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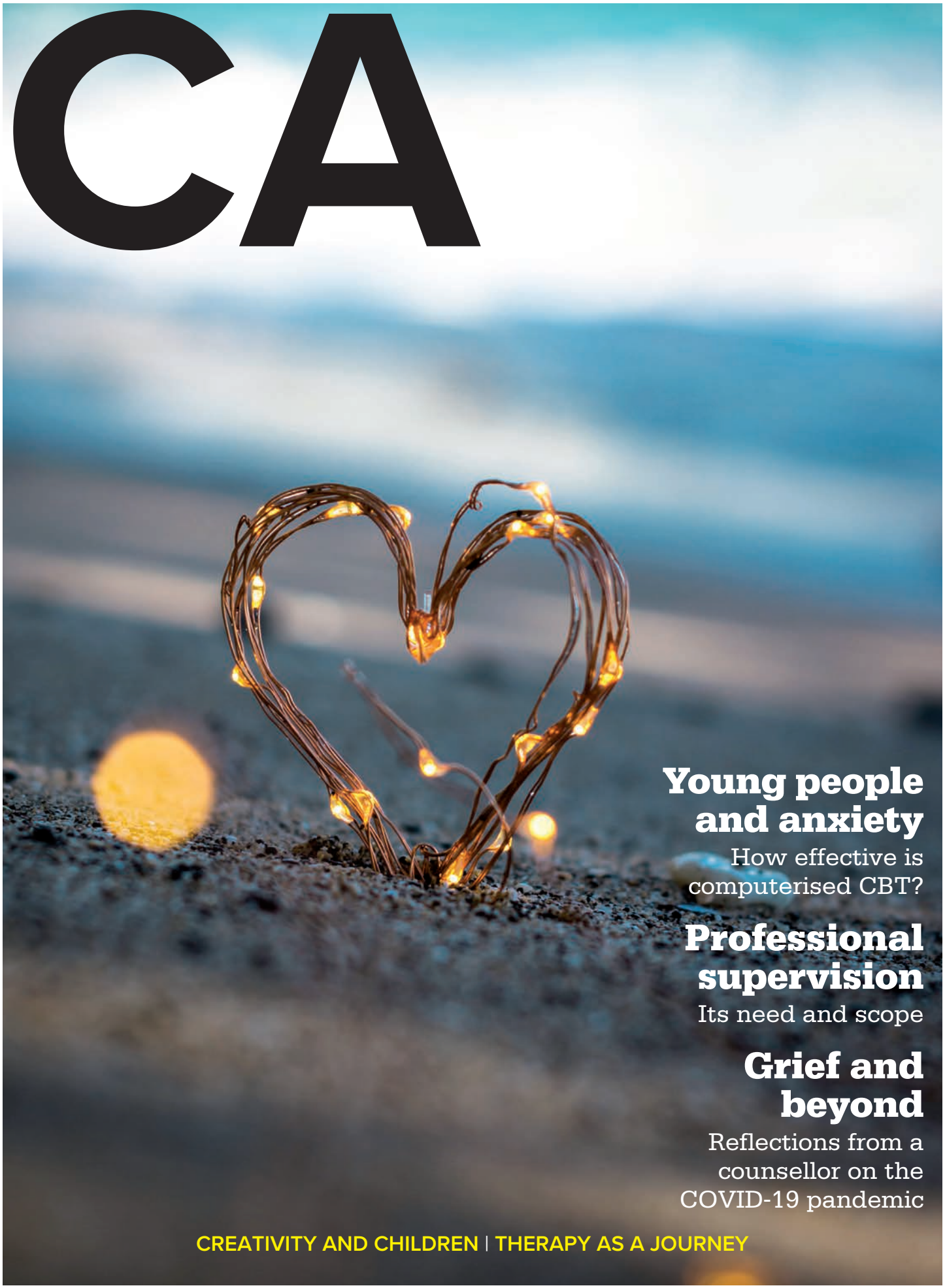

Young people and anxiety

How effective is computerised CBT?

Professional supervision

Its need and scope

Grief and beyond

Reflections from a counsellor on the COVID-19 pandemic

CREATIVITY AND CHILDREN | THERAPY AS A JOURNEY

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CONTENTS

FEATURES

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Letters to the editor should be clearly marked and be a maximum of 250 words. Submissions and letters may be addressed to:
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See page 50 for peer-reviewed article submission guidelines.

Editorial

Supporting people and their environments

Philip Armstrong
Editor

Pandemic brings counselling services to the fore

The background to this edition of *Counselling Australia* needs no introduction: the coronavirus that triggered the COVID-19 pandemic and that presents the entire world with a difficult, long-term recovery challenge. The disease for which there is currently no medical prevention or cure has delivered an unsettling reality check to 21st century living. It has changed everyone's lives and brought into sharp relief a number of issues affecting our members.

The combined pressures of enforced social isolation, sudden unemployment, limited recreation opportunities and a heightened level of community anxiety are testing many people's mental health.

Counsellors and psychotherapists are among the cohort of health professionals whose skill and experience has never been in greater need. The support they can provide in helping people to adjust, cope and even find optimism and confidence has never been so important or valued.

Many of our members adapted quickly to social distancing rules by providing online counselling and delivering their services through phone and digital platforms. In early April 2020, ACA launched an Online Counselling guide to assist members to deliver their services in new and innovative ways. However, as with face-to-face counselling services, confidentiality, security of documents and privacy measures still need to be firmly in place before providing online services. A copy of the Online Counselling 2020 guideline is available on the ACA website under the tab 'Publications & Resources'/ 'Download Documents'. You will need to login to your ACA account to access and download the document.

The current health and economic crisis has also highlighted the professional inequity inherent in counsellors not being recognised under Medicare, which limits the opportunities for people in need of access to counsellors.

In response to this, the Australian Register of Counsellors and Psychotherapists (ARCAP) has prepared a submission to the Federal Minister for Health to propose the addition of appropriately qualified and experienced counsellors and psychotherapists to the list of allied health professions in the Health Insurance (Allied Health Services) Determination 2014. This provides Focussed Psychological Strategies under the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative (BAI).

The submission makes the point that counsellors and psychotherapists are a qualified and skilled but under-utilised component of the mental health workforce. It outlines why counsellors and psychotherapists are an appropriate, cost-effective option for patients with mild to moderate mental health issues, while also having the expertise to support patients with more complex mental health issues.

The rationale for adding counsellors and psychotherapists to Medicare-funded mental health providers is to improve access to, and targeting of, services provided under the BAI.

The most recent national figures on MBS-funded mental health services indicate that usage has nearly doubled over the past decade, with 10.2 per cent of Australians accessing services in 2017-18 compared to 5.7 per cent in 2008-09 (AIHW 2019a).

However, access to services is not proportionate to need, with very high uptake in metropolitan areas and relatively low access in areas where there is a shortage of services – particularly rural and remote areas, where the underlying need for mental health supports is greatest (AIHW 2019b).

There is also a disproportionate reliance on services provided by mental health professions with relatively high per capita service fees, and whose workplace distribution is overwhelmingly urban based (AIHW, 2019b).

The addition of counsellors and psychotherapists as BAI providers would help address service shortages in rural and regional areas, as well as in metropolitan areas with poor service access. It would have a positive impact on the per capita service costs for government and on out-of-pocket costs for consumers accessing services under the BAI. It will also improve consumer choice by making a wider range of skilled mental health professionals available under the MBS to all Australians.

The combined pressures of enforced social isolation, sudden unemployment, limited recreation opportunities and a heightened level of community anxiety are testing many people's mental health.

We encourage you read the submission in its entirety by visiting the ACA website and clicking 'Publications & Resources', 'Download Documents' and then 'Medicare Submission'.

On a final housekeeping note we have cancelled the mini conference in Perth (planned for 22 August 2020) and the ACA National Conference in Darwin (18 to 20 September 2020) due to the social isolation and distancing restrictions. We are now planning for two conferences in 2021 – one to be held in a regional area and the other, the National Conference, to be held in a capital city.

Earlier in the year, ACA launched its own Facebook page. We've found that this is a quick and easy way to disseminate information to members and engage them in conversation. There has been a lot to talk about over the last few weeks and Facebook has proven to be an effective media platform to interact with members. Please visit the ACA Inc Facebook page and join in the conversation. You will find us by visiting this link: **www.facebook.com/theacainc**.

UPCOMING EVENTS 2020

Dry July

1 to 31 July

Dry July is a not-for-profit organisation aimed at improving the lives of adults living with cancer. By giving up alcohol for the month of July, participants have the opportunity to raise awareness of individual drinking habits and the importance of a healthy, balanced diet and lifestyle. For more information, visit **www.dryjuly.com**.

OCD and Anxiety Disorders Week

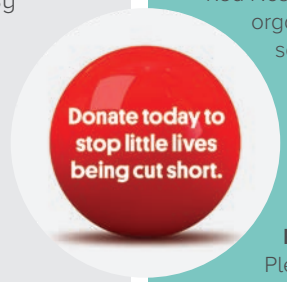
4 to 10 August

OCD and Anxiety Disorders Week is an awareness week dedicated to people living with anxiety and obsessive compulsive disorders. For more information, visit **http://understandinganxiety.wayahead.org.au/ocdanxietyawarenessweek**.

Red Nose Day

14 August

Red Nose Day is the major fundraiser for non-profit organisation Red Nose. The funds raised go towards saving the lives of babies and children during pregnancy, birth, infancy and childhood. For more information, please visit **https://rednose.org.au/section/red-nose-day**.



ACA Conferences cancelled

Perth 22 August | Darwin 18 to 20 September

Please unmark these dates in your diary for 2020. Thank you to everyone who expressed an interest in presenting and attending the planned conferences. We've received an outstanding response to the call for abstracts for both conferences. We hope to bring the paper presentations and workshops to you next year when we return to preparing the 2021 conference schedule. Please watch this space for some exciting news.

Online security

Ways of protecting yourself in the digital age

By Angela Lewis

In this issue we are going to take a look at online security and ways you can ensure safety, starting with the information you share on social media and then looking at the risks of using USBs.

Don't give away your security answers

You are probably not doing it deliberately, but let's think about how you might be doing it *inadvertently*. Security questions can be quite generic; they often include questions such as 'what was your first pet's name?', 'what was your first school?', 'favourite teacher?', 'mother's maiden name?' and so on. Cyber criminals can be smart when it comes to stealing personal information and will take the time to study a person online before trying to hack into their devices. So, using the example security questions above, think about what you might have shared on social media. On Instagram you might have shared a photo and hashtagged it something like #bestteacher, accompanied with a comment such as "Miss Graham inspired me to be a nurse".

On Facebook you might have posted a picture of your cat and comment: "it's been 10 years since Fluffy passed away, I miss him so much". And then you might notice a Facebook event for a school reunion and mark yourself as going to attend.

Before you know it, people know the name of your school, your occupation, your teacher and your first pet – simply through information you've shared. From this, hackers can put together a lot of information, very easily, just by observing what you innocently post. While it can sound dramatic, this is exactly how criminals do their homework when committing identity fraud. How do you get around it? Start by thinking twice about what you give away online and how it links to your security question and answers. Alternatively, you could use fake answers to the security questions and then keep a record of these somewhere secure – or even put them in another language or add a made-up word that makes sense to you.

I also recommend making your passwords nonsensical, random or so obtuse that they have no correlation to your life online. To achieve this, some people translate their passwords into a different language, type them backwards, use numbers in place of vowels or particular letters and ensure there are random symbols in the password.

USB safety

The USB (universal serial bus), otherwise known as a flash drive, data stick or thumb drive, is a portable device used for saving files.

What would you do if you found a USB lying around on a desk, left behind at an internet café or lying on the ground? If you are like most people then chances are you would probably be curious and plug it into your PC or laptop (particularly if it had a tantalising label like 'confidential' or was marked as being a high-capacity storage item).

Photo: 123rf

While a lone USB may well have been accidently left behind by someone, there is a very real possibility it was deliberately planted by a hacker who is banking on human curiosity to help them infect your device. Sadly, these enticements can also be aimed at children, and USBs decorated with – for example – a unicorn or in the shape of a robot or a popular cartoon character are left lying around to deliberately entice younger people, who may not immediately think about safety before picking up the 'free' USB.

While this does sound sinister, it is an easy way for hackers to access your computer – and through you! There are two ways the USB can achieve this; the first is by placing infected files on the USB, so when you click the file it plants a virus on your computer. (And while yes, you could run a virus scan on the drive before you open it, even that is not something I would recommend – the best thing would be not to plug it in at all.)

The second way is for the hacker to actually program the USB software, making it more efficient and dangerous, as the USB device will automatically upload malware onto any device it is plugged into – even before you open it, so the moment you plug the device in you are at risk. Without wishing to scare people, an infected USB can do lots of damage aside from downloading a virus, including:

- taking over your keyboard and entering predetermined keystrokes, forcing your PC to perform unwanted actions you wouldn't want;
- logging your keystrokes and sending the data to remote servers (that is how they can copy your passwords for banking and the like);
- changing or manipulating your files;
- infiltrating your webcam and recording you; or
- permanently destroying your device with a powerful electrical surge.

So, as you can see, a free USB device is definitely not worth the risk!

What is TikTok?

TikTok is a Chinese-owned mobile app that is very popular with the teenage market globally. It is aimed at a young audience who use it to easily create 15-second videos of themselves singing, dancing or lip-syncing to existing music – basically, it is online karaoke. India and Indonesia have banned the app and there are concerns around its safety and privacy. Given the app is popular with children, it has the potential to be utilised by sexual predators. Community concerns have also been raised because the app allegedly has the ability to convey location, image and biometric data to its Chinese parent company (which, due to Chinese internet laws, is itself legally unable to refuse to share data with the Chinese government). Despite that, TikTok was the seventh most downloaded mobile app of the decade (2010 to 2019). More information is available from online sources such as Wikipedia.

How to quickly close all Safari tabs on your iPhone

1. Open Safari on your iPhone.
2. Hold your finger down on the Tabs icon (the two squares bottom right).
3. When the prompt opens, choose Close All Tabs (the number of open tabs are listed) or choose Close this Tab if you are only closing the one you are viewing.

Otherwise (and I just discovered this), if you are looking at your list of open windows, just hold down your finger on the Done button (bottom right) and you will also close all open tabs.

Ah, technology! ■

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

A LABYRINTH WALK AND MANDALA REFLECTION EXPERIENCE

Participant reports on a wellbeing resource

By Jessica Fleming, Misha Crosbie and Dr Mark Pearson

ABSTRACT

This article presents a novel combination of personal growth processes – labyrinth walking and mandala creation – that are showing therapeutic promise for reducing anxiety and depression and enhancing wellbeing. Labyrinth walking has been likened to a moving meditation, and mandala drawing has been shown to support self-reflection, integration and to reduce anxiety. To begin to substantiate extensive anecdotal observations, 13 participants in a morning's labyrinth walk and mandala-drawing program were asked to complete questionnaires about their experiences of the processes. Two main themes of journeying and appreciating time out for self-reflection emerged. Overall, participants found all stages of the program protocol supportive, with the most appreciation expressed for the mandala creation, the walking and the group sharing. All would consider another labyrinth walk within a month or two. We found therapeutic value in this combination of modalities that met a need for personal growth and contributed to experiences of peace, harmony and connection with others. We hope to contribute to the body of substantiating literature through further research.

Introduction

On 14 September 2019 we held a group labyrinth walk and mandala-drawing workshop for counselling students and professionals in a university setting. This article is an attempt to explain:

- why we would do this;
- what a labyrinth walk is;
- what mandala drawing is (in this context);
- the protocol we used; ;
- some participant outcomes; and
- the program's potential to become a more widely used, evidence-based, wellbeing and self-reflection resource.

We have had extensive experience walking and presenting with the labyrinth, in particular the 11-circuit Chartres floor labyrinth, an exact facsimile of the one that has inspired people since the 13th century in Chartres Cathedral, south of Paris. Labyrinths have been created for over 4000 years and appear in a wide range of cultures, such as Native American, Greek, Celtic and Mayan (Tunajek, 2012). Labyrinths on cathedral floors became known as a symbol of pilgrimage (Morrison, 2003). Interest in the Chartres floor labyrinth has been revived over recent years by the Reverend Canon Lauren Artress (1996), at Grace Cathedral in San Francisco.

In addition to the few outcome studies, we have observed that the process of walking the labyrinth offers people the opportunity for reflection, and a range of responses may arise: memories, kinaesthetic sensations, emotions, insights and inspirations, to name a few. Whatever a person is moving through in their life, the end result of the walk has shown to be consistently beneficial (for examples, see Assam, 1998; Katsilometes, 2010; Zucker et al., 2016). This report is our first attempt to gather participant experiences in a systematic way to shape more extensive outcome research with the labyrinth and mandala processes.

A labyrinth is not a maze; there are no blind alleys. There is one winding path into the centre and the same path to walk out on. Interestingly, the word for meditation in Latin is *meditere*, which means

Photo: Unsplash/Ashley Batz

'to find the centre' (Griswold, 2001, p. 107). Walking the labyrinth can be a metaphor for walking to the centre of one's self. It takes approximately 20 to 30 minutes to walk (on average). Over the years participants have called the process a "walking meditation" or a "centring exercise". The labyrinth's form is circular, with a subtle but detectable reference to the four quadrants. As the path weaves among the four quadrants, the labyrinth seems to have an inherent ordering principle for the brain, in particular the right hemisphere (Tunajek, 2012). In fact, the labyrinth itself could be called a mandala.

The word 'mandala' is based on the Sanskrit word for circle. In its oldest historical usage it refers to a circle containing a design that implies or overtly indicates the four cardinal points and a centre. In the ancient Hindu and Tibetan drawings a god or a goddess was often represented at the centre. Both the process of creating and contemplating a mandala was used in different cultures for meditation and spiritual evolution. A well-known example is the sand mandala, or the Kālacakra ('Wheel of Time') mandala, formed from coloured grains of sand by Tibetan monks (Bühnemann, 2017).

The circle is one of the oldest and strongest symbols used by humans to represent wholeness. For example, it was central in ancient Chinese cosmology (Doeringer, 1982), and has been described as a central symbol in Native American rituals (Garrett, Garrett & Brotherton, 2001). Its use in healing drawings was explicitly described at length by Carl Jung in his research and in his own healing process (Jung, 1957/1980). As a process to aid integration after labyrinth walks, we use an adapted form in which a lightly pencilled circle is drawn on an A3 page of paper. Using oil-based pastels, participants are invited to draw reflexively and intuitively. Whether a person stays inside the circle or covers the whole page, the pencil circle is a constant suggestion toward healing and wholeness. It seems to promote psychic integration.

The two modalities of labyrinth walking and mandala drawing have small, slowly emerging evidence bases. Labyrinth walking is a physical, emotional and sensory experience, and can support small

to medium improvements in blood pressure (Sandor & Froman, 2006), reduce dysfunctional thinking (Lizier et al., 2018), and reduce stress (Zucker et al., 2016). Labyrinth walks have been shown to support creating a calmer state (Assam, 1998), to support learning (Marshall, 2003), and to enhance a spiritual quest (Katsilometes, 2010). Mandala creation has been shown to support mental health and wellbeing (for examples, see Babouchkina & Robbins, 2015; Kima et al., 2018; Pisarik & Larson, 2011).

The project aims included gaining qualitative feedback on participants' experiences, and their perspective of the usefulness of the seven protocols for the program of labyrinth walking followed by mandala drawing, which could be the basis for further study.

The protocols

We have a standard seven-step protocol for a group process, as follows.

1. It begins with personal introductions from all participants.
2. Next, we offer a brief history of the labyrinth.
3. Then suggestions are made about the various intentions and concepts people use to walk it.
4. Suggestions are also offered for approaching the mandala drawing, including the idea that it is about personal expression rather than great artistry.
5. The group labyrinth walk is usually undertaken in silence.
6. The mandala drawing is also undertaken in silence, as is any written recording or significant journalling about the walking experience.
7. Considerable time is allowed for optional personal sharing from each of the participants regarding the whole of their experience with the walk and the drawing. We observe that the interpersonal connection that arises through this final stage completes the internal experience with a subtle, but profound sense of community.

Method

This was a qualitative investigation. Phenomenological (lived experience) data was sought, to gain an understanding of participants' perceptions, feelings and general responses to the processes. Additionally, participants' experience of the value of the seven protocols of the program was sought. An anonymous six-item paper questionnaire was distributed at the close of the program (see Appendix, p. 12), completed privately, and placed in a box for researchers to collect after the program. All participants in the walk and mandala drawing program agreed to be participants in the study. Within a reflexive process (Goldstein, 2017), responses were analysed through thematic analysis (Braun & Clarke, 2006) and through simple frequency counts.

The researchers were both facilitating the program and participating, while maintaining a level of presence to participants. This seemingly dual relationship was intended to support participants' self-focus, self-exploration, self-reflection and self-direction, rather than needing participants to keep attentive to external direction. The shared lived experience of the processes provided insights for the researchers and aimed to create

a non-hierarchical atmosphere of freedom for participants. University of the Sunshine Coast ethics approval was granted.

Participant feedback

There were 13 participants: three male and 10 female. They were recruited through university social media and community networks. There was a wide age range, from 21 to 79 years. In terms of previous labyrinth experience, four had previously participated in a labyrinth walk and nine had not. All participants in the walk were advised that if they wished to have their feedback included in the pilot study, anonymous submission of the questionnaire would be taken as their consent.

MAJOR THEMES

Two main themes emerged from participants' summaries of their experiences in the program. The theme of 'journey' emerged for how participants viewed and experienced the processes, suggesting that the experiences were viewed as occurring within a broader arc of personal growth. For example: "I appreciated meeting like-minded people on a journey of self-discovery".

Taking time out from everyday responsibilities for reflection and connecting with others was also a major theme. For example, responses included, "time out, inner focus, being together" and "got me out of the house and met other souls on different journeys". Some of the words participants used to describe their experiences were peace, reflection, clarity, balance, transformative, inner focus and flow.

RESPONSES TO PROTOCOLS

In feedback on which steps of the protocol were more or less relevant or supportive (see Appendix Question 3), most indicated that all steps were supportive ("All of these – beautifully put together"). Four participants cited the group sharing and sense of community as important to their experience, and another four stated an interest in exploring creative arts therapies and exposure to new modalities as imporatant. One commented directly that the "time drawing afterwards really helped to shape the feelings from the labyrinth", while another found the reflection time valuable, sharing her insight: "I don't need to try to live a spiritual life. I am spirit."

All participants reported that the steps of the protocol were supportive; nothing was reported as unsupportive. The time creating the mandala was indicated as one of the most helpful aspects, with the walk and the group sharing as close seconds. Altogether, participants reported deep engagement in these complementary activities, and felt the activities contributed to their individual quest for meaning.

COMFORT

Eleven participants reported finding no uncomfortable aspects of the program; however, one found settling into the group of strangers initially a little uncomfortable. One participant found that it was a revealing experience and some discomfort was connected with this.

PROGRAM IMPROVEMENTS

Eleven of the 13 participants felt there was no way the program could have been a richer experience, two did not comment, and one suggested experiencing the walk outside might make it richer, to "include the elements as well".

There are, around the globe, a number of outdoor labyrinths, and anecdotal feedback suggests these do support a feeling of connection with nature. Whether the outdoor setting supports internal self-reflection to the same extent remains to be explored.

FURTHER INTEREST

All participants indicated an interest in considering another labyrinth walk in the future, in one to six months' time. Sandor and Froman (2006) found, in a three-month follow-up to their labyrinth study, that six of seven participants had independently walked the labyrinth again two to three times on average.

Conclusion

The two modalities of labyrinth walking and mandala drawing seem to complement and support one another. Both are based on the integrative circle, and both are quiet, reflective activities that provide space from the intensity and distractions of daily life. While the labyrinth walk is a more ephemeral experience, the process of drawing a mandala can anchor and sometimes amplify the insights and self-awareness that arises during the labyrinth walk.

We see potential therapeutic value in this combination of modalities. Global conditions continue to deteriorate and general levels of anxiety continue to increase among people of all ages. The World Health Organization

The process of walking the labyrinth offers people the opportunity for reflection, and a range of responses may arise: memories, kinaesthetic sensations, emotions, insights and inspirations, to name a few.

reports a 50 per cent increase in global levels of depression and anxiety between 1990 and 2013 (WHO, 2018). We feel this combination of creative arts therapeutic modalities, presented within a low-cost program that builds self-reflection and ownership of personal development, may be especially helpful in strengthening mental health resilience.

Further research is needed to gain a more generalisable view of possible outcomes. This research would gather feedback from a larger number of participants, possibly including a clinical population, with follow-up reporting over time. Further peer-reviewed research on outcomes from labyrinth walks and this form of mandala drawing are needed to substantiate this evidence of positive benefits from a single labyrinth event. We hope to contribute to that body of substantiating literature through further research.

Appendix

Feedback on your experience of the labyrinth walk and mandala drawing

1. Could you share a few words that might sum up ways today's experience might have been useful for you?
2. Have you participated in a labyrinth walk previously? If so, was that experience similar or different to today's experience?
3. Could you indicate any specific aspect(s) of the experience that were most or least supportive or relevant for you?
   - the introduction to the morning
   - the reflection time
   - the walk on the labyrinth
   - time creating a mandala
   - group sharing
   - social connections
   - the presenter(s)
   - taking time out from everyday life
4. Would you consider exploring a labyrinth walk again if it was offered? If so, how soon?
5. Was there any aspect of the event that you were uncomfortable with?
6. Are there any ways you feel the event could have been a richer experience for you? ■

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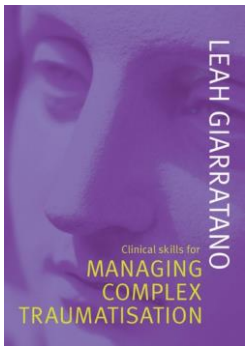

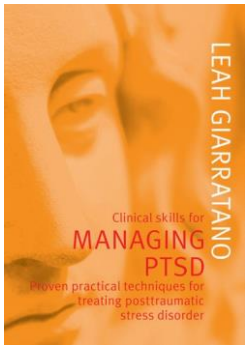

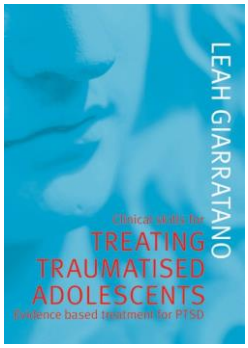

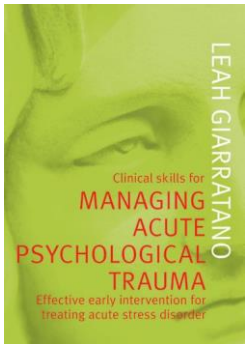

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Creativity amongst children

Can children's creativity be fostered through improvisational exercises?

By Evelyn Antony

Abstract

Improvisational exercises play a role in fostering a child's creative abilities, enabling better socio-emotional development and communication skills in later development. This review paper investigates how creativity has been assessed and defined in previous developmental and educational psychological literature, focusing on the benefits of pretend play and improvisational teaching during music lessons in classrooms. By shedding light on this literature, better insights as to how child therapists use different types of therapeutic interventions, with pretend play and improvisation at the forefront, are addressed. The implications of using improvisational exercises during training programs for trainee counsellors are also addressed.

The role of pretend play: implications for therapy

The importance of cultivating creativity has been recognised by psychologists, teachers, musicologists and educators. Creativity is defined as an acquired behaviour, which is teachable, learnable and crucial for human development (Koutsoupidou & Hargreaves, 2009).

How is creativity assessed in children and what are the implications of developing creative abilities in adulthood? In developmental psychological research, creativity is assessed through tasks involving problem-solving and imitation; for example, watching an adult turn screws with a screwdriver and asking children to suggest alternative uses for it, as opposed to its standard function (Nielsen, 2012).

Moreover, research has investigated how creativity and imagination is cultivated in children, particularly through pretend play scenarios (for example, having a tea party with toys). Whilst pretend play enables children to develop good socialising and communication skills, it also allows them to discover their social environment, enhancing their reasoning and negotiation skills (Nielsen, 2012). These skills provide a good foundation in early development and can be linked to concepts that are needed throughout adulthood, such as in situations where moral decision-making and prosocial behaviour may be assessed.

The impact of pretend play on children has been explored in experimental conditions with adults as 'role models' or through a child's discovery of the environment in which they play. Yet, questions remain regarding the educational contexts that influence a child's creativity and, more so, how different teaching styles can influence a child's ability to express themselves. The importance of understanding educational contexts and the link to creativity amongst children stems from research on cognitive immaturity – that is, whether children are perceived as inefficient for being overly dependent on their parents (Bjorklund & Green, 1992).

However, cognitive immaturity is said to be adaptive, as children have more time to develop their social skills, which is nurtured further through pretend play and having imaginary friends. The benefits of cognitive immaturity can also be extended to other domains such as language acquisition and egocentricity, where children are in the process of developing key skills, such as the knowledge of self-concept, attention and memory (Bjorklund & Green, 1992).

Moreover, the role of pretend play in social development has also been investigated in literature focusing on therapeutic interventions from the perspectives of psychotherapists and counsellors. According to Russ and Fehr (2013), pretend play can form foundations for different types of therapeutic approaches. An example of this is parent–child therapy, whereby pretend play is used to improve relationships between parents and children. Adopting a parent–child therapeutic approach can be beneficial in situations where a child has experienced trauma or neglect. Using pretend play in these contexts (continued page 16)

allows a child to explore and identify the emotions that once affected them, with parents re-enacting scenes and being actively involved.

Improvisation in music lessons: educational contexts

Teachers play a role in fostering creativity amongst children, particularly during music lessons. Hirsh-Pasek, Hyson and Rescorla (1990) explored whether academically pressuring children during the initial stages of primary education would hinder creativity, by assessing the uniqueness and number of children's responses in a set of tasks. The researchers found a negative association between the expression of creativity and high academic pressures, as maternal expectations and the school environment in which a child was learning led to inhibitions in creativity. From the findings, it is apparent that a child's creativity is influenced by a nurturing environment (in both the home and school), how adults treat children and, more importantly, the opportunities that children are presented with to explore their environment freely with minimal constraints. The study raises an important issue of how teaching styles can hinder a child's ability to express themselves. Therefore, it should be questioned: should teachers conduct class lessons where children have the freedom to learn through trial or error or do teachers want to prioritise the acquisition of skills and knowledge through traditional lessons?

Creative activities in the classroom, including opportunities to deliver music lessons, depend upon the education system, the learning outcomes that need to be achieved and different teaching styles (for example, strict versus liberal). Understanding how this impacts children's psychological and socio-emotional development can provide developmental researchers with better insights for testing creativity. A study by Koutsoupidou (2008) explored the opinions of teachers, lecturers and music specialists on the education system in England. It focused on how various teaching objectives in music lessons (such as creativity, rhythmic development, confidence, precision and originality), and the associated outcomes, were representative of how musical skills are typically assessed – technically, expressively and socially – in classrooms. In the study, creativity was defined as the ability to make music without the aid of music notation, compared to originality, which was the ability to express music in a unique fashion. This is an important difference and is supported in developmental psychological research as seen earlier.

In the example provided in the Nielsen (2012) study, where children suggest alternative uses of a screwdriver, both creativity and originality are being assessed. In the Koutsoupidou (2008) study, interviews were conducted to investigate whether improvisation is a good teaching tool. All participants suggested that improvisation provides psychological and social benefits, since children have the freedom to express themselves while building confidence and becoming actively involved in their learning. A further study by Koutsoupidou and Hargreaves (2009) supported these findings, as they found that improvisation had significant effects on children's development of creative thinking in music.

Is a child's creativity better assessed through their existing skills (such as a test at school) or through their interactions in pretend play and imaginary scenarios, and where improvisation is advocated? More importantly, how is creativity being measured – through achievements or potential?

Measuring creativity is also important to assist counsellors in identifying the most appropriate therapeutic intervention for a child. How can counsellors and therapists incorporate improvisation to gain a better understanding of their interactions with clients, as well as enhance their observational skills? Lawrence and Coaston (2017) address this question by suggesting that improvisational exercises should be part of training programs for counsellor or therapist trainees. More specifically, exercises that assess ambiguity, emotional awareness and appropriate risk-taking empower therapists and counsellors with the confidence to use what they have learned during therapeutic interventions.

Measuring creativity in the classroom: insights for child therapists

A further study focusing on how creativity is measured in the classroom found that there are limitations for existing measures due to the lack of agreement around creativity as a construct in the literature (Barbot, Besançon & Lubart, 2011). The introduction

of a multifaceted tool, such as EPoC (Evaluation of Potential for Creativity), allows researchers to assess divergent-exploratory thinking and convergent-integrative thinking through verbal and graphic tests. It can therefore be considered as a good measure in evaluating creativity across various existing skills, as well as abilities that can be enhanced with practise (Barbot, Besançon & Lubart, 2011). Furthermore, EPoC can be used in educational institutions to understand where a child is best placed across various subjects (in different groups with varying degrees of difficulty). However, by incorporating tasks that involve spontaneity and freedom of expression on a continuous basis and as part of curricula, educational institutions can help children develop lifelong skills and be better equipped in handling situations that are worrying or that have a negative impact. Moreover, child therapists can benefit from using EPoC prior to play therapy, as it is a multifaceted tool that measures different modes of thinking and is therefore important in understanding how creativity emerges.

Understanding how creativity is assessed is beneficial in research that focuses on motivation and mindsets. Specifically, Dweck (2017) suggests that intrinsic motivation (task oriented) and extrinsic motivation (reward oriented) are key driving forces in understanding children's abilities to complete tasks. This can be linked to how creativity is assessed, as intrinsic motivation may be a better predictor than extrinsic motivation in understanding an individual's engagement in creative activities. As suggested by Haimovitz and Dweck (2017), intrinsic and extrinsic motivation often depends upon whether a child has a fixed mindset – that is, they believe that they possess a certain amount of ability and that it cannot be changed, or a growth mindset (believing that guidance and hard work will develop their abilities).

Additionally, factors such as praise from parents, how teachers conduct their lessons (with regards to improvisation, whether they follow a set lesson plan or allow room for change and unfamiliar activities) will determine whether children learn from their failures.

How can motivation and mindsets be linked to improvisational teaching? Since children are given the opportunity to learn through trial and error,

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their fears associated with being punished or with taking too long to answer questions are reduced. Nevertheless, this type of teaching and learning process must be carefully regarded; does the child have prior knowledge of the subject to deal well with unexpected situations and to 'think on their feet'? As seen in earlier literature, pretend play can aid children in reducing 'the fear of the unknown', allowing them to develop better problem-solving techniques. This process can be better advocated by child therapists, particularly during trauma-focused cognitive behavioural therapy, where children may be given the opportunity to utilise concepts in pretend play; for example, imagining scenes to reduce anxiety symptoms through relaxation or to re-enact traumatic experiences (Russ & Fehr, 2013).

Conclusion

In recent years, there have been changes in how lessons are being delivered to children. For example, the development of e-learning has promoted better student engagement with discussion forums and educational videos, which typically assess skills like problem-solving, critical thinking and creativity. E-learning and improvisational teaching can be combined to better children's learning experiences, particularly in a practical sense (such as music lessons and role play). Furthermore, the skills that are acquired during improvisational exercises can improve a child's self-esteem and public speaking, which are much needed in further education and in the workplace.

Improvisational teaching is an inclusive process that enables teachers and children to acquire life experiences, as well as classroom experiences, that are important for development and education. For child therapists to understand how improvisation plays a role in therapeutic interventions, training courses should be offered whereby improvisational exercises like 'group think' (which focuses on the here and now) and 'that's that' (devised to measure spontaneity) can improve self-reflection and active listening skills. The skills acquired in such courses and training opportunities can enable child therapists to develop a greater understanding of improvisation as a therapeutic technique and to utilise proven exercises when delivering treatment.

Future research should investigate whether such improvisation can be advocated better at home, amongst families, to improve social bonding and relationships. Fostering children's creativity at a young age can lead to them becoming innovative and critical thinkers, which is not only in the best of interest of those individuals and their families, but also of various industries, businesses and the economy. By understanding how creativity manifests during childhood and the importance of developing such abilities, child therapists and newly qualified counsellors are better equipped in implementing therapeutic interventions. When these interventions involve some aspect of improvisation, either through exercises as part of counsellor training or through a specific type of therapy involving pretend play, there are increased chances of having better creative interactions and spontaneity. ■

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Professional supervision in mental health practice

The need and scope for professional supervision, with a focus on India

By Dr Vasuki Mathivanan and Philip Armstrong

ABSTRACT

There is a critical need for more mental health professionals in a country like India, which has a considerable lifetime prevalence (13.7 per cent) of mental morbidity. This paucity is further exacerbated with the existing services lacking the requisite professional standards due to the absence of mandatory guidelines that regulate the same. Professional supervision is considered the best means of quality control, which again lacks a definite structure in India and is not widely practiced. The purpose of this study was to examine the perceptions of professional supervisors regarding the relevance of professional supervision in mental health practice, particularly counselling, in the Indian context. An explorative qualitative methodological approach was applied. A focus group discussion was conducted amidst nine female supervisors, chosen through purposive sampling, mainly because they had obtained certification as professional supervisors under the RISEUP (Relationship-based Integrated Supervision and Education to Unlock Potential) program by the Indian Academy of Professional Supervisors (IAPS). The focus group was conducted by a moderator, using a predetermined topic guide. Thematic analysis of the responses yielded seven broad themes:

- professional certification – strengths and gains;
- skill repertoire – similarities and differences;
- the professional supervisor – roles and responsibilities;
- supervisee to supervisor – the challenge of transition;
- supervisor–supervisee – the power and balance;
- self-care – practice to preach;
- professional supervision in mental health practice – need and relevance in India.

Findings reported in this investigation are consistent with the rationale behind professional supervision and imply the need for intensifying research efforts to empirically validate its indisputable role in enhancing the standards and credibility of mental health practice, especially in the Indian context.

BACKGROUND

Mental health is the basis of individual wellbeing and optimum productivity, but such disorders

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form the top rung of the infirmity ladder that contribute to India's disease burden. The National Mental Health Survey 2015-16 indicates the lifetime prevalence of mental morbidity to be 13.7 per cent, with current mental morbidity being 10.6 per cent (Murthy, 2017). This proportion amounts to nearly 150 million Indians being considered to be included in some type of diagnostic category. No further justification is required to declare the compelling need for an adequate number of qualified mental health professionals who can address these issues. The available data, however, reveals disheartening results.

The Union Ministry of Health and Family Welfare reports an availability of 3500 psychiatrists, which is about one psychiatrist for over 200,000 people. According to the National Crime Records Bureau (2015), the mental health workforce available in the country – including clinical psychiatrists, psychologists, psychiatric social workers and psychiatric nurses – amounts to a mere 7000, while the present requirement is around 55,000 (Sharma, 2018). Adding to this situation, studies suggest that even the existing counselling services lack definition – that is, anyone can offer the same service with little or even no training (Arulmani, 2007). It is reported that a majority of counselling psychologists began practicing without practical training and limited public awareness (Bedi et al., 2020). As a result, it becomes apparent that the current mental health practice in the country calls for professional supervision, since such practice is recognised as an active contributor to enhancing professionalism and the individual competence of mental health practitioners (Woo et al., 2016). Supervised practice serves as a quality control mechanism and is the best means through which counselling effectiveness can be monitored and evaluated.

The Psychology Board of Australia (2018) defines supervision as "an interactive process between a supervisee and a supervisor. It provides the supervisee with a professionally stimulating and supportive opportunity for growth. Supervision involves a special type of professional relationship in which supportive direction, facilitative activities, and instructive critique are given by the supervisors to help the supervisee achieve their professional goals" (Bhola et al., 2017).

A more formal definition of supervision is that it is a contractual, professional relationship between two or more individuals engaged with counselling activities, which leads to reflection on the counselling situation and its structure, while providing emotional support and advice, containment and the setting of clear boundaries for the counsellor and their counselling work (Bradley & Ladany, 2001).

Supervision shields clients from the risk of oversight and triggers the faculties of critical thinking, objective insight and self-reflection in the counsellor. It serves the multiple functions of:

- weaving the professionals into a network;
- bestowing a sense of professional identity;
- replenishing their power of surviving an eventful practice;
- equipping them with emerging trends and requisite skills in the field;
- providing constructive feedback; and
- supporting them to overcome compassion fatigue and subsequent ineptitude (Australian Institute of Professional Counsellors, 2010; Myall, 2017; Transitional support, 2007).

Most of the research into counselling supervision has occurred in the US (Bradley & Ladany, 2001). Professional supervision in counselling is not a common occurence in India

and, where it exists, it is devoid of any definite structure or form. It is generally presumed that those who could counsel can also supervise others. The multiple roles that supervision entails – namely mentor, teacher, consultant and advisor – necessitate skills of a higher order.

A review of literature about professional supervision reveals a dearth of research in the country, which might be because it is not mandatory for Indian counsellors to undergo any formal training or obtain a licence prior to practicing. Given the fact that even a psychology graduate in India with no adequate practicum or experience can be a competitor to a trained mental health practitioner, it becomes imperative to subject the counselling process to empirical enquiry, build models that can guide the practice and, more importantly, prescribe mandatory prerequisites prior to plunging into practice. Moreover, the growing censure against professionalism and alleged depravity is surfacing as a serious challenge to mental health professionals. Clinical supervision is widely recognised in several parts of the world and there has been an emergence of quite a few models of supervision, but empirical evidence to substantiate its practice is limited (Kuhne et al., 2019).

In light of the above discussion, it is obvious that mental health practice in India should be regulated through quantifiable specifications to maintain adequate standards of professionalism and protect client safety outcomes, which can be achieved by encouraging professional supervision. If supervision is to be recognised as indispensable to effective mental health practice in India, it is essential to research its value to the **(continued page 24)**

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supervisor–supervisee dyad, and the conduct and development of the supervision process.

The present study responds to this call for a stronger support base to underline the relevance of supervision practice in the Indian context.

OBJECTIVE

The objective of the study was to examine the perceptions of professional supervisors and supplement non-empirical evidence for establishing the relevance of professional supervision in mental health practice, particularly counselling, in the Indian context.

METHOD

Since the purpose of the study was to substantiate the bearing of professional supervision on effective mental health practice, an explorative, qualitative, methodological approach was considered fitting to explore the experiences and observations of supervisors.

Design and setting

It was deemed apt to obtain data through focus groups rather than individual interviews as a structured interaction would restrict the free flow of diverse opinions and viewpoints. A focus group discussion (FGD) was conducted amidst members of the Indian Academy of Professional Supervisors (IAPS).

IAPS is a professional body of proficient supervisors, established with the mission of elevating the institution to the status of a licensing authority in the country. Though mental health has received increased attention concerning the stigma surrounding it, which has gradually diminished in India over the last decade, there remain no prescribed standards to regulate the profession. As mentioned earlier, there is a critical need for professional supervision to guide the processes and procedures involved in mental health practice. The IAPS was given the task of formulating norms and codes of supervision practice. It is mandatory for counselling professionals to undergo their specialised training before applying for membership. Only those with a minimum of seven years of counselling practice can enrol for the training. The certification program adopted by IAPS has been recommended by the Australian Counselling Association (ACA) based on the RISEUP (Relationship-based Integrated Supervision and Education to Unlock Potential) model proposed by Dr Amstrong (2018) and has been adopted by several counselling associations of the Asia Pacific Rim countries. The three-day instruction includes approximately 24 hours of face-to-face supervision training and 40 hours of pre-workshop study, followed by a formal evaluation.

Sampling and selection

Purposive sampling, a commonly used process in qualitative research, was employed to choose the study sample. It is applied when the researcher decides what needs to be **(continued page 25)**

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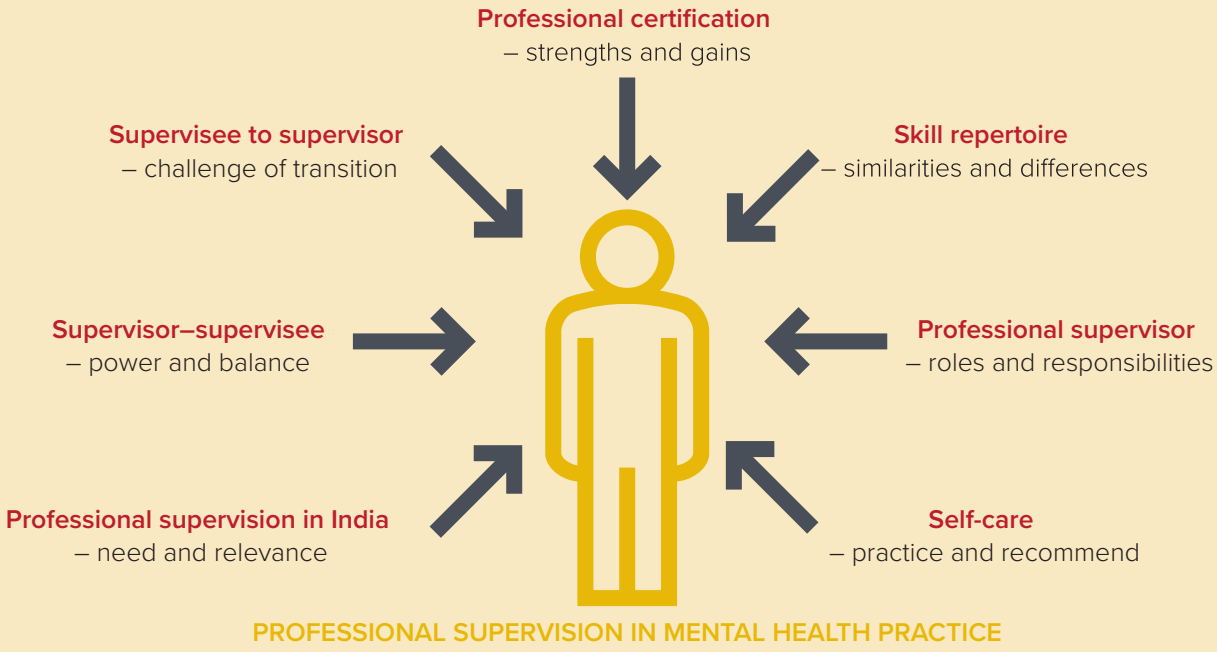
*Phoenix Australia (2013). Australian guidelines for the treatment of acute stress disorder and posttraumatic stress disorder. Phoenix Australia.

FIGURE 1 Themes derived from FGD on professional supervision.



known and sets out to find people who can and are willing to provide the information by virtue of their knowledge or experience (Bernard, 2006). A total of nine female supervisors with considerable years of experience and pertinent expertise were selected, mainly because they had obtained certification as professional supervisors under the RISEUP program and expressed immediate willingness to participate and contribute.

The members were followed up through tele-conversations and were requested to confirm their readiness to share their expertise through participation in the FGD. It did not require much persuasion to mobilise them for the study, as they were part of a well-informed group who could comprehend the need for building a strong evidence base to establish a firm grounding for professional supervision.

Conduct of FGD

The willingness of the members towards FGD participation was confirmed in writing through a consent form provided to them prior to the discussion, which was stored separately from the FGD information. A moderator conducted the focus group using a predetermined topic guide, which was developed in consideration of the study objective. It was prepared carefully by the researchers in order not to miss any relevant questions that would contribute value to the study findings.

The participants had the intention of the study and the value of their contribution fully explained to them. The moderator assured anonymity of responses and maintenance of confidentiality, and clarified that their responses would be used only for research purposes. The discussion lasted for two hours, as participants' inclination to respond did not recede. The session audio was recorded with the approval of the members. This was simultaneously supported by manual documentation, whenever the pace of the discussion allowed it.

Data analysis

Responses obtained from the FGD were analysed using thematic analysis. Thematic analysis is an excellent approach to research when you are trying to find out something about people's views, opinions, knowledge, experiences or values from a set of qualitative data (Maguire & Delahunt, 2017).

The recorded discussion was listened to several times to clarify ambiguities and was transcribed verbatim. The final version included participant pauses, as well as paraphrasing and endorsing viewpoints of other members and fillers. The transcription had no cues that revealed participant identity, referring to them as PS 1 to PS 9. The second stage of analysis involved meticulous scrutiny of the transcribed version to determine broad categories, followed by identification of core themes and subthemes. Considering the confines of this paper and the adequacy of data, the final step yielded seven broad themes (Figure 1). These were:

- professional certification – strengths and gains;
- skill repertoire – similarities and differences;

Participants felt that, despite their professional experience and successful practice, it was more gratifying to conduct the counselling process with a definite structure.

- professional supervisor – roles and responsibilities;
- supervisee to supervisor – the challenge of transition;
- supervisor–supervisee – the power and balance;
- self-care – practice and recommend; and
- professional supervision in mental health practice – need and relevance in India.

Participant details gathered from their self-introductions revealed that they all were well-qualified counselling practitioners, duly certified by the RISEUP program to conduct professional supervision. They had a rich history of practice ranging from 10 to 25 years. In addition, many of them had other professional affiliations to their credit. The group was a combination of members from heterogeneous work settings, namely medicine and psychiatry, social work, corporate training, academic teaching with criminal psychology, law, parenting-focused NGO and institutional, psychological setup, soft skill training with the merchant navy, learning disability and clinical psychology. Four of the group members had been exposed to supervision in both formal and informal ways prior to certification, with the rest of them being new to supervision but not mental health practice. The theoretical bearing on their practice was varied with the application of various therapies and methods, namely cognitive behavioural therapy, solution-focused therapy, neuro-linguistic programming, and transactional analysis.

Professional certification – strengths and gains

All the participants were excited to respond to the question about the gains they derived from the certification program in professional supervision. Most were interested in describing how the supervision model RISEUP gave them a structure that they could apply in their counselling sessions. One of the participants stated, "[It] actually gave me a lot of structure in the way I'm learning my counselling practice … because I had a structure to begin with, I had a model to follow right from the beginning to supervise supervisees." (PS 1)

Participants felt that, despite their professional experience and successful practice, it was more gratifying to conduct the counselling process with a definite structure. Being equipped with the same boosted their levels of confidence in handling their clients, as mentioned by a participant: "Three days of training gave me a lot of confidence, so that is the reason where I started getting interns where I felt like, yeah, I have a structure with me so that I can take it forward. I will say that was a great learning over the period of the training." (PS 9)

When a few participants expressed that there was more clarity about the sequence of steps to be followed during the course of helping the supervisee, the others agreed. One of the participants opined that the model served as a checklist, enabling them to verify aspects that they adhered to or had missed out.

One member recalled some of the salient actions emphasised in the training model, such as maintaining confidentiality, contracting with the supervisee, and adherence to legal and ethical considerations. Yet another member expressed that the issue of ambiguity in setting up a specific duration for the counselling sessions was solved, as the model provided guidelines. One discussant noted that the model could be used as teaching material and two others endorsed it by mentioning that it helped to teach 'freshers', who aspired to develop their professional skills.

The main point that evoked a unified response from all the respondents was that the certification created a platform for like-minded professionals to come together for mutual learning on a higher level, to build their capacities to train the younger generation and, more importantly, to fight as a body to strengthen professional ethics. The fact that they would always be able to rely on their peers for any professional clarification in times of process ambiguity made them feel empowered. One member added, "… Just knowing that there are other supervisors with me is … very satisfying, and it's very consoling." (PS 3)

One member opined that the aspect of business management was one of the highlights of the training model, which regulated the generation of income from the profession.

"I think, in the end, we also need to be gratified with money in some way, so this model has given that

particular aspect. I think it is that one cut in that diamond which is really important, a very brilliant touch that is there ...” (PS 3)

Overall, the responses did not recognise any identifiable lacuna that could undermine the efficacy of the model. Integrating business management into the model appears to be a unique feature, not encountered in the literature review conducted by the researcher.

Skill repertoire – similarities and differences

There was a slight difference in outlook amongst the members when they were questioned whether the skills required by a supervisor and supervisee are the same. One member began by saying, “Not exactly different, but higher-order thinking as a supervisor, while seeing [the] client through supervisee’s eyes [and] help the supervisee also gain knowledge.” (PS 2)

But later on, as they approached the question with a deeper sense of inquiry, there was consensus about the difference in the level of competence required for the roles of counsellor and supervisor. Interestingly, it was triggered by one of the FGD participants, who focused on one of the key features that differentiated the process of counselling and supervision, which contributed in a valuable way to the subsequent discussion on this theme. This feature was the directive approach that is adopted in supervision but not in counselling.

One participant said, “... Counselling and supervision – it’s very, very different ... There are points which PS 1 and PS 6 have brought up very beautifully, and also PS 2, but ... I would add that supervisory skills are so very directive and you have to be clearly directive.” (PS 3)

The same member added, “If you wear the counsellor hat, the supervisor hat is a completely different one because there is an administrative aspect, there is an economic aspect, there is a self-care aspect, there is a clinical aspect and there are so many levels of which you are looking at a person – the supervisee. So I think it’s a very different hat that you wear.” (PS 3)

The viewpoints of other members were also congruent with the aforementioned statements, substantiated by the quote of a member: “Counsellors are here to not give advice; we are trained to not tell somebody what to do, but as supervisor, we have to tell because [you are] responsible for the counsellor [and supervising] their practices, so if they are doing something which is not ethical or legal, or whatever other areas they may be stepping into, you have to tell them.” (PS 6)

The skillset for effective supervision, prescribed by the members, included:

- deep learning of various counselling techniques;
- a broader vision and holistic approach to read behind the lines and sense beyond what is being told;
- analytical thinking of a higher order;
- empathetic connection and caring confrontation towards the supervisee – to criticise shortcomings, but in a non-judgemental manner;
- clarity of communication while guiding the supervisee;
- emotional stability and objectivity;
- openness to new learning;
- ability to identify gaps that the supervisee may have;
- networking skills;
- knowledge about legal and ethical requirements; and, more importantly,
- clinical wisdom – the ability to extract learning points from personal and general life experiences and draw insights from it for judicious use in the appropriate context.

Finally, a general consensus with respect to this theme was that, while the requisite knowledge, skills and attitudes for both counselling and supervision are similar, the latter is more demanding in terms of the dual responsibility inherent in the role: that of directly handling the supervisee and indirectly handling the supervisee’s client. Therefore, supervision challenges the professionals to upgrade themselves with the skillset described above, in addition to the essential prerequisites of counselling.

Professional supervisor – roles and responsibilities

Almost all participants identified roles and responsibilities with skills and competencies. One member added that a professional supervisor should play multiple roles, that of a friend, philosopher and guide. But the majority opinion rested with the chief role of a mentor, as verbalised by one participant: “... because you need to have the wisdom too, you know ... zero in on what are the issues and, of course, mentoring and guiding.” (PS 4)

One member had a different point to add: “I would add the role

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of a cheerleader or someone who can absorb the mistakes or the failures that the supervisee may have had, and absorb that and take them forward – so, someone who lifts their spirits and confidence in themselves." (PS 1)

Further, one FGD member said that supervision involves the additional responsibility of committing oneself to minimise the supervisees' dependence on the supervisor through enhancing their capacities. In other words, accountability for the supervisee's holistic development lies with the supervisor.

Supervisee to supervisor – the challenge of transition

Three of the discussants observed that the transition from one role to the other was quite natural and spontaneous, but the other six felt it was very challenging. For example, PS 3 said, "The transition for me was difficult. I'm seeing the client through my supervisee."

They added, "Initially, there was a bit of changing hats, looking through somebody else, so it's more like a third eye, which I felt was initially difficult ..." (PS 3)

"For me, the process was being put in the role of a supervisor and feeling extremely unprepared for it – [it] was a very big struggle." (PS 3)

Agreeing that each role entails its own set of functions while offering a new thought for analysis, one member said, "Here I can detach from the situation and look at the supervisee or someone who is struggling with a client ..." (PS 1)

The same member further explained that they were less emotional while guiding the supervisee to handle a client's predicament when compared to instances when they had to deal with the client as a counsellor directly.

"I'm less emotional when I'm a supervisor, probably, than comparatively. I'm not saying as a counsellor I'm supposed to be [unemotional], but we don't have these emotions that we personally go through, which as a supervisor we – I – did not go through." (PS 1)

Altogether, each respondent had a different perspective on the dynamics of transformation that stemmed from diverse individual experiences. The discussion culminated in total agreement regarding the differences in donning the two roles – the supervisor and the supervisee.

Supervisor–supervisee relationship – power and balance

This theme evoked mixed responses among the focus group members, with most of them having a different point to present. It also triggered a brief discussion of the challenges faced by the supervisor in this relationship.

One member felt that the relationship should be on equal terms. "Your supervisee may be having equally or even more experiences in terms of seeing eye to eye, as a colleague [it] is an important thing in this." (PS 3)

Yet another member stated, "Here [the] relationship has to be

> "Anything to do with mental health is emotionally draining, so one of the primary things that is needed is self-care."

professional and kept as detached as possible." (PS 1)

Adding to this, one participant expressed, "Because it is directive, there has to be a power balance there and somewhere where we need to be more assertive and authoritative, especially when it comes to supervision." (PS 2)

In stark contrast to opinions supporting empathetic connection, one respondent declared, "I never connect with that person. I empathise, I look into their problems, I facilitate. Other than that, I don't sympathise and connect with that person personally." (PS 8)

The following response implied a judicious mix of professionalism and informal guidance: "A supervisor should be very clear that he or she is a facilitator in improving the counselling process rather than, you know, having the power relationship." (PS 4)

"There is friendliness, there is self-facilitation, there is a distance also – and if things don't work out, there is someone else you can go to." (PS 4)

To conclude this theme, the result is the need for contracting and fixing the professional boundaries in the supervisor–supervisee relationship. At the same time, the supervisor should be adaptive enough to suit the supervisee's individual needs.

Self-care – practice and recommend

All of the participants in the focus group either expressed in their own words or endorsed others' views about the aspect of self-care, which had two dimensions to it – personal and professional. The former refers to taking care of one's physical and mental health as the helping process gradually gathers a lot of emotional clutter for the practitioner over a period of time, and not adhering to a work–life balance would take a toll on their overall wellbeing. Professional self-care refers to self-development in terms of building on a practitioner's expertise.

One member stated, "Anything to do with mental health is emotionally draining, so one of the primary things that is needed is self-care." (PS 4)

A few members noted how professional supervision helped intra-individual analysis leading to identification of areas for improvement. "As a counsellor, it was something to understand more about myself, how to take myself further as well as to work with my supervisee." (PS 5)

Approaching the aspect of self-care from the outlook of intellectual nourishment appears to be quite a reflective thought.

Professional supervision in mental health practice – need and relevance in India

There was unanimous agreement with regard to the need for professional supervision in mental health practice in the Indian context for various reasons. The significant gaps cited by the group members to justify the need were:

- lack of a standardised process for counselling, leading to increased subjectivity with no effective means of ensuring precision;
- the growing number of ill-equipped and unethical practitioners;
- quacks with no personal qualities required for the profession; and
- the absence of a regulatory body to specify inclusion criteria and provide certification.

All the members concurred that these flaws would affect client safety outcomes and make mental health practice less professional. The following comments by the FGD members substantiate the above statements.

"In the Indian context, very often people who are likely to be very effective counsellors hesitate a lot … although they have the training and experience, simply because they feel [they] may not be doing [it] right. So having a supervisor, they would be so happy because then they know that they can go ahead and try, someone is there to check and balance, give them the confidence that they are on the right track." (PS 6)

"We don't have a regulatory body that keeps a check over it, where, as a professional advocate, I have a bar council number and, if there is someting [unethical] in my profession, there is a constant check. As a special educator, I am a member of the Rehabilitation Council of India [and] there is a check. There are rules and regulations, but as a counsellor, we don't have that." (PS 8)

"Here I find they are not [well] prepared at a young age at a PG level, so that is why it is essential that we need to have a supervisor to help them out." (PS 4)

"Anybody who is in the field of either psychology, sociology or human development, when they are doing their post-graduation, they should be assigned a supervisor, where they do at least six months of counselling … I think that should be **(continued page 32)**

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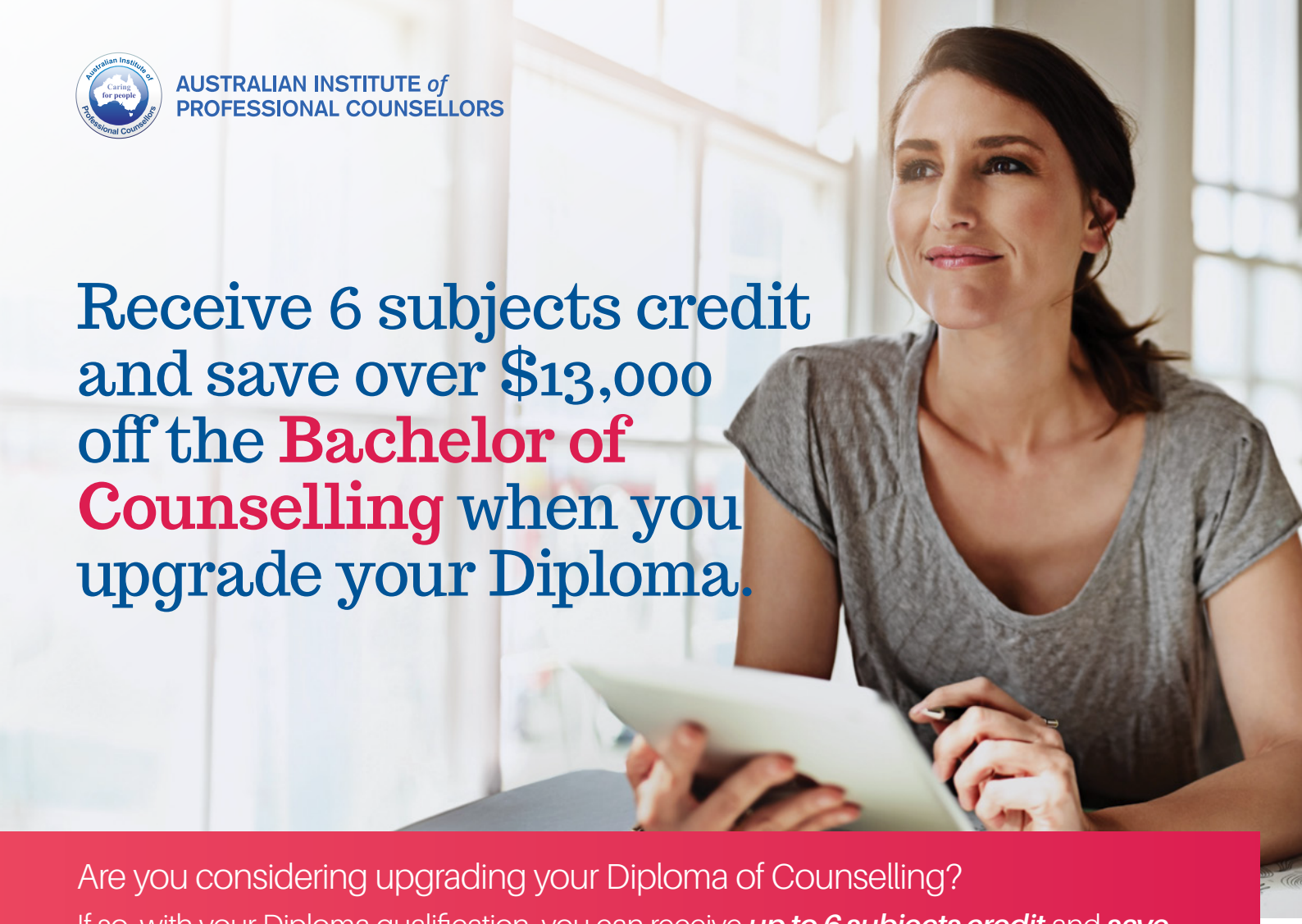

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made mandatory." (PS 4) A recurring point recognised by the participants was that it was increasingly becoming a practice to consider counselling as a professional option, even by people who did not possess any requisite qualification. They had a misconception that it did not require any specialised skill, was not governed by any strict rules and that it can be taken up by anyone. "[We need to] popularise and publicise that it is not a field you can easily get in to." (PS 1)

There was widespread concern amongst them that untrained practitioners increased the odds of misguiding clients, the repercussions of which might prove costly for the latter. Therefore, professional supervision was viewed as a monitoring process that could monitor the supervisee's means and methods of resolving the client's predicament. They observed, "[The] chances of ineffective handling of clients are less because there is someone to supervise (like a checkmate), clients will be more confident ..." (PS 1)

On the whole, there was no dissent about the inevitable role of professional supervision in the country.

DISCUSSION

The purpose of this study was to gather qualitative evidence towards the establishment of professional supervision in the Indian context. The results presented in the preceding segment substantiate the role of professional supervision in refining several features of mental health practice, which would increase the credibility of the counselling profession.

The study sample was drawn from a heterogeneous mix of practitioners from diverse backgrounds, each with their own methods of practice. But with regard to supervision, there was no dissent about the need for a uniform procedure concerning supervision, with a series of predetermined steps. It can be easily understood that prescribing a definite structure to any helping process is integral to better planning of sessions, and to the comprehension of competencies required in every step, the subsequent self-development by the supervisor, and the reduction of role ambiguities in both partners – all of which will contribute to improved outcomes. A clearly formulated structure is proposed as a vehicle for reducing supervisee anxiety (Suzanne, 1993). The emphasis almost all participants placed on having a definite structure to conduct the process of supervision indicates the significance of standardising any professional endeavour. Regardless of experience, the participants developed more confidence after supervision training, as the model equipped them with the required checklist for both self and process verification. Their enhanced sense of self-reliance does not stem from this clarity alone, but also from the reassurance derived from their professional affiliation to IAPS, which makes mutual learning and support readily available. Peer group supervision decreases professional isolation and augments professional support and networking, thus reducing the stress of clinical work (Center for Substance Abuse Treatment, 2009).

The Association of State and Provincial Psychology Boards (2019) has prescribed a set of relevant skills for professional supervisors, some of which include:

- the ability to provide supervision in multiple modalities (group and individual);
- the ability for self-assessment;
- needs analysis of supervisees;
- the promotion of learning and growth; and
- active engagement in reflective practice.

Apart from endorsing all these required skills, the study's findings uphold the significance of clinical wisdom, articulated by the respondents in simple terms as the ability to apply insights gained from personal life experiences in the appropriate context. This feature has been reported in a recent phenomenological study where wisdom gains sanction as an indispensable component of effective psychotherapy. It concludes that wisdom is cultivated when an individual reflects on life experiences and derives insights from them, uses cognitive abilities to put things together and has emotional self-awareness (Osterlund, 2014).

One of the significant differences between the roles of a supervisor and supervisee is the supervisor's additional responsibility of ensuring the integrated development of the supervisee, which demands the expertise of a higher order. Findings in this study lend support to not only the dual responsibility inherent in the position of a supervisor, but also the multiple roles that need to be maintained. The role and skillset of a clinical supervisor widely vary from those of a counsellor, requiring the execution of many other roles, namely teacher, coach, consultant, mentor, evaluator and administrator (Center for Substance Abuse Treatment, 2009).

Trained professionals exhibit more confidence, competence, commitment for reflective practice and undivided focus on clients. In the article 'Making the transition from practitioner to supervisor: reflections on the contribution made by a post-qualifying supervisory course' (Patterson, 2017), it was recognised that there is the need for supervision training to ease the process of transition from supervisee to supervisor. There was also partial agreement that the transition was personally challenging. The basis of these conflicting opinions may lie in the misconception that years of counselling practice and past supervisory experience would suffice to place oneself into the role of a supervisor.

Given the pivotal role of the supervisor–supervisee relationship in creating successful outcomes for the latter, results from this research indicate mixed individual perceptions regarding the power definition in this alliance. Previous studies recommend that the relationship should have a flexible but formal structure with predefined boundaries (NSW Council of Social Service, 2015). A similar study conducted among counsellors engaged in substance abuse treatment also asserts that the standard of clinical supervision is grounded in a positive relationship between the supervisor–supervisee dyad that promotes client welfare and the professional development of the supervisee (Center for Substance Abuse Treatment, 2009).

Professional supervision has been found to be challenged with confrontational criticism, direct attribution of blame, unclear agendas, and instructive rather than interactive learning processes (Grant et al., 2012; Ladany, 2004; Ratliff et al., 2000). In this study, the trained professionals agreed upon a strict process when negotiating such issues that may be encountered in the supervisory process.

The results of this investigation admit that self-care is indispensable to the avoidance of vulnerability to compassion fatigue, burnout, countertransference, empathy fatigue, and vicarious/secondary trauma (Hiott, 2014). It is quite apparent that only those with better self-management can cope with everyday stressors in their practice (Self Care in Therapy, 2019). The study findings demonstrate the significance of self-care, not only in terms of physical and emotional wellbeing but also intellectual nourishment, where supervision provides avenues for introspection and consequent self-improvement.

Resonating with previous studies, the current research alerts mental health practitioners about the paucity of empirical inquiry in professional supervision, especially its effectiveness in generating the required outcomes (Kuhne et al., 2019; Schofield & Grant, 2013; Watkins, 2014). Research has pointed out that studies on supervision are almost absent in India (Bhola et al., 2017).

The present findings point out the need to establish professional supervision as a mandatory process to regulate mental health practice in India and maintain professional standards. This is consistent with the observation made in a recent study that trained mental health practitioners are scarce in India and that this poses a significant obstacle in providing structured therapy (Bhola et al., 2017). The results have also made it evident that supervision is critical to client safety outcomes. This concurs with a research article, which affirms that adequate supervision facilitates not only the professional growth of the supervisor and supervisee, but also the overall development of the field and its practice (Valentino et al., 2016).

LIMITATIONS

This investigation is confined by a limitation, which is not exceptional to a qualitative design. The number of trained professional supervisors being scant, in the Indian context, only a single FGD was conducted with a small sample size.

IMPLICATIONS

Findings reported in this investigation are consistent with the rationale behind professional supervision and imply the need for intensifying research efforts to enumerate its gains, especially in the Indian context. In light of the limited availability of Indian studies, revealed by a review of past literature, it would not be a baseless assumption to state that the present inquiry is a pioneering study. This is more so because the findings have been obtained from a study sample who are experienced practitioners with certification in professional supervision, gained through the only program of its kind in the entire country. Given the difficulties in demonstrating the effect of supervision on client outcomes, the results indicate the relevance of probing further to empirically validate the indisputable role of professional supervision in enhancing the standards and credibility of mental health practice. ■

About the authors

Dr Vasuki Mathivanan PhD is an accomplished psychologist with over two decades of experience in the field of mental health. She has extensive experience in training, teaching, counselling and guidance, and clinical supervision. On completion of her PhD from the University of Madras, she started her career as a freelance psychologist in Chennai, when the field of mental health was in its nascent stage. To channel and consolidate her vast experience and to render a service to the society, she established Explore Counselling (http://explorecounselling.com), an organisation with the committed motto of "Hopeless to Hopeful".

Having interacted with multidimensional stakeholders in the field of mental health over two decades, Dr Mathivanan felt a compelling need to support and monitor mental health professionals to hone their skills, so they deliver effective therapy to their clients. This need, coupled with her association with international experts in the field of counselling and psychology, gave birth to the establishment of the Indian Academy of Professional Supervisors. She is the founder and president of IAPS.

Philip Armstrong is an adjunct senior industry fellow, University of South Australia, and co-editor of the textbook *Practice of clinical and counselling supervision*. He has trained supervisors in Australia, China, India, Singapore, Hong Kong and the Philippines. He is the vice-chair of the ACA Professional College of Supervision.

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– Dr Vasuki Mathivanan

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THERAPY AS A JOURNEY

Could the COVID-19 journey be our communal rite of passage?

By Kim Billington

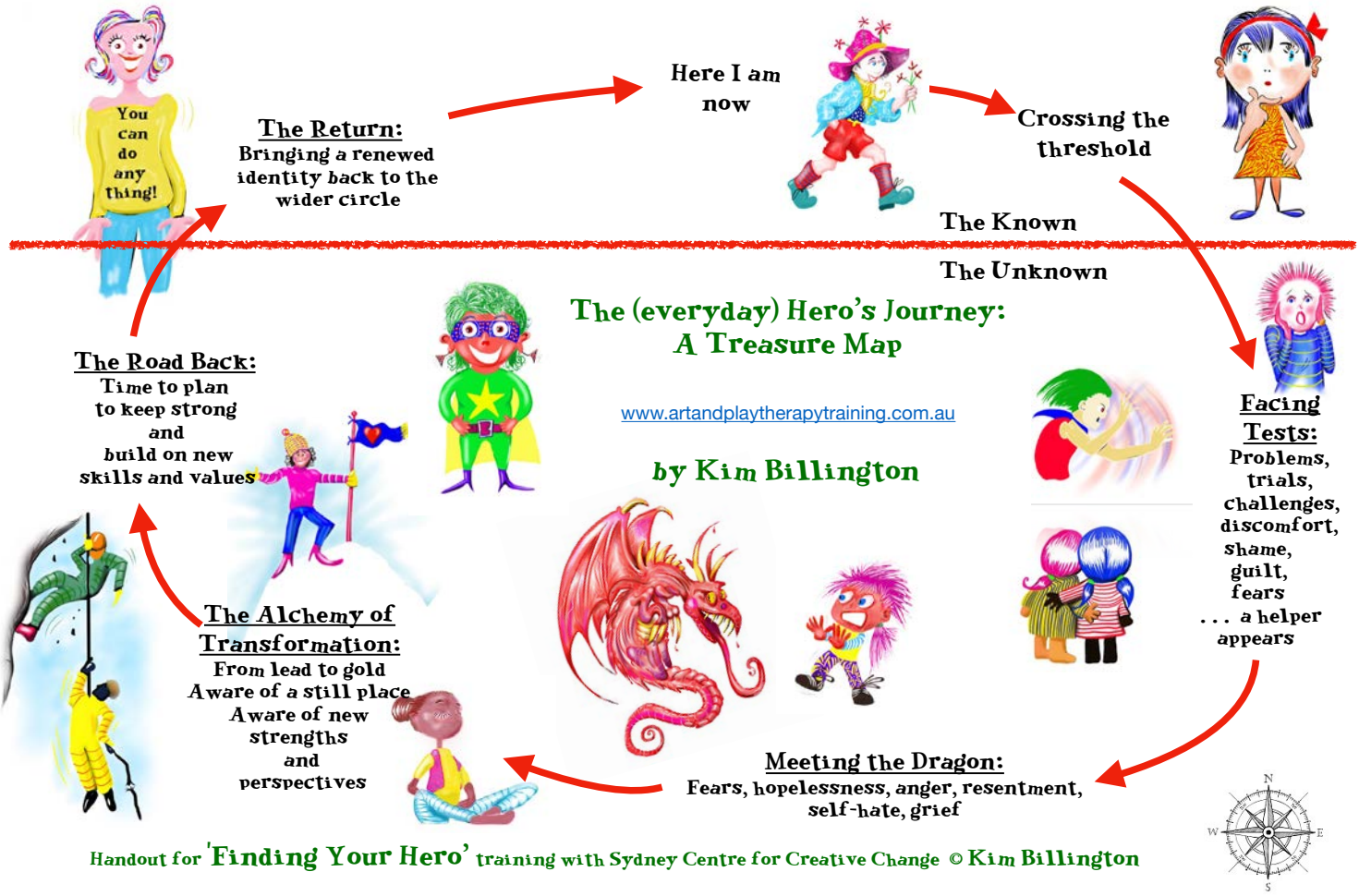
Photo: Unsplash/T K Hammonds

This year, the world has changed drastically with the spread of the coronavirus, and we are experiencing huge global troubles. We have been thrown from the known to the unknown. Van Gennep (1960) would compare such a crisis to a 'rite of passage'. He saw that when things are dire, we transition through three distinct stages. These stages are:

- separation from the known and familiar;
- liminality, transition, 'betwixt and between' – being a stage of confusion or aloneness, but also exploring a new heightened sense of possibility; and
- reincorporation, where new roles, responsibilities and freedoms are won and communal acknowledgement is given.

This can be applied to the COVID-19 pandemic. We have witnessed, and shown others, we can garner courage and can overcome the many new and challenging experiences and emotions brought on by this pandemic. Even when isolated from our usual, meaningful activities and valued connections, we have been able to draw on strengths or awaken slumbering future hopes. We have been uplifted by and celebrate the examples of others, who have nobly pressed on and done what needs to be done. Many people were choosing acts of courage and kindness amid the mayhem of the pandemic.

As early as 1985, Michael White and David Epston were using the rite of passage metaphor for the process of therapy. This enables people to imagine and explore what is possible in the face of hardship and arrive at a point



where they might resurrect special knowledge and relate differently to their prior situation with a renewed identity.

The rite of passage metaphor suggests there is a map of experiences that can be expected when going through hard times. In *The hero with a thousand faces*, Joseph Campbell illustrates 12 stages of the archetypal journey.

As a counsellor, I use a map with clients to illustrate this (see above).

It is accompanied by a list of questions (see page 37).

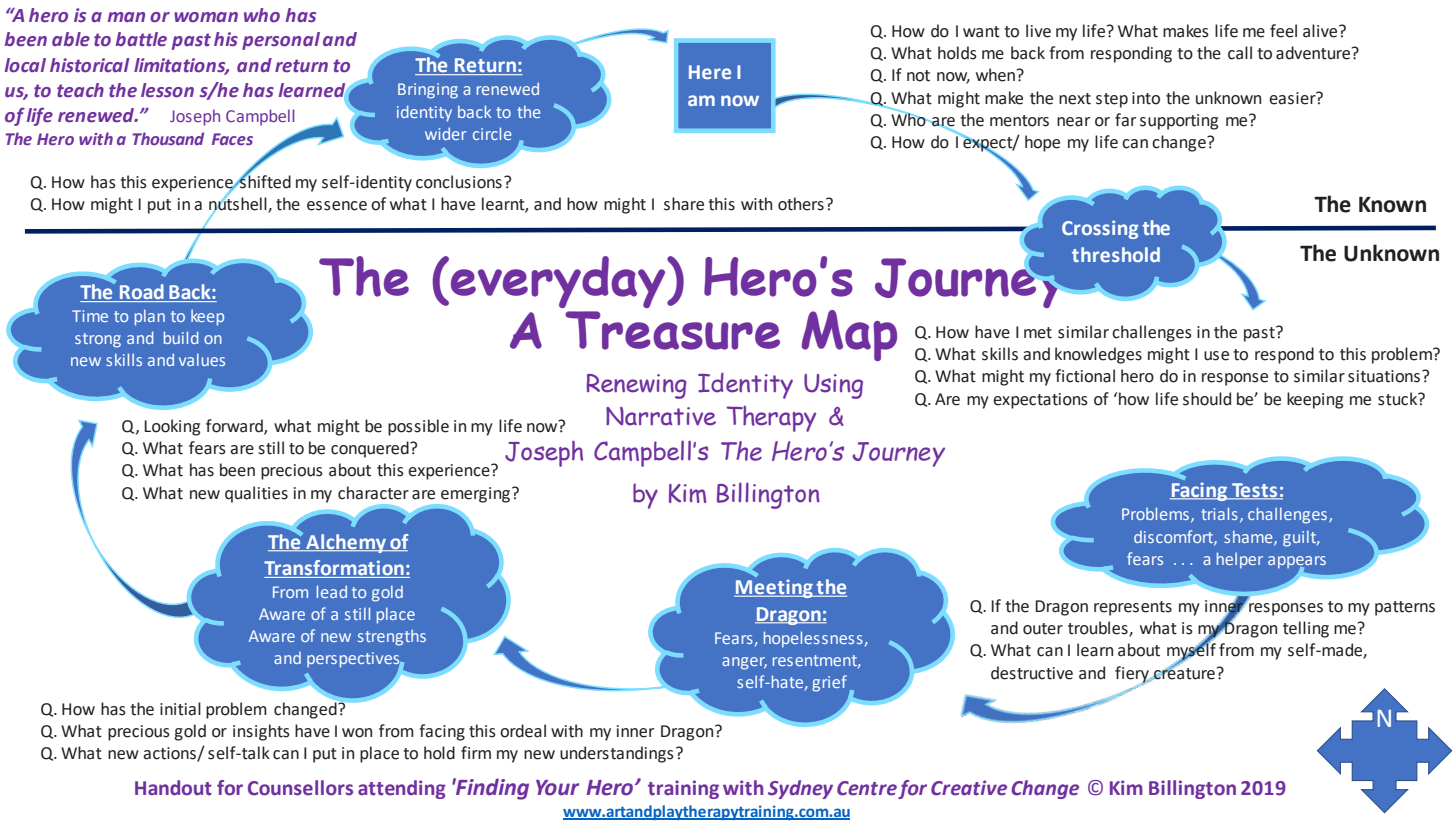
Clients easily relate to the stages of the hero journey and feel the burden of shame and invisibility drop away. Like the hero, they might start out carefree and ordinary, but they have found that suddenly they've had to face forces that feel more powerful than themselves. However, helpers always arrive. Inner changes take place as they face the darkest times, and at last they can break through prior limitations. Lost or unknown powers are revived and brought forward to help others.

Renowned author Stephen King used the concept of the hero's journey to guide his plot lines, acknowledging the influence of Campbell's work. George Lucas invited Campbell to help him write the plots for the Star Wars films, saying that we are all connected by a basic need to hear such stories and understand ourselves through these journeys.

I often ask clients about their movie or storybook heroes. We might discuss examples such as Mulan, who disguises herself as a man so she can defeat the Huns and save China at a time when women were greatly underestimated.

Harry Potter is a mistreated, ordinary-looking boy, vulnerable to all the fears that any of us could ever experience. Luke Skywalker is living a normal and humble life as a farm boy on his home planet of Tatooine prior to him initially refusing the call but then stepping into the unknown.

In all the stories, mentors appear along the way: Mulan meets Mushu, Luke meets Ben Konobi, Dorothy meets the Tin Man, and so on. No



matter how desperate the situation, someone has the hero's back – and so they are able to identify and hold onto their values and do not give up or give in.

As you can imagine, these approaches can bring a sparkle to therapy, with many memorable conversations where people make new meanings about their identity and what they have learned.

Sometimes I also introduce real-life heroic figures such as Rosa Parks, who, in 1955, stood up for her rights by refusing to give up her seat on a segregated bus to a white passenger. In doing so, she became a international icon for resistance to racial segregation, a movement that led to long-overdue equal rights for African Americans.

Clients begin their therapeutic journey feeling isolated and in lockdown with their problems. Hopefully, through counselling they can explore, articulate and celebrate their stories of resilience, their strengths, hopes and their capacity to be guided by their values and beliefs. We discover that the journey through hardship is also a learning journey – some call it the hero's journey. The knowledge that people reach out and help one another in hard times is something I am happy to have learned along the 2020 pandemic journey. ■

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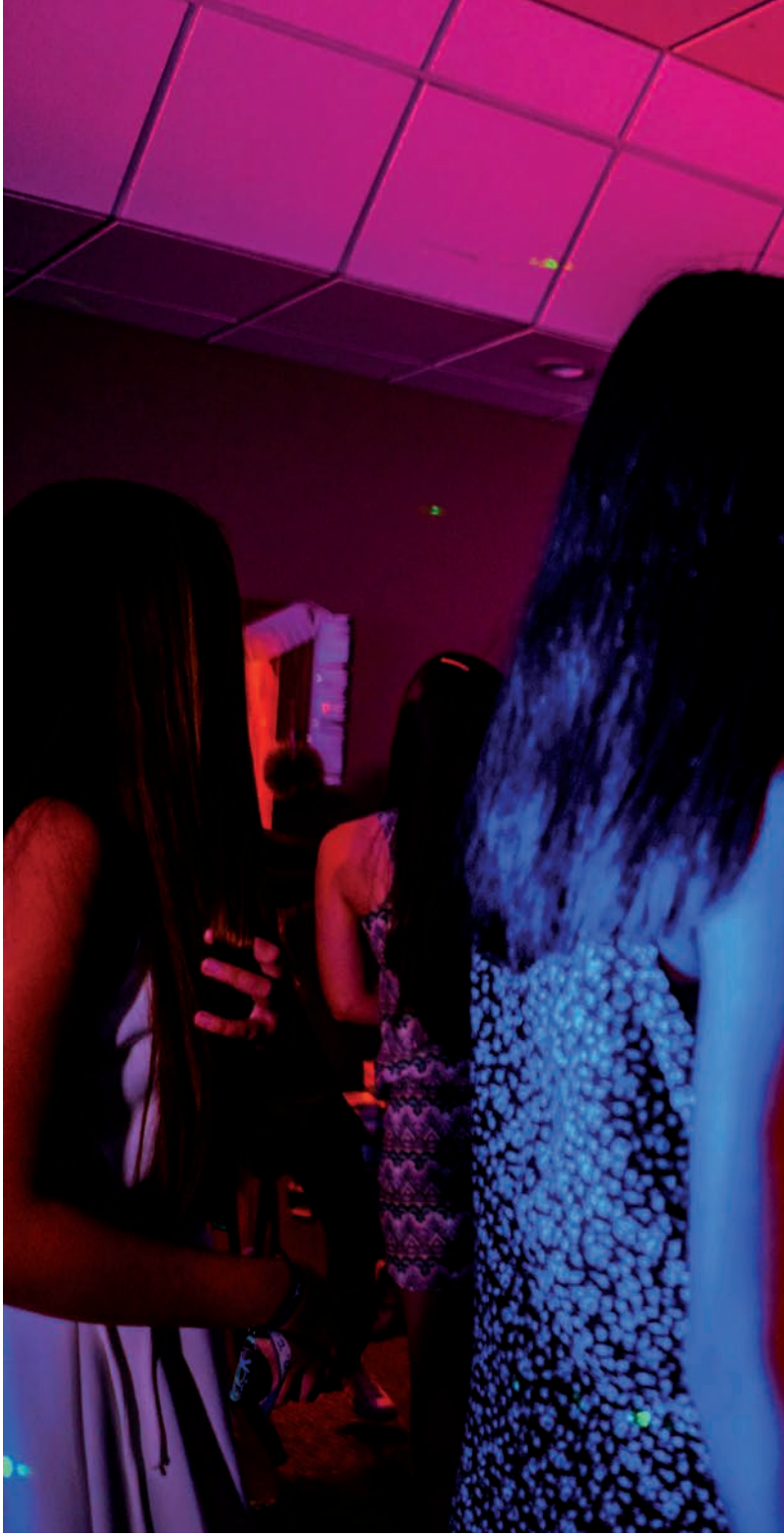

Young people, anxiety and cCBT

How effective is computerised CBT for treating anxiety in children and adolescents?

By Rachel Murray

Abstract

Anxiety disorders are the most common mental health disorders experienced by children and adolescents, with the majority not receiving any type of treatment even though studies highlight anxiety's strong link to future psychiatric disorders. This review introduces computerised cognitive behavioural therapy (cCBT) as a form of therapy that can greatly support children and adolescents in dealing with their anxiety in a convenient, affordable and private environment. Four specific cCBT programs, which are delivered via a computerised format, will be explored in regards to their effectiveness in treating anxiety. The ability to find effective ways to connect with and support anxious children and adolescents is highly relevant in an age where online learning, world pressures and anxiety have become even more intertwined.

Introduction

Computerised cognitive behavioural therapy (cCBT) is a developing area of therapy for working with children and adolescents. This literature review looks specifically at the effectiveness of cCBT for anxious children and adolescents aged seven to 18 years. It is important to find convenient and effective ways to treat anxiety in children and adolescents as, if left unattended, anxiety issues lead not only to daily life struggles, but also to more severe mental health issues later in life. cCBT offers an accessible and effective way to deal with anxiety in children and adolescents, although there are some challenges associated with the delivery of therapy via a computer.

This literature review begins by defining anxiety and its prevalence

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in childhood and adolescence, followed by a discussion around cognitive behavioural therapy (CBT) and its treatment of child and adolescent anxiety. cCBT is then explored by comparing studies that focus on four current cCBT programs: BRAVE-ONLINE for children, BRAVE-ONLINE for adolescents, Cool Teens and Camp Cope-A-Lot. The aim of the review is to develop an awareness and understanding of these programs that can support children and adolescents with anxiety, so that practitioners and school counsellors can utilise these and provide awareness to others of these alternatives to face-to-face CBT.

Anxiety

Anxiety or fear are normal human responses to an anticipated future or current threat; however, it is only when the anxiety or fear causes a significant and detrimental impact on daily life for a period of time that an anxiety disorder can be identified (American Psychiatric Association, 2013; Andrews et al., 2004; Stallard, 2014). There is a range of anxiety disorders including separation anxiety, panic, agoraphobia, social anxiety and generalised anxiety, which often show an overlap in symptoms and have links to depression (American Psychiatric Association, 2013; Andrews et al., 2004; Stallard, 2014). Anxiety affects not only adults, but also adolescents and children.

Anxiety disorders are the most prevalent mental health issues for children and adolescents.

Anxiety disorders are the most prevalent mental health issues for children and adolescents. An estimated 10 per cent of this population, at some stage before the age of 16, meet the *Diagnostic and Statistical Manual of Mental Disorders* (DSMV-5) criteria for anxiety.

An estimated 10 per cent of this population, at some stage before the age of 16, meet the *Diagnostic and Statistical Manual of Mental Disorders* (DSMV-5) criteria for anxiety, with females exhibiting more anxiety issues then males (Costello, 2003; Essau, Conradt & Petermann, 2000; Stallard, 2014). Anxiety disorders can affect all areas of life, including social interaction and performance at school (Stallard, 2014). Fears and worries are linked to developmental stages and it is suggested that factors such as temperament, genetics, environment, cognition and individual learning experiences are influential in the development of an anxiety disorder (Perini & Rapee, 2014; Stallard, 2014). Further research shows that childhood anxiety disorders are a predictor for adolescent and adult psychiatric disorders, so early intervention is valuable in promoting good mental health for the future (Bittner et al., 2007; James et al., 2013; Pine et al., 2009; Reef et al., 2010).

CBT for child and adolescent anxiety

CBT is a well-designed, practical and established program of therapy that follows a planned approach to overcoming anxiety disorders within a set time frame (Pine et al., 2009; Perini & Rapee, 2014; Stallard, 2014). Children and adolescents respond well to working with a therapist, in individual or group programs, to learn about anxiety and their thoughts, as well as practising behaviours to relieve their symptoms (Pine et al. 2009; Stallard, 2014). CBT has been shown to provide positive results in the treatment of anxiety disorders in children and adolescents, being at least as effective as medication and other approaches (James et al., 2013). Additionally, due to CBT's highly structured approach and psychoeducational learning and strategies, it is the ideal therapy to be integrated into a computerised or online therapy program (compared to more process-orientated therapies such as psychodynamic therapy).

Another significant issue around anxiety is that only around 30 per cent of children and adolescents seek any form of treatment (Essau et al., 2000). This may be due to the family's inability to recognise the anxiety, a lack of awareness of mental health supports available, and financial and time restrictions (Booth et al., 2004). This low figure indicates the need to reach many more children and adolescents with anxiety. Consequently, CBT is now progressing into a therapy that utilises the benefits of computerised CBT programs to reach more children and adolescents.

Using computerised CBT with children and adolescents

The use of cCBT for anxious children and adolescents has been developing over the last couple of decades, with a range of computerised programs designed to suit ages seven to 18 years. These developments have evolved due to the effectiveness of cCBT for adults with anxiety (Richardson, Stallard & Velleman, 2010; Kendall et at., 2011). Today's access to computers at home, at school, in libraries and other community centres provides a new pathway to support children and adolescents with anxiety. cCBT includes CBT programs that are computer-based, with no therapist interaction, and also computer-assisted, with some form of therapist interaction. The computerised programs consist of a set number of computer-based sessions, to be completed over a defined number of weeks and may include videos, interactive activities, rewards, written tasks, exposure practice, self-rating, knowledge reviews and therapist contact (Kendall et al., 2011). Research exploring the development and content of these cCBT programs discusses the advantages and disadvantages of this type of innovative therapy for anxiety.

Advantages and disadvantages

There are a range of advantages in providing cCBT for anxious children and adolescents. Firstly, programs can be made into a

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standardised format that can be altered for improvements; however, this can lead to non-personalised treatment plans and a lack of sufficient personal connection with a therapist (Berry & Lai, 2014; Greist, 2008; Kendall et al., 2011; Richardson et al., 2010). Secondly, cCBT provides greater access to therapy at a reduced cost for children and adolescents, who may not seek out face-to-face treatment (Kendall et al. 2011; Richardson et al., 2010). This assumes that children and adolescents are made aware of the availability of the program at school, at home or in a community setting. Thirdly, private computer access can provide a sense of privacy when undergoing the program, although it can be argued that there are also privacy concerns with any computer-based technology (Kendall et al., 2011). Finally, having a sense of control over their progress and the ability to revisit parts of the program allows the participant to feel a sense of mastery when using cCBT (Berry & Lai, 2014; Kendall et al., 2011).

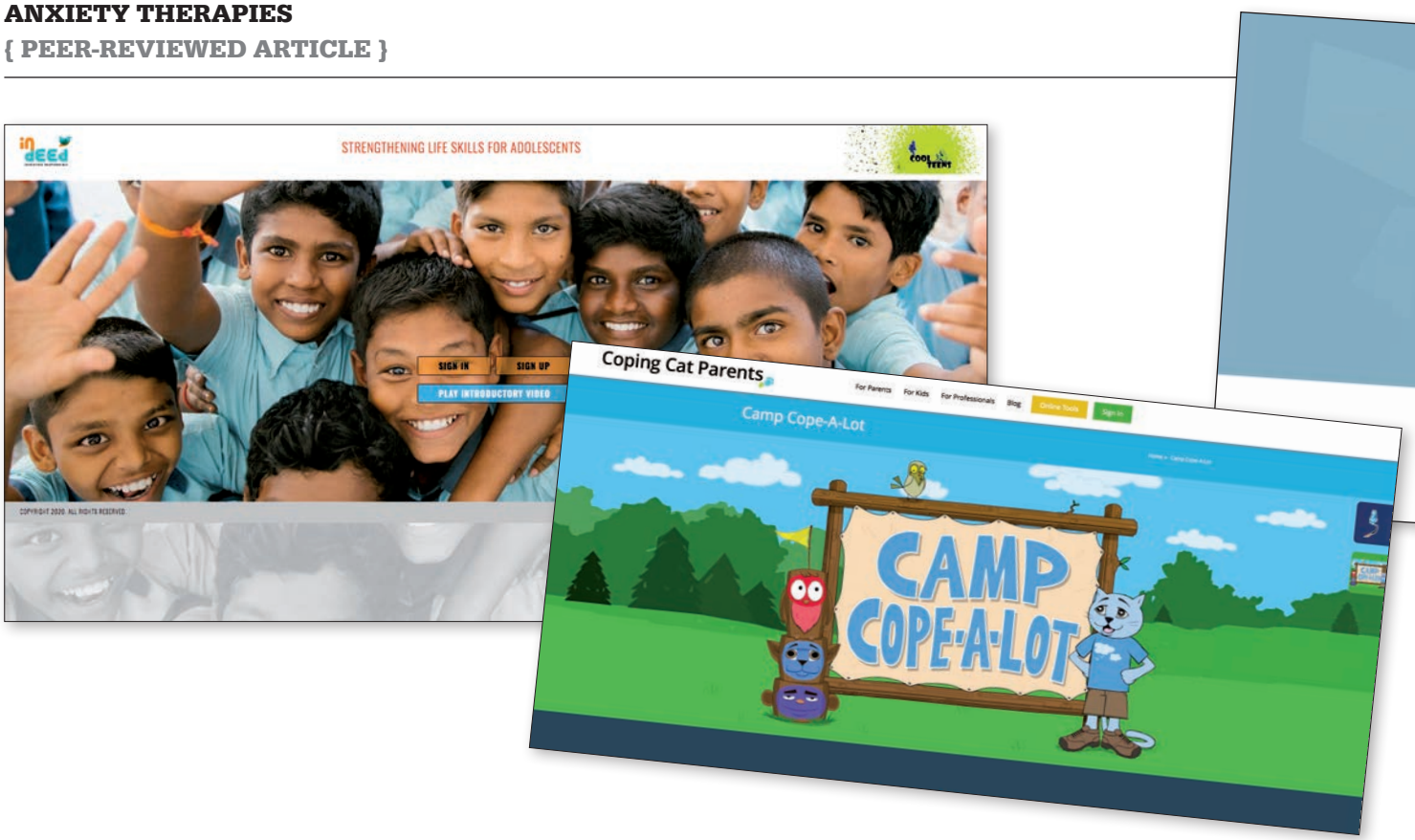
Comparison of cCBT programs

There have been few randomised controlled trials around the effectiveness of cCBT in its treatment of children and adolescents with anxiety; however, four recent randomised controlled studies provide insights into this expanding area of research (March, Spence & Donovan, 2009; Khanna & Kendall, 2010; Spence et al., 2011; Wuthrich et al., 2012).

March et al. (2009) focused on the BRAVE-ONLINE Program (BC) for children aged seven to 14 years, as did Spence et al. (2011), for adolescents aged 12 to 18 years (BA). Wuthrich et al. (2012) studied the Cool Teens CD-ROM Program (CT) for 14 to 17 year olds, whereas Khanna and Kendall (2010) researched the Camp Cope-A-Lot Program (CCAL) for the seven to 13 year age group. Programs covered both the child and adolescent age groups and all provided some form of therapist or facilitator assistance, so were computer-assisted programs and not stand-alone computer-based programs for anxiety. These studies will be critically analysed to determine the effectiveness of their treatment of childhood and adolescent anxiety and to also provide ideas to enhance future research.

Program structure

A brief overview of each study's structure will be given to provide a better understanding of each cCBT. Both BC and BA are 10-week online, password-protected programs, with one-hour sessions for the child or adolescent and five one-hour sessions for parents,



followed by two booster sessions (March et al., 2009; Spence et al., 2011). Access to new material is made available when set material has been completed, while a therapist supports via email and two telephone calls, one before the first session and one to discuss the hierarchy for exposure (March et al., 2009; Spence et al., 2011). In comparison, the CT is a 12-week program that proceeds through eight 30-minute modules, with open access to all material (Wuthrich et al., 2012). The adolescent decides on the amount of parental support required, with therapist support consisting of eight telephone calls with the adolescent and three telephone calls with the parent (Wuthrich et al., 2012). The fourth program, CCAL, is based on the face-to-face Coping Cat program and is a 12-week program of 35-minute levels, with the first six levels completed independently and the last six levels assisted by a non-CBT trained coach (Khanna & Kendall, 2008; 2010). Parents also receive two sessions with the coach (Khanna & Kendall, 2010). It was not clearly stated whether the coach-assisted sessions were face to face or by other means of communication, which was in contrast to the clear descriptions provided in the other programs.

Each of the four studies had the purpose of determining the efficacy of the particular cCBT program in relation to treating anxiety in either children or adolescents (Khanna & Kendall, 2010; March et al., 2009; Spence et al., 2011; Wuthrich et al., 2012). Both the BA and the CT programs only compared to a waitlist (those not yet receiving treatment), BC compared the cCBT to individual CBT and a waitlist, while CCAL compared to individual CBT and another anxiety education program (Khanna & Kendall, 2010; March et al., 2009; Spence et al., 2011; Wuthrich et al., 2012). As a result, both BC and CCAL are stronger studies due to their broader treatment comparisons.

Comparing program participants and measures

The four programs were similar in the participant selection and diagnostic measures applied. All participants were randomly selected, including both male and female participants, and all programs used the DSM-IV for selection of participants with a primary anxiety disorder (Khanna & Kendall, 2010; March et al., 2009; Spence et al., 2011; Wuthrich et al., 2012). It can be noted that BC and BA did not include panic disorder, obsessive compulsive disorder or post-traumatic stress disorder, and would benefit from their inclusion in future programs (March et al., 2009; Spence et al., 2011). BA provided a good sample size with 115 participants, followed by BC with 79, CCAL with 49 and CT with 43. Three studies reported medium to high socio-economic participants, with CCAL having not recorded this information. All programs used the Anxiety Disorders Interview Schedule for Children as the main form of assessment for pre and post-results, which the mother or father and the child or adolescent completed. Questionnaires were also provided to determine the user satisfaction levels of the cCBT programs.

Comparing program results

Many results were recorded in the studies; however, for ease of reporting, comparisons are made

only of the primary anxiety disorder and whether the participants were no longer diagnosed with this disorder after cCBT treatment, as per the DSM-IV. Post-treatment all programs showed significant effectiveness in decreasing anxiety symptoms, with the following results revealing the percentage of participants no longer diagnosed with their primary anxiety condition: BA 30 per cent, BC 36 per cent, CT 41 per cent and CCAL 70 per cent (Khanna & Kendall, 2010; March et al., 2009; Spence et al., 2011; Wuthrich et al., 2012). Unfortunately, a limitation of the CCAL program was that it did not provide any follow-up results post-treatment, whereas BC, BA and CT provided a range of follow ups, which showed a doubling in the percentage of participants no longer diagnosed with their primary condition (Khanna & Kendall, 2010; March et al., 2009; Spence et al., 2011; Wuthrich et al., 2012). March et al. (2009) attributes this increase to the participants fully completing the program after the initial time period, a theory also supported by Spence et al. (2011). As a consequence, altering the program length may support participants to complete all activities within a more suitable time frame.

Another disadvantage was the absence of follow-up results for waitlist groups in the three studies that included a waitlist. BC and CCAL provided results for the face-to-face CBT group, which showed similar significant effectiveness as the cCBT groups (Khanna & Kendall, 2010; Spence et al., 2011). This result continues to show support for the effectiveness of CBT when working with children and adolescents. For future studies, there is a need to provide a range of follow-up results in order to enhance the findings (Rooksby et al., 2015). All of these results are significant factors when thinking about the further development of cCBT.

Strengths and weaknesses

A number of strengths and weaknesses have already been referred to; however, others are also worth mentioning for future research in this area. In all studies, participants reported a high level of program credibility and medium to high levels of satisfaction after using a cCBT program (Khanna & Kendall, 2010; March et al., 2009; Spence et al., 2011; Rooksby et al., 2015; Wuthrich et al., 2012). BA provided the best sample size, the most comprehensive follow up and group comparisons, which are considerations for a more comprehensive study in the future (Spence et al., 2011). Khanna and Kendall (2010) point to their use of mainly Caucasian and moderate to high socio-economic participants, so there seems to be a need for a more robust participant selection, as anxiety is not limited to this group of participants. Authors of the BA and BC programs both draw attention to the difficulties in the creation of hierarchy for exposure therapy, due to their minimal therapist interaction, in comparison to CCAL, which had face-to-face contact and no reported hierarchy development issues (Khanna & Kendall, 2010; March et al., 2009; Spence et al., 2011). Further research into the most effective and efficient levels of therapist interaction in cCBT would be important in resolving this issue. Finally, although each study draws attention to the possible cost savings, due to less

therapist contact, no economic comparison data is provided and this would be important for future research development (Khanna & Kendall, 2010; March et al., 2009; Spence et al., 2011; Rooksby et al., 2015; Wuthrich et al., 2012). Overall, the four studies showed effectiveness in treating anxiety in children and adolescents; however, improvements in the research methods and the results recorded would provide further evidence of success and increased acceptance of cCBT.

Recommendation for therapists

Practitioners and school counsellors are encouraged to view each program as all programs show effectiveness in treating anxiety, with BA, BC and CT being designed in Australia and CCAL designed in the United States. BA and BC are free programs, CT is based on a yearly access fee for the individual adolescent and CCAL works on a subscription basis that allows for multiple users of the program. Program selection will depend on client needs and the practitioner's work setting.

Conclusion

Cognitive behaviour therapy has provided successful intervention into the treatment of anxiety disorders in children, adolescents and adults; however, with the high number of children and adolescents being diagnosed with an anxiety disorder and a large percentage of these not receiving any treatment, there is a need to provide a more accessible form of CBT. Computerised CBT opens the doorway to providing a more accessible way to present this standardised treatment. Randomised controlled trials show effectiveness in reducing or eliminating anxiety disorders when cCBT programs are completed. Future studies could improve the efficacy of the results by overcoming these following limitations: narrow socio-economic selection of participants, low participant numbers, questions around the balance of therapist to non-therapist contact, lack of follow-up periods, medium completion rates within the set time frame and lack of data about cost savings.

Further discussion around the use of cCBT within the school, home and community environment, with a computer-based, non-therapist contact program may benefit those children and adolescents who are not diagnosed with an anxiety disorder, but who are struggling with some form of anxiety. cCBT has the potential to reach large numbers of children and adolescents and positively influence their current life and their future mental health. With the high access to computers in today's society and children's and adolescents' ongoing anxiety issues, the continued research into the development of effective cCBT programs can provide an invaluable resource to support children and adolescents in achieving and maintaining positive mental health throughout their lifetime. ■

Key findings

- Anxiety is the prevalent mental health disorder for children and adolescents.
- Childhood anxiety is a predictor for future psychiatric disorders.
- Early intervention is valuable.
- CBT is an effective evidence-based therapy for anxiety.
- Only 30% of children and adolescents with anxiety seek face-to-face treatment.
- Computer-based CBT (cCBT) provides an alternative to face-to-face CBT.
- cCBT showed similar effectiveness to face-to-face CBT in treating anxiety in children and adolescents.
- cCBT can improve the accessibility, cost effectiveness and privacy of support for children and adolescents with anxiety.
- Future cCBT studies require a focus on exposure therapy, cost savings and possible online privacy issues.
- Examples of current programs include BRAVE-ONLINE for children, BRAVE-ONLINE for adolescents, Cool Teens and Camp Cope-A-Lot.
- All programs show effectiveness in supporting children and adolescents with anxiety.
- Program selection is dependent on individual client need, costs, personal preference and specific therapeutic work setting (such as private practice, community support organisation or school).

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About the author

Rachel Murray is a recent graduate of the Queensland University of Technology, from which she graduated in 2019 with a Master of Education: Guidance and Counselling. She has numerous qualifications including a Graduate Certificate in Artistic Therapies (Counselling), Advanced Diploma of Holistic Counselling, Graduate Diploma of Education and Diploma of Yoga Teaching. She is currently a primary school teacher and has previous experience working as a counsellor for children, adolescents and adults.

GRIEF AND BEYOND

Counsellor `Orlaith Sheill reflects on her experiences and emotions of living through the COVID-19 pandemic.

By `Orlaith Sheill

As the early morning birds chirp, I sit and write with tears behind my eyes. I have a hot coffee and a moment to myself; a rare thing right now, and I am grateful for it.

Since the coronavirus-induced fear and uncertainty hit our world, I have been trying to think about how, as a counsellor, I can offer support. I have not had the opportunity – until now – to even consider what that might be, what with adjusting to working remotely, my changing personal and professional worlds, and juggling new rules and ways of living. The cycle continues and each day is about adaptation. Sound familiar?

As a grief/bereavement counsellor, I support people in their adaptation and processing of life's challenges and difficulties. Right now, I cannot do this face to face; however, I can do it remotely – and I can share some of my thoughts in the hope that it might just help one person to feel less isolated and more supported in their vulnerability.

I wish to share with you that my dominant feeling right now is that of grief. I am naming that today. I hope that calling it what it is allows others to do so too. In fact, we are grieving collectively. Grief can make you feel like you are going crazy; it impacts every part of our being. Your own grief may look confusing, like fear, anger, impatience or intolerance; you may lose your temper, feel irritated, out of control, overwhelmed or stressed. You could be hyper-vigilantly washing your hands, refraining from touching things, and keeping your distance from everyone. You could experience panic, sadness, tears, breaking down over small things, inability to sleep, or obsessively turning to social media and news

Photo: Unsplash/Annie Spratt

to feel some semblance of control … I could keep going. Grief shows itself in so many ways and can be extremely challenging to manage. It is also a tall order to develop a clear way of coping when everything is changing by the minute and is in a state of flux.

My strongest grief emotion right now is sadness. I am feeling the loss of what was normal before this time. Recently, a Bruce Springsteen song made me cry, from not knowing when I will see family and friends again who live on the other side of the world. I miss the simplest of things, yet when I allow the tears to surface or they decide to surprise me, there is also a bright side – my gratitude for all that I treasure in my life. It's for the simple things that I grieve and the freedom we take for granted.

Everything has changed for now, and with this comes loss – for what we had and, even though this is temporary, having no end date compounds that feeling of loss. When we experience loss, we are forever changed, and now our world is too. That does not mean we will not return to normalcy, but it will be different, and we will be different. We will adapt, grow and evolve in this experience, yet there will be things and aspects in the future that we will miss from before this time.

Remember – you are grieving personally but you are also surrounded by a world in collective grief. Do not underestimate what you are feeling from others around you and how we are processing these emotions together. You may gather strength in sharing with friends and family and, at other times, it may be confronting if people are in a different place to you. Strangely, this togetherness is within a social distancing and self-isolation context, which can make us feel so very alone. It is important to remind yourself that, while you may feel alone, you are not. We are in this together.

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It is imperative to think about what you can do – and you can name your own grief. Allow the feelings to be acknowledged; it is OK to be devastated by this. Tears will stop, and if you break down you will get back up. Fresh grief also stirs up the other losses we store within that are tucked away. Old or recent, loss might flare up and catch you off guard. You might find yourself feeling back to a time when you hurt before – just try to remember what got you through those times.

Focus on what you have control over. What can you do within the confines of our temporary new way of living? If you find yourself drifting to a place of panic and future thinking, that is normal; it is your survival instinct kicking in. I would encourage you to acknowledge that fear and come back to where you are in the present; come back to yourself, your strengths and what you are good at. Focus on what is going right, such as: the cup of coffee made in the morning that I drank while it was hot. It is one small thing, but it matters. When we notice the small things, we grow stronger in the scaffolding that they provide. Notice the things around you making your day more manageable. Draw up a sketch of your own scaffold. What surrounds you right now and holds you up? A visual of it, even in a rough sketch, can be a great reminder when you wobble.

And remember to go easy on yourself. Grief makes us tired, worn out and disillusioned; it has the force to bring us to our knees. However, in naming it as grief, we are acknowledging it and can do something about accommodating it in our lives. That does not mean to say you have to like it being here, but it is. Accepting it can ease the struggle with it.

Be kind to yourself and others. Self-compassion and kindness help soothe our highly strung systems, which are responding in fear and stress. For example, your heart may be beating fast, your tummy a mess with jitters, you may not feel like eating or you are eating a bit more than usual. You may feel nauseous, your head may hurt or your eyes may feel tired. Maybe you cannot think straight or worry and anxiety

Photo: Unsplash/Danielle Macinnes

will not leave you alone. All of these things indicate an activated system. You could find yourself quite reactive; that is your system ready to fight, flight or freeze – it is in survival mode. Remembering to go easy on yourself is important to calm your system down. It can be as simple as acknowledging 'I am so on edge; I need to go sit outside and listen to the sounds for five minutes' or 'I need to go and have a cry in the shower'. Crying is wonderful for soothing, it is a release, and it is OK to cry.

In your grief, acknowledge that this is a temporary place. We need to hunker down to get past this and you are doing your best to do so. It is quite a process to adapt and find new structure to get through this, particularly when it feels like shifting sand and you cannot find your footing. When you admit your feelings and allow yourself to feel it, you can make sense of it and you can learn to manage it. You then have power over your feelings rather than being overpowered by them. Feelings come and go, they are not static. Try to allow feelings in rather than block them out as you do what is needed to stay safe and at home. We are in the motion of grieving while having to deal with a lot of change, pressure and stress, which overwhelm to say the least. So, when you feel calm or joy, soak it up. Give yourself permission to experience the light and goodness, as this will fill you up to have the energy to ride the next wave. You can do this. ■

About the author

**`Orlaith Sheill** is a registered level four counsellor; specialist bereavement counsellor and educator; and fertility counsellor and clinical supervisor. She is a specialist counsellor in loss, change, life transitions, bereavement and non-death losses, as well as IVF. `Orlaith's qualifications include a Master of Couple and Family Therapy and a Graduate Diploma of Counselling.

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