Nurses want more relevant and accessible education

The nurses in this study were all interested in improving their confidence by receiving more education to help them deal with patients who are psychologically distressed and have suicidal ideation. It is clear from the interviews that nurses value getting information and education on topics which are practical for them, including what resources are available, how to ask relevant questions, and gaining tips on speaking appropriately with anxious, depressed and suicidal patients. Continuous education and lifelong learning is valued in nursing.

All the nurses believed that they should have received training in mental health as an undergraduate student and also more educational updates as they progressed through their career. This finding is in line with the findings of Prince (2011) which also showed nurses had a desire for more education in dealing with suicidal patients. This finding is also supportive of the research findings of Coppens et al. (2014), Egan et al. (2012), Kishi et al. (2014) and Perboell et al. (2015) as each of those studies showed that when nurses receive education and training in suicide prevention their confidence and level of competence in dealing with suicidal patients improves.
"I just think that nurses could get more education. I think we should have placements in mental health, because there's a high population of patients who are coming in with mental health problems, and they're on general wards." (Amanda)

Certain nurses need suicide prevention training more than others

All of the nurses were interested in gaining further knowledge in suicide prevention; however, the nurses who have to deal with suicidal patients more frequently are more motivated to receive education than the nurses who encounter suicidal patients rarely or less frequently.

This is consistent with the findings of a quantitative study by Kishi et al. (2011) which showed that nurses with more exposure and experience in dealing with suicidal patients tend to have more positive attitudes towards suicide prevention training.

This is a significant discovery, as it shows that nurses are more likely to show interest in having suicide prevention training if they have had greater exposure to suicidal patients.
"There are different roles in nursing, nursing priorities depend on what area you are in. I think all nurses need suicide prevention training but I think there's no point in nurses doing it if they don't have an interest or don't feel that there's a need." (Mary)

The interviews showed that nurses value and appreciate the importance of psychological and holistic patient care. However, they are under immense pressure and they have little faith in the hospital and mental health systems and they feel like they do not have the relevant training, skills, time, resources or support to provide psychological care.

They tend to prioritise physical patient care and rely on their life and professional experience to help them to deal with patients in psychological distress. They are willing to get more relevant education in suicide prevention and mental illness if they can see that it will be useful for them and if they will be supported in doing so.

TABLE 2: LIST OF THEMES

THEME 1. Physical care comes first

"The physical demands on nurses are very high. Does that mean that they are the best people to provide the psychological care? It may not be reality." (Jess)

"It's still really a physical role, in my mind, that I have as a nurse. Because nurses' time is taken up so much with just the physical aspects of caring for a patient." (Anne)

SUBTHEME 1a. Nurses feel underconfident outside of physical care

"I find looking for physical illness so much easier. Everything is connected and that's what you're taught in university". (Amanda)

"I've found mental health nursing my biggest challenge because physical things I felt I could deal with a lot easier. (Jim)

"I don't think as a general nurse you're really equipped to deal with mental health." (Rebecca)

SUBTHEME 1b. There is no time for psychological care

"Because the patient has come there in a distressed state, you feel like you need to give them your attention, but you might not have that allocated time to be expected to be doing that because you're expected to be doing other things." (Mary)

"It is hard with time constraints, when you know that there's other people that you've got to see and other things to be doing." (Jim)

"Well, actually, I feel like enough is enough. I know the mental and spiritual side is important of course, but I don't have time to deal with it." (Anne)

THEME 2. Nurses rely on personal experience to understand the importance and the need for psychological and holistic patient care

"So, from my own life I would know how I would like to treat this patient. That's only from life experience." (Claire)

"Having personal experiences is so often how you cope. I think that helps a lot." (Anne)

"Providing psychological care is something that you develop. As you become more experienced, you do things almost intuitively." (Jess)

THEME 3. Mental healthcare is hopeless

"You just feel a bit disheartened and you're like, 'Oh, there's nothing I can do for them.' Mental illness is so much harder to treat and it's harder to see progress." (Amanda)

"There needs to be more mental health funding. It's hard to get people into programs, often they're ready to access something but there's nothing available, it's frustrating because you sometimes think, well, what's the point if there's nothing I could do about it." (Mary)

"Staffing does not take into account the emotional and spiritual side of people. The government just treat people for physical ailments, all else seems to be forgotten. There needs to be plans for suicide prevention, but unless you put more nurses on, I don't see how you are going to get there." (Anne)

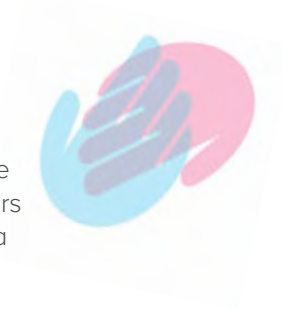
SUBTHEME 3a. Mental illness stigma still exists

"Healthcare workers aren't very understanding of mental illness." (Mary)

"I couldn't wait for my psychiatric shift to end. I felt so afraid. I could actually feel my heart racing. I think the attitude of nurses needs to change, I feel like we're not trained well enough so we don't see mental health and suicide as illnesses like the way you would see somebody who has a physical illness like a broken leg or a head injury." (Amanda)

"If you've got a broken bone you can see what's wrong with you and it's just a broken bone, but with mental illness people attach negative connotations, seeing that person as crazy." (Rebecca)

Clinical implications



It is important that more work is done to help change nurses' negative attitudes and to reduce stigma, as they are major barriers in reducing suicide rates. Stigma about mental illness may deter patients from revealing their suicidal ideation to others (Corrigan & Watson, 2002) and if nurses are at the frontline of treatment and the preferred confidants for distress, then this is a significant public health issue. General nurses need more education and training about mental illness in general and suicide prevention in particular. As nurses believe that they need suicide prevention training at differing levels, depending on their areas of specialisation, it may be helpful to conduct an educational needs assessment of nurses prior to the provision of education and training. One of the other clear implications of this study is that nurses feel an enormous time pressure and are inadequately supported to take an active role in suicide prevention. In order to become more active, competent and confident to take on this role, nurses need to be in an environment that is sufficiently resourced with enough staff to reduce their time pressure. They may benefit from information on compassion fatigue, burnout and self-care and they will also need time to debrief, reflect on their experiences and have access to

THEME 4. Nurses fear not being able to cope and burning out

"I don't think working with patients who are suffering with severe mental illness would be very good for my own personal wellbeing." (Claire)

"It's very hard to take on other people's sadness. If I found someone who had suicided, then of course you're thinking, 'Oh my gosh, what else could I have done? What could I have done differently?' As a nurse, you put yourself through a lot of guilt." (Anne)

"I think sometimes you just have to become numb to an extent. If you try to take it all in, it would be too much. Sometimes it's really, really upsetting. Often you just have to get on and do things that are clinical." (Jess)

SUBTHEME 4a. Nurses have a desire for more support

"There should be more supports. Nurses are also at risk of suicide as they are dealing with such vulnerable people all the time. I actually didn't know that there is free counselling for nurses and I think that should have been highlighted." (Amanda)

"I felt quite alone. I didn't feel like there was a lot of support to draw (from) and I think you need it. Some people argue for supervision, and my thoughts are it should be offered." (Mary)

"I sometimes think if nurses had a debrief about what was difficult that week, that actually, one, might be good for staff and, two, allow a forum for what sort of education might be needed." (Jess)

THEME 5. Nurses want more relevant and accessible education

"I think that more education on psychological care would be great." (Anne)

"I think suicide prevention should be an annual competency you have to do. There should be a first aid equivalent to suicide prevention, to give us an outline or a framework to follow." (Amanda)

"I would definitely be very interested to go and take a day course to develop and grow my knowledge and my confidence at interacting with and looking after patients who are contemplating suicide." (Claire)

"If I could do a study day that involved suicide prevention as an in-service at the hospital I would definitely, for sure. I think that would be super helpful." (Jim)

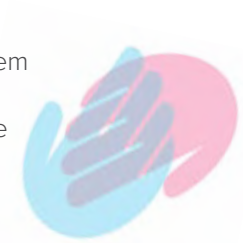
SUBTHEME 5a. Certain nurses need suicide prevention training more than others

"There are different roles in nursing. Nursing priorities depend on what area you are in. I think all nurses need suicide prevention training but I think there's no point in nurses doing it if they don't have an interest or don't feel that there's a need." (Mary)

"In my role as a recovery nurse I guess suicide prevention doesn't become part of my skillset because of the specialisation." (Jess)

"I think nurses might be more likely to go and get suicide prevention training in the areas where they've dealt with people who have physically harmed themselves." (Jim)

"I think training can be really effective. I got a little bit more training in regards to suicidal ideation and mental health just because I needed to in my role." (Rebecca)



counselling. The healthcare system needs to pay special attention to nurses' risk of compassion fatigue and burnout along with putting the necessary supports in place to address and prevent nurses becoming 'burnt out'. Otherwise, burnout will have a negative impact on the nurses' wellbeing and the quality of patient care provided (Green, Albanese, Shapiro, & Aarons, 2014; Sarafis et al., 2016), including any current strategies to improve suicide prevention at the frontline.

Hulatt (2017) suggested that nurses should get structured supervision and debriefing to assist in their role in suicide prevention. Clinical supervision (CS) would be one option for that, as it has been shown to provide stress relief for nurses (Koivu, Saarinen, & Hyrkas, 2012; Wallbank & Hatton, 2011). CS was introduced in nursing as an educational approach to help improve nursing care (White & Roche, 2006). The aim of CS is to help improve nurse-patient interaction and nursing practice (Van Ooijen, 2000). CS is a form of professional support, skill development and learning, whereby clinicians are assisted in developing their practice through a process of reflection and discussion with knowledgeable and experienced colleagues (Brunero & Stein-Parbur, 2008; Carroll, 2010). CS could possibly help to reduce and prevent compassion fatigue and burnout in general nurses within Australia, as the nurses here revealed that reflection on their experiences assists them when caring for patients in psychological distress, and they would also like time to debrief. CS is well established in the UK and in the US; however, in Australia, CS tends to be in place for mental health nurses but not routinely for general nurses (Taylor & Harrison, 2010). The introduction of CS could potentially enable general nurses in Australia to take on a role in suicide prevention by allowing them to reflect on, and learn from, their experiences in the safe and supported environment which they crave. More research in this area

would improve our knowledge of how to support nurses and nursing care at the frontline of suicide prevention.

Limitations

One possible limitation to this study is that compassion fatigue or burnout was not measured. Therefore, the significance of nurses' compassion fatigue and risk of burning out is unclear. It may be useful for future researchers to use a compassion fatigue measurement instrument such as the Compassion Satisfaction and Fatigue Test (CSFT) or the Professional Quality of Life (ProQoL) scale to obtain a more accurate measure of nurses' compassion fatigue and risk of becoming burnt out. The CSFT and the ProQoL are commonly used measures of the positive and negative affect of helping others who experience suffering and trauma (Bride, Radey, & Figley, 2007).

Implications for future research

More research into compassion fatigue and nursing is warranted. Nurses have a particularly high risk of getting compassion fatigue; however, compassion fatigue is under-recognised and under-researched in nursing (Boyle, 2011). Only a few studies have investigated the efficacy of clinical supervision on burnout (Edwards et al., 2006; Koivu et al., 2012). There is also a lack of evidence to support the efficacy of clinical supervision in reducing compassion fatigue and burnout in nursing (Proctor, 2010; Williamson & Dodds, 1999). Further research is required to investigate the effects of clinical supervision on compassion fatigue and burnout, to see if clinical supervision can really help reduce compassion fatigue and burnout in nurses. Further research is also required into how the health system could assist in reducing the time pressure faced by nurses, to help address their sense of hopelessness and their inability to respond to suicidal patients, to enable them to improve the provision of psychological care and take on a role in suicide prevention. ■

About the author

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Marie has over 15 years experience working in the healthcare industry. Marie currently works at Alfred Health as both a registered nurse and as a grief counsellor. She has a huge passion for holistic healthcare, wellbeing and she is fascinated by the mind–body connection. She is currently studying hypnotherapy at the Australian Academy of Hypnosis. She has also worked on the helpline at The Anxiety Recovery Centre Victoria (ARCVic) and has been a school counsellor at Sacred Heart Catholic Primary School in Croydon, Victoria.

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TIPS FOR SUCCESSFUL SESSIONS

By Dr Judith Boyland

Helping people to feel OK, comfortable, and confident in their own skin can be incredibly rewarding. How we go about achieving these outcomes can be challenging and is most surely complex. The one element common to all scenarios is that we are companions on a journey towards a state of what Berne describes as OKness, where focus is on the enhancement of wellbeing amidst what Glasser might refer to as the reality of a lived experience marked by emotional chaos and diminished needs gratification. As Erickson reminds us, people do not come into therapy to change their past but to create their future. In this pursuit, Erickson asks us to consider that patients (clients) are people who have had too much outside programming – so much, that they have lost touch with their inner-selves.

The late and great Milton Erickson once gave this advice to clinicians, the day you think you have done your best work is possibly the day you have done your worst work and the day you think you have done you worst work is probably the day you have done your best work. The difference lies in who's doing the work: clinician or client. The story is also told of an occasion when Erickson held an audience of several hundred practitioners in the palm of his hand when, after keeping them waiting well beyond his due appearance time, he wheeled himself onto the stage in his classic purple suit and uttered the words, "Observe! Observe! Observe!" Then, having shared his wisdom, he paused a moment and simply turned his chair: exiting the stage and leaving his audience to ponder and to wonder on the magnitude, the simplicity, and the brevity of what they had witnessed.

Erickson's wisdom is encapsulated in his post-modern approach to therapy: that is, placing the problem on the outside and discovering new and creative possibilities for managing the presenting issues. For Erickson, the unconscious mind is a creative and solution-generating organism: its function is to create and generate solutions and in therapy it is the client who holds the key to unlocking that treasure chest of possibility.

For us in the supporting role, it all revolves around how we measure our 'best days' and our 'worst day'. When we are connecting with our clients in an empathic, sensitive and respectful manner, we are setting the scene for 'best'. When we observe with all of our senses, we are setting the scene for the 'best'. When we bracket our biases and judgements and come with an open mind, we are setting the scene for the 'best'. When our focus is on what it is that the client wants and expects, we are setting the scene for the 'best'. When we guide and support our client along a pathway where she/he is the one doing the work of creating and generating solutions, we are doing our 'best'.

'Best' will emerge through introducing the right therapeutic intervention at the right time. 'Best' can be a place of quiet contemplation or it can be sitting silently, listening to and observing an outpouring of pent-up emotion. Never be afraid of the silence for it is in that space that our clients are free to feel, to reflect, to reconceptualise, and to reframe. They are free to think about what it is that they want – or don't want. They are free to evaluate what they are already doing that is working to help them to get what they want and they are free to face, to own, and to name what is not working. They are also free to consider what they might be prepared to do differently. And they are free to define for themselves the point at which they believe the price they need to expend is too high.

This model of engagement I refer to as 'Jude's Recipe for Feeling OK'. The process is outlined in five steps, each taking as long as it takes and each initiated through a probing, open-ended question: the essence of which is phrased in the language used by the client:

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1. **What do you want? – This could be phrased as the 'magic' question.**
2. **What are you already doing that is helping you to get what you want?**
3. **What might you be doing that is not helping you to get what you want?**
4. **What are you prepared to do to help you to get what you want?**
5. **How are you going to know when the price is too high?**

When and how I pose these questions to my client is critical. It is all about timing and all about linguistics: all about observing when the client is ready to take each step in creating and generating his/her own solutions and all about using the language of the client as discovered through my observations.

Be patient and before venturing to solutions, allow your client to tell his/her story – as much or as little as he/she might choose. This could be all done and dusted during the first session or it could be several sessions down the track. It could be using verbal, written or expressive modality. An important point to consider is that maybe your client has never known the experience of owning or sharing a personal view or opinion, or may never have even considered that they have a right to want for themselves on a personal level. They may never have felt safe in entrusting their story to another human being.

Context is all-important and for the client who has a history of parental, family, social, cultural, religious, and/or political oppression, even the thought of the freedom to be allowed to have and to name a personal want could be overwhelming, daunting, fearful, and beyond the realm of perceived possibility: it could even be morally, culturally, or religiously inconceivable. In these situations, it may be easier to come through the back door and support the client in being able to define what it is that she/he does not want.

When we get to the point where the client clearly sees that it may be helpful to consider what needs to change in the pursuit of feeling OK, this will not only open up a world of possibility but also responsibility – and this could be very scary. It may be easier to live in a world where one can blame others rather than own the consequences of one's own choices. Taking that first step into unknown territory may require our client to heed the challenge offered by Susan Jeffers, "Feel the fear and do it anyway". Or it may elicit a Meat Loaf response, expressing commitment and determination dressed with a modicum of moderation – "I would do anything..., but I won't do that. No, no, no, I won't do that".

Tips for a successful session can be summed up in the notion of being fully interested and fully present with the client in now time. Observe! Observe! Observe! See with every sense of our being and don't be afraid of silence. In the collective words of Erickson, "Observation yields wisdom." Therapists must give freedom to patients – the patients' welfare is the only concern. Every person's map of the world is as unique as their thumbprint. There are no two people alike. No two people who understand the same sentence in the same way. So in dealing with people, you try not to fit them to your concept of what you think they should be.

In honouring the uniqueness of each client we learn that unique people require unique observations and unique interventions. As our clients go about creating their own unique solutions, we use whatever they present to us to support and assist: their desires and expectations; their language, emotions, and resistance; their symptoms and their signs as reflected in our observations. As Erickson suggests, engage the scientific side of your mind in wondering what the real situation is and as you try to appraise it, do so with an appreciation and understanding of the normal and the usual, which is requisite for any understanding of the abnormal or the unusual. Above all else, be You: the best You that only You can be. Be interested and curious and you are on the way to having your 'best' day. ■

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GIVING UP ON THE 'EXPERT'

Practices for client-directed therapy

By Chad Loftis

Frequently in our work as therapists we are encouraged to spend a great deal of time, energy and money on learning new therapeutic theories and techniques that will, we are told, bring about faster and more profound healing in our clients. More often than not, they turn out to be less miraculous – less of a panacea – than we had hoped.

While I love learning and developing innovative new ways of working with different problems I have become increasingly aware that what makes the biggest difference to my clients are usually those 'simple' and fundamental practices that are rarely the subject of training weekends or intensive workshops.

John McLeod points out that years of research and hundreds of comparative studies between therapies have "reached a dead end" – failing to demonstrate any meaningful advantage of one approach over any other[1]. What has been shown is that therapy in which the client feels safe and connected to the therapist and therapy that privileges the client's worldview and goals has more likelihood of success[2] – not least because clients more often stay in therapy when therapy feels both safe and helpful.

A theme that has become much more prominent in my work over the last few years – even as I pursue new ways to work with particular problems – is that of learning how to fit therapy to each client rather than hoping (or forcing) the client will fit the therapy. Below are just a few of the practices I have

found increasingly helpful. Some of them would be considered the most basic skills a therapist should possess and, for that reason, have often been the first to atrophy as I have become more experienced.

Truly listening

When my colleagues and I train lay counsellors at our centre in Thailand, listening skills is the very first lesson. It is the most basic skill a therapist has to learn and yet every time I teach it I am still challenged to reflect on whether or not I am really giving this to my clients now after 13 years of work as a therapist.

Having the answers, or trying to seem like I do, is the enemy of true listening. When I maintain my ostensible role as 'the expert' on human psychology or behaviour, it usually stifles my listening skills. That role demands that I know what to say and understand 'what is really going on' after only hearing a little bit about a person's life. As 'the expert' I fret internally about what direction the therapy should take next or what perfectly-phrased question will change my client's life, while completely missing the importance of what they are actually saying.

I am learning, instead, to take the role of advocate for my clients' perspective on their own life – an expert in being curious. Cultivated curiosity is probably the most important tool in learning to truly listen. It encourages me not to assume anything and to ask 'dumb' questions. Cultivated curiosity prompts me to take the extra time necessary to stop and summarise what the person is saying and ask, "Am I understanding that right?" or "Is this what you mean?" When my goal is to ensure that the client's perspective is the ascendant perspective in the room I can make my clients feel, in the words of a man who met with me recently to debrief some traumatic incidents he and his wife had survived, "profoundly heard".

Using the client's language

As a narrative therapist I have in my work chosen to set aside the psychiatric diagnoses that still dominate our field in spite of being scientifically unreliable[3] and ethically questionable. I also try to avoid the pop psychology designations that do not appear in the DSM V but still hold considerable influence in Western culture as descriptions of 'personal dysfunction'. Instead, I try to use the same language as my clients to describe what is happening in their lives.

If a client tells me, "I really freak out when I can't do things right," I try to avoid saying, "This sounds like anxiety," or "You might be a perfectionist." I try to ask instead, "Tell me more about what being freaked out looks like," or, "What effect do freak outs have on your life?" Even if they proceed to describe what many professionals would call a panic attack I keep using their name for what is happening to them.

When my colleagues and I train lay counsellors at our centre in Thailand, listening skills is the very first lesson. It is the most basic skill a therapist has to learn and yet every time I teach it I am still challenged to reflect on whether or not I am really giving this to my clients now after 13 years of work as a therapist.

I have found that this helps me keep the client's perspective in focus as we talk or play in therapy and prevents time-wasting discussions about whether the diagnosis I have chosen fits. It also contributes to their feeling that I am really listening to them and, more than that, understanding what they mean. Although it is true that diagnostic terms are sometimes experienced as helpful in legitimising people's pain, they frequently have the effect of making people wonder if we really grasp what they are going through. When people can't recognise their own lives in the questions we ask or in the summaries we provide, they will feel less safe in therapy and less empowered to act.

Diagnoses can also significantly erode our ability to stay curious and listen well.

'Shared' notes

To take this even further, I have found the practice of writing down clients' key words or phrases on a whiteboard or on a piece of paper that we can both see extremely helpful. Not only does this further enhance the atmosphere of collaboration, it also allows clients to evaluate their own articulation of their lives. When their words are written down, clients can more easily decide whether those words adequately convey their meaning.

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It also helps them connect other thoughts and experiences to the primary issues that they have brought them to therapy.

Frequently, conversations have suddenly become clear and impactful for clients simply because I have switched from my notebook to the whiteboard and, when it is possible to take home a photo of the conversation, a sense of accomplishment lingers.

Letting clients determine direction

A few years ago I watched a video in which the well-known narrative therapist Michael White paused in the middle of an interview with a client to list three different directions he thought the conversation could take next. He left it to the client to decide which direction they would follow and the conversation went on to be a very significant one for the man.

Since I have started taking time to check with clients if they have an agenda for the session and using White's 'choose-your-own-adventure' method, I have found I waste less time in therapy and get to those things that are helpful to clients more quickly and with more predictability. I can often tell that I have come to a crossroad simply by paying attention to my own level of uncertainty about what to do next. Then I might say something similar to, "I'd like to pause so we can decide what to talk about next. I'm interested in asking you more about your father's death and what impact that has had on your life. I'm also interested in asking you about a few of the ways you hinted that you have been able to keep going in spite of your grief. Which seems most relevant to you? Or is there another topic you'd prefer?"

Sometimes, of course, people look bewildered and say, "I don't really mind... You choose!" Generally, if I wait a moment, they will just begin speaking about whichever topic is really most on their mind. At other times I decide which path to take but the question itself has put us on alert that the client should be satisfied with any topic we pursue.

In general, I also find it helpful to check-in from time to time about whether or not we are on the right track – particularly if clients begin to show signs of losing interest or becoming agitated. An example of a simple question is, "Does what we are talking about right now feel relevant to you?" People often politely say yes but, if in fact they disagree, will follow that up with another suggested focus. This helps strengthen the collaborative atmosphere of the session and saves time by avoiding power struggles or periods of disengagement from the client in which little is being accomplished.

Of course, there are times when we suspect that our clients need to be pushed to speak about things they would rather avoid. Even in these cases I prefer to stop and talk about this rather than attempt to unilaterally enforce my own agenda. In my experience, this always turns out to be best for the progress of therapy.

Feedback-informed therapy

Scott Miller and his colleagues have developed a simple method for formalising this input from clients. Four question FIT (feedback-informed therapy) surveys are given to the client before and at the end of each session and take about 20 seconds or less to complete. The Outcome Rating Scale, given before therapy, allows the client to quickly indicate how well they are doing across four domains of life (individual wellbeing, interpersonal wellbeing, social wellbeing and overall wellbeing). This provides the therapist and the with client a basic way of determining whether or not the therapy is achieving its healing objective. At the end of each session, the client can fill out an equally simple Session Rating Scale that helps them communicate to the therapist whether or not they feel heard and respected, feel comfortable with the therapist's methods, are happy with the topics being discussed and feel the therapy is, overall, a good fit[4].

When I am asking the right questions throughout my sessions I am rarely surprised by the information in the FIT assessment. However, it still offers people who visit me an opportunity to communicate things they aren't able to when asked directly. One boy, for example, was too polite to tell me that he wanted to spend more time playing with the toys rather than playing games outside. But he was able to mark 'dissatisfaction' on the 'what we did today' vector of the Session Rating Scale. I asked for his advice about what to do and the following week he was much more engaged!

Ultimately, each of these practices demands from me a willingness to acknowledge my missteps in therapy, to admit to my clients that I don't have all the answers and to collaborate with them to create an individual therapy that will ultimately be helpful to them. Stepping down from the expert's perch is sometimes unnerving but it is always freeing for my clients and for me. ■

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1 Paraphrased from a formal interview between John McCleod and David Denborough conducted in 2013 for the Masters of Narrative Therapy, Melbourne University. See also McCleod, J 2013, *An Introduction to Research in Counselling and Psychotherapy (SAGE)*, London, pp. 27–28.

2 Miller, S; Duncan, B; Hubble, M 2004, 'Beyond integration: the triumph of outcome over process in clinical practice', *Psychotherapy in Australia,* February, vol. 10, no. 2, pp. 2–19.

3 See, for example, the discussion in Van der Kolk, B 2014, *The Body Keeps the Score*, Penguin, New York. And Aboraya, A 2007, 'The Reliability of Psychiatric Diagnoses', *Psychiatry*, vol, 4 (1), pp. 22–25, Edgmont.

4 For a discussion of FIT and its benefits as well as free FIT assessment tools, see www.scottdmiller.com.

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eSafety, mental health and young people

Some issues to consider

By Dr Ebinepre Cocodia

Abstract

Online engagement and internet safety continue to be forefront issues for children and young people. This paper sheds light on current online safety themes associated with young people's internet experiences. Increasingly, it is evident that some online activities may lead to risky behaviours, which in turn cause psychological distress in some cases. Initial steps we can take to help promote eSafety and avert mental issues are outlined based on the existing online safety research.

Introduction

Some of my previous research projects examined young people's growing exposure to technology and online gaming and its subsequent impact on cognitive development. In particular, findings indicated that more access to technology within educational settings and computer games helps to increase visuospatial abilities (Cocodia, et al.,

2003; Cocodia, 2015). Fast-forward to almost 20 years later and we are clearly in a place where society as a whole depends heavily on internet technology. Young people are reportedly spending up to 3.1 hours per day online (Zilka, 2018). Activities such as and financial transactions, shopping, health, social services, education and training provide examples of positive online experiences for many people. Counsellors also offer services online. Thus making the internet essential for our everyday dealings.

eSafety is described as the awareness of possible dangers while conducting online activities (also known as internet safety or online safety). It is described as the deliberate effort to stay safe on the internet from incidents such as verbal/non-verbal abuse, intimidation, all forms of cyberbullying, grooming, online stalking and much more. Thus, eSaftey involves managing our personal safety online, managing risk to our private information online and protecting our information from cybercrime (Office of the Children's eSafety Commissioner, 2018).

Young people and eSafety

Significantly, young people are tuned into the internet whether for their work or for recreational purposes. Although there are numerous benefits of the internet, challenges to eSafety are well documented (Telethon Kids Institute, 2013) amongst young people. Where young people are concerned, the rapid advances in technology and easier access to internet has led to concern amongst parents, carer and schools about risky online behaviour (Furnell, von Solms, & Phippen, 2011). Negative experiences online include cyberbullying, online pornography, sharing nude images, sexting, exposure to violence, harassment and stalking. These are especially prevalent activities amongst young people today. The argument is that new technologies, access to the internet and resources previously unavailable to young people are believed to heighten such risky behaviours. For instance, the increasing interest in social media platforms such as Instagram, Facebook, Twitter, and online gaming provide opportunity for online engagement and risk-taking behaviour. Other safety concerns include excessive time spent online, trickery, dealing with unwanted contact, outing, exclusion and grooming (Zilka, 2018).

Each of the above-mentioned issues may present real problems for young people including psychological distress and in some instances suicidal ideation (Rikkers, Lawrence, Hafekost, & Zubrick, 2016). In many cases victims may initially disclose details of these negative online experiences with parents, friends, carers, teachers and school counsellors. Where these risky behaviours lead to psychological distress the main concern is to provide psychological help first and and help prevent mental health problems triggered by the negative online experiences. For instance, many of us in our professional practice have encountered case scenarios where a young person becomes emotionally distressed due to one of the more of the risky behaviours listed. These include cyberbullying, sexting, sharing nude images, outing, or trickery. A multiple-pronged response may be necessary to assist the young person during this difficult time. Depending on the age of the young person, a parent, carer, school counsellor or law enforcement, for example, may be called upon to intervene in support of the victim. It is not unusual for friends or families faced with the evidence of their young person's distress to be initially overwhelmed or uncertain about how to help when confronted with the evidence of the negative online experience. Some rightfully turn to experts for advice while others may be unsure about where to go for help.

The initial response is to care for the mental health and wellbeing of the victim. Hence, in the case of young people, the collaboration between the school and home will be more productive at this stage. Investigations at this level include a move to explore the extent of the damage to the victim's image by examining the online activity. Key

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to caring for the victim's wellbeing include reassuring the young person that the unacceptable material shared or posted online has been removed and is no longer published or accessible via the internet. Other steps may be taken by the school counsellor, parents, carer or law enforcement, for example, to provide professional support for the victim.

It should be noted that Australia's eSafety Commission (Office of the Children's eSafety Commissioner, 2018) is a valuable resource where anyone, including young people, can contact the Office directly to assist in removing unacceptable or negative material published online where eSafety issues including cyberbullying, sexting, and sharing nude images or related issues have been clearly established. Significantly, Australia is one of only a few countries in the developed world that has an eSafety organisation dedicated to providing such services to the citizens.

Parents, carers, teachers, school counsellors or other support people may find that much of the worry is lifted when families of the victim, any loved ones and the young person involved have the offending material successfully removed from cyberspace. However, this does not in anyway suggest that psychological distress is subsequently resolved. Rather, the focus may then shift to supporting the mental health and wellbeing of the young person based on the appropriate therapeutic interventions.

Some eSafety strategies

A scan of the existing literature shows that numerous strategies exist (Furnell, von Solms, & Phippen, 2011; Office of the Children's eSafety Commissioner, 2018; Rikkers, Lawrence, Hafekost, & Zubrick, 2016; Zilka, 2018). Below are some useful strategies.

- Development of eSafety resources in schools and higher education setting.
- Empowering young people to know their rights.
- Promoting the role of the eSafety Commission in supporting young people and families to have positive online experiences.
- Emphasising the importance of parental awareness and involvement, including opening up the dialogue on eSafety with the young person.
- Promoting peer-to-peer education.
- Encouraging young people to develop their own strategies to stay safe online.
- Exploring the perception and understanding of online risks.
- Understanding good and bad online practices.

Conclusion

This paper has provided an overview of current eSafety issues which young people and their families may encounter. The role of parents, carers, school counsellors and law enforcement in supporting the young person was touched upon. The importance of the role of the eSafety Commission for children and young people today was highlighted. Some strategies to help young people understand the importance of eSafety were outlined above. Significantly, the key focus of eSafety is maintaining a positive online experience.

Research shows that the mental health and wellbeing of young people may be impacted by the experience of online activities such as cyberbullying, excessive online gaming, sexting and sharing nude images without consent. Other risky behaviours were also outlined in this short paper. In conclusion, it is evident that although young people now have natural expectations to have access to the internet, self-care should be promoted to stay safe online. ■

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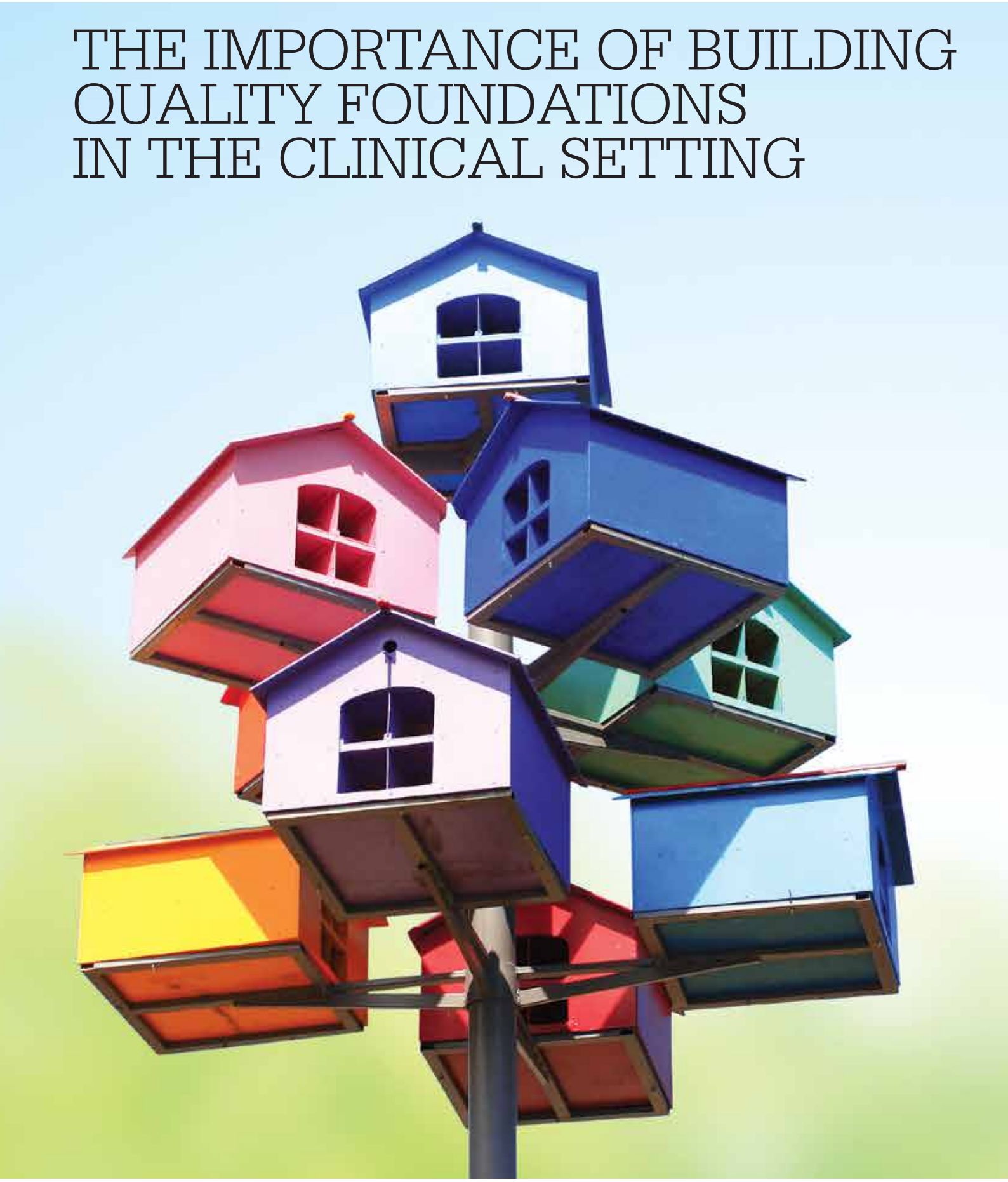
THE IMPORTANCE OF BUILDING QUALITY FOUNDATIONS IN THE CLINICAL SETTING



Building a stable foundation is key to the success of a counselling session and, consequently, the success of the clinician.
By Tanya Curtis

One of the questions that is often asked of a counsellor is, "What makes a successful clinician?" From experience in the clinical setting since 2002, my response is always: "The success of any clinician is determined by the quality of the foundations that have been built." In the counselling clinic, clinicians are exposed to people from all walks of life; people of different ages, genders, origins, backgrounds, intellects, religions and abilities, with different experiences of life, hurts, ways of expressing themselves and reasons for attending counselling.

When you have so many people with so many different experiences, is there a formula that works for all? The simple answer – yes. If yes, then how? Build a foundation where people feel safe to express and in time, support people to build their own foundations so they feel safe to be in the world.

What is meant by building a foundation?

In the clinical setting, clients will typically relate to the analogy of building a house.

When asked what is the most important part of building a house, the answer is the foundations; which is true, the foundations are a very important part of building a house.

Clients are then asked, "But don't all houses have foundations?" Again, the answer is always yes.

This leads to a conversation that starts to explore why there can be two houses in the same street, both experiencing the same storm and then exploring the following question:

"If all houses have foundations, why is one house left standing and another flattened, when both houses experienced the same storm?"

The answer lies not in the fact that both houses have foundations, nor that both houses have experienced the storm, rather that there have been different quality materials that went into building the foundations. Thus, it is not whether a house has a foundation or not that is important, rather it is the 'quality of the materials' that the house was built with in the first place.

Take the image of the house in Figure 1, a house that clearly illustrates a solid foundation that has allowed a solid house to be built upon it. However, Figure 2 shows a house that has, shall we say, quite an unstable foundation. Noting again that both houses do have foundations.

Figure 1

Figure 2

Should a severe storm be experienced by either of these houses, the natural consequences are that the house in Figure 1 will likely be left standing, while the house in Figure 2 is more likely to be severely damaged, possibly flattened. But was it the severity of the storm that left that house standing (Figure 1) or flattened (Figure 2) or was it the quality of the materials that were put into the house *before* the storm even arrived?

This analogy is reflective of each person and each relationship in life. Metaphorically, we are each our own house, while every relationship we are in is also another house. Figuratively, we all have many houses in our lives as we all have many relationships with other people, including but not limited to partners, children, parents, siblings, family, friends, colleagues, clients, ourselves etc.

If each and every relationship is a house, then each relationship has a foundation and will experience storms, also known as challenges in life.

Should the relationship be left standing at the end of the storm, it is not a result of the intensity of the storm, rather the result of the quality of the materials that were put into the relationship *before* the storm arrived.

Our every movement of every second of every day is contributing to the foundations that are being built when we are with ourselves and/or any other person.

The foundations of a house may be made from bricks and mortar etc., whereas the foundations of our relationships are based on the words, actions, thoughts, feelings and our every movement of when

we are with a person and when we are not with them.

The words each person does say or doesn't say are contributing to the foundations, as are the tone of the voice, the speed of delivery etc. If we took the time to micro-analyse each person's every word, action, thought and feeling it would be fair to say that each belong to building either (1) a rocky foundation which is more likely to be severely damaged when the storms of life hit or (2) a solid foundation which is more likely to withstand them.

For example:

1. **Judgement of a person's actions, choices, past experiences etc. will lead to a rocky foundation, whereas understanding will build a solid foundation.**

2. **Inconsistency results in unpredictability and thus builds a rocky foundation, whereas consistency results in predictability and building a solid foundation.**

3. **The need for a person to be different leads to a rocky foundation, whereas attempting to understand why a person has made the choices they have made builds a solid foundation.**

4. **Projecting your own pictures of how a person should be creates a rocky foundation, whereas getting to know a person for their own unique being builds a solid foundation.**

This list of examples is endless; however, what is of value in the clinical setting is that each person is offered the opportunity to bring awareness to the fact that they are responsible for the quality of the material that they bring to building:

1. **Their own foundations and relationship with themselves, and**

2. **The foundations of the relationships they have with all other people (clients, partners, children, parents, siblings, family, friends, colleagues etc.).**

Thus, in the clinical setting a practitioner and client can be made aware that any relationship that has crumbled, either in the clinical setting or a person's life outside of the clinical setting, is not the result of the life storms that have been presented (as is often mistakenly assumed), but rather is the result of the quality of the materials that have been put into every moment by each and every person in the relationship before the life storm; albeit that each person is only ever responsible for the quality material they themselves contributed.

For a client to feel safe to be honest in the clinical setting and explore all the factors that have contributed to them booking a counselling appointment, they require a quality foundation that allows them to feel safe … and each clinician is responsible for building this quality foundation.

And in time, each client can be offered the opportunity to explore the quality of the materials they bring to all of their relationships and examine whether the materials they have contributed need to be changed or be further expanded upon. ■

About the author

Tanya Curtis
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MBehMgt, MCoun, BHlthSci. (BehMgt), Assoc Dip Ed. (Child Care)
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Tanya Curtis has been working as a counsellor and behaviour specialist in university settings since 2002 and in her own private practice, Fabic, since 2006. Tanya supports people of all ages who have been experiencing their own unique challenges in life. Her ability to combine her experience and qualifications of behaviour with her counselling skills brings a unique and very successful approach. Along with her experience and qualifications, Tanya's commitment and dedication to forever deepening her understanding of people and behaviour supports her to effect lasting change for clients who have previously tried many other avenues.

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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.

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- 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.

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- 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.
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