

CA

Reflections on reflective practice

Critiquing conceptions of
reflective practice in guidance
and counselling literature

A little bit of shame goes a long way

Addressing the universal
emotions of shame and
guilt in therapy



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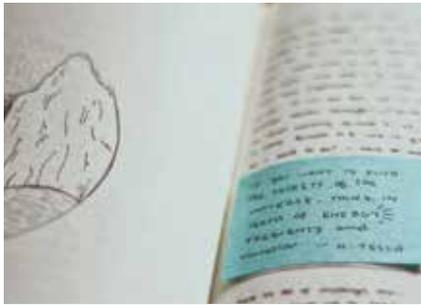
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Co-editor

Dr Philip Armstrong FACA

Matthew Bambling PhD

Technology adviser

Dr Angela Lewis
MACA PhD

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Editorial advisory group

Dr Travis Gee PhD

Dr Nadine Pelling PhD

Dr Ann Moir-Bussy PhD

Dr Philip Armstrong
FACA

Adrian Hellwig M. Bus(com),
B. Theol, Dip. Couns

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Submissions and letters
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**The Editor
Australian Counselling
Association
PO Box 88
GRANGE QLD 4051
aca@theaca.com.au**

See page 67 for
peer-reviewed article
submission guidelines.

Editorial

Countdown to APRCCC conference

It's important, and professionally stimulating, to continually access contemporary thinking, experience and research – and we are fast approaching the 6th Asia Pacific Rim Confederation of Counsellors Conference, which will provide this valuable opportunity.

This gathering of counselling specialists from around the world will run from 27 to 29 September 2019 at the Hilton Hotel in Brisbane.

The conference has attracted 103 speakers – 42 with PhD qualifications – from countries including the USA, Canada, Indonesia, Philippines, Malaysia, Singapore and Hong Kong. The program includes 69 interactive workshops, two forums, 18 paper presentations and a gala dinner. It will be an opportunity to network with peers, trainers, NGO representatives, IT consultants and many more in counselling and counselling services.

A package for \$830 includes a pre-conference masterclass, a variety of workshops and the gala dinner. More information is available at www.theaca.net.au/conference-2019/index.php.

The subjects explored in this issue of CA include the use of free-access screening assessment instruments in clinical decision-making; stress and anxiety impacts among university students; and a case study examining treatment of trauma victims.

The article on using evidence-based screening assessment tools looks at how a counsellor could administer, score, holistically interpret, and integrate client data into existing clinical decision-making practices.

Our report on student wellbeing looks at psychological distress in graduate students and seeks to gain a better understanding of their perceived work–life balance and its correlation to psychological wellbeing.

A case study explores grief in continuing trauma – in this case, in a survivor of torture. The article emphasises the significance of complicated grief and its long-term consequences on the human psyche.

Finally, ACA members were surveyed to ascertain the most popular destination for the 2020 ACA National Conference. The three equally popular nominations were Darwin, Margaret River and the Gold Coast, with Darwin emerging victorious. More information about the 2020 ACA National Conference will be published in future editions.

If you would like to contribute an article to CA, see page 67 for submission guidelines.



Dr Philip Armstrong
Co-editor



UPCOMING EVENTS

6th Asia Pacific Rim Confederation of Counsellors Conference

27–29 September 2019, Brisbane

The theme of the 2019 APRCCC is 'Insight and learnings from around the Pacific Rim: meeting your community's mental health needs', and delegates are invited to join top academics, practitioners and speakers from around the world as they share their work. The conference is aimed at building the capacity of professionals who deliver frontline mental health services and will showcase the latest research and treatment strategies in a range of areas, including alcohol and drug use, trauma, suicide prevention, family violence, disability services, LGBTQIA+ issues, regional mental health services, and more. For more details visit www.theaca.net.au/conference-2019/index.php.

World Mental Health Day

10 October 2019

Help shed a more positive light on mental illness by making a #MentalHealthPromise. At home, at work, with family and friends or in the wider community, we can all do something to help reduce stigma around mental illness and make way for more people to seek help and support. Go to the World Mental Health Day website and select a suggested 'mental health promise', or write your own promise – it's up to you. If you write your own, you can upload a photo of yourself or something connected to your promise. There is also a range of images for you to choose from, if you prefer. You can make as many promises as you like, you don't have to stop at just one if you feel you have more to give! Visit <https://1010.org.au/> to make your promise and help reduce the stigma around mental illness.



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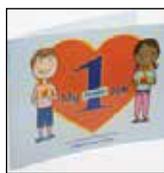
Book Reviews

Set of three books
By Tanya Curtis
Intro by Órlaith Sheill

It was a very special experience to have my daughter and her friends, who visited these school holidays, read and review this beautiful book collection. They sat out in the winter sun and read and wrote quietly, then they discussed each book as a group. This shared experience was perfect for the books' messages to be planted in each of the children's precious beings. This collection of books is a wonderful medium of connection and support to those working with children and families. I read all three books to my three-year-old daughter, who delighted

in the illustrations but did not quite grasp the stories or concepts; however, the messages of positivity were being communicated and absorbed as we read together. The building of a sense of self with the support of reading and the connection with a parent or carer is key, particularly for families who are finding such engagement challenging, perhaps because they are experiencing their own pain and difficulties. These books could encourage and promote positive relationships with one another and oneself. As a clinician, I am so very grateful to have such books as tools that I can use within the therapeutic relationship to support children and families and to ensure that the

messages within the books continue to be heard. There is nothing quite like a book that you can pick up at any time as a gentle reminder of these messages. The differences in each of the girls' reviews highlights the fact that we all have varied perspectives – an important fact for us to remember when using any book as a tool of support. It may provide joy and interest through its illustrations, its messages may or may not hit home, the story might be heard or disregarded. In this case, four children of differing ages all enjoyed and took something that mattered to them from this collection. Thank you for this.



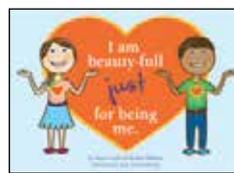
My number 1 job
By Tanya Curtis
Review by Cora Sheill-Gilchrist (aged 11 years)

My number 1 job is a really good book that leaves you feeling confident and ready to take on the world. I enjoyed how at the end it explains how to execute your number one job, that is "to love you". I feel like a 10-year-old child or older may find this book a bit predictable and perhaps a little slow going to read. However, in saying this, I think a child from four to nine years old will find that this book has a powerful message and will also help them understand how to help other people to do their "number 1 job".



Whoops ... is one of my favourite words
By Tanya Curtis
Review by Rachel George (aged 11 years)

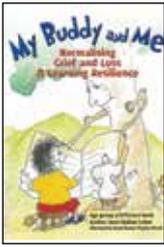
The book *Whoops ... is one of my favourite words* has a positive message towards learning from your mistakes. The book is straightforward and is aimed at kids between the ages of four and nine years. It teaches young kids to not get frustrated at their mistakes but to look at them as new ways to learn and develop, as a better human being. Mistakes can cause stress and anxiety, but this book demonstrates that you don't have to be perfect. Personally, I found this book a bit predictable, but as it is aimed at younger readers it is not a big issue. I enjoyed the images because I think they contrasted well with the words. Overall, I think this book teaches that we are all human and to love ourselves, mistakes and all.



I am beauty-full just for being me
By Tanya Curtis
Review by Aleyna Bilgic (aged 11 years)

I am beauty-full just for being me has a really powerful and heartfelt message that is really important for everybody to know and learn. I am glad that it talks about humans of all ages, because it is really important for people who feel discouraged about their appearance (even adults!) to hear this message. This book would be helpful towards people who don't feel good about their appearance, and it builds courage and gives support, letting people know that it's not how you look that determines your beauty, because your true beauty comes from within, and it will always be there, forever, whatever obstacles we have to face during life, it will always be there. I think the age group that, from reading, would be okay for any age, but

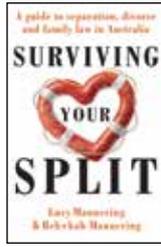
I think the illustrations could be more detailed. Also, I think that the way they wrote beauty-full instead of beautiful was really good because the message is that we are FULL of beauty. Overall, I think that *I am beauty-full just for being me* is a great book with a beauty-full message, we should love ourselves just the way we are.



My buddy and me

By Jane Oakley-Lohm
Review by Michael Woolsey

Jane Oakley-Lohm's *My buddy and me* expertly deals with resilience, grief and loss for primary school-aged children. This is done through the symbolism of a tree undergoing changes. Resilience is a great life skill for children to learn; it assists them to be ready for setbacks in life and to gain the ability to bounce back. Oakley-Lohm has handled this idea nicely in her text and it has been captured well in the hand-drawn illustrations by Phyllis Nicoll. The book looks at how a child's resiliency levels are increased as they become more in control of the situation that they felt had control of them. It has an underlying theme of empowerment: the child being empowered and learning to empower themselves resonates throughout the story, resulting in the realisation that life goes on. Oakley-Lohm's experiences with the topics covered in this book are evident and well conveyed. I would recommend this book to explain grief and loss to primary school-aged children, whether in the classroom as a teaching aid or at home. *My buddy and me* is available at www.balancingoflife.com.au/shop-1.

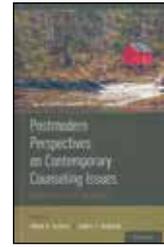


Surviving your split: a guide to separation, divorce and family law in Australia

By Lucy Mannering and Rebekah Mannering
Review by Deborah Stevens

Surviving your split is a must-have on the book shelves of those working in family law or mediation, or those counselling clients through this life situation. An easy read that is informative, practical and humorous, it can serve as a reference, recovery or resource manual, to assist anyone in navigating the deep waters of separation and divorce (without drowning!). The book covers aspects of separation and divorce, from the first few days, to telling children, family and friends, and dealing with infidelity justification, as well as surviving significant milestones while moving toward thriving in a new life. Lucy and Rebekah Mannering write from the perspective of experience and profession; Lucy is in corporate banking and Rebekah is a specialist family lawyer. They provide explanations to unpack the acronyms and terminology used by lawyers and the court, along with useful worksheets and lists to help save time and money. The case studies they use to illustrate these topics provide a realistic perspective on how separation, divorce and family law relate in real life situations

and outcomes. The material is presented in a practical step-by-step way, demystifying the realms of expectation, rumour and the unknown bureaucratic nightmare. As an FDRP (you will become familiar with this acronym!) this is a book I will be recommending to my clients who are experiencing separation and divorce at any level or stage. I am not one to read a book like *Surviving your split*, mainly due to the prospect of being put into a mind-altering state because of the overuse of jargon or baffling information. This book did not affect me in this way, but rather was enlightening, a belly laugh and very genuinely written. I would highly recommend this book to colleagues, clients and those who work in family law.



Postmodern perspectives on contemporary counseling issues: approaches across diverse settings

By Mark B. Scholl and James T. Hansen
Review by Dr Judith R. Boyland

Postmodern perspectives on contemporary counseling issues: approaches across diverse settings, edited by Mark B. Scholl and James T. Hansen, presents a comprehensive collection of papers written by scholars and practitioners associated with universities across the USA. The primary focus of the collection is the development and use of innovative approaches and methods of engagement to support and help clients in their journey towards personal empowerment and the attainment of their goals. In keeping with a postmodern philosophy, all approaches are client-focused and respect the unique internal meaning structures, types of issues and worldviews that clients bring to counselling in the quest to alleviate their psychological and emotional pain. Specific issues addressed cover a broad gambit including sexual concerns, sexual abuse, substance addiction, loss and grieving, trauma, eating disorders, social justice, men's wellness, masculine truths, gender socialisation, disaster response, probation and parole, career guidance, poverty, family, marriage,

school counselling, and life crises and transitions. The client base features adolescent survivors of sexual abuse, sexually abused adults, grieving children and adolescents, college-age clients, university students, ex-offenders, couples, and persons who identify as LGBTQIA. Strengths and limitations of various therapeutic approaches are featured across five sections and include:

- solution-focused therapy;
- narrative therapy;
- other postmodern therapeutic models such as a collaborative therapies approach incorporating acceptance, empowerment and meaning; dialectical humanism featuring the practice of possibilities; and the counsellor-advocate-scholar approach to social justice counselling;
- integrative postmodern therapeutic models incorporating application within the contextual structures of a workshop series and clinical frameworks; and
- counsellor education.

This book would be a helpful resource for practitioners, supervisors and counselling educators.

MAKE YOUR PRESENTATION A WINNER

Most of us will, at some point in our careers, be called upon to address a group, be that small or large. Are you ready?

By **Angela Lewis**

Avoid boring the audience

Most presentations are backed up by some type of visual medium, such as Microsoft PowerPoint. The most common mistake that presenters tend to make is to read verbatim from what is already displayed on the screen or slide that the audience is viewing. People can read much faster than you can read aloud and they will finish reading the screen before you, making your commentary superfluous!

Try putting up a few key points, or better still, diagrams or pictures, and then adding the verbal commentary – this gives a fresher spin to your presentation as the audience doesn't know what is coming next, and it allows you to personalise the content based on the audience and the visual cues you are getting from them.

Another way to quickly disengage the audience is by using a jargon-filled script, clichéd graphics that everyone has seen before (duck hitting the computer with hammer, anyone?) and not speaking with passion and conviction. I know 'passion' sounds like a funny word, but if you are not engaged with the content and are going through scripted text in a lockstep fashion, you won't harness the attention of audience. Speak clearly, try to use real-life stories

and experiences and don't be afraid to go off-script a little so you are genuinely working to your audience.

Getting lost in the slideshow

Nothing looks sloppier and more out of control than when you click on the wrong slide, lose your place in the slide, and then lose control of what you were intending to say next as you flick back and forth and start to sweat when you can't find your place. This is an easy one to solve – practise, practise and more practise, and have a hard copy of your presentation handy so you can glance down and get your bearings. If you do lose track, stop and take a breath and, if you are confident enough, speak without the slides.

You versus the clock

If you don't take the opportunity to practise and time the presentation, you're bound to either run out of time before you finish discussing your key points, or you will finish early and be left desperately asking for questions to fill in the time. Practise by speaking the words aloud and rehearse as if you have a room full of people. Use a timer to check where you are at. If you still unsure you can hide a few slides to have on-hand if you need to add more at the last minute.



My computer says no!

For any presenter, their worst nightmare is the technology breaking down – the computer freezing, the video not playing, the screen goes blank ... You never know when technology will go pear-shaped. In an ideal world you would have access to a technical helper who can dive in and fix the equipment, but as we all know this is hardly ever the case.

When a technological breakdown occurs, you need to think on your feet. Stay calm (I know, easy to say) and remember, there was a time not so long ago when nobody used PowerPoint, they just spoke and engaged with the audience! If you planned ahead and printed out the slides, then you have your talking points and script – you just need to be doubly engaging, passionate and energetic, and ensure that you hold their attention because the focus is now completely on you.

Take some time to think about how you would handle a situation such as this, so that you have run it through your mind and, if the worst happens, you can recover quickly. Remember your human-to-human connection and that you are in charge – your audience won't panic if you remain confident, focused and in control. ■

ONLINE COUNSELLING SERVICES

By **Angela Lewis**

Telehealth services for people in rural areas

The Australian Government's Better Access initiative was recently expanded to include telehealth consultations to improve access to mental health services for people in regional, rural and remote Australia.

Eligible patients are required to have a mental health treatment plan and to be located in a rural and remote area, namely, Modified Monash Model (MMM) areas four to seven. To find out if a patient is located in an eligible area, you will need to access the MMM Locator, select the 'MMM classification' and enter the location.

The MMM was developed in 2015 by the Department of Health to address the disparities in health service access that exist across Australia. Those interested in seeing if clients qualify for the full Medicare rebate now available for mental health services can google 'Modified Monash Model' or 'MMM Locator', or go to the Department of Health's website www.health.gov.au and search for more information there.

Further resources

Free online therapy programs are available at www.mentalhealthonline.org.au (funded by the Australian Government Department of Health and Ageing) or can be found by searching www.ruralhealth.org.au.

In terms of paid resources, there are many out there including the online health platform Lysn (pronounced 'listen'), available at www.lysnhealth.com.au or as an app on mobile devices. This group advertises as providing services from qualified Australian psychologists and enables you to talk to a psychologist of your choice via video teleconferencing.

Another app, Talkspace (www.talkspace.com), connects people with licensed therapists via a messaging service. Based on the information on the site, packages start at \$160 and the therapist will respond up to twice daily.

It's a good idea to google for more information and practitioners to give you an idea of what is being offered in the market.



Shaking meditation

Shaking meditation (also known as bio-energy meditation) is intended to help people shake loose so-called physical or spiritual blocks that are stopping them from leading a happy, healthy life. Session times vary, but they are run in a group format and usually involve some type of circle formation where people are encouraged to shout, laugh and move as they wish; there is also meditation-style chanting as you would find in traditional yoga. This therapy originated in Bali, but is now practiced around the world. Google 'dynamic meditation', 'bio-energy meditation' or 'power-shaking meditation' for more information. ■

As is always the case, all website addresses and user instructions supplied were correct at time of submission and neither the ACA nor Angela Lewis receives any payment or gratuity for publication of any website addresses presented here.

Reflections on reflective practice

Critiquing conceptions of reflective practice
in guidance and counselling literature

**By Rebecca Albert and
Professor Margaret-Anne Carter**

Abstract

Reflective practice (RP) – the ability to consciously critique experiences to evaluate cognitive, affective and behavioural decisions – is vital for professional growth, particularly for counselling professionals. This article provides critical reflections on RP by analysing conceptions and models across helping professions to examine how it has evolved. The authors provide an overview of the research scope, which details the search strategy and criteria for exploring RP in literature from across the educational, health, psychological, social work and counselling fields. This involves examining various definitions, frameworks and uses of RP. The authors endeavour to highlight the underlying assumptions and perspectives of RP by examining historical conceptions, areas of contention and gaps in the research. To illuminate such complexities, a dimensional concept analysis approach is used. Reflective practices, such as journaling, are pivotal in supervision influencing professional growth and informing ethical practice. With a specific reference to counsellors, this literature review discusses the following research questions: ‘How has reflective practice evolved from a social constructivist perspective?’ and ‘How do particular reflective practices, such as supervision and journaling, enhance self-awareness and clinical competence for novice and experienced counsellors alike?’ Consequently, this research emphasises the importance of embedding reflective frameworks as a stimulus and response for counselling practitioners to develop understanding, knowledge and skills that will sustain them in the field.



Reflective practice has become an essential component for quality, ethical practice in the helping professions. Aspects and frameworks of RP have long been part of a common vocabulary across disciplines in education, health, psychology, social work and counselling. Examining RP’s evolution in these fields offers insight into its theoretical development and fresh applications. This is significant for counselling professionals because several disciplines have long

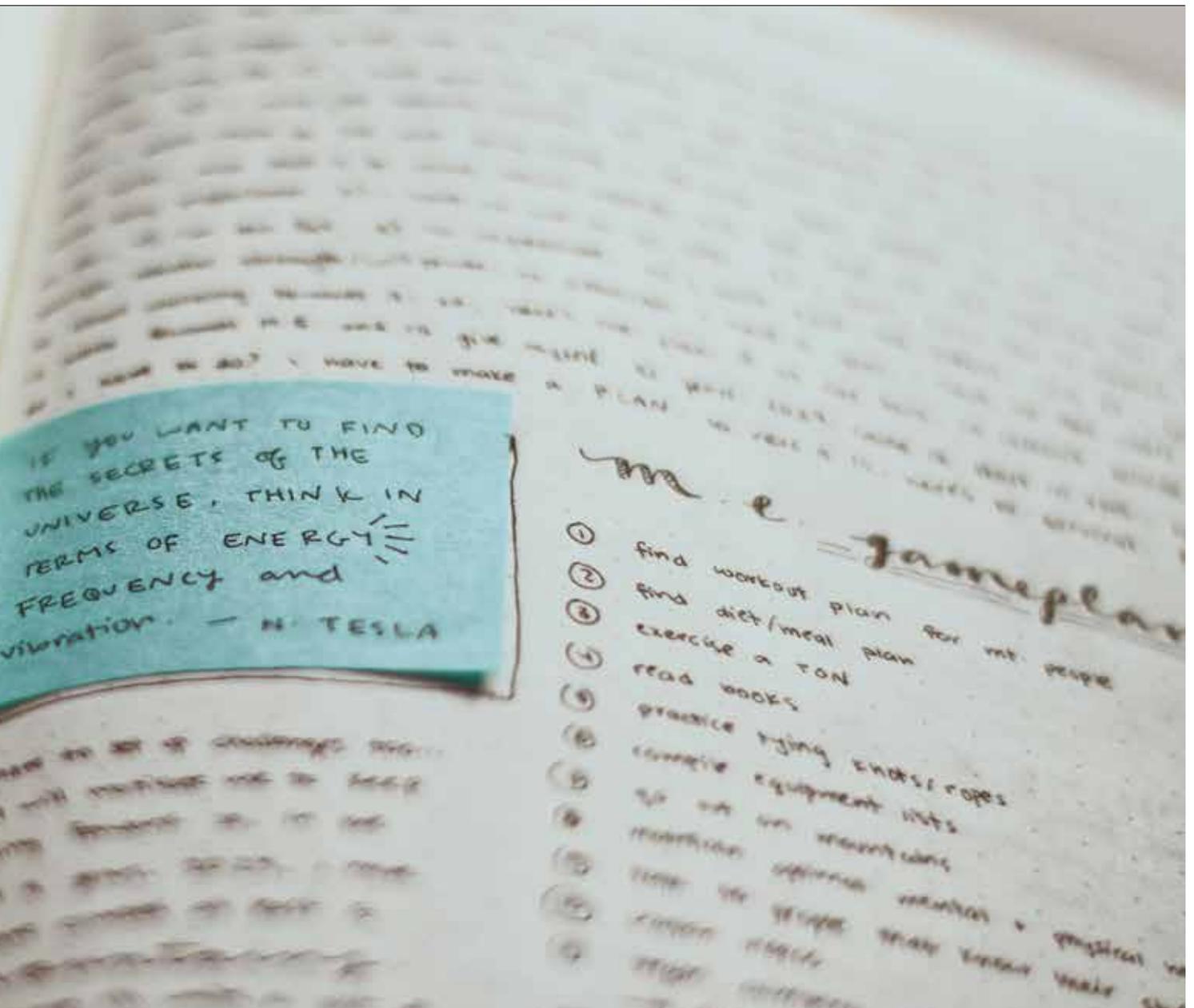


Photo: Unsplash

promoted integration of theory-informed RP, which has assisted the development of counselling practice and supervision. To ensure meaningful professional growth, counsellors would benefit from understanding how RP can be embedded to enhance perceptions and interactions.

This literature review explores the main ideas, theories and concepts of RP in helping professions. The authors examine the literature to consider how particular reflective practices, like supervision and journaling,

enhance the competence of counsellors. Such a review of literature is necessary for practising counsellors, since it considers the efficiency and effectiveness of RP during and between supervision sessions.

Since RP is defined and used ambiguously throughout professional literature, this review considers how conceptualisations of RP have evolved with the question: 'How has reflective practice evolved from a social constructivist perspective?' Next, focusing on literature from the

counselling profession, the authors ponder the usefulness of reflective journaling for supervision. This deliberation seeks to explore the question: 'How do particular reflective practices, such as supervision and journaling, enhance self-awareness and clinical competence for novice and experienced counsellors alike?' To ensure relevance for both practitioners and academics, this article suggests clinical implications and further practice-based research in RP.

Scope, collection and analysis of literature

Literature search strategy

An initial literature search was conducted using James Cook University's OneSearch to access a range of educational, psychological, medical and general databases (ProQuest, Wiley Online, Taylor & Francis, Emerald Insight and Elsevier). To broaden the scope, search terms included the keywords 'reflective practice' and 'helping professions'. In subsequent searches, 'reflective practice' was coupled with 'counselling' or 'counseling' or 'guidance'. Only studies published in English from January 2008 to April 2019 were included. Backward searching of reference lists from several articles yielded additional relevant articles about landmark work on reflective practice, including theorists such as Dewey (1933) and Schön (1983, 1987). After duplicates were excluded, the searches on RP in the broader context of helping professions yielded 4919 results, with 3264 of those being journal articles to which James Cook University had full-text access. Literature within the field of counselling consisted of 2398 records. From here, screening for inclusion commenced.

Study selection (inclusion/exclusion criteria)

Since this literature review was conducted as part of the first author's postgraduate studies, research was restricted by the time constraints of a 13-week subject. After the preliminary search, the titles and abstracts of the first

100 articles were screened and assessed for relevance. Articles were retained if their abstracts:

1. involved RP in helping professions;
2. considered professional development or clinical competency; and
3. mentioned particular frameworks or models associated with RP.

Thirty-four studies were deemed relevant. After a specific search on RP in counselling, titles and abstracts of another 100 journals were reviewed and 10 articles were added to the existing research. Of these 44 studies, 28 were qualitative in nature, five used quantitative methods and 11 were literature reviews. Eight studies involving reflective, dialogue, video and visual journaling were examined more closely to investigate the purpose and practicality of reflective journaling in guidance and counselling. Exploring the evolution of RP seeks to answer the first research question of how RP helps professionals to create and sustain their identities.

Analysis of literature

Reflective practice is a multifaceted concept to examine since it has many forms, definitions, and uses. To illuminate such complexities, a dimensional concept analysis approach (Bowers & Schatzman, 2009) was selected to consider RP's social construction and varying perspectives (Goulet, Larue & Alderson, 2015). Schatzman (1991), the original developer of dimensional analysis, believed researchers must 'dimensionalise' a concept by extracting multiple

dimensions and clarifying linkages, contexts, and consequences.

Throughout the literature-sampling process, articles were contextualised in this way. This resulted in the main ideas, diverse theories and concepts being extracted, critically examined and linked according to similar themes and findings.

Numerous analyses of the concept of RP have been conducted across health professional disciplines. Although each provides valuable evidence on the benefits of RP, it is worthwhile to further consider the evolution of RP from a social-constructivist epistemological position because this offers insights into historical implications, underlying assumptions, areas of contention and current applications. This leads into the second research question involving how reflective practices, such as journaling, enhance supervisory experiences for counsellors.

Conceptions of reflection: defining RP in the helping professions

As RP continues to evolve in helping professions, inconsistencies in definitions and applications remain. This influence affects how this concept is understood and enacted. Such discrepancies are magnified by the interchangeable use with similar concepts like reflexivity, self-awareness, self-evaluation and critical reflection. An early proponent of experiential learning, educationalist John Dewey asserted that reflective thought was the "active, persistent, and careful consideration of any belief or supposed form of

knowledge” (Dewey, 1933, p. 118). This deliberate cognitive process involves sequencing interconnected ideas, pondering underlying beliefs, and allowing for doubt and perplexity before considering possible solutions for practical problems (Cropley, Hanton, Miles & Niven, 2010).

Rodgers (2002) expands Dewey’s seminal work, suggesting reflection is not an end in itself, but rather a tool or vehicle to transform raw experience into meaning-filled theory grounded in experience. This promotes the moral growth of individuals and society. Rodgers (2002) highlights four key components from Dewey. First, Rodgers posits reflection is a process for making sense of one’s experiences through grounded educative situations that broaden thought and action. Second, reflection must be systematised into a disciplined, rigorous way of thinking that takes time. Third, reflection occurs via interaction with others through shared responsibility. Finally, reflection requires a mental attitude that prizes personal and intellectual growth. This requires an open-minded shift from self-absorption to self-awareness. While reflecting for intentional, informed practice is important, more recent conceptualisations propose RP goes beyond the intellectual to involve the whole person, including emotions and behaviours (Ghaye, 2010).

Donald Schön’s contributions to RP in the 1980s further developed its design and implementation, characterising it as a cyclical interaction of learning and experience (Schön, 1983, 1987).

Schön believed practitioners could critique their practice through examining various clinical experiences. Although a full discussion of Schön’s theories lies beyond the scope of this review, the concepts of technical rationality, reflection-in-action, and reflection-on-action will be briefly defined here.

Technical rationality was premised on erroneous divisions of theory and practice. The assumption that professionals must first acquire substantive theoretical understanding before refining practical techniques is accepted by most. Yet others contend conscious, informed decisions continue to develop throughout one’s professional journey (Edwards & Thomas, 2010).

Reflection-in-action involves conscious thinking and modification through interactive reflection (Burhan-Horsanlı & Ortaçtepe, 2016). Farrell (2012) suggests practitioners reflecting “on their feet” (p. 12) assists them to immediately appraise actions as they confront situations. According to Schön (1983), seeking continuous learning is vital for professional growth.

Through *reflection-on-action*, practitioners evaluate previous experiences to consider opportunities and alternatives for bettering outcomes (Burhan-Horsanlı & Ortaçtepe, 2016). Further to reflecting on past and present circumstances, van Manen (1991) proposes a third form, *reflection-for-action*, which considers strengths, weaknesses, strategies and techniques with a view to improving future practice. Schön’s original claims have been criticised for

being based on sparse empirical evidence (Rolfe & Gardner, 2006), and reflection-in-action remains undervalued (Edwards, 2014). Furthermore, such definitions of RP offer little practical advice on *how* to reflect meaningfully on clinical practice. Therefore, models or frameworks that examine layers and cycles of reflection offer more real-world support for helping professionals.

Such reflective models prompt insightful self-awareness and self-evaluation. However, the issue for most professionals is not the importance of RP, but rather which model/s to adopt. Kolb (1984) proposes four sequential steps (concrete experience, reflective observation, abstract conceptualisation and active experimentation) that form an experiential learning cycle. This model provides a useful framework for developing the ability to evaluate decisions and actions. In a counselling context, this self-evaluation is enhanced by regular interaction with a supervisor. Irrespective of the developmental stage of the counsellor, RP in supervision is foundational for ethical practice (Stoltenberg & McNeill, 2010). This corresponds to the Australian Counselling Association’s Code of Ethics and Practice, which clearly stipulates actively monitoring competence and efficacy through purposeful supervision and professional development for all counsellors (Australian Counselling Association, 2015). Traditional approaches to supervision, still commonly used today, include retrospective reflection-on-practice through case discussion and reviews of clinical

processes (Senediak, 2013).

A common model used to facilitate such a review is Gibbs' (1988) reflective cycle, which consists of six stages for structured debriefing: Description, Feelings, Evaluation, Analysis, Conclusion, and Action Plan. A decade later, Brookfield (1998) introduced the concept of considering situations through various lenses that viewed situations from differing perspectives, including colleagues' experiences and theoretical/philosophical beliefs. Critically reflective thinking is also promoted through myriad other frameworks, including Johns' (1995) guided reflection and five patterns of knowing; Borton's (1970) 'What? So what? Now what?'; and Ash and Clayton's (2009) 'DEAL' model. Such frameworks may provide structure for articulating and evaluating learning experiences, yet these still neglect to specifically define the concept of RP.

RP is commonly mentioned in nursing and educational literature, yet it remains an ill-defined, elusive term. Numerous authors (for example, Edwards, 2017; Gentile, 2012; Hickson, Lehmann & Gardner, 2016; Khan, 2017) have provided various definitions of RP, often adjusting Dewey and Schön's definitions to fit particular disciplines. For example, Gentile (2012) defines RP in nursing as "a deliberate process that actively engages an individual in exploring his or her experiences. The exploration of decisions, thoughts and feelings should inform and improve practice" (p. 102). Building on affective domains, Cleary, Horsfall, Happell and Hung (2013) consider RP to be multifaceted to

activate cognitive and emotional capacities for constructive learning, potentially resulting in attitudinal or behavioural changes. In educational research, RP is defined as vital for enhancing teaching quality (Akinbode, 2013), self-awareness (Minott, 2011) and autonomous behaviours (Cooke, 2013). Despite different conceptualisations, there is generally a consensus that RP closely corresponds to a cyclical process of reviewing cognitive, affective and behavioural experiences to enhance professional practice.

In this article, a counselling definition will be adopted following Griffith and Frieden's (2000) view that reflective practice is "the *active, ongoing* examination of the *theories, beliefs and assumptions* that contribute to counsellors' *understanding* of client issues and *guide their choices* for clinical interventions" (p. 82, emphasis added). This approach reflects the cyclical, ongoing nature of critically and holistically examining taken-for-granted thoughts and behaviours to improve practice.

Mapping the field: exploring reflective practice research in helping professions

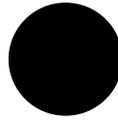
Clarifying the conceptualisations and evolution of RP provides a basis for exploring current research in the helping professions. Since its conception, RP has become the cornerstone of pedagogy and professional preparation in health sciences, education, social work and psychology. Boud (2010) asserts that RP is particularly appropriate for nursing and teaching because these

professions emphasise personal interaction between professionals and clients. Over a third of research literature deemed relevant for this article investigates nursing, with a recent focus on RP for competency assessment. In the UK and Australia, nurses consciously integrate RP into portfolios for registrations and revalidations (Dean, 2016; Finch, 2016). Nicol and Dosser (2016) challenge the perception of retrospective reflection for performativity agendas, instead encouraging purposeful, focused RP before and during case management. To fine-tune such thinking, they recommend regularly discussing case studies with supervisors and colleagues. Sharp (2018) notes that clinical supervision is not evident in all settings, and encourages journalling using Gibbs' (1988) reflective cycle to examine incidents and experiences. While reflective journalling is encouraged in nursing and education, there is limited research on counsellors using this approach.

Narrative research in Victoria, Australia has investigated alternative forms of RP, proposing digital storytelling as an engaging variant of reflective processes to assist with re-imaging responses to clinical events (Paliadelis & Wood, 2016). Using a qualitative descriptive methodology, Paliadelis and Wood (2016) examined reflections on a range of political, professional, technical and clinical issues that nursing graduates face. While most authors accept RP as essential for clinical competency development (such as Chelliah & Arumugam, 2012; Cropley et al., 2010), several

researchers critique such regulation using Foucauldian discourse analysis to examine discursive practices (for example, Fejes, 2012; Kelsey & Hayes, 2015). Kelsey and Hayes (2015) disagree with conventional understandings of RP as beneficial, believing that forcing expected behaviours and thinking models can be controlling and oppressive. Similarly, Nelson (2012) suggests that RP is so integrated and ingrained that researchers rarely explore the epistemological basis of RP's standing as an authoritative discourse. RP can also be conceived as a governing technology that discursively influences a professional's subjectivity (Fejes, 2008).

Educational disciplines have extensive literature on RP, with most studies focusing on pre-service and/or beginning teachers. Penn-Edwards, Donnison and Albion (2016) analysed survey and focus group responses from 160 pre-service teachers and staff at a regional Australian university to obtain various perceptions on reflective thinking, writing and practice. Their key research findings included



About the authors

Rebecca Albert
Guidance officer,
primary teacher
and student welfare
officer, Queensland
Department of
Education
Master of Guidance
and Counselling (James
Cook University)
Bachelor of Education
with Honours (Class 1)

**Professor Margaret-
Anne Carter**
Discipline chair for
counselling, Australian
College of Applied
Psychology, Brisbane
Adjunct Associate
Professor, College
of Arts, Society and
Education, James Cook
University
Doctor of Education
Master of Educational
Studies
Bachelor of Education
Studies
Diploma of Education

that immersive RP potentially leads to developing a personalised pedagogy of self that empowers coping and self-reflective skills. In pre-service teaching, RP apparently moves through different cognitive levels including descriptive, self-focused, instrumental-reflexive, dialogical-reflexive and transformative-reflexive, which Roters (2015) believes fosters transformative professional growth. Some researchers argue that levels of RP can be simplified using Lee's (2005) three-stage hierarchical model: recall, rationalisation and reflectivity. For example, Cavanagh and Prescott (2010) documented the growth of RP after conducting interviews with three beginning teachers over two years. Their findings indicated self-reflection might begin with descriptive recall evaluating technical aspects of teaching, yet over time reflective stances demonstrated levels of practical rationalisation and reflectivity that considered various perspectives.

Qualitative research involving interviews, autoethnographies or action research appears to better encapsulate

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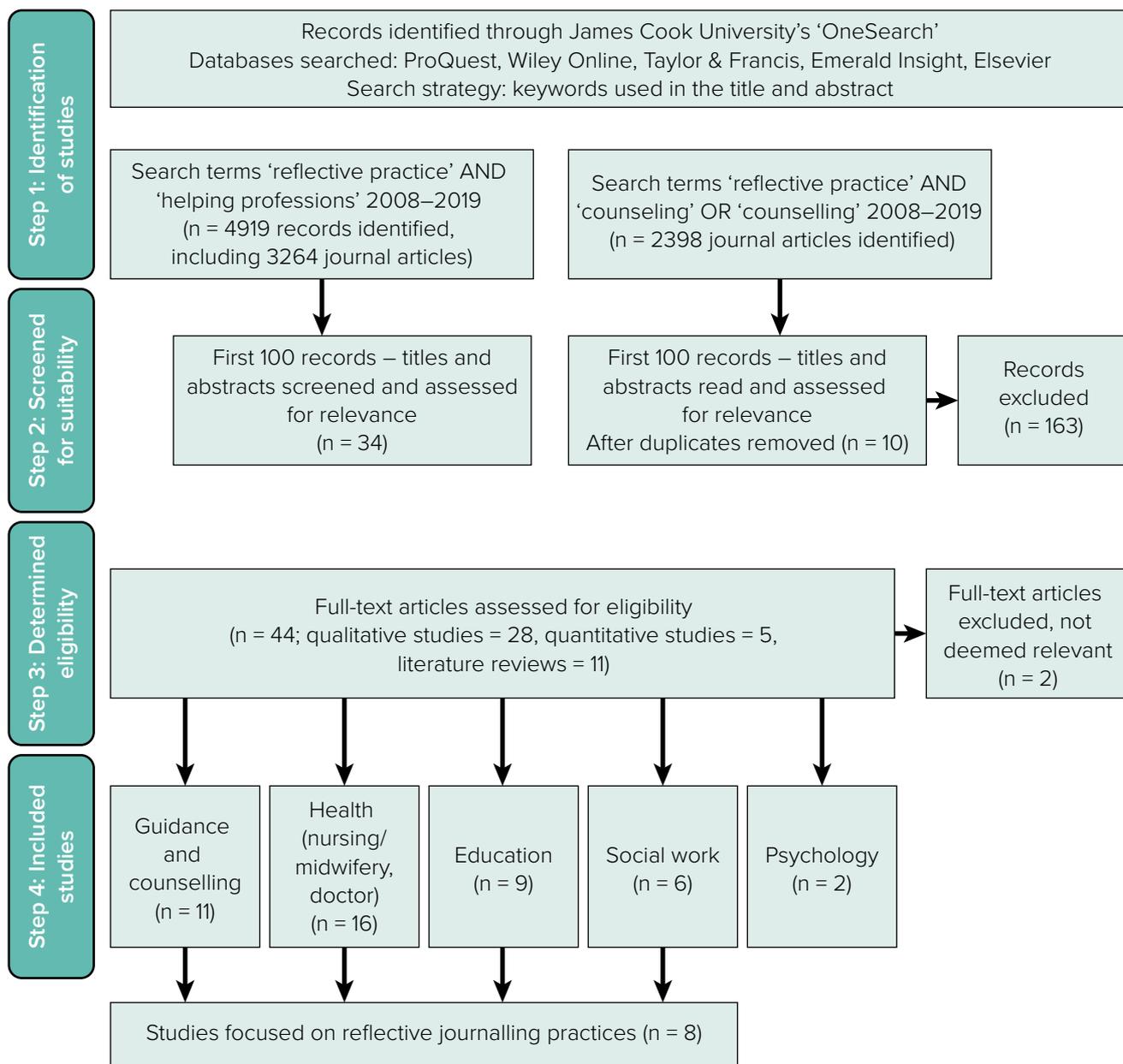
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www.mlfl.com.au

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FIGURE 1 Process followed for literature selection.



For access to the inventory, please contact Rebecca Albert (rdris6@eq.edu.au).

participants' lived experiences of RP (see du Preez, 2008; Sellars, 2012). However, Aldahmash, Alshmarani and Almufti (2017) conducted surveys that examined how RP was used by 458 science teachers. Their research findings were consistent with Edwards and Thomas' (2010) claim that RP is essential for performativity agendas. However, educators must continue to critique the processes and products of RP to ensure that these challenge taken-for-granted

theories, beliefs and assumptions. This pertinent message relates to counsellors to ensure the core of their practice involves empathic understanding of clients' issues before using RP to guide clinical interventions. Evidently, the majority of research in RP has evolved in nursing and educational discourses. These models have greatly influenced how RP is conceived and adopted in counselling practice. This leads to the second research question, 'How do

particular reflective practices, such as supervision and journaling, enhance self-awareness and clinical competence for novice and experienced counsellors alike?'

Reflective practices in counselling: experiences with supervision and reflective journaling

Supervisory experiences. Since RP is the cornerstone in ethical counselling, developing reflective thinking skills is a key goal for

counsellors. Senediak (2013) notes researchers concur that clinical supervision is vital for teaching strategies that facilitate RP. However, Edwards (2014) argues that RP in supervision can be problematic as an emphasis on individualistic approaches overstates individual control in a world of work characterised by teamwork and interprofessional collaboration, thus minimising workplace context. Additionally, during RP in supervision, the power differential may influence the supervisee to perceive themselves as being inferior or judged, particularly because reflection may prompt self-criticism rather than self-praise (Campling, 2016). Therefore, it is vital that counselling supervisees are encouraged to have curious, introspective practices that sensitively self-evaluate, to move away from an evidence and competency-based approach that may foster feelings of inferiority (Gates & Sendiack, 2017). Nonetheless, many researchers acknowledge that RP during supervision is positively correlated to clinical competence, providing counsellors with critical skills to question assumptions and biases metacognitively (Mullen, Uwamahoro, Blount & Lambie, 2015; Park-Taylor et al., 2009; Tobias, Ives & Philip, 2016). This corresponds closely to the intentions of RP outlined in Griffith and Frieden's (2000) previously cited definition. Despite emerging research on the benefits of written RP, limited studies investigate how reflective journaling enhances supervision and clinical competence in counselling.

Reflective journaling. Effective counsellors require reflexive

awareness of their assumptions and interpretations of counsellor–client interactions (Willig, 2019). Stimulating such 'reflexive reflectivity' may be developed through strategies including mentors modelling introspective dialogue and analytical thinking, questioning to frame supervision sessions, and reflective journaling (Senediak, 2013). In the latter, the counsellor engages with a series of prompts designed to critique their thoughts, assumptions, expectations, feelings and actions, with a view to examining alternative interpretations and influences. In the health sciences, qualitative research on RP has been conducted on a larger scale through thematic analysis of 102 student journals, 12 teacher journals and transcripts from focus group interviews (Ruiz-López et al., 2015). Findings from this study included that reflective journaling during clinical placements helps build trust in supervisory relationships by providing a non-threatening opportunity for purposeful interaction and ongoing supportive dialogue.

In social work practice, dialogue journaling is becoming a popular form of interactive writing in which the supervisee and supervisor regularly engage in written conversation (Gursansky, Quinn & Le Sueur, 2010; Jensen-Hart, Shuttleworth & Davis, 2014; Moore, Bledsoe, Perry & Robinson, 2011). In one case study, 15 dialogue journals were analysed and found to provide an outlet for values discussion and growing self-awareness through strengths-based feedback (Jensen-Hart et al., 2014). The authors in this study advocated

that journals help to process overwhelmed feelings leading to proactive application of knowledge and skills.

Consequently, this interactive supervisory tool holds promise for enhancing RP for counsellors. However, in a counselling context, there is limited existing research on the usefulness of solitary reflective journaling. Relevant studies are qualitative in design and reliant upon participant self-report (Bassot, 2014; Deaver & McAuliffe, 2009; Schmidt & Adkins, 2012; Woodbridge & O'Beirne, 2017). In their phenomenological study of four counselling students' experiences with reflective journaling, Woodbridge and O'Beirne (2017) identified several key benefits including bridging the gap between experience and reflection through freely disclosing practical, personal and ethical challenges. In a similar study of six counselling students who journalled during internships, Schmidt and Adkins (2012) found participants perceived journaling as a significant tool for fostering growth as a professional practitioner over time.

Alternative modes of journaling. Since written expression poses a challenge for some counsellors, other researchers have investigated the use of video journals. In one phenomenological study, all seven participants stated video journals allowed greater authenticity while reducing concern that assessment was simply critiquing their writing style (Parikh, Janson & Singelton, 2012). Where distance poses challenges for supervision, Wright and Griffiths (2010) argue that RP

via technology (telephone, Skype and email conversations) offers opportunities for meaningfully discussing case management through reflection in verbal or written forms. Another potential practice involves visual journaling through focused art-making that expresses innermost feelings (Deaver & McAuliffe, 2009). According to Hayman, Wilkes and Jackson (2012), a challenge of journaling – whether visual, verbal or written – involves the sense of feeling exposed and vulnerable after revealing such personal reflection to one’s supervisor. Studies are yet to investigate how to minimise this concern, and limited research exists on overcoming inherent challenges and barriers associated with reflective journaling.

Critical RP that examines counsellors’ attitudes and values to challenge assumptions helps to promote reflexivity, which Corey, Schneider Corey, Corey and Callanan (2014) describe as self-awareness for ethical practice. Bassot (2014) also recommends reflective journaling to ensure culturally sensitive practice, with the justification that recording experiences helps foster critical thinking and problem-solving skills. For uncertain or reluctant writers, he provides a template with prompts regarding unpacking the experience, theoretical connections and preparation for future situations. These prompts include questioning the situation, context and contributory factors of the situation before engaging in structured reflection on goals, cultural issues, assumptions, feelings and consequences.

Bassot’s (2014) template for reflective journaling also includes a section for theoretical implications and how the experience has modified the counsellor’s thinking into creating new strategies for future practice.

RP is not exclusively an intellectual observational function, but also an experiential, affective function (McIlveen & Patton, 2010). While reflective models contain similarities, each incorporates slightly different foci and priorities. For example, Ziomek-Daigle (2017) recommends the use of Ash and Clayton’s (2009) DEAL model of critical reflection (describe, examine and articulate learning), arguing that this approach deepens learning through confronting bias, inviting alternative perspectives and examining causality. Since few researchers dispute the benefits of reflective journaling (Campling, 2016; Hayman et al., 2012), it is surprising minimal research has appeared in counselling literature.

Further research and clinical implications

Reflective practice is considered the cornerstone for competent, ethical practice in the helping professions. Commonly described as a cyclical process that reviews cognitive, affective and behavioural decisions, RP deepens and develops during supervision. While there is contention on how to define RP, most authors conceive this as a conscious, continuous process that examines inherent theories, beliefs and assumptions to guide practice (Roters, 2015; Schmidt & Adkins, 2012). Many practising counsellors would agree that reflective journaling has merit for reinforcing

and applying RP to enhance supervisory experiences. However, future studies are warranted to consider how to consciously, meaningfully engage in regular RP amidst competing priorities. After all, if counsellors ‘neglect to reflect’ are they being ethical, responsible or effective? Many can appreciate the importance of RP as a skill-developing process, but many would also agree that reflection through a structured framework is another competing priority in already crowded supervisory agendas.

This research has sought to investigate the main ideas, theories and concepts of RP in the literature from several helping professions. A key finding was that a wide variety of reflective models are used, yet limited research has investigated reflective journaling. Each of the eight articles previously mentioned that addressed journaling were small-scale, qualitative studies. This constrains generalisability and findings are not necessarily transferable to other populations. Furthermore, since these studies focus on pre-service or beginning practitioners, there appears to be a significant gap regarding uses, benefits and challenges of reflective journaling for counsellors in other stages of their careers. The available research suggests reflective practice enhances clinical competence; however, this is based on narrow samples of mostly Caucasian participants. More research is needed on RP in guidance and counselling contexts, including through more culturally diverse samples, to increase generalisability of results. Although RP has strong

theoretical orientations, future research may compare models and frameworks to determine more effective, unified approaches for helping professionals. RP holds promise for positive learning from clinical experiences to manage links between values and actions. Systematic and rigorous RP, preferably through adopting a user-friendly framework, has potential to enhance supervision and lifelong reflectivity in counselling practice.

This article has concentrated on how RP enhances self-awareness, critical thinking and clarity to inform ongoing professional development. Another approach may involve investigating how counsellors model reflective processes to enhance their clients' reflective practices. After all, often a counsellor's main objective is to promote reflectivity. Before counsellors can model RP to clients, they must first adopt clear frameworks they use themselves. Counsellors need also be mindful of the ethical imperative to actively and consciously reflect, including through regular supervision and professional development (ACA, 2015). While there is obvious agreement that RP is important and ethical, we need to delve deeper into this concept to appreciate its importance. Highlighting the evolution of conceptualisations, intricacies and complexities of RP allows us to move forward while considering how we will adopt and adapt research-based models and frameworks in our own practice. Reflective journaling through a variety of mediums offers an avenue for us to tell our professional stories, developing insights and awareness along the way. Rather than the perspective that reflective practices are an idealistic extra to fit in, it is time to prioritise perceptive self-awareness and growth. Reflecting on reflective practice is vital, ethical and transformational. ■

References

- Akinbode, A (2013). 'Teaching as lived experience: The value of exploring the hidden and emotional side of teaching through reflective narratives.' *Studying Teacher Education*, vol. 9(1), pp. 62-73. doi:10.1080/17425964.2013.771574
- Aldahmash, AH; Alsharani, SM; Almufti, AN (2017). 'Secondary school science teachers' views about their reflective practice.' *Journal of Teacher Education for Sustainability*, vol. 19(1), pp. 43-53. doi:10.1515/jtes-2017-0003
- Ash, SL; Clayton, PH (2009). 'Generating, deepening, and documenting learning: The power of critical reflection in applied learning.' *Journal of Applied Learning in Higher Education*, vol. 1(1), pp. 25-48. Retrieved from <http://hdl.handle.net/1805/4579>
- Australian Counselling Association (2015). *Code of ethics and practice*. Retrieved from <https://www.theaca.net.au/>
- Bassot, B (2014). 'Enabling culturally sensitive career counseling through critically reflective practice: The role of reflective diaries in personal and professional development.' In G. Arulmani (Ed.), *Handbook of career development international perspectives*, pp. 453-464. New York, NY: Springer.
- Borton, G (1970). *Reach, touch and teach: Student concerns and process education*. New York, NY: McGraw-Hill.
- Boud, D (2010). 'Relocating reflection in the context of practice.' In H. Bradbury; N. Frost; S. Kilminster; & M. Zukas (Eds.), *Beyond reflective practice: New approaches to professional lifelong learning*, pp. 25-36. London, United Kingdom: Routledge.
- Bowers, B; Schatzman, L (2009). 'Dimensional analysis.' In JM Morse; PN Stern; J Corbin; B Bowers; K Charmaz; AE Clarke (Eds.), *Developing grounded theory: The second generation*, pp. 86-126. Walnut Creek, CA: Left Coast Press.
- Brookfield, S (1998). 'Critically reflective practice.' *Journal of Continuing Education in the Health Professions*, vol. 18(4), pp. 197-205. doi:10.1002/chp.1340180402

- Burhan-Horsanli, E; Ortaçtepe, D (2016). 'Reflective practice-orientated online discussions: A study on EFL teachers' reflection-on, in and for-action.' *Teaching and Teacher Education*, vol. 59(1), pp. 372-382. doi:10.1016/j.tate.2016.07.002
- Campling, P (2016). 'The opportunities and pitfalls of reflective practice in an age of austerity.' *Psychotherapy and Politics International*, vol. 14(1), pp. 48-60. doi:10.1002/ppi.1372
- Cavanagh, M; Prescott, A (2010). 'The growth of reflective practice among three beginning secondary mathematics teachers.' *Asia-Pacific Journal of Teacher Education*, vol. 38(2), pp. 147-159. doi:10.1080/13598661003678968
- Chelliah, KK; Arumugam, Z (2012). 'Does reflective practice enhance clinical competency in medical imaging undergraduates?' *Procedia – Social and Behavioral Sciences*, vol. 60(1), pp. 73-77. doi:10.1016/j.sbspro.2012.09.349
- Cleary, M; Horsfall, J; Happell, B; Hung, GE (2013). 'Reflective components in undergraduate mental health nursing curricula: Some issues for consideration.' *Issues in Mental Health Nursing*, vol. 34(2), pp. 69-74. doi:10.3109/01612840.2012.722171
- Cooke, SD (2013). 'Examining transcription, autonomy and reflective practice in language development.' *RELC Journal: A Journal of Language Teaching and Research*, vol. 44(1), pp. 75-85. doi:10.1177/0033688212473271
- Corey, G; Schneider Corey, MS; Corey, C; Callanan, P (2014). *Issues and ethics in the helping professions* (9th ed.). Boston, MA: Brooks/Cole Cengage Learning.
- Cropley, B; Hanton, S; Miles, A; Niven, A (2010). 'The value of reflective practice in professional development: An applied sport psychology review.' *Sport Science Review*, vol. 14(3), pp. 179-208. doi:10.2478/v10237-011-0025-8
- Dean, E (2016). 'Reflective practice is vital to the revalidation process.' *Nursing Children and Young People*, vol. 28(3), pp. 8-9. doi:10.7748/ncyp.28.3.8.s8

- Deaver, SP; McAuliffe, G (2009). 'Reflective visual journaling during art therapy and counselling internships: A qualitative study.' *Reflective Practice*, vol. 10(5), pp. 615-632. doi:10.1080/14623940903290687
- Dewey, J (1933). *How we think: A restatement of the relation of reflective thinking to the educative process*. Boston, MA: D.C. Heath.
- du Preez, J (2008). 'Locating the researcher in the research: Personal narrative and reflective practice.' *Reflective Practice*, vol. 9(4), pp. 509-519. doi:10.1080/14623940802431499
- Edwards, G; Thomas, G (2010). 'Can reflective practice be taught?' *Educational Studies*, vol. 36(4), pp. 403-414. doi:10.1080/03055690903424790
- Edwards, S (2017). 'Reflecting differently. New dimensions: reflection-before-action and reflection-beyond action.' *International Practice Development Journal*, vol. 7(1), pp. 1-15. Retrieved from <https://search-proquest-com.elibrary.jcu.edu.au/>
- Edwards, S (2014). 'Finding a place for story: Looking beyond reflective practice.' *International Practice Development Journal*, vol. 4(2), pp. 1-14. Retrieved from <https://search-proquest-com.elibrary.jcu.edu.au/>
- Farrell, TS (2012). 'Reflecting on reflective practice: (Re)visiting Dewey and Schön.' *TESOL Journal*, vol. 3(1), pp. 7-16. doi:10.1002/tesj.10
- Fejes, A (2008). 'Governing nursing through reflection: A discourse analysis of reflective practices.' *Journal of Advanced Nursing*, vol. 64(3), pp. 243-250. doi:10.1111/j.1365-2648.2008.04800.x
- Finch, A (2016). 'Revalidation and reflective practice.' *Nursing Management*, vol. 23(1), pp. 22-25. doi:10.7748/nm.23.1.22.s26
- Flaskas, C (2012). 'The space of reflection: Thirdness and triadic relationships in family therapy.' *Journal of Family Therapy*, vol. 34(2), pp. 138-156. doi:10.1111/j.1467-6427.2012.00587.x

Gates, NJ; Sendiack, CI (2017). 'Neuropsychology supervision: Incorporating reflective practice.' *Australian Psychologist*, vol. 52(3), pp.191-197. doi:10.1111/ap.12242

Gentile, DL (2012). 'Applying the novice-to-expert model to infusion nursing.' *Journal of Infusion Nursing*, vol. 35(2), pp. 101-107. doi:10.1097/NAN.0b013e3182424336

Ghaye, T (2010). 'In what ways can reflective practices enhance human flourishing?' *Reflective Practice*, vol. 11(1), pp. 1-7. doi:10.1080/14623940903525132

Gibbs, G (1988). *Learning by doing: A guide to teaching and learning methods*. Oxford, United Kingdom: Oxford Brookes University.

Goulet, M; Larue, C; Alderson, M (2016). 'Reflective practice: A comparative dimensional analysis of the concept in nursing and education studies.' *Nursing Forum*, vol. 51(2), pp. 139-150. doi:10.1111/nuf.12129

Griffith, BA; Frieden, G (2000). 'Facilitating reflective thinking in counselor education.' *Counselor Education and Supervision*, vol. 40(2), pp. 82-93. doi:10.1002/j.1556-6978.2000.tb01240.x

Gursansky, D; Quinn, D; Le Sueur, E (2010). 'Authenticity in reflection: Building reflective skills for social work.' *Social Work Education*, vol. 29, pp. 778-791.

Hayman, B; Wilkes, L; Jackson, D (2012). 'Journaling: Identification of challenges and reflection on strategies.' *Nurse Researcher*, vol. 19(3), pp. 27-31. Retrieved from <https://search-proquest-com.eibrary.jcu.edu.au/>

Hickson, H; Lehmann, J; Gardner, F (2016). 'Exploring the development of reflective capacity in young people.' *Children Australia*, vol. 41(2), pp. 154-161. doi:10.1017/cha.2016.6

Jensen-Hart, S; Shuttleworth, G; Davis, JL (2014). 'Dialogue journals: A supervision tool to enhance reflective practice and faith integration.' *Social Work and Christianity*, vol. 41(4), pp. 355-372. Retrieved from <https://search-proquest-com.eibrary.jcu.edu.au/>

Johns, C (1995). 'Framing learning through reflection with Carper's fundamental ways of knowing in nursing.' *Journal of Advanced Nursing*, vol. 22(2), pp.226-234. doi:10.1046/j.1365-2648.1995.22020226.x

Kelsey, C; Hayes, S (2015). 'Frameworks and models – scaffolding or strait jackets? Problematising reflective practice.' *Nurse Education in Practice*, vol. 15(6), pp. 393-396. doi:10.1016/j.nepr.2015.05.006

Khan, MI (2017). 'Reflection and the theory-practice conundrum in initial teacher education in the UK.' *FWU Journal of Social Sciences*, vol. 11(6), pp. 64-71. Retrieved from <https://search-proquest-com.eibrary.jcu.edu.au/>

Kolb, D (1984). *Experiential learning: Experiences as the source of learning and development*. Neward, NJ. Prentice Hall.

Lee, H (2005). 'Understanding and assessing preservice teachers' reflective thinking.' *Teaching and Teacher Education*, vol. 21(6), pp. 699-715. doi:10.1016/j.tate.2005.05.007

McIlveen, P; Patton, W (2010). 'My career chapter as a tool for reflective practice.' *International Journal for Educational and Vocational Guidance*, vol. 10(3), pp. 147-160. doi:10.1007/s10775-010-9181-0

Minott, MA (2011). 'A reflective approach to teaching practicum debriefing.' *Teacher Education and Practice*, vol. 25(2), pp. 287-301. Retrieved from <https://search-proquest-com.eibrary.jcu.edu.au/eric/index?accountid=16285>

Moore, SE; Bledsoe, LK; Perry, AR; Robinson, MA (2011). 'Social work students and self-care: A model assignment for teaching.' *Journal of Social Work Education*, vol. 47(3), pp. 545-553. doi:10.5175/JSWE.2011.201000004

Mullen, PR; Uwamahoro, O; Blount, AJ; Lambie, GW (2015). 'Development of counseling students' self-efficacy during preparation and training.' *The Professional Counselor*, vol. 5(1), pp. 175-184. doi:10.15241/prm.5.1.175

Nelson, S (2012). 'The lost path to emancipatory practice: Towards a history of reflective practice in nursing.' *Nursing Philosophy*, vol. 13(3), pp. 202-213. doi:10.1111/j.1466-769X.2011.00535.x

Nicol, JS; Dosser, I (2016). 'Understanding reflective practice.' *Nursing Standard (Royal College of Nursing)*, vol. 30(36), pp. 34-42. doi:10.7748/ns.30.36.34.s44

Paliadelis, P; Wood, P (2016). 'Learning from clinical placement experience: Analysing nursing students' final reflections in a digital storytelling activity.' *Nurse Education in Practice*, vol. 20(1), pp. 39-44. doi:10.1016/j.nepr.2016.06.005

Parikh, SB; Janson, C; Singelton, T (2012). 'Video journaling as a method of reflective practice.' *Counselor Education and Supervision*, vol. 51(1), pp. 33-49. Retrieved from <https://search-proquest-com.eibrary.jcu.edu.au/>

Park-Taylor, J; Kim, GS; Budianto, L; Pfeifer, G; Laidlaw, P; Sakurai, M; Pfeifer, J (2009). 'Toward reflective practice: A multicultural competence training model from a community mental health center.' *Professional Psychology: Research and Practice*, vol. 40(1), pp. 88-95. doi:10.1037/a0013828

Penn-Edwards, S; Donnison, S; Albion, L (2016). 'Developing the inner teacher: Guiding the reflective practice of first year preservice teachers.' *International Journal of Pedagogies and Learning*, vol. 11(1), pp. 10-21. doi:10.1080/22040552.2016.1187646

Rodgers, C (2002). 'Defining reflection: Another look at John Dewey and reflective thinking.' *Teachers College Record*, vol. 104(4), pp. 846-866. doi:10.1111/1467-9620.00181

Rolfe, G; Gardner, L (2006). "Do not ask who I am...": Confession, emancipation and (self)-management through reflection.' *Journal of Nursing Management*, vol. 14(8), pp. 593-600. doi:10.1111/j.1365-2934.2006.00717.x

Roters, B (2015). 'Preservice teachers' professional growth as leaders: Empowerment through research-orientated reflective practice and didactic expertise in Germany.' In L. Orland-Barak & C. J. Craig (Eds.), *International teacher education: Promising pedagogies*, pp. 31-49. Bingley, United Kingdom: Emerald Group Publishing.

Ruiz-López, M; Rodriguez-García, M; Villanueva, P; Márquez-Cava, M; García-Mateos, M; Ruiz-Ruiz, B; Herrera-Sánchez, E (2015). 'The use of reflective journaling as a learning strategy during the clinical rotations of students from the faculty of health science: An action-research study.' *Nurse Education Today*, vol. 35(10), pp. 26-31. doi:10.1016/j.nedt.2015.07.029

Schatzman, L (1991). Dimensional analysis: Notes on an alternative approach to the grounding of theory in qualitative research.' In D. R. Maines (Ed.), *Social organization and social process*, pp. 303-314. New York, NY: Aldine De Gruyter.

Schmidt, C; Adkins, C (2012). 'Understanding, valuing, and teaching reflection in counselor education: A phenomenological inquiry.' *Reflective Practice: International and Multidisciplinary Perspectives*, vol. 13(1), pp. 77-96. doi:10.1080/14623943.2011.626024

Schön, DA (1983). *The reflective practitioner*. New York, NY: Basic Books.

Schön, DA (1987). *Educating the reflective practitioner*. San Francisco, CA: Jossey-Bass.

Sellars, M (2012). 'Teachers and change: The role of reflective practice.' *Procedia – Social and Behavioural Sciences*, vol. 55(1), pp. 461-469. doi:10.1016/j.sbspro.2012.09.525

Sendiack, C (2013). 'Integrating reflective practice in family therapy supervision.' *Australian and New Zealand Journal of Family Therapy*, vol. 34(4), pp. 338-351. doi:10.1002/anzf.1035

Sharp, L (2018). 'Reflective practice: Understanding ourselves and our work.' *Australian Nursing and Midwifery Journal*, vol. 25(10), pp. 48-48. Retrieved from <http://go.galegroup.com.eibrary.jcu.edu.au/>

Stoltenberg, CD; McNeill, BW (2010). *IDM supervision: An integrative developmental model for supervising counsellors and therapists* (3rd ed.). New York, NY: Routledge.

Tobias, C; Ives, JE; Garnham, AP (2016). 'Nursing supervision: Challenges and opportunities for success.' *Learning Disability Practice*, vol. 19(6), pp. 33-38. doi:10.7748/ldp.2016.e1734

van Manen, M (1991). *The tact of teaching: The meaning of pedagogical thoughtfulness*. Albany, NY: SUNY Press

Willig, C (2019). 'Ontological and epistemological reflexivity: A core skill for therapists [Special issue].' *Counselling and Psychotherapy Research*, pp. 1-9. doi:10.1002/capr.12204

Woodbridge, L; O'Beirne, BR (2017). 'Counseling students' perceptions of journaling as a tool for developing reflective thinking.' *Journal of Counselor Preparation and Supervision*, vol. 9(2), pp. 1-29. doi:10.7729/92.1198

Wright, J; Griffiths, F (2010). 'Reflective practice at a distance: Using technology in counselling supervision.' *Reflective Practice*, vol. 11(5), pp.693-703. doi:10.1080/14623943.2010.516986

Ziomek-Daigle, J (2017). 'Using reflective writing practices to articulate student learning in counselor education.' *Journal of Creativity in Mental Health*, vol. 12(2), pp.262-270. doi:10.1080/15401383.2016.1187581

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Studying with good spirits

Examining perceived work–life balance and perceived wellbeing among graduate students.

By Samantha Greenwood

Abstract

Graduate-level study is an undoubtedly stressful endeavour. Despite high reported levels of anxiety and depression, psychological wellbeing pertaining to graduate students as a specific population is an understudied topic. Research linking psychological wellbeing with perceived work–life balance could provide insight into graduate student distress. The current study aims to gain a better understanding of graduate students' perceived levels of work–life balance as a correlate of psychological wellbeing during the academic semester. Thirty-four full-time master's or PhD-level students at the University of Queensland were recruited to fill out a brief survey examining perceived levels of psychological distress and levels of fulfilment in areas suggested by Whittington, Maellaro and Galphin's (2011) 'Whole-life model'. Of the sample surveyed, 55 per cent of participants indicated that it was difficult to achieve work–life balance during the academic semester and 47 per cent indicated that academic workload negatively affected wellbeing, with anxiety symptoms most frequently reported. Moreover, half of the present sample reported having actively sought (32 per cent) or have considered seeking (18 per cent) medical or counselling support due to academic stress. While it is still unclear as to what areas in students' lives lack balance, findings suggest a general association between perceived dominance of academic work and decreased sense of wellbeing. These preliminary results indicate that further investigation into specific factors that contribute to work–life balance among graduates is warranted. The addition of demographic-related questions and a larger sample collection may also be considered for future research.

Introduction

University is a stressful time for students. While the strain involved with higher-level study can be a period of adaptive stress (Brown & Ralph, 1999), scholars have pointed out a rising prevalence of mental health issues among university students, prompting a significant review of policy within some higher education institutions (Simpson & Ferguson, 2012). Indeed, a meta-analysis conducted by Robotham and Julian (2006) suggests that increasing financial pressures, unfamiliarity with the host university and high assessment workload all contribute to psychological distress for students. Further, high pressure associated with post-secondary study has been connected with self-harm and suicidal ideation among the student population (Scott, 2000).

Graduate students in particular – that is, those enrolled in master's or PhD-level study – are notably vulnerable to academia-related stress due to high program demands (Evans, 2011). Despite some research suggesting that graduate students are more likely to access mental health resources (Wyatt & Oswald, 2013), those in graduate-level study are over six times more likely to experience anxiety and depressive symptoms compared to non-students (Evans et al., 2018), and are at higher risk of low life satisfaction (UC Berkeley, 2014), aversive mental

health symptoms (Garcia-Williams, Moffatt & Kaslow, 2014) and suicide (Silverman et al., 1997). Additionally, graduate students may experience unique stressors such as lack of adequate mentoring (Castello et al., 2017), low quality student–supervisor relationships (UC Berkeley, 2014), high pressure to produce data to compete for funding, or an environment where it is frowned upon to leave the laboratory “before sundown” (Evans et al., 2018).

Stress associated with poor work–life balance may help to explain the prevalence of declined mental health among graduate students. Evans (2011) suggests that, due to high program demands and an intrinsic passion to devote leisure time to their areas of study, graduate students may neglect other activities that promote psychological wellbeing, such as socialisation with friends and family or physical fitness. Indeed, Costello et al. (2017) reveal that many PhD students consider dropping out of their programs due to a perceived lack of appropriate work–life balance.

The correlation between adequate work–life balance and psychological wellbeing is a relatively established topic within the scholarly community. However, while some existing research promotes the link between perceived work–life balance and wellbeing among industrial employees (Haider, Jabeen & Ahmad, 2018) and working academics (Kingman & Jones, 2008), little is known about the perceived work–life balance of master’s and PhD-level students. Considering that many of these

students are training to practice in vocational fields such as healthcare or research (Robotham & Julian, 2006), examination of wellbeing and perceived work–life balance within this level of study could be an important first step in preventing student dropout and increasing psychological wellness among future professionals.

The purpose of the study is to investigate reported levels of work–life balance and psychological wellbeing among full-time master’s and PhD students. Elements of adequate work–life balance will draw from Whittington, Maellaro and Galphin’s (2011) ‘Whole-life model’, which postulates that “life success” is the achievement of personal wellbeing as a result of balanced attention to one’s work, community, personal and spiritual growth and family – as opposed to the traditional view that “life success” is exclusively equivalent to “career success”. Thus, this preliminary study will aim to gather a ‘snapshot’ of perceived levels of personal wellbeing, as well as perceived balance of time spent doing academic activities versus time spent doing activities that promote wellbeing such as the active pursuit of leisure (Haworth & Veal, 2004), regular physical exercise (Department of

Health, 2004) and quality of sleep (Orzech et al., 2011). The current study proposes that if students report an imbalance between academic work and attention to other life activities (in that student time is disproportionately spent on academic endeavours), then students will experience a lower sense of personal wellbeing as a result of academic stress. In short, this preliminary study intends to capture a snapshot of graduate student wellbeing as a result of work–life balance.

Methods

Data for the study was collected via an online questionnaire, using the online survey tool checkbox.com. This study also received ethical clearance from the University of Queensland Behavioural and Social Sciences Ethical Review Committee (BSSERC) (clearance number: NMSW 2018/14).

Informing theories

Questions used for the survey will be informed by Whittington, Maellaro and Galphin’s ‘Whole-life model’ (2011), which challenges the traditional understanding that “life success” is the result of career endeavours exclusively, and states instead that psychological wellbeing emerges from balanced

Stress associated with poor work–life balance may help to explain the prevalence of declined mental health among graduate students.

attention to many facets of one’s life. For instance, those who have a lack of balance between work and other areas of life are at higher risk of burnout, stress and role dissatisfaction (Whittington, Maellaro & Galphin, 2011), while those whose roles in life are better balanced tend to have a “buffer” that protects them from the distress of a particular role, resulting in a higher sense of wellbeing (Greenhaus & Powell, 2006).

Thus, survey questions will mostly focus on:

- time spent on activities associated with wellbeing (while being applicable to the average student), such as socialising with friends and family, engaging in exercise, engaging in spiritual activity, and quality of sleep;
- perceived student wellbeing (notably proportion of the time students are distressed as a result of academic work); and
- whether students had accessed (or considered accessing) medical or counselling support as a result of academic stress.

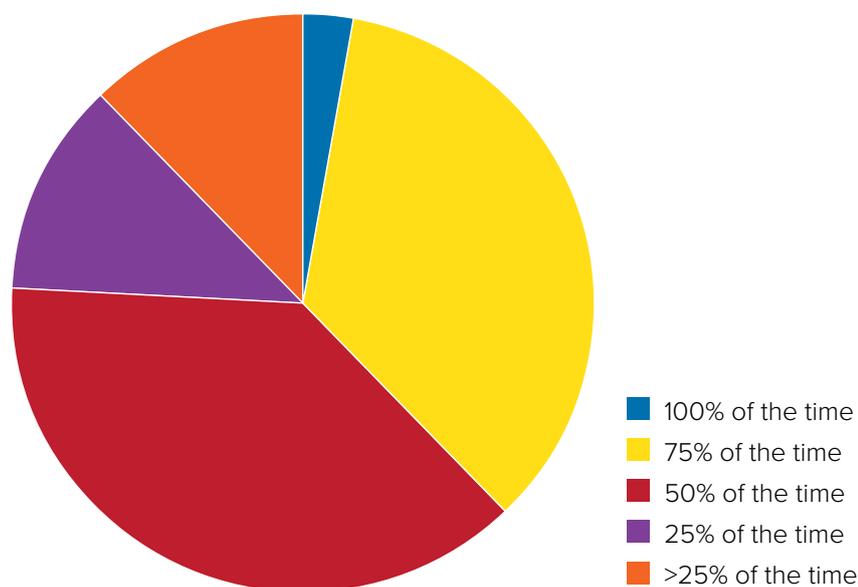
Participants

Participants were recruited from the University of Queensland (UQ). In order to participate in the survey, participants had to be enrolled in full-time study in a master’s or PhD program. The survey was advertised via flyers posted in high-traffic areas of UQ’s three main campuses – the St. Lucia, Herston and Gatton campuses – in an attempt to recruit as many participants as possible. As an incentive, participants were offered the chance to win a \$100 gift card for a local restaurant. In total, 34 students completed the survey.

TABLE 1 SURVEY QUESTIONS USED FOR THE STUDY.

A) Demographic-related questions
1. Are you currently enrolled in a master’s or PhD-level course?
2. How many years of your program have you completed so far? (multiple choice)
B) Work–life balance-related questions
1. On average, how much of your time (outside of class) is spent on academic-related activities? (multiple choice)
2. During the academic semester, approximately how many times per week do you engage in physical, aerobic exercise? (multiple choice)
3. During the academic semester, approximately how many times per week do you engage in social activities? (multiple choice)
4. How often do you think academic-related activities interfere with your ability to sleep? (multiple choice)
5. I find it difficult to achieve work–life balance during the academic semester (true/false)
6. I feel like I have adequate time for leisure-related activities during the academic semester (true/false)
7. I find it easier to achieve work–life balance during academic breaks (true/false)
8. When you consider a life that is well balanced, what percentage of the time would you ideally spend on the following activities during the academic semester? (Estimated numerical value is indicated in the following areas: a) academic activity; b) socialisation with friends and/or family; c) leisurely activity; d) spiritual activity; e) physical exercise; f) non-academic commitments – paid employment, child care, errands; and g) other)
9. When you consider the percentage of your time spent during the academic semester, what percentage of the time would you actually spend on the following activities during the academic semester? (Estimated numerical value is indicated in the following areas: a) academic activity; b) socialisation with friends and/or family; c) leisurely activity; d) spiritual activity; e) physical exercise; f) non-academic commitments – paid employment, child care, errands; and g) other)
C) Wellbeing-related questions
1. During the academic semester, I feel the following emotions over half of the time (please tick all that apply): a) hopeless; b) depressed; c) fatigued; d) anxious; e) restless; f) overwhelmed; g) content; h) well-rested; and i) stressed)
2. I find it hard to stay motivated on academic-related tasks during the academic semester (true/false)
3. Overall, I think the amount of academic work I have negatively impacts my sense of wellbeing (true/false)
4. Please choose the statement that is most true for you: a) I have actively sought medical or counselling support because of academic-related stress; b) I have considered seeking medical or counselling support because of academic stress; c) I experience academic stress, but I have not considered seeking medical or counselling support for it; d) I experience minimal academic-related stress and do not feel I require medical or counselling support; e) I do not experience academic-related stress

FIGURE 1 Proportion of time students report spending on academic activity outside of class.



Materials

A total of 15 questions were used in the online survey (see Table 1). The questions all required either true or false, multiple choice or select a numerical value responses. The survey was an original composition by the researcher, designed to be as short and non-invasive as possible so as to avoid the paradox of asking busy students to fill out a long, time-consuming questionnaire. Questions were delivered online and accessible via a link found on the survey's advertising flyer.

Analysis

The results were analysed using descriptive methods (such as pie charts and graphs) to gain a snapshot of students' perceived wellbeing as a result of perceived work-life balance.

Results

Of the sample (n=34), 56 per cent of students reported being currently enrolled in a master's program, while 44 per cent of students reported being enrolled in a PhD program. Further, of the sample, 50 per cent of students indicated that they had been enrolled for less than one year during the time of

the survey, followed by 32 per cent of students who indicated one to two years, 14 per cent of students who indicated three to four years, and three per cent of students who indicated four to five years.

1) Work-life balance-related questions

Time spent on academic activities outside of class

The majority of respondents (73 per cent) reported spending approximately 50 to 75 per cent of non-class time on academic activities. This was followed by 24 per cent of students indicating spending a quarter or less of non-class time on academic activity, and three per cent of students reporting spending all non-class time on academic activity.

Frequency of physical exercise

Thirty-two per cent of students reported engaging in physical exercise two to three times per week, followed by 24 per cent who indicated one to two times per week, 18 per cent who indicated over three times per week, 18 per cent less than once per week, and nine per cent who reported rarely engaging in physical exercise during the academic semester.

Frequency of social activity

Forty-one per cent of respondents indicated that they socialised approximately one to two times per week, followed by 24 per cent of respondents who indicated over three times per week, 15 per cent who indicated that they socialise once per week, 12 per cent of respondents who indicated two to three times per week, and nine per cent of students indicated that they rarely socialise during the academic semester

Whether academic activity interferes with sleep

Forty-one per cent of students indicated that school impacts sleep mostly during heavy assessment periods, followed by 32 per cent who advised that school sometimes interferes with sleep, 18 per cent of students advised that school never interferes with sleep, and nine per cent who indicated that school consistently interferes with sleep.

1.a) Work-life balance (true or false)

I find it difficult to achieve work-life balance during the academic semester (true/false)

For this question, 55 per cent of respondents indicated true and 45 per cent indicated false.

I feel like I have adequate time for leisure-related activities during the academic semester (true/false)

For this question, 52 per cent of students indicated true and 48 per cent of students indicated false.

I find it easier to achieve work-life balance during academic breaks (true/false)

For this question, 52 per cent of students indicated true and 48 per cent of students indicated false.

1.b) Amount of time 'ideally' versus



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'actually' spent on various life activities

When asked about proportion of time ideally spent on various life activities, participants indicated an average of 44 per cent of time spent on academic activity, 15.6 per cent of time spent on socialisation, 12.9 per cent of time spent on leisurely activity, four per cent of time spent on spiritual activity, 11.2 per cent of time spent on physical exercise, 11 per cent of time spent on non-academic commitments, and 1.3 per cent of time on 'other' activities.

When asked about proportion of time actually spent on various life activities, participants indicated an average of 57.6 per cent of time spent on academic activity, 10.8 per cent of time spent on socialisation, 8.9 per cent of time spent on leisurely activity, 2.5 per cent of time spent on spiritual activity, 6.5 per cent of time spent on physical exercise, 11.9 per cent of time spent on non-academic commitments, and 1.8 per cent of time on 'other' activities.

2) Wellbeing-related questions
Emotions felt over half the time

For this question, the following emotions were reported being felt over half the time by students: hopeless (7.32 per cent), depressed (4.88 per cent), fatigued (13.82 per cent), anxious (19.51 per cent), restless (9.76 per cent), overwhelmed (13.01 per cent), content (7.32 per cent), well rested (4.88 per cent), and stressed (19.51 per cent).

2.a) Wellbeing true or false

I find it hard to stay motivated on academic-related tasks during the academic semester (true/false)

For this statement, 61 per cent of

students indicated 'true' and 39 per cent of students indicated 'false'.

Overall, I think the amount of academic work I have negatively impacts my sense of wellbeing (true/false)

For this statement, 47 per cent of students indicated 'true', and 53 per cent of students indicated 'false'.

2.b) Whether students have sought counselling for academic-related distress

When asked whether students have sought, or considered seeking, medical or counselling support for academic-related stress, 32 per cent of participants indicated that they have actively sought these supports, 18 per cent reported having considered these supports, 12 per cent reported feeling academic-related stress but not seeking support, 29 per cent reported feeling minimal academic stress and feeling like they don't

require the supports, and nine per cent of students advised that they do not experience academic-related stress.

Discussion

The aim of this preliminary study was to gain a snapshot of perceived work–life balance and perceived levels of psychological wellbeing among full-time master's and PhD-level students during the academic semester. In terms of demographic information, the majority of respondents were master's-level students (56 per cent), compared to PhD students (44 per cent). Moreover, the majority of students indicated having completed less than two years of their program at the time of data collection. This has important implications for results, as time spent on a degree could be indicative of burn out (Zhang et

FIGURE 2 Average amount of time 'ideally' versus 'actually' spent on various life activities as reported by participants.

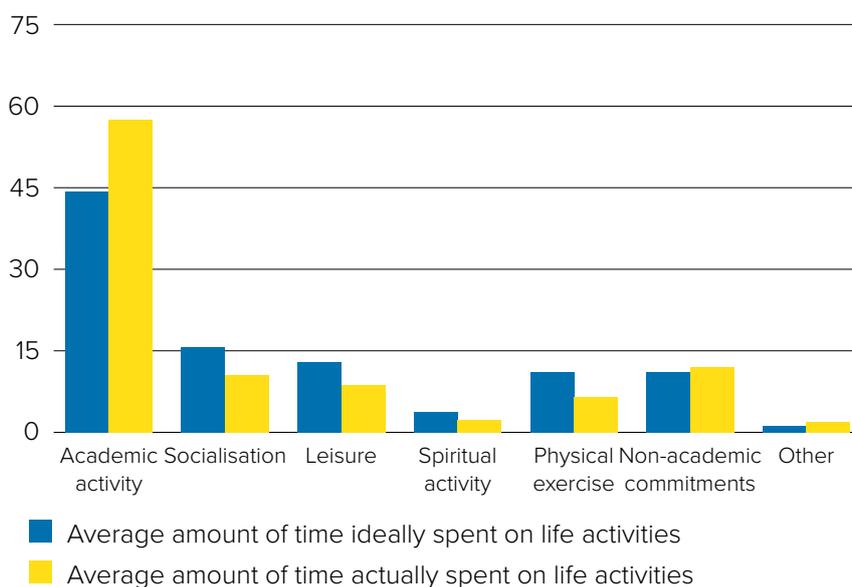
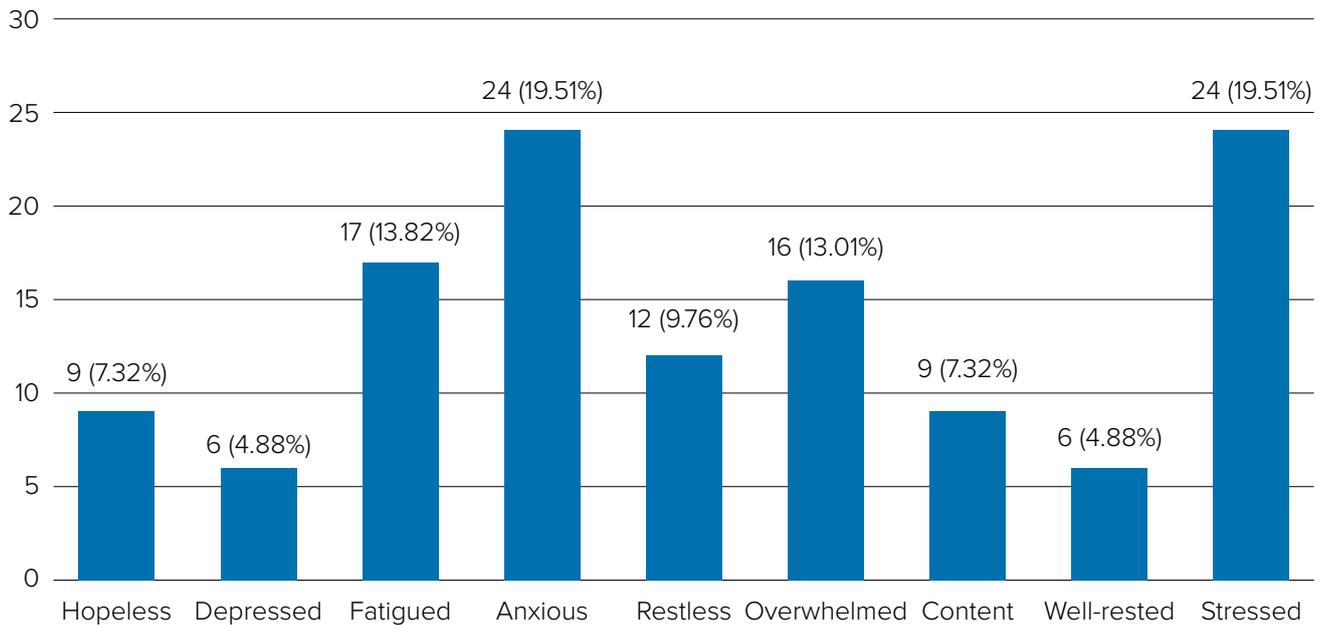


FIGURE 3 Emotions felt over half the time as reported by participants.



al., 2015) or familiarity/comfort with campus supports (Oswalt, Lederer & Chestnut-Steich, 2018), which could impact levels of wellbeing.

Most notable findings for this study are:

1. graduate students generally associate decreased wellbeing with a lack of adequate work–life balance (though whether there is a need for increased time spent on the wellbeing-promoting activities cited in the survey remains unclear);
2. anxiety (and anxiety-related symptoms) was the highest-reported emotion, felt over half the time by students; and
3. over half of graduate students surveyed indicated that they have actively sought – or have considered seeking – medical or counselling support as a result of academic stress.

Work–life balance

Survey results indicate that the amount of academic work and its effect on work–life balance is a valid concern for graduate students. For one, approximately half of the sample answered ‘true’

to survey items:

- I find it difficult to achieve work–life balance during the academic semester;
- I find that it is easier to achieve work–life balance during academic breaks; and
- overall, I think the amount of academic work I have negatively impacts my sense of wellbeing.

They also answered ‘false’ to: “I feel like I have adequate time for leisure-related activities during the academic semester”. Moreover, students seemed to consistently indicate that they spend more time than is ideal on academic activity, and less time than is ideal on activities that promote wellbeing, such as socialisation, leisurely activity, spiritual activity and physical exercise (see Figure 2). These preliminary results suggest that, to some degree, graduate students desire more balance between academic and non-academic activity in their lives.

In addition, over three quarters of students indicated that they spend 50 per cent or more time outside of class on academic activities. This is a potentially troubling find when viewed through a work–life balance

lens, as it is assumed that graduate-level students spend a significant portion of their time in class already (considering students sampled are engaged in full-time study courses). However, it is worth noting that some PhD students may not engage in classes per se, and may spend most of their academic time engaged in research or teaching in lieu of classroom time. This may result in an inaccurate depiction of time spent outside the classroom and its effect on one’s work–life balance. Thus, future studies may seek to tease out the differences in academic activity experienced by master’s-level versus PhD-level students – in order to get a better picture of where academic activity is occurring and how it is being spent – before examining how much time is taken up by academic activity.

Activities that promote wellbeing

While the current sample seems to indicate that adequate work–life balance is a concern, the areas in which balance could be improved remain unclear. For instance, most of the sample indicated that they engage in some exercise

on a weekly basis at least. Level of socialisation and quality of sleep follow a similar trend – high variability of responses is observed, with most participants indicating that they engage in at least some socialisation per week, or that their sleep is only sometimes affected by academic work. These figures indicate that students are finding time to engage in some physical activity, some socialisation activity, and are, for the most part, getting adequate sleep (with the exception of during heavy assessment periods).

A possible interpretation of these results is that different levels or quality of socialisation or exercise may be acceptable or sufficient for different types of people, and that reported frequency alone is not adequate to describe wellbeing. For instance, Ibarra-Rovillard and Kuiper (2011) demonstrate that the quality of one's social connection – rather than the frequency – is an important indicator of psychological wellbeing. Thus, future research may want to modify questions such as these so as to fit the participants' level of perception of the variable, rather than elicit a strict factorial report of number of times engaged in it. An alternative question could be: "How satisfied are you with how often you socialise during the academic semester?"

Additionally, the level of aerobic activity indicated by the sample and its correlation with wellbeing remains unclear. While many studies suggest a positive correlation between regular physical activity and psychological wellbeing (Appelqvist-Schmidlechner et al., 2017), current results suggest that graduate students' perceived

anxiety remains high despite highly variable reports of physical activity frequency. Like socialisation, perceived satisfaction with activity level may be a more accurate determinant of mental health levels than objective levels of aerobic fitness (Lindwall et al., 2012). Thus, future research may ask: "Are you satisfied with your current level of fitness/physical activity?"

Lastly, whether reported levels of sleep are associated with reported levels of wellbeing remains unclear. While it is well documented that sleep quality is often compromised for students (Wang et al., 2016), only nine per cent of the present sample indicated that university study consistently interfered with sleep. This suggests that sleep is not a major factor when considering wellbeing within this sample. The level of leisure reported is somewhat clearer; nearly half of students surveyed reported that university study interferes with leisure. This could help explain high reported levels of anxiety and low reported levels of wellbeing as leisure activities provide a buffer against academic distress (Zhang & Zheng, 2017).

Mental health symptoms

Stress and anxiety were the two symptoms most commonly reported by the sample as being experienced over half the time, followed reports of feeling 'fatigued' and 'overwhelmed'. These accounts are not surprising, given the large body of research documenting the high prevalence of stress among graduate students (Wyatt & Oswalt, 2013). What is interesting about this finding is the low reported levels of depression-related symptoms,



Illustration: 123RF.

considering that a good deal of studies indicate depression as being a major source of mental health distress among students (Hyun et al., 2006; Piumatti, 2018). Indeed, Piumatti (2018) states that depression is the most common mental health problem affecting young university students. However, in the present study, experiencing feeling 'depressed' or 'hopeless' over half the time was only reported by 4.88 per cent and 7.32 percent of respondents, respectively.

An interpretation for this finding may lie within the possible variation of mental health symptoms between student groups. For instance, most studies that report findings similar to Piumatti et al. (2018) (in that depressive symptoms are most likely reported) include both undergraduate and graduate students in the sample, which may suggest differences in the experience or manifestation of mental health symptoms between these groups. An alternative interpretation is that the students surveyed feel more 'lack of motivation' symptoms than they do 'hopeless' or 'depressed' symptoms (as is evidenced by the response rate to the survey question: "I find it hard to stay motivated on academic-related tasks during the academic semester"). Since lack of motivation is a common symptom of depression (Smith, 2013) – and since

not all depression symptoms are the same and can be paradoxical (Moran, Mehta & Kring, 2012) – it is possible that depressive feelings are manifested through varying levels of motivation.

Moreover, the vast majority of students indicated that they have been in their program for less than a year (50 per cent) or one to two years (32 per cent), thus, it is possible that high rates of anxiety could be explained by adjustment/transition into their new program. Future research on the topic should consider using a more detailed means to assess the severity of mental health symptoms for graduate students – as well as further unpack how mental health symptoms differ between graduate and undergraduate students, as this could have implications for the type of counselling that could best target this population.

Help-seeking behaviour

Results of this study indicate that approximately half of graduate students engage in medical or counselling services in order to gain support for academic distress. Assuming that seeking help is directly associated with the experience of adverse mental health symptoms, this finding would be consistent with research indicating that university students (graduate students in particular)

are vulnerable to adverse mental health symptoms (Garcia-Williams, Moffatt & Kaslow, 2014; Evans et al., 2018). Moreover, while some research indicates that less than half of students classified as having major depression or anxiety have sought help within the last year (Hunt & Eisenberg, 2010), it is worth noting that much of this research is conducted with undergraduate students. Indeed, Wyatt and Oswalt (2013) found that graduate students are more likely than undergraduate students to utilise mental health supports on campus. Thus, it is possible these results indicate that:

- a) there is high need – and thus high utilisation – of mental health supports for graduate students; or
- b) there is high utilisation of mental health resources among graduate students because of familiarity of and comfort with resources on campus.

It is also important to account for the possibility that the rate of help-seeking behaviour is not perfectly indicative of mental health prevalence. For instance, stigma associated with adverse mental health symptoms (Gaddis, Ramirez & Hernandez, 2018) or a lack of willingness or openness to access mental health supports (Oswalt, Lederer & Chestnut-Steich, 2018) could be barriers to accessing help. Thus, it is possible that some students sampled may be experiencing low levels of wellbeing but still not choosing to seek support. Future studies may want to include items screening for these factors (for example, "I want to seek support but feel like I cannot", or "I do/don't believe supports offered on campus are helpful for me"). This may be helpful

Results of this study indicate that approximately half of graduate students engage in medical or counselling services in order to gain support for academic distress.

in gaining a clearer understanding of help-seeking behaviour as an indicator of wellbeing among graduate students. Regardless, these findings suggest that graduate students display a high need for mental health and medical supports on a university campus.

Strengths, limitations and future directions

This preliminary study is one of the few specifically examining psychological wellbeing among graduate students. As such, these results could provide important information for counsellors working with master's and PhD-level students. Additionally, this study examines perceived levels of work-life balance as a possible correlate to perceived wellbeing, which has not yet been considered with graduate students (Evans et al., 2018). This study also reveals a high prevalence of anxiety-related symptoms and a relatively low prevalence of depressive symptoms within this population, which is an unexpected result and could have important treatment implications.

The survey used for the current study was brief and accessible, which facilitated use for students and provided a quick glimpse of perceived wellbeing and perceived satisfaction in other areas of life. While the brevity and ease of the survey is a strength, it also fails to provide important demographic information (such as age, gender, ethnicity and area of study of participants), which could provide deeper insights into the work-life balance and wellbeing of this population.

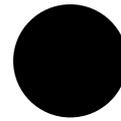
As mentioned above, while students report a perceived

imbalance between academic activities and activities that promote wellness, students also report spending at least a moderate amount of time engaging in activities that promote wellbeing. This observation suggests a limitation of the study – if students report poor work-life balance, it would be expected that lower amounts of time would be spent in other activities. There are a number of possible interpretations of this finding:

1. levels of exercise, socialisation and sleep are not areas of work-life balance that are suffering;
2. the amount of time spent within these realms is inconsistent with the perception of what is satisfactory to the individual; or
3. that other factors are more powerful indicators of wellness than the variables examined by the current study.

For example, stress could be affected by other elements such as financial hardship (Sawyer & Wilson, 1992) and the quality of the relationship with one's supervisor (Evans et al., 2018). Gaining a better understanding of the effects of alternative influences on graduate student distress could assist counsellors to support or refer graduate students based on specific needs (for example, student financial aid). Naturally, a larger sample size could also provide clarity about these trends.

Lastly, this study used a mixed sample of both master's and PhD-level students. While it is probable that both categories of students experience similar hardships that could affect wellbeing, there are distinct



About the author

Samantha Greenwood is a registered counsellor with the Australian Counselling Association. She has a Master of Counselling from the University of Queensland and a Bachelor of Arts (major in Psychology) from the University of British Columbia. She also presented at the 6th Asia Pacific Rim Confederation of Counsellors Conference in September 2019.
E samm.greenwood@gmail.com

differences between programs that may have implications within counselling. For instance, some programs may be more lab and research-based (and may possibly have no classroom components at all), while other programs may be more coursework-based. These qualities may affect work-life balance in different ways, particularly in regards to time spent in the classroom, for while class lectures have a distinct end time, time in the lab may not. Additionally, other programs that look similar to graduate programs in terms of workload are sometimes technically classified as 'undergraduate' degrees (such as veterinary and medicine programs). Thus, these categories of students were not included in the study, despite high reported levels of academic workload and psychological distress among these cohorts (Yusoff et al., 2013; Drake, Hafen & Rush, 2017).

Future studies may want to adjust inclusion criteria and differentiate types of students in order to gain a better understanding of specific stressors faced by students in a higher research or professional-level degree. ■

References

Appelqvist-Schmidlechner; Vaara; Mäkinen; Vasankari; Kyröläinen (2017). 'Relationships between leisure time physical activity, physical fitness and mental health among young adult males.' *European Psychiatry*, vol. 41(SS), S179.

Brown, M; Ralph, S (1999). 'Using the DYSA programme to reduce stress and anxiety in first-year university students.' *Pastoral Care*, vol. 17(3), pp. 8-13.

Castello, M; Pardo, M; Sala-Bubaré, A; Suñe-Soler, N (2017). 'Why do students consider dropping out of doctoral degrees? Institutional and personal factors.' *Higher Education: The International Journal of Higher Education Research*, vol. 74(6), pp. 1053-1068.

Department of Health, 2004. *At Least Five a Week; Evidence on the Impact of Physical Activity and its Relationship to Health: A Report from the Chief Medical Officer*. Department of Health, London.

Drake, A. A; Hafen, M. R; Rush, B (2017). 'A decade of counseling services in one college of veterinary medicine: Veterinary medical students' psychological distress and help-seeking trends.' *Journal of Veterinary Medical Education*, vol. 44(1), pp. 157-165.

Eisenberg, D; Gollust, S, Golberstein, E; Hefner, J (2007). 'Prevalence and correlates of depression, anxiety, and suicidality among university students.' *American Journal of Orthopsychiatry*, vol. 77(4), pp. 534-542.

Evans, T (2011). 'Balancing act: Balancing study, work and personal life.' *Teacher: The National Education Magazine*, pp. 48-51.

Evans, T; Bira, L; Gastelum, J. B; Weiss, L. T; Vanderford, N.L (2018). 'Evidence for a mental health crisis in graduate education.' *Careers and Recruitment*, vol. 36(3), pp. 282-284.

Gaddis; Ramirez; Hernandez (2018). 'Contextualizing public stigma: Endorsed mental health treatment stigma on college and university campuses.' *Social Science & Medicine*, vol. 197, pp. 183-191.

Garcia-Williams, A; Moffitt, G; Kaslow, L (2014). 'Mental health and suicidal behavior among graduate students.' *Academic Psychiatry*, vol. 38(5), pp. 554-560.

Greenhaus, J; Powell, G (2006). 'When work and family are allies: A theory of work-family enrichment.' *Academy of Management Review*, vol. 31(1), pp. 72-92.

Haider, S; Jabeen, S; Ahmad, J (2018). 'Moderated mediation between work life balance and employee job performance: The role of psychological wellbeing and satisfaction with coworkers.' *Journal of Work and Organizational Psychology*, vol. 34, p. 29.

Haworth, J; Veal, A (2004). *Work and leisure*. London; New York: Routledge

Hunt; Eisenberg (2010). 'Mental health problems and help-seeking behavior among college students.' *Journal of Adolescent Health*, vol. 46(1), pp. 3-10.

Hyun, J; Quinn, B; Madon, T; Lustig, S (2006). 'Graduate student mental health: Needs assessment and utilization of counseling services.' *Journal of College Student Development*, vol. 47(3), pp. 247-266.

Ibarra-Rovillard; Kuiper (2011). 'Social support and social negativity findings in depression: Perceived responsiveness to basic psychological needs.' *Clinical Psychology Review*, vol. 31(3), pp. 342-352.

Kinman, G; Jones, F (2008). 'A life beyond work? Job demands, work-life balance, and wellbeing in UK Academics.' *Journal of Human Behavior in the Social Environment*, vol. 17(1-2), pp. 41-60.

Lindwall; Ljung; Hadžibajramović; Jonsdottir (2012). 'Self-reported physical activity and aerobic fitness are differently related to mental health.' *Mental Health and Physical Activity*, vol. 5(1), pp. 28-34.

Moran, E; Mehta, N; Kring, A (2012). 'Emotional responding in depression: Distinctions in the time course of emotion.' *Cognition & Emotion*, vol. 26(7), pp. 1153-1175.

Orzech, K.M; Salafsky, D.B; Hamilton, L.A (2011). 'The state of sleep among college students at a large public university.' *Journal of American College Health*, vol. 59(7), pp. 612-619.

Oswalt, S; Lederer, A; Chestnut-Steich, K (2018). 'Who is willing to come back? College students' willingness to seek help after using campus mental health services.' *Journal of American College Health*, pp. 1-7.

Pelletier; Laska (2012). 'Balancing Healthy Meals and Busy Lives: Associations between Work, School, and Family Responsibilities and Perceived Time Constraints among Young Adults.' *Journal of Nutrition Education and Behavior*, vol. 44(6), pp. 481-489.

Piumatti, G (2018). 'Motivation, health-related lifestyles and depression among university students: A longitudinal analysis.' *Psychiatry Research*, vol. 260, pp. 412-417.

Robotham, D; Julian, C (2006). 'Stress and the higher education student: A critical review of the literature.' *Journal of further and higher education*, vol. 30(02), pp. 107-117.

Sawyer, D; Wilson, C (1992). 'Financial worries of chemistry graduate students.' *Journal of Chemical Education*, vol. 69(11), p. 874.

Simpson; Ferguson (2012). 'Mental health and higher education counselling services: Responding to shifting student needs.' *JANZSSA*, (39), pp. 1-8.

Scott, K (17 May 2000) 'Fifth Suicide at Edinburgh University', *The Guardian*, p. 9.

Silverman, M; Meyer, P; Sloane, F; Raffel, M; Pratt, D (1997). 'The big ten student suicide study: A 10-Year Study of Suicides on Midwestern University Campuses.' *Suicide and Life-Threatening Behavior*, vol. 27(3), pp. 285-303.

Smith, B (2013). 'Depression and motivation.' *Phenomenology and the Cognitive Sciences*, vol. 12(4), pp. 615-635.

The Work Foundation (2005). *Work-life balance*. University of Bristol Available at: www.bris.ac.uk/pwe/work_life_balance.html.

UC Berkeley (2014). Graduate student happiness and wellbeing report. University of California, Berkeley, Available at: http://ga.berkeley.edu/wpcontent/uploads/2015/04/wellbeingreport_2014.pdf

Wang, L; Qin, P; Zhao, Y; Duan, S; Zhang, Q; Liu, Y; Hu, Y; Sun, J (2016). 'Prevalence and risk factors of poor sleep quality among Inner Mongolia Medical University students: A cross-sectional survey.' *Psychiatry Research*, vol. 244, pp. 243-248.

Whittington, J. L; Maellaro, R; Galpin, T (2011). 'Redefining success: The foundation for creating work-life balance.' In *Creating Balance?: International Perspectives on the Work-Life Integration of Professionals* (pp. 65-77). Springer Berlin Heidelberg.

Wyatt, T; Oswalt, S (2013). 'Comparing mental health issues among undergraduate and graduate students.' *American Journal of Health Education*, vol. 44(2), pp. 96-107.

Yusoff, M; Esa, A; Noor, S; Yaacob, M (2013). 'The effectiveness of medical student well-being workshop to improve medical students' psychological distress symptoms.' *European Psychiatry*, vol. 28(S1).

Zhang, S; Shi, R; Yun, L; Li, X; Wang, Y; He, H; Miao, D (2015). 'Self-regulation and study-related health outcomes: a structural equation model of regulatory mode orientations, academic burnout and engagement among university students.' *Social Indicators Research*, vol. 123(2), pp. 585-599.

Zhang, J; Zheng, Y (2017). 'How do academic stress and leisure activities influence college students' emotional well-being? A daily diary investigation.' *Journal of Adolescence*, vol. 60, p. 114.



An exploration of traumatic grief within the context of continuing trauma

**By Julie Savage, Dr Shakeh Momartin,
Robin Bowles and Mariano Coello**

Abstract

Most victims of human rights violations commonly experience an array of psychological complications, some of which are grief, anxiety and post-trauma symptoms. The effects of torture are intense and the road to recovery is arduous. The following case study presents the case of a female survivor of torture and trauma who, following a prolonged treatment intervention on a face-to-face and regular basis, was able to modify her condition by narrating and processing her negative experiences and being allowed to mourn, cry and work through her intense pain and anguish. This article also emphasises the significance of complicated grief and its long-term consequences on the human psyche. Judith Herman's three stages of treatment have been used in this case as a broad guide for the intervention.

Introduction

Complicated grief is a common experience suffered by most refugees and survivors of war trauma and organised violence, the impact of which can develop into a complex condition. It is widespread due to political/religious conflict, forced displacement, seeking asylum in refugee camps and eventual resettlement. The relationship between traumatic events and psychiatric morbidity in refugees has been extensively studied over the years (Silove, 1999; Mollica et al., 1999; Weine, 1999), although in comparison, effects



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About the authors

Julie Savage
Therapist
E julie.savage@health.nsw.gov.au

Dr Shakeh Momartin
Clinical psychologist, senior research officer, acting team leader.
Affiliation: International Rehabilitation Council for Torture Victims (IRCT), University of Sydney.
E shakeh.momartin@health.nsw.gov.au

Robin Bowles
Psychotherapist
E robin.bowles@health.nsw.gov.au

Mariano Coello
Clinical services and research coordinator
E mariano.coello@health.nsw.gov.au

of traumatic and complicated loss have attracted much less scientific study, despite pervasive experiences among war-traumatised populations (Silove, 1999). Compared to normal grief, complicated grief is associated with prolonged disability, negative health outcomes and suicidality (Horowitz, 1997).

The process of grief is a normal reaction to the experience of loss. Mental health professionals working in the area of grief and loss have long agreed that the grieving individual should be allowed to

mourn for a period of time without being subjected to diagnosis or medicalisation. However, recent research has revealed that grief can become complicated due to several reasons, such as circumstances around loss (disappearances, unknown location or method of murder of loved one, kidnappings, mass executions) and accumulation of anguish (Morina et al., 2010; Lichtenthal, 2011). Just as the healing of a physical wound can be complicated, so can the intensity and extent of grief symptoms (Shear et al., 2011).

Although complicated grief can be common among refugee populations exposed to severe human rights abuses and torture, it can sometimes overlap with post-traumatic stress disorder (PTSD) and depression to varying degrees (Momartin et al., 2004). Nevertheless, research and clinical experience has shown that not



everyone who experiences torture will develop PTSD, although they might suffer from interrelated symptoms (Dohrenwend et al., 2013). A study by Momartin and colleagues (2004) showed no link between PTSD and grief in Bosnian survivors of war and trauma, other than a low-order association with PTSD intrusion dimension. In contrast, depression was strongly associated with traumatic grief and its subscales. Only the subgroup with comorbid grief and depression reported higher levels of traumatic loss. Survival guilt is also a common response following loss and/or traumatic experiences with significant victimisation (Lifton, 1993), leading to strong negative emotions associated with self-loathing or shame, which contribute to social isolation and helplessness (Gilbert, 2009). Guilt can occur not only in relation to what we ought or ought not to do, but also in relation to our views about what we ought to be (Nader, 1997). What is possible under normal circumstances, however, is often not possible under traumatic conditions.

In the following section, the case of a female survivor of torture and trauma will be presented; she will be referred to as “Dana” throughout the article. Possible explanations for her elevated depressive symptoms and grief have been proposed. Consent was sought from the patient for her de-identified story to be documented and disseminated to other professionals. This case is an example of the painful and complicated stories experienced by many refugees. The complete story is more extensive than the scope of this article allows. For the purpose of this article, only

some of the main issues in the context of a larger trauma impact – namely complicated grief and complications surrounding loss – will be discussed.

Case study: brief background

Dana, a woman in her thirties, had arrived from a small country riddled with political conflict and upheaval. She reported having been involved in social/political activities in her homeland, assisting poor communities to develop projects relieving longstanding poverty. She reported being among other young idealistic students who maintained a strong political understanding and desire to change the government from a dictatorial-style to one where everyone would be heard. Dana married a fellow activist in her circle. During the same period, a sudden government crackdown on political movements commenced to suppress militants’ intents for an alternative government. As a result, Dana was arrested and imprisoned for a number of months and severely tortured.

Some of the torture methods that she reported were:

- deprivation of food and water for extended periods of time;
- electric shocks to genitals and other parts of her body;
- sleep deprivation;
- being kept naked and hooded for long periods of time;
- being immersed in cold and hot water (‘submarino’);
- continuous water drips on the forehead;
- continuous sexual assaults and multiple rapes; and
- witnessing friends being tortured and murdered.

Following her release from

capture, Dana lived in hiding with her husband and other activists. This was a highly challenging period as it was the height of government crackdown by the military against their movement. During this difficult time, Dana fell pregnant and gave birth to a daughter. Five days after the birth of the child, Dana’s husband left the shelter to obtain food and supplies, but never returned. Dana later heard from fellow activists that her husband had been killed by the military as he was purchasing supplies, although she never learned the facts surrounding his death. The unknown circumstances of his death caused in her deep sadness, which spiralled into depression. She decided to focus on raising her daughter, retreating from political activity as a survival strategy for her and her child. Following a suggestion from a migration agent, she arranged passage to Australia and arrived in Sydney with her daughter.

Clinical presentations

Dana was referred to the New South Wales Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) by a welfare agency assisting asylum seekers, where she had initially applied for financial assistance. During the assessment interview, while disclosing her story, Dana reportedly became overwhelmed with sorrow, cried uncontrollably and showed signs of intense distress, prompting the caseworker to refer her to STARTTS immediately.

During her first interview at STARTTS, Dana declared that she had not been able to “calm down”

since the agency interview and that she had been experiencing frequent flashbacks. At times she started shaking and crying, becoming agitated, saying that she had never before disclosed her experiences and “opened up in depth”.

During the description of her emotional state, she reported she had been feeling depressed and indifferent to life, found it difficult to fall asleep and woke often during the night, experiencing nightmares, regular fierce headaches and fever. She also described experiencing intrusive thoughts and images of her husband’s “lifeless body” and felt strong feelings of guilt for surviving the violence in her country of origin when her husband and other fellow activists perished. She mentioned that she often experienced flashbacks and nightmares of her torture and feelings of horror.

Despite her torture experiences, Dana emphasised her loss and grief issues, inconsolably crying during the sessions. Some of her other clinical presentations included being in a constant state of fear and anxiety, revealing that since “opening up about her past” she was unable to engage fully with her surroundings. She continuously questioned the meaning of life, reflecting on the existential meaning of survival and whether meaning only existed in the context of her political beliefs and the camaraderie with her husband. These doubts about herself and her values coexisted with the deep love that she felt for her child. Upon initial assessment, she revealed that she had been feeling these doubts for the last four years, since the death of her husband.

A model for working with traumatic and complex losses

Trauma psychotherapist Judith Herman’s three-phase model for working with trauma (1992)

provided a useful framework for thinking about the work with Dana. Herman’s model, acknowledging that prolonged, accumulated and repeated trauma or loss can lead to a complex type of grief, helped the therapist work with the traumatised client in her healing process and on her journey to recovery. Within this model, there are three interconnected processes of working with trauma:

1. establishing safety;
2. working through the trauma; and
3. reconnection with others (Herman, 1992).

Recovery and healing occurs primarily through the therapeutic relationship, through which the survivor can recreate new connections and relationships and rebuild capacities for trust, autonomy, competence, identity, confidence and empowerment. (Herman, 2003).

Dana’s presentation appeared to point to two main areas:

- her complicated grief and traumatic loss issues, which mostly dominated the initial assessment sessions; and
- post-traumatic issues related to her torture, which she raised to a lesser extent.

“All the pain started with the death of my husband,” Dana emphasised, accentuating the emotional suffering of loss. While both of these main themes were interconnected and were examined in depth, it was grief and loss issues that came to predominate the work. Therapy sessions attempted to include an understanding of the sociocultural contexts, which had, over the years, shaped the way trauma was experienced and expressed. The therapy model needed to accommodate the different interpretations and existential meanings of trauma in her cultural context.

In preparation for treatment (as the case is sensitive), clinical

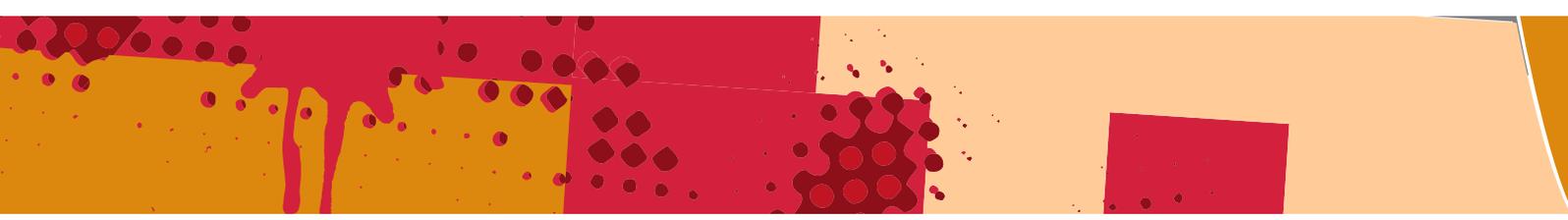
observations were used to monitor her progress and symptoms, and standardised measures were used – part of a standard comprehensive assessment package for minimum dataset collection for STARTTS clients – in order to determine the intensity of symptoms.

1) The Hopkins Symptoms Checklist-25

The Hopkins Symptom Checklist-25 (HSCL-25) (Mollica et al., 1987) has been widely used in post-conflict and refugee populations to assess symptoms of depression and anxiety. It comprises a 10-item subscale for anxiety and 15-item subscale for depression, with each item on a Likert scale from 1 (not at all) to 4 (extremely). The HSCL-25 records the level of symptoms over the preceding week. This measure has yielded high test-retest reliability ($r=0.89$ for the total scale; $r=0.82$ for each scale), and sound validity in relation to identifying cases of depression confirmed by clinical interview (88 per cent sensitivity, 73 per cent specificity) (Mollica et al., 1987).

The anxiety subscales of the HSCL-25 for Dana yielded a score of 2.7, indicating that her reported symptoms of anxiety were clinically significant and highly elevated (individuals with score of >1.75 are considered symptomatic). Symptoms reported included shaking, feeling fearful, nervous and keyed up, and suffering severe headaches and restlessness.

The depression component of the HSCL-25 indicated her reported symptoms were clinically significant (score= $3.4>1.75$), with elevated symptoms including constantly crying, feeling low in energy and motivation, and feeling lonely, hopeless and sad throughout the day. It is noteworthy that at the time of assessment, the DSM-IV version of the measure was used (APA, 1994).



2) The Harvard Trauma Questionnaire

The Harvard Trauma Questionnaire (HTQ) (Mollica et al., 1992) is the most widely used international instrument measuring trauma exposure and symptoms of PTSD across refugee populations. The trauma section assesses events typical of the experiences of refugees. Personally experienced trauma events were used to generate a summary count for overall trauma exposure. In previous studies, the trauma section has demonstrated robust interrater ($k=0.93$) and test-retest reliability ($r=0.89$). The traumatic stress symptoms are derived from the DSM-III-R/DSM-IV criteria for PTSD. The scale has demonstrated high interrater ($r=0.98$), test-retest ($r=0.92$) and internal reliability ($r=0.96$) (Mollica et al., 1996).

The HTQ yielded a score of 2.7 (a score equal to or greater than 2.5 is considered symptomatic for PTSD), indicating that Dana had a clinical diagnosis of PTSD (DSM-IV). Some of the symptoms she experienced were recurrent thoughts about the traumatic events, flashbacks, disturbed sleep, nightmares, irritability, anger and avoiding thoughts about the events.

Commencing the healing process, Dana's emotional state and symptoms were assessed with the abovementioned measures in order to obtain a pre-intervention account of her mental state.

Stages of treatment

Herman's three-phase model was used as a broad guide for Dana's intervention. As is common in psychotherapy, the process moved freely between the phases rather than following a linear progression.

Phase 1: Establishing safety

This stage involved the important first steps of assessment and introductions, which have to be achieved gradually, allowing time and space to slowly present Dana's painful experiences during sessions. Establishing safety for the client is a primary step in this stage, which has to be maintained and carried through the entire psychotherapy. This step should not be imposed; rather, Dana was given the space to gently familiarise the therapist with her case in order to begin work together, controlling the amount and intensity of material disclosed. The focus of this phase is not to process trauma; however, an inevitable narration of highly traumatic events uncovered as the sessions continue, progressively revealing painful memories, at a modulated pace.

Given the tragic loss of her husband, Dana suffered daily from feelings that were not consciously related to her trauma and losses. The loss was felt more intensely because of shared common existential values and beliefs, including political ideology. Since his death, she described feeling as if she "had lost her spirit" and questioned her worth in the world. She also expressed that she "had lost the essence of life and the meaning for the fight". In addition, she reported that her mother, who she described as a source of support and emotional stability, had passed away in recent years.

As her daughter was born while she was in hiding and shortly before the death of her husband, Dana experienced confounding feelings of inadequacy as a single mother, describing herself as

a "broken person". It was clear that Dana experienced negative thoughts about herself, which hindered her healing process. Self-care was employed and encouraged by the therapist during these sessions, as it is common for trauma victims to increase vulnerability to revictimisation through self-destructive and self-neglect behaviours (Chu, 1998). In later sessions, a focus on self-care attempted to eliminate Dana's feelings of unworthiness, instilling a positive sense of identity and hope. The therapist introduced a number of relaxation and distraction techniques to alleviate Dana's anxiety symptoms, including grounding, self-soothing breathing techniques and squeezing a stress ball, which helped her overcome intrusive thoughts and reorient to the present.

It is noteworthy that, being an asylum seeker, there were additional complications connected to Dana's life such as settlement and financial challenges, gaining a protection visa, and cultural and linguistic complications which potentially could delay the healing process and hinder a well-ordered progression of steps. This is expected and the therapist tried to work in congruence with Dana's cultural and personal expectations, discussing possible interruptions and obstacles.

Phase 2: Working through traumatic losses

Focusing on Dana's traumatic losses was the lengthiest phase, spanning several months. Dana had mentioned that she felt "lost in her grief", so this phase involved processing unresolved grief, loss and traumatic memories. The aim

was to integrate the traumatic memories into a coherent narration of her life, along with working through the intense negative affect associated with these memories.

The multiple losses had proved challenging for Dana and she struggled to find the strength to continue life in a meaningful way. The compendium of stresses, losses and legal status (pursuing a protection visa) had an important destructuring or disorganising effect, as it created an uncertainty about the future and a constant fear of being returned to the country of origin, where she believed her life would be jeopardised. An important step in this stage was to increase her emotion-regulation capacities and manage the symptoms that caused her suffering on a daily basis. This involved expressing intense feelings of grief in the therapy process, and Dana eventually recognised that,

through this process, she had internalised a different way of working through pain. This required the establishment of safety – a state of mind that she had lost throughout her ordeal.

An important aspect of this phase was that the therapist acknowledged the trauma events, respecting the memories and allowing time for discussion during sessions. The therapeutic alliance was vital for rebuilding relationship patterns based on trust and cooperation, as opposed to the coercion and control of the relationship Dana had with the torturers/perpetrators while she was in prison. Both Dana and the therapist tried to patiently delve into the past at a tolerable pace, while treatment progressed. This stage also encouraged tapping into Dana's inner strengths and finding empowerment and resilience – capabilities which she

previously possessed as a political activist but had lost touch with following trauma.

Survivor guilt was an important issue that was raised during sessions. This is a very common consequence of torture and trauma and can be a manifestation of PTSD, which is beyond the scope of this article. Suffice to say that the pain of multiple losses was extremely difficult for her to manage, especially because she physically survived the violence while loved ones did not. Dana was encouraged and allowed to remember, mourn and eventually work towards accepting the loss of her husband. She recalled and processed traumatic memories within the safe space of therapy. This technique encourages a balance between facing painful memories while preserving safety (Herman, 1997). Moreover, the 'testimony' technique was a helpful

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and effective process allowing her to find meaning in and direction to the trauma story. This can have a healing effect by processing existential doubts regarding meaning of life, political cause and survivor guilt surface while working towards reframing the trauma story. Dana's collaboration and rapport with the therapist facilitated the opportunity to narrate her traumatic experiences within the safety of therapy.

Despite Dana's commitment to the counselling sessions and the positive therapeutic relationship, she would sometimes avoid attending STARTTS, using the pretext of work or other commitments. Following a few missed appointments, this issue was raised and explored. She disclosed that she initially found it difficult and overwhelming to discuss painful events and that avoidance had been her way of coping. It seems that, as a victim of trauma, she had put aside her pain and anguish, focusing instead on the broader political aspects and meaning of events. The positive therapeutic relationship enabled Dana to feel safe, but nevertheless the sessions were distressing, containing agonising descriptions, images and memories of the past. It was noticeable that the therapists' unpacking painful memories, albeit gradual, destabilised her, veering into what George Weinberg (1996) calls "uncomfortable territory", portrayed as "things get worse before they get better" (p. 151). At this stage, grasping the gravity of unresolved memories, Dana would actively find various excuses to avoid therapy. A common feature emerging was the intensification

of existing symptoms and internal conflict. Although this was potentially a transitional stage, it was vital to avoid demoralisation and to work through unresolved personal grief that had been disregarded and pushed aside. The therapeutic relationship helped Dana and the therapist influence each other's ideas and 'give and take' suggestions from each other. The therapist equated it to a "dance" whereby both present their thoughts, wait for reaction from the other and respond accordingly. Skewes McFerran and Finlay (2018) refer to this therapeutic dance as delicate, respectful and tolerant, and curious and collaborative.

Dana had to learn to accept that her past would often frustrate, anger and upset her, and hence learn to calm and centre herself after inevitable sadness, and effectively respond in a constructive manner towards coping and management. Consequence awareness was discussed, which taught her to identify triggers related to painful memories and accept that the temporary pain must be endured to achieve progress. Grounding strategies

were also practiced to be used at times of distress, so that Dana could physically and mindfully undertake her own healing.

With ongoing support, Dana was able to gradually regulate her overwhelming emotions and develop a personal narrative of her traumatic past, allowing memories to surface. Despite the complexity of her feelings, Dana felt reassured and supported, aiming for a new chapter in her life while slowly moving towards recovery. The environment of therapy was non-judgmental, safe and conducive to healing, and there was a sense of progress. The therapist provided 'therapeutic holding' – a psychoanalytic concept of "comforting" (Winnicott, 1953) and "containment" (Bion, 1962) by processing thoughts and feelings with the client and representing them in a more stable and less destructive way. The therapist was consistently present as an attuned, solid, reliable and trustworthy presence, offering the safe environment crucial for recovery. It is through this positive therapeutic relationship that Dana felt emotionally held and protected,

With ongoing support, Dana was able to gradually regulate her overwhelming emotions and was able to develop a personal narrative of her traumatic past, allowing memories to surface. Despite the complexity, Dana felt reassured and supported, aiming for a new chapter in her life while slowly moving towards recovery.

while her anxiety, anger, confusion and pain were managed as safely as possible by her therapist.

Phase 3: Reconnection with others

This phase focused on maintenance and reconnection with surroundings. Dana was supported by the therapist to rebuild her present life as much as possible while pursuing new goals. Nevertheless, sometimes these steps did not transpire effortlessly in the way they were intended, as uncertainty and complications unique to an asylum seeker's life often overshadowed progress. Therefore, the maintenance phase was achieved with patience, compassion and consideration for unpredictable hurdles on her way to recovery. Dana was encouraged to practise strengthening internal skills for managing painful and unwanted memories, minimising unhelpful or harmful responses to them and learning new coping mechanisms for future.

Certain concrete steps were taken to increase Dana's sense of power and control, such as keeping herself occupied. She was able to form friendships, although occasionally her lack of trust had to be revisited and reviewed. Towards completion of her therapy, Dana was ready to revisit memories of her political/activist past and she decided to record her memories in order to help others who had experienced similar events. During final sessions, the therapist and Dana agreed that, while she was unable to change the past, Dana could make it her mission to educate others by telling her story. Most seek answers for their painful experiences within themselves, which can become harsh and self-blaming. Dana, on the other hand, was encouraged to use her political past, to engage in the wider society and to 'rise above' or accept her painful past – and through this

process help others to do the same. This corresponds with Herman's impression of sense of connection being restored by another's display of generosity, which is a belief that the victim felt to have been irretrievably destroyed.

Upon retesting at post-intervention, Dana's HSCL-25 score for anxiety had subsided from 2.7 to 1.5, indicating that her reported symptoms had clinically decreased. She no longer experienced constant fear, worry or tension, and her severe headaches had ceased. The depression component of the measure indicated that her initial reported symptoms of depression had also significantly reduced from 3.4 to 1.6, indicating that her presentation of sadness, low motivation and low energy had subsided.

At this stage, the therapist clarified and renewed goals for ongoing therapy and they mutually decided that although a good sense of self had been accomplished, continuous treatment was necessary to survive through daily challenges.

Discussion and overall therapeutic benefits

It is increasingly acknowledged that asylum seekers and refugees experience a wide array of traumas with diverse consequences. Traumatic events, such as the violent killing of family members, are complex and can signify threat. Hence, it is not surprising to observe a complex pattern of comorbidity in their manifestation of traumatic stress reactions. However, research increasingly indicates that although complicated grief and PTSD share symptoms of intrusion, they can be distinguished from each other, supporting the premise that grief is triggered by loss and PTSD by exposure to life threat. Given the persistent symptoms with incapacitating effects, recognising unresolved grief earlier would help

with the provision of appropriate intervention. As experience has shown, the value of an ongoing reliable therapeutic frame and a caring relationship within the context of cultural and personal values is critical for working through traumatic losses.

The tragic circumstances and subsequent trauma affected Dana's capacity to be self-compassionate, therefore the focus of therapy was to be nurturing. She found it difficult to be compassionate towards herself, almost to the point of rebelling against recovery. At times, therapy became unbearable for her and she was unable to engage; however, her positive relationship with the therapist eventually addressed this and she was able to progressively trust in the process.

From working through her multiple losses, Dana was able to start to reclaim and relish fond memories, even though this was painful. She seemed to feel more accepting and less engulfed in the enormity and tragedy of her grief.

We know that traumatic events destroy the sustaining bonds between survivor and community, which affects their sense of worth and self. As an outcome of the nurturing therapeutic relationship, Dana is more present in her connection with her daughter and other family members. She also started making new friends in her community, formed a solidarity network, joined a women's group at STARTTS and participated in several outings, engaging in various recreational and psychoeducation classes. She expressed on several occasions during follow-up sessions that she felt empowered and able to make decisions for her own life, and was able to look forward to the future. The solidarity of her new connections was an effective way of building protection against despair. These connections helped re-create a sense of belonging, restoring humanity and

empowerment, which trauma had damaged.

Conclusion

Our clinical experience as counsellors and trauma therapists has shown us that it is important to be guided by what our clients are telling us, by what they emphasise in their narration and presentation, and by the process the clients follow. As a result, we aim to foster personal growth by assisting the client to gain insight into acceptance of their feelings, values and behaviours.

Dana's primary struggle with loss and grief dominated her therapy process. The non-directive method of psychotherapy described here provided unconditional positive regard and supportive containment of Dana's traumatic losses and related emotions, while also working through her self-criticism, guilt and withdrawal from others. This eventually helped Dana see herself more clearly and explore new areas of thinking, influencing the direction of therapy. Therapy helped return her self-worth and, at the same time, tapped into her experiences to connect with others around her. ■

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References

- American Psychiatric Association, Committee on Nomenclature and Statistics (1994). *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Washington, DC: American Psychiatric Association.
- Bion, W.R (1962). *Learning from Experience*. London: Heinemann.
- Chu, J.A (1998). *Rebuilding shattered lives: The responsible treatment of complex post-traumatic and dissociative disorders*. New York: John Wiley & Sons.
- Dohrenwend, B.P; Yager, T.J; Wall, M.M; Adams, B.G (2013). 'The roles of combat exposure, personal vulnerability, and involvement in harm to civilians or prisoners in Vietnam War-related posttraumatic stress disorder'. *Clinical Psychological Science*, vol. 1(3): pp. 223–238.
- Gilbert, P (2009). *The compassionate mind*. London: Constable.
- Herman, J.L (2003). 'The mental health of crime victims: impact of legal intervention'. *Journal of Traumatic Stress*, vol. 16 (2): pp. 159–166.
- Herman, J.L (1997). *Trauma and recovery: the aftermath of violence - from domestic abuse to political terror*. New York: Basic Books.
- Herman, J.L (1992). *Trauma and Recovery*. Basic, New York.
- Horowitz M.J; Siegel B; Holen A; Bonanno, G.A; Milbrath, C; Stinson, C.H; (1997). 'Diagnostic Criteria for Complicated Grief Disorder'. *American Journal of Psychiatry*; vol. 154, pp. 904–910.
- Lichtenthal W.G; Nilsson M; Kissane D.W; Breitbart W; Kacel E; Jones E.C; Prigerson HG (2011). 'Underutilization of mental health services among bereaved caregivers with prolonged grief disorder'. *Psychiatry Services*, vol. 62 (10): pp. 1225-1229.
- Lifton, R.J (1993). 'From Hiroshima to Nazi doctors: The evolution of psychoformative approaches to understanding traumatic stress syndromes', (pp. 11-23). In J.P. Wilson & B. Raphael (eds). *International Handbook of Traumatic Stress Syndromes*. New York: Plenum Press.
- Luxenberg T; Spinazzola J.H; Hunt C; van der Kolk, B (2001). 'Complex Trauma and Disorders of Extreme Stress (DESNOS) diagnosis'. *Directions in Psychiatry*; vol. 21, pp.373-414.
- Mollica R.F; McInnes K; Sarajlic N; Lavelle J; Sarajlic I; Massagli M (1999). 'Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia'. *Journal of American Medical Association*; vol. 282, pp. 433-439.
- Mollica, R.F et al. (1987). 'Indochinese versions of the Hopkins Symptom Checklist-25: a screening instrument for the psychiatric care of refugees'. *American Journal of Psychiatry*, vol. 144(4): pp. 497-500.
- Momartin, S; Silove, D; Manicavasagar, V; Steel, Z (2004). *Complicated Grief in Bosnian Refugees: Associations With Posttraumatic Stress Disorder and Depression Comprehensive Psychiatry*, Vol. 45, No. 6 (November/December), 45, pp. 475-482.
- Morina, N; Rudari, V; Bleichhardt, G; Prigerson, HG (2010). 'Prolonged grief disorder, depression, and posttraumatic stress disorder among bereaved Kosovar civilian war survivors: a preliminary investigation'. *Int J Soc Psychiatry*, vol. 56 (3): pp. 288-297. 10.1177/0020764008101638.
- Nader, K (1997). 'Treating traumatic grief in systems'. In Figley, C.R; Bride, B.E; and Mazza, N (eds.), *Death and Trauma: The Traumatology of Grieving*, London: Taylor and Francis, pp. 159-192.
- Prigerson H.G' Horowitz M.J' Jacobs S.C' (2009). Prolonged grief disorder: psychometric validation of criteria proposed for DSM-V and ICD-11. *PLoS Med*.
- Shear M.K; Simon N; Wall M; Zisook S; Neimeyer R; Duan N; Reynolds C; Lebowitz B; Sung S; Ghesquiere A; Gorscak B; Clayton P; Ito M; Nakajima S; Konishi T; Melhem N; Meert K; Schiff M; O'Connor M.F; First M; Sareen J; Bolton J; Skritskaya N; Mancini A.D; Keshaviah A (2011). 'Complicated grief and related bereavement issues for DSM-5'. *Depression and Anxiety*, vol 28(2), pp. 103-17.
- Silove D (1999). 'The psychosocial effects of torture, mass human rights violations and refugee trauma; toward an integrated conceptual framework'. *Journal of Nervous and Mental Disorder*; vol. 187, pp. 200-207.
- Skewes McFerran, K; Finlay, L; (2018). *Resistance as a 'dance' between client and therapist. Body, Movement and Dance in Psychotherapy, An International Journal for Theory, Research and Practice*. Published online 26 March.
- Weine S.M (1999). *When History Is a Nightmare: Lives and Memories of Ethnic-Cleansing in Bosnia-Herzegovina*. New Brunswick, NJ: Rutgers University Press.
- Winnicott, D.W (1953). 'Transitional objects and transitional phenomena; a study of the first not-me possession'. *International Journal of Psychoanalysis*, vol. 34(2), pp. 89–97.



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Supporting clients who have persistent pain

A primer for counsellors

By Michelle E. Martin

Introduction

Chronic or persistent pain affects one in five Australians of all ages, with the rate increasing as people age (painaustralia.org.au, n.d.). It is one of the most common reasons people seek medical advice and is often the main reason cited for self-medication (Eccleston, 2001). In 2007, it cost the Australian economy in excess of \$34 billion (painaustralia.org.au, n.d.), and effective management can present a significant challenge to all healthcare professions. In 2017–18, the National Health Survey results of the Australian Bureau of Statistics (abs.gov.au, 2018) reported that 47.3 per cent of Australians surveyed had one or more chronic conditions, a 5.1 per cent increase in a 10-year period. These chronic health conditions included some key conditions associated with persistent pain such as back problems (16.4 per cent or four million people) and arthritis (15 per cent or 3.6 million people). These two conditions are some of the most prevalent chronic diseases in Australia, second only to mental health and behavioural problems and more pervasive than asthma, diabetes, cardiovascular diseases, cancer and kidney disease, yet the majority of Australians do not understand persistent pain and many healthcare professionals struggle to manage it. We also know that the prevalence of disability is high in conditions associated with persistent pain. In 2015, the Australian Institute of Health and Welfare report on chronic conditions and disability revealed that chronic or recurring pain or discomfort was rated as the predominant impairment, limitation or restriction for people with arthritis and related disorders (52.9 per cent) and for people with back pain and problems (63.5

per cent) (AIHW, 2018).

So what is chronic or persistent pain? We know that acute pain is a vital experience for survival – without it we can suffer injury or illness that can be life-threatening. Pain is defined as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (Iasp-pain.org, 2018). Importantly, the definition includes an emotional component. The experience of emotion is related to the ways in which the brain processes these signals that are later determined as pain. There is no one “centre for pain” in the brain, and many areas are involved in processing signals from the nervous system (Butler & Moseley, 2013; Moseley & Butler, 2015; Moseley & Butler, 2017). We know that there are a range of biological processes involved in delivering signals throughout the central nervous system, and that many systems are involved in determining an outcome from all the information received. We also now understand the concept of neuroplasticity a little better, recognising that the nervous system, including the brain,

is adaptable to a range of stimuli and can readily make the changes required to facilitate improved coping or to adopt new and different functions.

Experiencing emotion with pain also affects how we pay attention to the sensations, and may mean taking faster and more decisive action. The definition also allows for 'potential' damage, indicating a strong relationship between our perception of a threat to the body and the range of thoughts and emotions that align with this perception. The context in which pain occurs and the meaning of the pain to the individual, alongside other personal and cultural factors, needs to be considered. We all respond to pain with our own set of thoughts, emotions and behaviours. Sometimes these responses are helpful to begin with, but over time they may become unhelpful and, on occasion, harmful. Many myths and misunderstandings abound, and this can lead to increased fear of pain and to maladaptive responses. Psychological factors are therefore central to the pain experience (Eccleston, 2001), and given this, clinicians who support mental health and emotional wellbeing are a vital part of the multi-disciplinary pain management team.

The terms chronic and persistent are used interchangeably in Australia. Chronic or persistent pain is therefore defined as pain that "has lasted beyond the time expected for healing following surgery, trauma or other condition" (painaustralia.org.au, n.d.). Chronic pain, therefore, lacks the warning function that we see in acute pain. It can be thought of as a maladaptive

response to the initial stimuli, and serves no important biological function. A timeframe of three months (or 12 weeks) has frequently been used to determine if pain has transitioned from acute to chronic, however it should be noted that three months may be considered too short for recovery from some health complaints, for example, from a traumatic injury. Daily functioning, including the capacity to work within or outside the home, relationships, sleep and mental health are all potentially impacted by persistent pain. The level of perceived or actual disability also varies, with significant ramifications for the healthcare and welfare systems, as people struggle to manage the changes in their lives.

How can counselling help?

Counselling, or psychological support, is provided by a range of mental health clinicians, including but not limited to psychiatrists, counsellors, social workers, psychologists, mental health nurses, psychotherapists and mental health occupational therapists. It is not just about helping an individual with pain to manage the emotions associated with the physical pain itself. Counselling has the opportunity to provide a much broader level of support, including pain education and the introduction of specific pain-management strategies. Education regarding pain should always be provided in a timely fashion (Briggs, 2012; Butler & Moseley, 2013; Moseley & Butler, 2015; Moseley & Butler, 2017), and is invaluable as it provides a solid foundation for the use of multiple management strategies, importantly

providing a clear rationale for the non-medical approaches. The non-medical approaches encompass a range of coping strategies aimed at assisting clients to adopt new and more effective ways of management. These approaches take into account the difficulties that are inherent in treating persistent pain from a purely medical perspective, for example, managing the ineffectiveness, side effects or dangers associated with pain medications, navigating the laws regarding prescribing specific pain medications, or the lack of appropriate medical interventions for the individual's condition. For these reasons, pain cannot be managed purely by medical treatments, but requires a multi-modal approach.

Taking a history for a client with pain

Obtaining a thorough history for clients presenting with pain issues is important to clearly establish goals and identify the therapeutic pathway. A pain assessment should comprise an assessment session and the administration of relevant self-report measures, in addition to any information collated from other health professionals (Flor, & Turk, 2011; Winterowd et al., 2003). It is crucial that history-taking covers the presenting physical problem, that is, the pain history, and a broad psychosocial overview.

In examining the client's pain history, we look at the following:

- any diagnoses made or suspected;
- the date of onset and the time at which pain worsened or became harder to manage;
- precipitating factors including

what was happening at the time pain started or worsened;

- pain sites and which areas the client considers the worst;
- accompanying physical and emotional symptoms; and
- intensity levels, triggers and the pattern of the pain.

Understanding if the client is facing any legal or compensation issues is also important given the tremendous stress this can involve. A pain history should also include past and present treatments and the client's view of their effectiveness, information on their general health and, importantly, any history of substance use.

A full assessment of mental health

is also crucial, including assessment of risk and exploration of any trauma history, whether it has a direct relationship to the pain or not.

With a mental health assessment, understanding the client's locus of control is important, as is an appreciation of personality factors, their cognitive style and their perceptions and beliefs about pain. Many clients with pain have useful coping strategies that they do not view as such, therefore exploring coping styles can be useful to build upon or modify existing techniques. Understanding the client's expectations and their goals for attending the appointment are also valuable pieces of

information to guide your approach.

Furthermore, the client's pain history should include information on their daily functioning, including whether they pace activities well. Information can also be gathered about the client's appetite, self-care, exercise, sleep patterns, and their family and social functioning, including the quality of relationships and social supports. Taking a family history of pain or chronic illness, and coping style, may also prove useful.

Psychological management approaches

The psychological management approaches include a variety of

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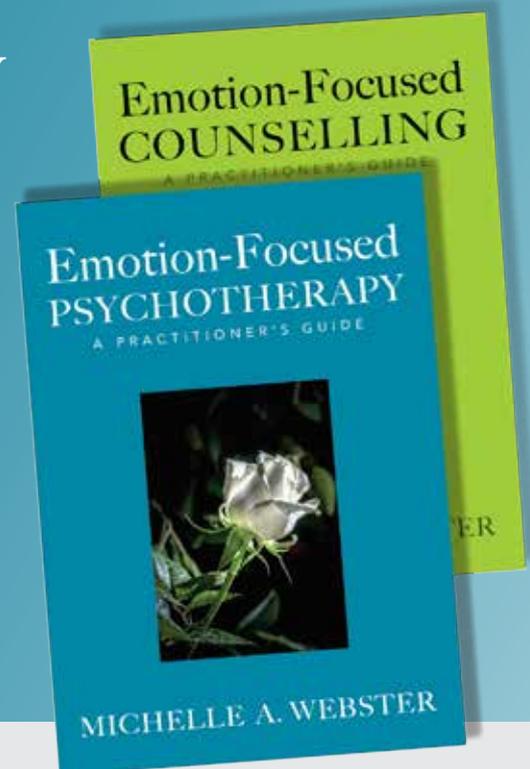
Emotion-Focused PSYCHOTHERAPY A PRACTITIONER'S GUIDE

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strategies aimed at improving and then maintaining a client's daily functioning in all domains (Davies et al., 2015; Eccleston, 2001; Eccleston et al., 2013; Flor & Turk, 2011; Moseley & Butler, 2015; Nicholas et al., 2011; Roditi & Robinson, 2011; Winterowd et al., 2003). Many paradigms are used in the pain management field including Cognitive-Behaviour Therapy (CBT), Acceptance and Commitment Therapy (ACT), hypnosis, and mindfulness-based approaches such as Mindfulness-Based Stress Reduction (MBSR) or Mindfulness-Based Cognitive Therapy (MBCT).

For individuals to cope better with a chronic condition like pain, the relationship between the physical and psychological must be addressed, and the psychological approaches such as those listed above enable a broad conceptualisation of the person's life and the factors that should be addressed. In most approaches,

a conceptualisation of the client's history is formulated following the assessment phase, and goal-setting is employed to begin addressing the client's needs.

This is guided by the clinician to ensure realistic and appropriate goals are the focus. A level of behavioural activation is aimed for, with approaches engaging clients from different perspectives. Alongside increased activities, clients should be taught activity pacing to ensure their activity levels are within realistic limits and to provide a platform from which to improve functioning. Approaches that are designed to calm the nervous system such as relaxation or meditation, or mindfulness techniques, are also central to more effective coping. Some clients may even benefit from hypnosis, an approach designed to address pain coping on many levels. Attentional techniques such as distraction and desensitisation may be employed,

and the client's cognitions and beliefs should be explored and addressed. In addition to this, managing sleep difficulties, stress, and relationship and interpersonal difficulties is important. Problem-solving and developing plans to deal with setbacks and flare-ups are also helpful.

The psychological approaches may be delivered on an individual basis, or via group therapy. Group therapy provides a unique experience for clients with pain, giving them access to peers who have similar experiences, and enabling clients to learn from each other as well as from the program. The mindfulness-based approaches, CBT and ACT, have a range of manualised group therapy programs that can be utilised.

When should I recommend more than counselling for my client?

In pain management, we often talk about 'clinical flags' or indicators that further investigation or treatment is required in some area. The psychosocial indicators are called 'yellow flags'. These are the factors that may indicate an increased risk of distress, disability or drug misuse, and include an individual's attitudes, beliefs, emotions and behaviours, as well as factors that may influence these areas such as family and work place (aci.health.nsw.gov.au, 2019).

The use of yellow flags originated with the treatment of chronic lower back pain; however, the concept is broadly used to identify significant psychosocial issues across a range of conditions and can be a useful screening tool to conceptualise potential future

difficulties. These flags may also provide a useful indicator for when further specialised input is required from a psychologist who works in pain management, or from a psychiatrist.

Initiating a referral to another healthcare professional can sometimes be difficult. If rapport is well-established, clients may have difficulty seeing the need for such a referral.

It can also be daunting for clients to consider a referral to a psychiatrist, particularly if they have struggled with the perception that people do not believe them.

Educating clients about the multidisciplinary nature of pain management at the very beginning of therapy can help prevent this issue. Establishing clear goals and review points throughout therapy is also useful, because it can help set up the expectation that counselling may be time-limited, and enables frequent opportunities to discuss progress and the need for additional input.

Providing the client with a clear rationale for further specialist input will also ease their concern. Initiating a referral to a psychiatrist or a psychologist under the Medical Benefits Schedule is the domain of the GP; however, counsellors can and should make specific requests to the GP when they see a clear need for their client.

Where can I learn more?

Counsellors and mental health professionals can access the wide variety of training opportunities now available in Australia and online. The initial focus for any healthcare professional working with clients with persistent pain should be on



About the author

Michelle E. Martin
 Clinical and health
 psychologist
 Central Adelaide
 Local Health
 Network, Pain
 Management Unit

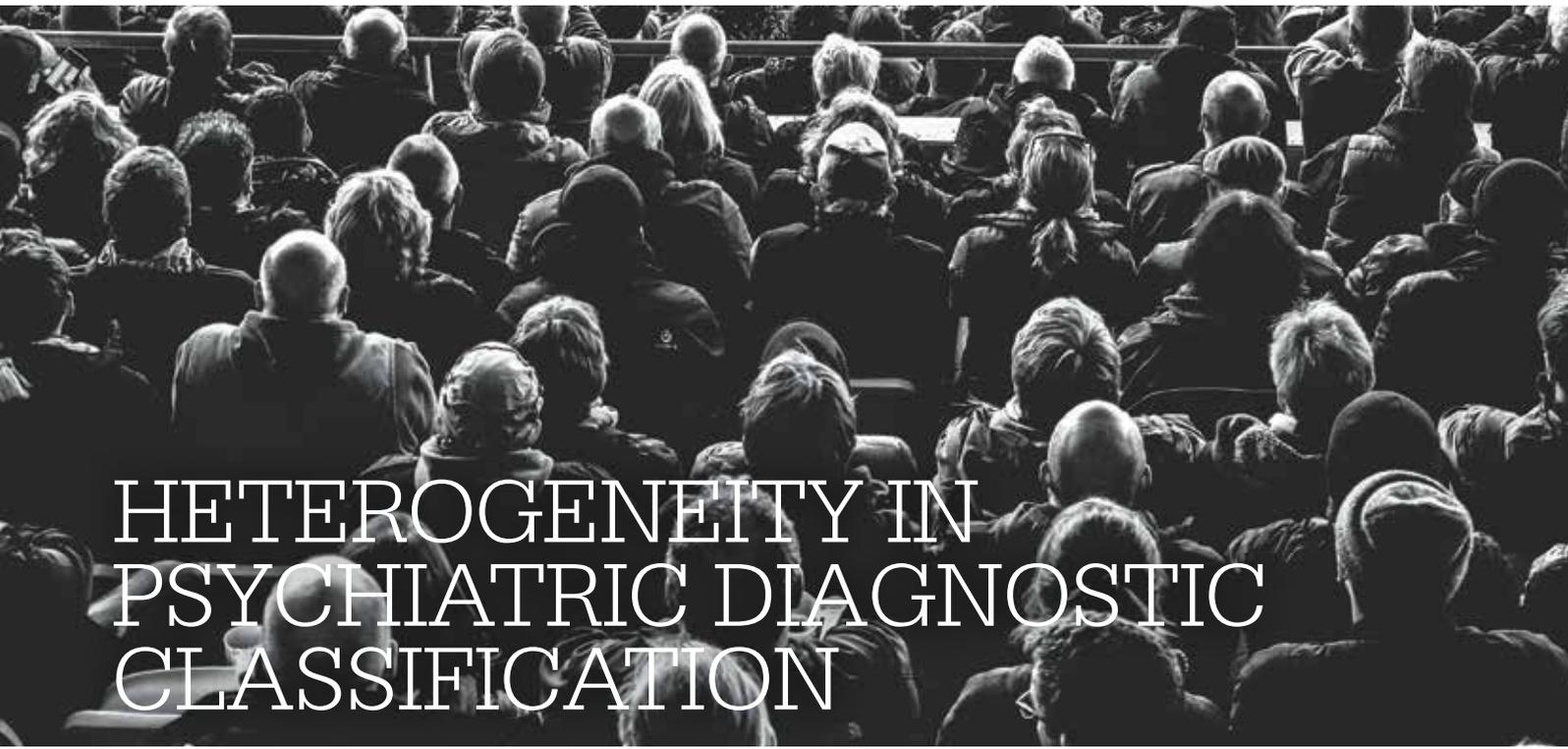
understanding the neuroscience of this complex phenomenon, and learning how to impart this knowledge gently and accurately to a client who may not fully understand why they have been referred for counselling. Clinicians should also access specific training on using and tailoring psychological techniques to pain management. The Australian Pain Society (Australian Pain Society, n.d.) provides professional links to various training opportunities and is recommended as a starting point for further information.

Conclusion

The reality is that persistent pain is a complex issue for both clients and healthcare professionals. Education regarding pain management, including public education, is vital to ensure early intervention to prevent chronicity, and to ensure that appropriate treatments are offered at the right time. In light of all the available research, it is clear that the counselling professions plays a vital role in supporting the mental health and wellbeing of clients with persistent pain. ■

References

- Abs.gov.au. (2018). 4364.0.55.001 - *National Health Survey: First Results, 2017-18*. [online] Available at: <http://www.abs.gov.au/ausstats/abs@.nsf/0/F6CE5715FE44AC1B1CA257AA30014C725?Opendocument> [Accessed 31 Jan. 2019].
- Aci.health.nsw.gov.au. (2019). *Pain Management Network: Yellow Flags - Psychological Indicators*. [online] Available at: https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0004/212899/Yellow_Flags.pdf [Accessed 31 Jan. 2019].
- Australian Institute of Health and Welfare (2018). *Chronic conditions and disability 2015*. Cat. no. CDK 8. Canberra: AIHW.
- Australian Pain Society. (n.d.). [online] Available at: <https://www.apsoc.org.au/> [Accessed 31 Jan. 2019].
- Briggs, E 2012. Evaluating the impact of pain education: how do we know we have made a difference? *British Journal of Pain*, vol. 6(2), pp.85–91.
- Butler, D.S.; Moseley, G.L. 2013. *Explain pain*. 2nd ed. Adelaide: NOI Group Publications.
- Davies, S; Cooke, N; Sutton, J 2015. *Rewire your pain: An evidence-based approach to reducing chronic pain*. Perth: Stephanie Davies.
- Eccleston, C 2001. Role of psychology in pain management. *British Journal of Anaesthesia*, [online] vol. 87(1), pp.144-152. Available at: <https://www.sciencedirect.com/science/article/pii/S0007091217363511> [Accessed 31 Jan. 2019].
- Eccleston, C; Morley, S; Williams, A 2013. Psychological approaches to chronic pain management: evidence and challenges. *British Journal of Anaesthesia*, [online] vol.111(1), pp.59-63. Available at: <https://academic.oup.com/bja/article/111/1/59/333864> [Accessed 31 Jan. 2019].
- Flor, H; Turk, D 2011. *Chronic pain*. Seattle: IASP Press.
- iasp-pain.org. 2018. *IASP Terminology - IASP*. [online] Available at: <https://www.iasp-pain.org/Education/Content.aspx?ItemNumber=1698#Pain> [Accessed 31 Jan. 2019].
- Moseley, G.L.; Butler, D.S. 2015. *The explain pain handbook: Protometer*. Adelaide: NOI Group Publications.
- Moseley, G.L.; Butler, D.S. 2015. Fifteen years of explaining pain: The past, present, and future. *The Journal of Pain*, vol. 16(9), pp.807-813.
- Moseley, G.L.; Butler, D.S. 2017. *Explain pain supercharged*. Adelaide: NOI Group Publications.
- Nicholas, D; Molloy, D; Tonkin, L; Beeston, L 2011. *Manage Your Pain*. 3rd ed. Sydney: Harper Collins.
- Painaustralia.org.au. (n.d.). *Painful Facts*. [online] Available at: <https://www.painaustralia.org.au/about-pain/painful-facts> [Accessed 31 Jan. 2019].
- Painaustralia.org.au. (n.d.). *What is Chronic Pain?* [online] Available at: <https://www.painaustralia.org.au/about-pain/what-is-chronic-pain> [Accessed 31 Jan. 2019].
- Roditi, D; Robinson, M.E. 2011. The role of psychological interventions in the management of patients with chronic pain. *Psychology Research and Behavior Management*, [online] vol. 4, pp.41-49. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3218789/> [Accessed 31 Jan. 2019].
- Winterowd, C; Beck, A; Gruener, D 2003. *Cognitive therapy with chronic pain patients*. New York: Springer.



HETEROGENEITY IN PSYCHIATRIC DIAGNOSTIC CLASSIFICATION

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Summary

A new study, published in *Psychiatry Research*, has concluded that psychiatric diagnoses are scientifically worthless as tools to identify discrete mental health disorders.

The study, led by researchers from the University of Liverpool, involved a detailed analysis of five key chapters of the latest edition of the widely used Diagnostic and Statistical Manual (DSM), on ‘schizophrenia’, ‘bipolar disorder’, ‘depressive disorders’, ‘anxiety disorders’ and ‘trauma-related disorders’.

Diagnostic manuals such as the DSM were created to provide a common diagnostic language for mental health professionals and attempt to provide a definitive list of mental health problems, including their symptoms.

The main findings of the research were:

- psychiatric diagnoses all use different decision-making rules;
- there is a huge amount of overlap in symptoms between diagnoses;
- almost all diagnoses mask the role of trauma and adverse events; and
- diagnoses tell us little about the individual patient and what treatment they need.

The authors conclude that diagnostic labelling represents “a disingenuous categorical system”.

Lead researcher Dr Kate Allsopp, from the University of Liverpool, says, “Although diagnostic labels create the illusion of an explanation they are scientifically

meaningless and can create stigma and prejudice. I hope these findings will encourage mental health professionals to think beyond diagnoses and consider other explanations of mental distress, such as trauma and other adverse life experiences.”

Professor Peter Kinderman, also from the University of Liverpool says, “This study provides yet more evidence that the biomedical diagnostic approach in psychiatry is not fit for purpose. Diagnoses frequently and uncritically reported as ‘real illnesses’ are in fact made on the basis of internally inconsistent, confused and contradictory patterns of largely arbitrary criteria. The diagnostic system wrongly assumes that all distress results from disorder, and relies heavily on subjective judgments about what is normal.”

Professor John Read, University of East London, says, “Perhaps it is time we stopped pretending that medical-sounding labels contribute anything to our understanding of the complex causes of human distress or of what kind of help we need when distressed.” ■



Researchers

Kate Allsopp,
John Read,
Rhiannon Corcoran
Peter Kinderman

Published

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neurosciencenews.com/meaningless-psychiatric-diagnosis-14434/?fbclid=IwAR20BtgZg2H63JNifK76Jklba-bmsH-fKSQbfStjnkMM2xlfpWKCvE4aHal

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A little bit of shame goes a long way

Shame and guilt are universal emotions and experiences, and it's important to address them during therapy.

By Kim Billington

Who has not a crop of images from our chequered childhoods and more recent pasts, together with a cluster of emotions where we cringe a little at our actions, and feel what we now know as 'shame'? Remember the time you, or someone you know, stole money or a toy, taunted another child, were mean to your sibling, were socially excluded or lied to your parent? These are often quite normal developmental behaviours. When I walk past a homeless person, I may feel disgust at the smell of urine or alcohol. I often block out what their harrowing journey might have been and replace it with judgement at the city for not helping out more. Then, in the comfort of my home, I may feel a private shame and some guilt that I did not help a bit.

Could you draw a timeline of your own multiple experiences of shame? Good reflective practice for counsellors means looking at both our professional practice and making sense of our own lives, including the integration of our emotional life. Since anger, shame, disgust and sadness are primary emotions, if we can become aware of these as being 'normal' for all humans, then we can possibly assist our clients to accept these often unpleasant emotions that can fuel anxiety and despair. We can invite these feelings to ride in and out of our lives on the waves of our breath. At least in the therapeutic space, we can talk about these fundamental human expressions openly, with curiosity and, if possible, with humour.

We may have had experiences of being sexually abused, bullied, or taunted for the colour of our hair or the sound of our name. For a long time after these situations,

we can still re-experience the painful shame, and it can stop us talking openly about these. Our identity seems tarnished by what others have done to us.

"The reason many of us struggle to identify our emotions properly is that they are often gone as fast as they appear. We are constantly experiencing new things, which means our emotions are rarely static [and] complicates our being able to identify what is going on with our emotions." (www.betterhelp.com/advice/general/what-are-primary-and-secondary-emotions)

Thomas Scheff (1994) refers to shame as the "master emotion". Shame is understood more broadly to be a corrective strategy used to reinforce social norms. Shame is a verb parents might use (hopefully in tiny doses) to gently prompt a child to 'do the right thing', such as "use gentle hands with your brother".

However, shame is also something you can locate and point to. So it must be a noun, and we can feel it strongly – often in the torso somewhere. It can be a painful feeling of humiliation or distress caused by an emerging consciousness of some behaviour others are saying is wrong, and we then feel that others have judged us to not be a good person. People stay in unhappy marriages because they might be ashamed of living in a smaller house, in a lesser suburb,



Photo:123Rf

FIGURE 1 The whiteboard can be used as an invitation to name struggles as well as positive experiences, annotated by related emotions and a scale for the stress or joy of each issue.

or drawing the ire of a ‘told-you-so’ relative who never liked their choice of partner. A person may feel shame after a suicide in the family, the loss of social status with a redundancy, having a family member with AOD issues, having personal internet exposures or of belonging to a religious group or race which has perpetrated violence on another group.

Guilt, on the other hand, is a more conscious thought and feeling, which

may also include shame. Guilt can happen when we judge ourselves to have consciously transgressed a value or ethical stance that we ourselves hold dear. Then we may have a feeling of regret for doing something. Some people avoid shame (who may be identified as having narcissistic traits and so lack empathy) and cannot bear to have their identity challenged by others, and so may plead ‘not guilty’ in court settings or find ways to blame

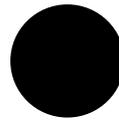
others for their own transgressions.

Many people have studied guilt and shame. “Freud proposes that we build defence mechanisms to protect us from the guilt we would experience if we knew just how awful our awful desires really were.” (www.psychologytoday.com/au/blog/fulfillment-any-age/201208/the-definitive-guide-guilt). Dr Brené Brown, research professor and bestselling author, also has some video resources on shame.

We do not often find the right person to whom we can confess, "I'm ashamed ..." Shame and guilt are emotions that bring up fears of rejection and judgment, anger at other's cruelties, and feelings of powerlessness. It can be safer to hide our experiences and associated shame from the world, and so we attempt to preserve our dignity by isolating these aspects of ourselves. We may be fortunate to have one, long-trusted friend with whom we can share some deep secret of a past wrongdoing or terrible experience. But our clients often do not have this luxury, and this lack can further isolate them from developing trusting relationships. Counselling can be a special opportunity to put shame on the table, since our work includes the safety of confidentiality.

In a conversation recently, a skilled and reflective supervisee told me, "Most of my expressions of important experiences in my life are blocked by shame."

This is how I generally start a second or third session: "So I've begun to understand some of your journey and challenges, can we do a stocktake of where you're at now?" I then draw a display (Figure 1) on the whiteboard and invite some conversations about the client's themes and their origins. Emotions and difficulties are normalised and can be externalised by saying, "So, when did depression and shame get a foot in the door at your place?"



About the author

Kim Billington is a counsellor, a counselling supervisor and a supervisor to master's counselling students at Monash University. She has a Master of Counselling from the Australian Catholic University and a Master of Narrative Therapy and Community Work from the University of Melbourne.

Clients like to take a photo of this co-created 'collage of life'. I remind them of the Yin/Yang symbol – showing that life is made up of both the 'good' and the 'not so good'. I may share Rumi's poem *The Guest House*, or William Blake's *Auguries of Innocence*, which reads: "Joy and woe are woven fine, a clothing for the soul divine." Then shame can be seen, felt and accepted ... and perhaps some burden may be lifted through the trust developed in our therapeutic alliance in the safety of a therapeutic space. ■



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DETERMINING EVIDENCE-BASED OUTCOMES USING FREE-ACCESS SCREENING ASSESSMENT INSTRUMENTS



By Michelle Perepiczka, Heather Smith, Nicole A. Cobb and Bradley T. Erford

Abstract

Counsellors should use free and efficient, evidence-based assessments and procedures to guide counselling services to better meet client needs. This article summarises how a counsellor could administer, score, holistically interpret and integrate client data into existing clinical decision-making practices. Four free-access screening assessment instruments that address the most pressing mental health concerns for adult and adolescent clients are explained in a fashion where clinicians can begin using them to assess depression (Center for Epidemiologic Studies Depression – Revised), anxiety (Hamilton Anxiety Scale), substance use (Alcohol Use Disorders Identification Test) and trauma (PTSD Symptom Scale). A client case example is provided to demonstrate specifically how a clinician could use these instruments within the counselling process, review the scores to track client progress across time, and incorporate the data to make informed decisions about client care.

In the ‘Global Burden of Disease Study’ (GBD), Whiteford et al. (2013) concluded the leading causes of disabilities around the world are now substance use and mental disorders. The largest proportion of people display anxiety disorders (3.83 per cent), followed by depression (3.77 per cent) and alcohol/substance use disorders (1.37 per cent) (Global Burden of Disease, 2016).

In addition, a majority of world inhabitants will experience trauma during their lifetimes (Kessler et al., 2017), and some of these people will develop post-traumatic stress disorder (PTSD) (Atwoli, Stein,



Photo: Chris Lawton / Unsplash

Koenen & McLaughlin, 2015). These disorders may be life-altering and often cause great challenges for individuals, families and communities. Particular groups (for example, women, refugees, people living in poverty and the LGBTQ community) display a higher proportion of mental disorders and are less likely to have access to mental health services (Benjet et al., 2016).

Exposure to severely stressful events, unsafe living conditions and poor health often contributes to the greater vulnerability of these populations. Untreated mental health disorders significantly and adversely affect the health,

social and economic functioning of communities (Marquez & Saxena, 2016).

Given the substantial prevalence of mental health disorders in the general population, it is essential for counsellors to identify people in need of assistance. Early detection and treatment of mental health issues is important for positively supporting the quality of life and wellbeing of people (Kessler & Wang, 2008). However, worldwide, rarely are systems in place for early detection and treatment of mental health and substance use problems. In addition, mental health disorders often are stigmatised, so many potential clients do not

seek out screening, diagnosis and treatment (Henderson, Evans-Lacko & Thornicroft, 2013).

The clinical benefits of assessment for client outcomes reach beyond initial screening. After a counsellor detects a mental health concern, the assessment data, in combination with comprehensive information about the client, can better support the rationale for the identified diagnosis and inform the development of the initial therapeutic recommendations (Erford, 2013). The same assessments can be used multiple times across the timeline of services to assess client progress toward goals; monitor symptom

improvement, deterioration or plateau; and guide treatment plan revision to be most relevant and impactful to that specific time period based on changing client needs (Balkin & Juhnke, 2018).

This article provides counsellors with a brief overview of some easy-to-use, free screening assessment options to help identify commonly encountered client problems (such as depression, anxiety, substance use and trauma) and measure relevant treatment outcomes across the timeline of care.

Each review summarises practical administration and scoring issues (for example, item format, time, subscales, scoring directions), interpretation, relevant psychometric data (that is, score reliability and validity), and strengths and weaknesses.

Highlights of free-access instruments used to identify and monitor counselling outcomes

Four free-access screening instruments were selected and reviewed to help counsellors assess commonly encountered client problems in clinical practice:

- Center for Epidemiologic Studies Depression Rating Scale – Revised (CESD-R);
- Hamilton Anxiety Rating Scale (HAM-A);
- Alcohol Use Disorder Identification Test (AUDIT); and
- the PTSD Symptom Scale (PSS).

This section will review use of each of these free-access instruments and how counsellors can use each for screening, tracking of symptoms or progress across time and determination of evidence-based outcomes with clients.

Photo: Markus Spiske / Unsplash



Center for Epidemiologic Studies Depression – Revised (CESD-R)

The Center for Epidemiologic Studies Depression Scale – Revised (CESD-R) helps to screen for depressive symptoms occurring during the previous two weeks (Eaton, Smith, Ybarra Muntaner, & Tien, 2004; Van Dam & Earleywine, 2011). The CESD-R can be used with clients at the start of services and across the course of care to track client experiences. Free access to the CESD-R is available at www.albany.edu/~me888931/CESD-R.pdf. The CESD-R is widely used in assessment of depression in the English-speaking population but has also been translated and adapted for use in Bengali (Bangladeshi), German, Korean, Mandarin, Polish, Spanish and Turkish. Importantly, several studies found cultural response bias in Asian populations. Asian respondents tended to overinflate responses on positively worded items (Demirchyan, Petrosyan & Thompson, 2011; Lee et al., 2011; Li & Hicks, 2010).

The CESD-R uses 20 items aligned with DSM-IV and ICD-10 depression criteria. The CESD-R is a self-report instrument usually requiring less than five minutes to administer and score. Clients respond on a five-point Likert-type scale: (0) “not at all, less than 1 day”, (1) “1–2 days”, (2) “3–4 days”, (3) “5–7 days”, and (4) “nearly every day for two weeks”. A simple sum total raw score ranges from 0 to 80 with a recommended cut-off raw score of 16 or higher indicating a risk for depression (Eaton et al., 2004).

The CESD-R displayed excellent score reliability and adequate score

validity. Kimong (in press) conducted a psychometric synthesis of the CESD-R and derived an average coefficient alpha of .92 across 10 studies with a combined sample size of 12,622 participants, very consistent with the findings of Eaton et al. (2004) and Van Dam and Earleywine (2011). Kimong also derived a mean ($M = 10.61$) and standard deviation ($SD = 12.02$) across combined samples ($N = 10,224$) of non-clinical participants. Williams et al. (2012) indicated that in a clinical sample of $N = 229$ and a CESD-R cut off score of 12, sensitivity was .72, specificity was .70, positive predictive value was .62, and negative predictive value was .79. Another study (Olagunju, Aina & Fadipe, 2013; $N = 200$) indicated a cut-off score of 15 resulted in a sensitivity of .96, specificity .69, positive predictive value of .54, and negative predictive value of .98. To assess concurrent criterion-related validity, Van Dam and Earleywine (2011) found moderate to high correlations with the State-Trait Inventory of Cognitive and Somatic Anxiety (STICSA; $r = .735$) and the Positive and Negative Affect Schedule (PANAS; $r = .567$), while Walsh (2014) revealed a strong negative correlation between the CESD-R and the Short-Form Questionnaire (SF-36) Mental Health subscale ($r = -.74$).

Hamilton Anxiety Scale (HAM-A)

The WHO (2017) reported 264 million people (3.6 per cent of the global population) had anxiety disorders in 2015, which is a 15 per cent increase in prevalence from accrued data 10 years prior. There is a global need for anxiety disorder screening tools like the

Hamilton Anxiety Rating Scale (HAM-A – sometimes referred to as HARS; Hamilton, 1959) that skilled medical and behavioural health clinicians or paraprofessionals can use to identify symptom severity. The HAM-A is a 14-item assessment measuring psychic anxiety symptoms (anxious mood, tension, fear, insomnia, cognitive ability, mood and present behaviour) and somatic anxiety symptoms (bodily sensations, cardiovascular, respiratory, gastrointestinal, genitourinary and autonomic observations) with a five-point Likert-type scale (0 = not present, 1 = mild, 2 = moderate, 3 = severe, 4 = very severe). Free access to the HAM-A is available at <http://psychology-tools.com/hamilton-anxiety-rating-scale> and it can be administered in 10 to 15 minutes by interview with a clinician. Translations are available in Cantonese, French or Spanish



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Depression, anxiety, alcohol misuse and trauma are common independent and co-occurring presenting concerns among clients seeking counselling services.

(Bruss, Gruenberg, Goldstein & Barber, 1994). The HAM-A can be used multiple times while services are rendered to monitor symptoms and progress.

The HAM-A responses are easily scored and interpreted (Beck & Steer, 1991). Scoring involves calculating a total raw score (range: 0 to 56) by adding the numerical values assigned to the selected option (0–4) for each of the 14 items. Original score interpretations for anxiety symptoms are: 0 to 16 – mild; 17 to 24 – mild to moderate; 25 to 30 – moderate to severe; and 31 or above – severe. Alternatively, Matza, Morlock, Sexton, Malley and Feltner (2010) recommended a change in optimal cut-offs and interpretations of anxiety symptoms to: 0 to 7 – none to mild; 8 to 14 – mild to moderate; 15 to 23 – moderate to severe; and 24 or above – severe.

Beck and Steer (1991) reported HAM-A scores to have adequate subscale internal consistencies ($\alpha = .73$ for the psychic scale and $\alpha = .79$ for the somatic scale). However, clinician administration methods influence interrater reliability, thus affecting instrument psychometrics. Clinicians following interview protocols outlined in The Hamilton Anxiety Rating Scale Interview

Guide (Bruss et al., 1994) had interrater reliability coefficients between $r = .79$ to $.81$, while those who did not use the standardised protocols had lower interrater reliability coefficients ($r = .73$ psychic scale, $r = .70$ for somatic scale, and $r = .74$ for total score; Maier, Buller, Philipp & Heuser, 1988). HAM-A scores demonstrated moderate concurrent validity with the Beck Anxiety Inventory ($r = .56$) (Beck & Steer, 1991) and Generalised Anxiety Disorder-7 (GAD-7; $r = .85$; Ruiz et al., 2011).

Alcohol Use Disorders Identification Test (AUDIT)

Harmful, hazardous and dependent alcohol consumption are common mental health concerns that occur in tandem with mental disorders, physical diseases, injuries to self and others, social conflicts and legal issues (WHO, 2018). To address the need to assess alcohol use risk level in medical and behavioural health, employee assistance, military, education and criminal justice settings, the WHO (2001) developed the Alcohol Use Disorders Identification Test (AUDIT). Free access to the AUDIT is available at http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf. AUDIT is a 10-item assessment aligned with

a wide spectrum of ICD-10 alcohol use criteria (Babor, Campbell Room, & Saunders, 1994; WHO, 1993). It can be administered in two to four minutes in more than 50 languages by interview or written self-report to assess recent alcohol use, alcohol dependence and alcohol-related problems in terms of how frequent (0 = never; 1 = less than monthly; 2 = monthly; 3 = weekly, and 4 = daily or almost daily) or if/ever problems are experienced (no; yes, but not in the last year; yes, during the last year – WHO, 2001). The AUDIT can be used in reoccurring fashion to monitor client alcohol use and recovery.

Scoring the AUDIT simply requires adding the sum of the numerical values corresponding to the 10 reported responses to obtain a total score (WHO, 2001). Scores between 0 and 7 suggest abstinence or low-risk alcohol use. Scores of 8 to 15 signify medium risk or harmful alcohol behaviours with psychoeducation recommended. Scores of 16 to 19 indicate high risk or hazardous drinking with brief counselling and monitoring recommended. Scores of 20 to 40 imply possible alcohol dependence with referral for further diagnostic evaluation and treatment recommended.

The AUDIT yields reliable and valid scores. Internal consistencies for the total score ranged from $.76$ to $.83$ across various subpopulations, settings, cultures, genders and ages (de Meneses-Gaya, Zuardi, Loureiro & Crippa, 2009). Test-retest reliability estimates ranged from $r = .60$ to $.86$ (Selin, 2003; Sinclair, McRee & Babor, 1992). The AUDIT scores had strong convergent validity with

the MAST ($r = .88$; Bohn, Babor, & Kranzler, 1995) and CAGE ($r = .78$; Hays, Merz, & Nicholas, 1995) and strong predictive validity with self-reported alcohol behaviours and related consequences (Conigrave, Saunders & Reznik, 1995).

PTSD Symptom Scale (PSS)

According to Kessler et al. (2017), a majority of the worldwide population will experience a trauma ranging across diverse experience types throughout their lifespan. A significant proportion of those individuals will develop PTSD (Atwoli et al., 2015). The PTSD Symptom Scale (PSS) is available to identify the subpopulation of adults whose trauma symptoms persisted to develop PTSD as defined by DSM-IV criteria (Foa, Riggs, Dancu & Rothbaum, 1993). Free access to the PSS is available at <http://depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/1%20Assessment/Standardized%20Measures/PSS-Adult.pdf>. (Note: assessment variations may be requested from the PSS authors directly.)

The 17 items of the PSS assess frequency of re-experiencing, avoidance and arousal symptoms within the previous two weeks across a four-point Likert-type scale (0 = not at all; 1 = once a week/a little bit/once in a while; 2 = two to four times per week/somewhat/half the time; and 3 = five or more times per week/very much/almost always). Researchers translated the PSS into multiple languages, adapted it for administration with children (CPSS; Foa, Johnson, Feeny & Treadwell, 2001), and modified the assessment to measure severity per DSM-III-R criteria (MPSS-SR; Falsetti, Resnick,

Resick & Kilpatrick, 1993). To date, researchers have not confirmed PSS psychometric alignment with DSM-5 PTSD diagnostic changes (APA, 2013).

The PSS is scored for severity and used to confirm DSM-IV diagnostic criteria (Hembree, Foa & Feeny, 2002). The PSS may be routinely re-administered to clients over the course of treatment to monitor changes in symptom severity. Administrators calculate a total score (ranging from 0 to 51) and a total raw score of 14 or above indicates a significant severity (Sin, Adben & Lee, 2012). DSM-IV diagnostic criteria B, C, D (American

Psychiatric Association, 1994) can be confirmed if one item on the re-experiencing, three items on the avoidance, and two items of the arousal subscales are indicated by scores of 2 or 3 on PSS aligned items (Hembree et al., 2002).

Researchers reported scores on the PSS to be psychometrically sound. Test-retest reliability ranged from .80 to .84 (Foa et al., 2001; Powers, Gillihan, Rosenfield, Jerud & Foa, 2012), interrater reliability ranged from .90 to .98 (Foa & Tolin, 2000), and internal consistency on the total score ranged from $\alpha = .89$ to .97 (and subscales ranged from $\alpha = .65$ to .95; Coffey,



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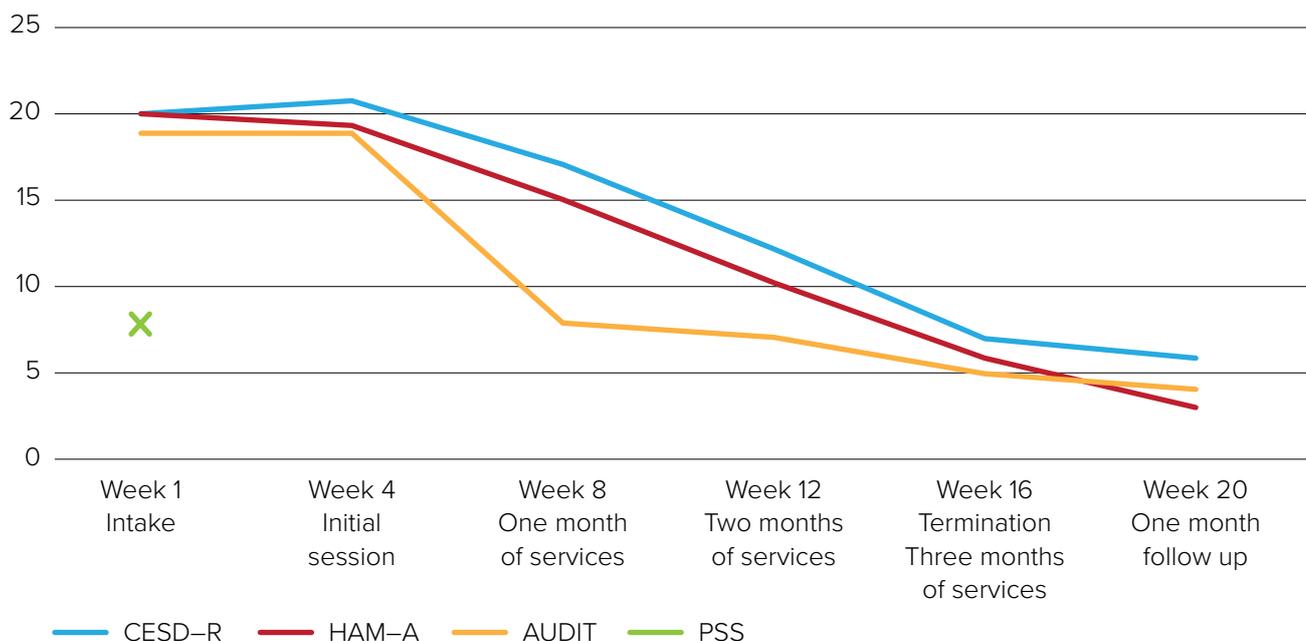


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FIGURE 1 Victoria's assessed symptomology visually across timeline of counselling services.



Dansky, Falsetti, Saladin, & Brady, 1998; Foa & Tolin, 2000; Powers et al., 2012). Researchers reported strong concurrent validity between scores on the PSS and SCID ($r = .73$, $\kappa = .75$) and CAPS ($r = .87$) (Foa & Tolin 2000; Powers et al., 2012); high convergent validity between PSS total score and the SCL-90-R PTSD Scale ($r = .79$), the IES ($r = .66$), and the PDS ($r = .78$) (Coffey et al., 1998; Powers et al., 2012); and appropriate divergent validity between the PSS and assessments for depression and anxiety (Foa et al., 2001).

Assessment application case study: Victoria

Depression, anxiety, alcohol misuse and trauma are common independent and co-occurring presenting concerns among clients seeking counselling services (APA, 2013). The case of Victoria is an

illustration of a client seeking symptom relief; however, Victoria's life trials and tribulations, as well as dedication to the counselling process to bring about life changes, mirrors the voices of many clients seen in clinical practice. The use of the CESD-R, HAM-A, AUDIT and PSS can aid the counselling process to help Victoria and other clients achieve symptom relief.

Victoria was a 25-year-old cisgender, bisexual female who identified as a graduate level educated, lower middleclass, Stateside Puerto Rican with strong family and Roman Catholic values. Victoria sought counselling for the first time after relocating to a new town away from social support for employment. At intake, Victoria was experiencing anxiety symptoms, changes in mood, and consuming about three alcoholic drinks at least four nights a week to relax. She

also reported surviving a sexual assault when she was a second-year college student.

Based on Victoria's disclosure, the CESD-R, HAM-A, AUDIT and PSS were integrated into clinical care across time: week one during intake; week four at the first session occurring one month after intake; week eight after one months of services; week 12 after two months of services; week 16 after three months of services and termination; and week 20 after a one month follow-up. The data from the assessments, in combination with Victoria's reflection on fit between the assessments and her experience, were used to inform clinical decisions such as medical necessity, appropriate level of care, and termination planning (Erford, 2013). Based on the assessments, the counsellor working with Victoria used a combination of cognitive behavioural therapy and

TABLE 1 Victoria's assessed symptomology across timeline of counselling services.

	Week 1	Week 4	Week 8	Week 12	Week 16	Week 20
	Intake	Initial session	One month of services	Two months of services	Three months of services – termination	One month follow-up
CESD-R	20	21	17	12	7	6
HAM-A	20	19	15	10	6	3
AUDIT	19	19	8	7	5	4
PSS	8*	–	–	–	–	–

- CESD-R depression raw score of 16 or higher indicates Victoria is at risk for depression.
- HAM-A anxiety raw scores for Victoria are interpreted within the following ranges: 0-7 none to mild; 8-14 mild to moderate; 15-23 moderate to severe; and 24 or above severe.
- AUDIT raw scores for Victoria are interpreted within the following ranges: 0-7 abstinence or low-risk alcohol use; 8-15 medium risk or harmful alcohol behaviours; 16-19 high risk or hazardous drinking; and 20-40 possible alcohol dependence.
- PSS trauma symptom raw score above 14 indicates severe levels needed care.

* Victoria's trauma symptoms at intake did not meet diagnostic criteria for trauma support services nor continual monitoring of trauma symptoms.

psychoeducation to address goals created collaboratively with Victoria. Across three months of counselling services, the assessed presenting concerns reduced in a steady progression and progress was maintained for at least one month after termination. Table 1 outlines Victoria's depression, anxiety, alcohol use and trauma symptoms across the timeline of care, and Figure 1 is a visual representation of Victoria's repeatedly measured symptomology.

Discussion: recommendations for counselling practice

There are many brief validated instruments that reliably measure change in severity of symptoms, yet mental health providers often do not use them (Hatfield, McCullough Frantz, & Krieger, 2010; Zimmerman & McGlinchey, 2008). Providers relying on clinical judgement alone

may find it difficult to hone clinical skills, evaluate effectiveness, or demonstrate impact to clients or payment sources without the use of instruments (Fortney et al., 2017). As a result, measurement-based care (MBC) and measurement feedback systems (MFSs) have been proposed for improving practice (Gleacher et al., 2015; Scott & Lewis, 2015). These terms refer to a process in which the provider uses validated measures across treatment to gather client progress and outcome data vital for evidence-based practice. Given the prevalence of depression, anxiety, trauma and alcohol and substance use disorders, counsellors need to use high-quality instruments to promote evidence-based practices.

This article presented four instruments that can be used by counselling practitioners to inform the initial client interview

and assessment, treatment planning, intervention and outcome evaluation. Excellence in clinical practice includes using multiple sources of data gathered to inform each step of the counselling process (Balkin & Juhnke, 2018). At least one barrier to the regular use of assessment instruments, cost, is removed when free-access, high-quality instruments are used (Beidas et al., 2015). Benefits of using these instruments during each step of the counselling process were described in this article.

Use of the CESD-R, HAM-A, AUDIT and PSS can provide detailed information helping counsellors to determine the nature of client's depression, anxiety, alcohol use and PTSD symptoms for more accurate screening and diagnosis (Beck & Steer, 1991; Eaton et al., 2004; Foa et al., 1993; WHO, 2001). Clients present with

narratives and goals for counselling and counsellors systematically gather this information to form an initial case conceptualisation. However, non-specific comorbid symptoms often overlap with a wide range of psychiatric and medical illnesses (APA, 2013). A client's physical symptoms may be similar to mental health symptoms, complicating mental health assessment and diagnosis. For example, pain or chronic medical morbidity can occur with depression, anxiety, trauma or alcohol and substance use disorders. Instruments can support efficiency in the assessment and diagnosis process compared to the time it may take for a counsellor to complete an extensive verbal history (Balkin & Juhnke, 2018).

The CESD-R, HAM-A, AUDIT and PSS could be administered in waiting rooms and results discussed with the client during an intake or initial interview, leaving more time for the counsellor to address specific items on each scale (Beck & Steer, 1991; Eaton et al., 2004; Foa et al., 1993; WHO, 2001). Responses on the CESD-R, for example, may indicate feelings of agitation, fatigue, worthlessness, loss of interest in aspects of life, sadness, difficulty concentrating, and problems with appetite and sleep (Eaton et al., 2004). The AUDIT provides detailed information on specific alcohol use behaviours (WHO, 2001), and the PSS provides detailed information on specific traumatic events (Foa et al., 1993). Use of these instruments during the assessment phase allows the practitioner to consider psychometric data that can be used in combination with a client's narrative to more comprehensively inform diagnosis

and treatment planning.

During treatment planning, counsellors co-create goals with clients for treatment (Balkin & Juhnke, 2018) while taking into consideration how clients understand, accept and demonstrate readiness for change (Prochaska & Prochaska, 2016). Use of any or all of the four instruments, as appropriate to the client's reported concerns, could serve to validate client experiences and expand their meaning-making around improving quality of life. The client can find meaning from the process of completing the instrument as well as in dialogue with the counsellor. The counsellor can also use specific items to assess differences in meaning-making from clients who represent various minority populations as there is evidence that symptomatology may be conceptualised and expressed differently. Individual differences are considered during treatment planning and can then be used to determine the most appropriate interventions (Erford, 2013).

Interventions capitalise on psychological or social actions to produce change in psychological, social, biological or functional outcomes (Beutler, Someah, Kimpara & Miller, 2016). The AUDIT is the only instrument reviewed that provides recommendations for treatment intervention (WHO, 2001), but the specific item responses for the CESD-R, HAM-A and PSS can also be helpful information when choosing specific interventions (Beck & Steer, 1991; Eaton et al., 2004; Foa et al., 1993). The unique information that is obtained through the use of one or all four

instruments can be used to target effective interventions for specific symptoms or diagnoses.

Outcomes of psychosocial interventions encompass desired changes in three areas:

- symptoms, including both physical and mental health symptoms;
- functioning, or the performance of activities (such as physical activity, activities of daily living, assigned tasks in school and work, maintaining intimate and peer relationships, family responsibilities, and involvement in community activities); and
- wellbeing (that is, spirituality, life satisfaction, quality of life, and the promotion of recovery) (Committee on Developing Evidence-Based Standards for Psychosocial Interventions for Mental Disorders, 2015).

Repeated use of one or all of the four instruments described here can provide information on symptom change, be used to show the client change over time, and serve to initiate conversations about overall outcomes. Again, specific responses to items can be reviewed in dialogue with the counsellor and expanded upon to include evaluation of functioning and wellbeing.

Conclusion

Anxiety, depression, alcohol use disorders and PTSD are common struggles across the world (GBD, 2016). Counsellors will need to be prepared to assess symptoms and severity levels with qualitative information gathered from clients, as well as from quantitative screening assessments. This dual approach to assessment may provide a more comprehensive perspective on clients to better

inform collaborative discussions between counsellors and clients around diagnosis, goal setting, and treatment planning from initial session through to termination (Erford, 2013). Free-access instruments such as the CESD-R, HAM-A, AUDIT and PSS are just a select cluster of measures clinicians could incorporate into their practice.

Authors' note

Michelle Perepiczka, Heather Smith, Nicole A. Cobb and Bradley T. Erford are faculty members in the human development counselling program in the Department of Human and Organizational Development at Peabody College at Walden University, Nashville, USA. Correspondence regarding this article should be sent to Dr Michelle Perepiczka at michelle.perepiczka@vanderbilt.edu.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Atwoli, L.; Stein, D. J.; Koenen, K. C.; McLaughlin, K. A. (2015). Epidemiology of post-traumatic stress disorder: Prevalence, correlates and consequences. *Current Opinion in Psychiatry*, 28, 307-311. <https://doi.org/10.1097/CO.0000000000000167>

Babor, T.; Campbell, R.; Room, R.; Saunders, J. (1994). *Lexicon of alcohol and drug terms*. Geneva, Switzerland: World Health Organization.

Balkin, R. S.; Juhnke, G. A. (2018). *Assessment in counseling: Practice and applications*. New York, NY: Oxford University Press.

Beck, A. T.; Steer, R. A. (1991). Relationship between the Beck Anxiety Inventory and the Hamilton Anxiety Rating Scale with anxious outpatients. *Journal of Anxiety Disorders*, vol. 5, pp.213-223. [https://doi.org/10.1016/0887-6185\(91\)90002-B](https://doi.org/10.1016/0887-6185(91)90002-B)

Beidas, R. S.; Stewart, R. E.; Walsh, L.; Lucas, S.; Downey, M. M.; Jackson, K.; Mandell, D.S. (2015). 'Free, brief, and validated: Standardized instruments for low-resource mental health settings.' *Cognitive and Behavioral Practice*, vol. 22, pp.5-19. <https://doi.org/10.1016/j.cbpra.2014.02.002>

Benjet, C.; Bromet, E.; Karam, E. G.; Kessler, R. C.; McLaughlin, K. A.; Russo, A. M.; Koenen, K. C. (2016). 'The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium.' *Psychological Medicine*, vol. 46, pp.327-343. <http://doi.org/10.1017/S003329171500198>

Beutler, L. E.; Someah, K.; Kimpara, S.; Miller, K. (2016). 'Selecting the most appropriate treatment for each patient.' *International Journal of Clinical and Health Psychology*, vol. 16, pp.99-108. <https://doi.org/10.1016/j.ijchp.2015.08.001>

Bohn, M. J.; Babor, T. F.; Kranzler, H. R. (1995). 'The Alcohol Use Disorders Identification Test (AUDIT): Validation of a screening instrument for use in medical settings.' *Journal of Studies on Alcohol*, vol. 56, pp.423-432. <http://doi.org/10.1080/13814780902855754>

Bruss, G. S.; Gruenberg, A. M.; Goldstein, R. D.; Barber, J. P. (1994). 'Hamilton Anxiety Rating Scale interview guides: Joint interview and test-retest methods for inter-rater reliability.' *Psychiatry Research*, vol. 53, pp.191-202. [http://doi.org/10.1016/0165-1781\(94\)90110-4](http://doi.org/10.1016/0165-1781(94)90110-4)

Committee on Developing Evidence-Based Standards for Psychosocial Interventions for Mental Disorders. (2015). 'Introduction.' In A. S. Butler, & M. L. Gonzalez (Eds.), *Psychosocial interventions for mental and substance use disorders: A framework for establishing evidence-based standards* (pp. 21 - 46). Washington (DC): National Academies Press.

Coffey, S. F.; Dansky, B. S.; Falsetti, S. A.; Saladin, M. E.; Brady, K. T. (1998). 'Screening for PTSD in a substance abuse sample: Psychometric properties of a modified version of the PTSD Symptom Scale Self-Report.' *Journal of Traumatic Stress*, vol. 11, pp.393-399. <http://doi.org/10.1023/A:1024467507565>

Conigrave, K. M.; Saunders, J. B.; Reznik, R. B. (1995). 'Predictive capacity of the AUDIT questionnaire for alcohol-related harm.' *Addiction*, vol. 90, pp.1479-1485. <http://doi.org/10.1046/j.1360-0443.1995.901114796.x>

de Meneses-Gaya, C.; Zuardi, A. W.; Loureiro, S. R.; Crippa, J. A. S. (2009). 'Alcohol Use Disorders Identification Test (AUDIT): An updated systematic review of psychometric properties.' *Psychology & Neuroscience*, vol. 2, pp.83-97. <http://doi.org/10.3922/j.pns.2009.112>

Demirchyan, A.; Petrosyan, V.; Thompson, M. E. (2011). 'Psychometric value of the Center for Epidemiologic Studies Depression (CES-D) scale for screening of depressive symptoms in

Armenian population.' *Journal of Affective Disorders*, vol. 133, pp.489-498. <http://doi.org/10.1016/j.jad.2011.04.042>

Eaton, W. W.; Smith, C.; Ybarra, M.; Muntaner, C.; Tien, A. (2004). 'Center for Epidemiologic Studies Depression Scale: Review and revision (CESD and CESD-R).' In M. E. Maruish (Ed.). *The use of psychological testing for treatment planning and outcomes assessment*, Volume 3: Instruments for adults (3rd ed.); 363-377. Mahwah, NJ: Lawrence Erlbaum. Author, B. T. (2013). *Assessment for counselors* (2nd ed.). Belmont, CA: Cengage Wadsworth.

Erford, B. T. (2013). *Assessment for counselors* (2nd ed.). Belmont, CA: Cengage Wadsworth.



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- Falsetti, S. A.; Resnick, H. S.; Resick, P. A.; Kilpatrick, D. G. (1993). 'The Modified PTSD Symptom Scale: A brief self-report measure of posttraumatic stress disorder.' *The Behavior Therapist*, vol. 16, pp.161-162.
- Foa, E. B.; Johnson, K. M.; Feeny, N. C.; Treadwell, K. R. H. (2001). 'The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties.' *Journal of Clinical Child Psychology*, vol. 30, pp.376-384. http://doi.org/10.1207/S15374424JCCP3003_9
- Foa, E. B.; Riggs, D. S.; Dancu, C. V.; Rothbaum, B. O. (1993). 'Reliability and validity of a brief instrument for assessing posttraumatic stress disorder.' *Journal of Traumatic Stress*, vol. 6, pp.459-473. <https://doi.org/10.1002/jts.2490060405>
- Foa, E. B.; Tolin, D. F. (2000). 'Comparison of the PTSD Symptom Scale—Interview version and the Clinician-Administered PTSD Scale.' *Journal of Traumatic Stress*, vol. 13, pp.181-191. <http://doi.org/10.1023/A:1007781909213>
- Fortney, J. C.; Unützer, J.; Wrenn, G.; Pyne, J. M.; Smith, G. R.; Schoenbaum, M.; Harbin, H.T. (2017). 'A tipping point for measurement-based care.' *Psychiatric Services*, vol. 68, pp.179-188. <https://doi.org/10.1176/appi.ps.201500439>
- Gleacher, A. A.; Olin, S. S.; Nadeem, E.; Pollock, M.; Ringle, V.; Bickman, L.; Hoagwood, S. (2015). 'Implementing a measurement feedback system in community mental health clinics: A case study of multilevel barriers and facilitators.' *Administration and Policy in Mental Health and Mental Health Services Research*, vol. 43, pp.426-440. <http://doi.org/10.1007/s10488-015-0642-0>
- Global Burden of Disease. (2016). *Global Burden of Disease (GBD) Study 2016*. Retrieved from <http://ghdx.healthdata.org/gbd-2016>
- Hamilton, M. (1959). 'The assessment of anxiety states by rating.' *British Journal of Medical Psychology*, vol. 32, pp.50-55. <http://doi.org/10.1111/j.2044-8341.1959.tb00467.x>
- Hatfield, D.; McCullough, L.; Frantz, S. H. B.; Krieger, K. (2010). 'Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change.' *Clinical Psychology & Psychotherapy*, vol. 17, pp.25-32. <http://doi.org/10.1002/cpp.656>
- Hays, R. D.; Merz, J. F.; Nicholas, R. (1995). 'Response burden, reliability, and validity of the CAGE, Short MAST, and AUDIT alcohol screening measures.' *Behavioral Research Methods, Instruments & Computers*, vol. 27, pp.277-280. <http://doi.org/10.3758/BF03204745>
- Hembree, E. A.; Foa, E. B.; Feeny, N. C. (2002). *Manual for the administration and scoring of the PTSD Symptom Scale - Interview (PSS-I)*. Retrieved from www.istss.org/resources/browse.cfm
- Henderson, C.; Evans-Lacko, S.; Thornicroft, G. (2013). 'Mental illness stigma, help seeking, and public health programs.' *American Journal of Public Health*, vol. 103, pp.777-780. <http://doi.org/10.2105/AJPH.2012.301056>
- Kessler, R. C.; Wang, P. S. (2008). 'The descriptive epidemiology of commonly occurring mental disorders in the United States.' *Annual Review of Public Health*, vol. 29, pp.115-129. <http://doi.org/10.1146/annurev.publhealth.29.0209.07.090847>
- Kessler, R. C.; Aguilar-Gaxiola, S.; Alonso, J.; Benjet, C.; Bromet, E. J.; Cardoso, G.; Koenen, K. C. (2017). 'Trauma and PTSD in the WHO: World mental health surveys.' *European Journal of Psychotraumatology*, vol. 8(5), pp.1-16. <http://doi.org/10.1080/20008198.2017.1353383>
- Kimong, P. J. (in press). 'Psychometric synthesis of the Center for Epidemiologic Studies Depression Scale – Revised (CESD-R) across cultures.' *Dissertation Abstracts International Section A: Humanities and Social Sciences*.
- Lee, J. J.; Kim, K. W.; Kim, T. H.; Park, J. H.; Lee, S. B.; Park, J. W.; Steffens, D. C. (2011). 'Cross-cultural considerations in administering the Center for Epidemiologic Studies Depression Scale.' *Gerontology*, vol. 57, pp.455-461. <http://doi.org/10.1159/000318030>
- Li, Z.; Hicks, M. H. R. (2010). 'The CES-D in Chinese American women: Construct validity, diagnostic validity for major depression, and cultural response bias.' *Psychiatry Research*, vol. 175, pp.227-232. <http://doi.org/10.1016/j.psychres.2009.03.007>
- Maier, W.; Buller, R.; Philipp, M.; Heuser, I. (1988). 'The Hamilton Anxiety Scale: Reliability, validity and sensitivity to change in anxiety and depressive disorders.' *Journal of Affective Disorders*, vol. 14(1), pp.61-68. [http://doi.org/10.1016/0165-0327\(88\)90072-9](http://doi.org/10.1016/0165-0327(88)90072-9)
- Marquez, P. V.; Saxena, S. (2016). 'Making mental health a global priority.' *Cerebrum*, vol. 1, pp.10-16.
- Matza, L. S.; Morlock, R.; Sexton, C.; Malley, K.; Feltner, D. (2010). 'Identifying HAM-A cutoffs for mild, moderate, and severe generalized anxiety disorder.' *International Journal of Methods in Psychiatric Research*, vol. 19, pp.223-232. <http://doi.org/10.1002/mpr.323>
- Olagunju, A. T.; Aina, O. F.; Fadipe, B. (2013). 'Screening for depression with Center for Epidemiologic Studies Depression Scale - Revised and its implication for consultation-liaison psychiatry practice among cancer subjects: A perspective from a developing country.' *Psycho-Oncology*, vol. 22, pp.1901-1906. <http://doi.org/10.1002/pon.3234>
- Prochaska, J. O.; Prochaska, J. M. (2016). *Changing to thrive: Using the stages of change to overcome the top threats to your health and happiness*. Center City, MN: Hazelden Publishing.
- Powers, M. B.; Gillihan, S. J.; Rosenfield, D.; Jerud, A. B.; Foa, E. B. (2012). 'Reliability and validity of the PDS and PSS-I among participants with PTSD and alcohol dependence.' *Journal of Anxiety Disorders*, vol. 26, pp.617-623. <http://doi.org/10.1016/j.janxdis.2012.02.013>
- Ruiz, M.; Zamorano, E.; Garcia-Campayo, J.; Pardo, A.; Freire, O.; Rejas, J. (2011). 'Validity of the GAD-7 scale as an outcome measure of disability in patients with generalized anxiety in primary care.' *Journal of Affective Disorders*, vol. 128, pp.277-286. <http://doi.org/10.1016/j.jad.2010.07.010>
- Scott, K.; Lewis, C. (2015). 'Using measurement-based care to enhance any treatment.' *Cognitive and Behavioral Practice*, vol. 22, pp.49-59. <http://doi.org/10.1016/j.cbpra.2014.01.010>
- Selin, K. H. (2003). 'Test-retest reliability of the alcohol use disorder identification test in a general population sample.' *Alcoholism: Clinical and Experimental Research*, vol. 27, pp.1428-435. <http://doi.org/10.1097/01.ALC.0000085633.23230.4A>
- Sin, G. L.; Abidin, E.; Lee, J. (2012). 'The PSS-SR as a screening tool for PTSD in first-episode psychosis patients.' *Early Intervention in Psychiatry*, vol. 6, pp.191-194. <http://doi.org/10.1111/j.1751-7893.2011.00327.x>
- Sinclair, M.; McRee, B.; Babor, T. F. (1992). *Evaluation of the reliability of AUDIT*. University of Connecticut School of Medicine, Alcohol Research Center, (unpublished report).
- Van Dam, N. T.; Earleywine, M. (2011). 'Validation of the Center for Epidemiologic Studies Depression Scale—Revised (CES-D-R): Pragmatic depression assessment in the general population.' *Psychiatry Research*, vol. 186, pp.128-132. <http://doi.org/10.1016/j.psychres.2010.08.018>
- Walsh, T. (2014). *The conceptualization of depression and acculturative stress among Latino immigrants: A comparison of scores from non-Hispanic whites and persons of Mexican origin on the Center for Epidemiologic Studies Depression Scale - Revised (CESD-R)* (Doctoral dissertation) Retrieved from ProQuest Dissertations & Theses Global. (Order No. 3634102).
- Whiteford, H. A.; Degenhardt, L.; Rehm, J.; Baxter, A. J.; Ferrari, A. J.; Erskine, H. E.; Vos, T. (2013). 'Global burden of disease attributable to mental and substance use disorders: Findings from the Global Burden of Disease Study 2010.' *Lancet*, vol. 382, p.1575. [http://doi.org/10.1016/S0140-6736\(13\)61611-6](http://doi.org/10.1016/S0140-6736(13)61611-6)
- Williams, J. R.; Hirsch, E. S.; Anderson, K.; Bush, A. L.; Goldstein, S. R.; Grill, S.; Marsh, L. (2012). 'A comparison of nine scales to detect depression in Parkinson disease: Which scale to use?' *Neurology*, vol. 78, pp.998-1006. <http://doi.org/10.1212/WNL.0b013e31824d587f>
- World Health Organization. (1993). *The ICD-10 classification of mental and behavioral disorders: Diagnostic criteria for research*. Geneva, Switzerland: Author.
- World Health Organization. (2001). *AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for use in primary health care* (2nd ed.). Geneva, Switzerland: Author.
- World Health Organization. (2017). *Depression and other common mental health disorders: Global health estimates*. Geneva, Switzerland: Author.
- World Health Organization. (2018). *Global status report on alcohol and health*. Geneva, Switzerland: Author.
- Zimmerman, M.; McGlinchey, J. B. (2008). 'Why don't psychiatrists use scales to measure outcome when treating depressed patients?' *Journal of Clinical Psychiatry*, vol. 69, pp.1916-1919.

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