COUNSELLING AUSTRALIA JOURNAL

VOLUME 22 NUMBER 2
WINTER 2021

CAJ

Regional counsellors' perspectives on their self-care needs

Interrupting with intention Understanding interrupting within a collaborative therapeutic relationship

Childhood trauma Its impact on mind, brain and body development

TECHNOLOGY UPDATE | NEWS AND REVIEWS

AUSTRALIAN INSTITUTE *of*
PROFESSIONAL COUNSELLORS

Receive a full semester of credit and save up to $10,000 off the Master of Counselling with a related qualification.

Are you considering upgrading your qualifications with a Master of Counselling?

If so, and you have a degree in a related field, you could receive up to a full semester's credit and ***save up to $10,000.***

AIPC's Master of Counselling is one of the most flexible programs available:

- Learn in highly supported, personal cohorts
- Study externally from anywhere in Australia, even overseas
- Residential Schools available in **Brisbane, Sydney, Melbourne and Perth**
- Start with just 1 subject
- Open up additional employment and career opportunities.

And being **FEE-HELP approved**, you start now and pay later.

What some of our graduates are saying...

"AIPC's course material is excellent; it is structured and is user friendly with information being specific. AIPC tends to meet the needs of people. I believe that study will not end here for me as I am already looking at post graduate work. My difficulty is finding an institution as well structured as AIPC. And yes, guess what, nobody compares! I am in the process of negotiating my next course with AIPC. On a final note, AIPC have made it possible for me to achieve my dream. Thank you."

Angela, AIPC Higher Education Graduate

"When I first found out about the course I was excited at the prospect of doing a degree that was solely focused on Counselling and run by an Institute who specialise in providing counselling training. All in all I have enjoyed my study in the course and would recommend it to others who are looking for a flexible degree that they can do at home."
Claudia, AIPC Higher Education Graduate

"The Institute has been an exceptional institution to study through. I have studied with a few institutions over the years but the Institute has by far been the best. What I particularly like is the fact that the lecturers manage to afford students a great degree of flexibility in terms of fitting their studies into their day to day lives whilst maintaining an extremely high standard of education."
Will, AIPC Higher Education Graduate

Support is always close...

Sydney | Melbourne | Perth | Brisbane | Adelaide | Regional QLD | Gold Coast | NT/Tasmania

Learn more here: www.aipc.net.au/master-of-counselling

CONTENTS

FEATURES

REGULARS

ISSN 1445-5285

Editorial

Royal Commission to probe veterans' mental health and suicide

Philip Armstrong
Editor

In April, Prime Minister Scott Morrison announced the Government will recommend to the Governor-General the establishment of a Royal Commission into Defence and Veteran Suicide.

This is an important step towards addressing a mental health issue that has been well recorded over a long period of time. The death of any Australian Defence Force (ADF) member is always felt deeply across the community. Tragically, and heartbreakingly, this too often represents veterans taking their own lives.

ACA will respond fully to the Royal Commission through written and public submissions and statements. Counsellors can play a key role in offering services to veterans and their families as part of a national initiative through the Department of Veterans' Affairs (DVA).

The DVA states, "The Royal Commission is expected to examine systemic issues and any common themes and past deaths by suicide of ADF members and veterans, and the experience of members and veterans who may continue to be at risk of suicide.

"[The inquiry] includes all aspects of service in the ADF and the experience of those transitioning; the availability and quality of health and support services; pre-service and post-service issues for members and veterans; members' and veterans' social and family contexts, such as family breakdown; as well as housing and employment issues for members and veterans."

The Royal Commission will be asked to make any recommendations, including recommendations about any policy, legislative, administrative or structural reforms.

The Minister for Veterans' Affairs Darren Chester says the Royal Commission is part of the government's work "to build confidence, trust and hope for current and future veterans and their families that they will be supported". He says the Royal Commission "will provide an opportunity for us all to reset; to further increase our understanding of this issue, and unite the Parliament, the ex-service community, and the families who have been affected by suicide." Minister Chester is now leading a public consultation process to inform the Terms of Reference. Information about the Royal Commission will be updated on the DVA website.

The Royal Commission will be asked to be aware that its inquiries, including its findings and recommendations, will provide a foundation for the future work of the National Commissioner for Defence and Veteran Suicide Prevention.

Other news of professional interest to members is the release in New South Wales of the consultation draft of the Children's Guardian Regulation 2021, and the final report to the Federal Government by the National Suicide Prevention Adviser.

Children's Guardian Regulation 2021

The NSW Government Office of the Children's Guardian has released the consultation draft of the Children's Guardian Regulation 2021. The proposed regulation supports the establishment of a residential care workers register in NSW. This is to provide additional safeguards for children and young people in statutory out-of-home care and in residential care.

Members are reminded that the NSW Working with Children Check must be renewed every five years.

National Suicide Prevention

In July 2019, Prime Minister Scott Morrison appointed a National Suicide Prevention Adviser, Christine Morgan, to work towards a zero suicide goal. Morgan's final report to government has been published and comprises the following components:

- Executive Summary;
- the Compassion First report, which details insights from people who have a lived experience of suicide and suicide distress;
- Connected and Compassionate (Final Advice) report and recommendations; and
- Shifting the Focus, a guide and decision-making tool to support engagement of all government portfolios in suicide prevention; and appendices to support the Advice.

These reports can be read at https://www.health.gov.au/resources/publications/national-suicide-prevention-adviser-final-advice.

Caring for the carers

The mental health and wellbeing of everyone is important – including that of counsellors and mental health practitioners. This issue, *Counselling Australia* delves into the self-care and mental wellbeing of those in the caring professions, and how some regional counsellors maintain mental strength and wellbeing.

Turn to page 9 for the article 'Regional counsellors' perspectives on their self-care needs'.

Photo: Unsplash

UPCOMING EVENTS 2021

Daffodil Day

28 August 2021

Daffodil Day is a fundraising event run by Cancer Council Australia. Daffodil Day is the biggest fundraising event on the Cancer Council's calendar and is always hugely successful.

Unfortunately, everyone knows someone affected by cancer. It is shocking to know that 50 per cent of all Australians will be diagnosed with some form of cancer in their lifetime. But there is still hope because, over the years, cancer research has made monumental discoveries and huge progress. Research is made possible through much-needed fundraising days like Daffodil Day.

For more information, please visit https://www.twinkl.com.au/event/daffodil-day-2021.

R U OK? Day

9 September 2021

R U OK? Day is the national day of action dedicated to reminding everyone that every day is the day to ask, "Are you OK?" and support those struggling with life's ups and downs.

For more information about R U OK? Day please visit www.ruok.org.au/join-r-u-ok-day and for educational resources, go to www.ruok.org.au/education.

World Suicide Prevention Day

10 September 2021

World Suicide Prevention Day is observed on 10 September each year to promote worldwide action to prevent suicides. Various events and activities are held during this occasion to raise awareness that suicide is a major preventable cause of premature death.

World Suicide Prevention Day gives organisations, government agencies and individuals a chance to promote awareness about suicide, mental illnesses associated with suicide, as well as suicide prevention. Organisations such as the International Association for Suicide Prevention (IASP) and World Health Organization (WHO) play a key role in promoting this event.

For more information, please visit www.awarenessdays.com/awareness-days-calendar/world-suicide-prevention-day-2021.

World First Aid Day

12–13 September 2021

Since 2000, World First Aid Day has been organised by the Red Cross and Red Crescent societies. Together, the societies raise public awareness of how first aid can save lives, both in every day and crisis situations.

First Aid counts as any emergency treatment or medical assistance given to an injured or unwell person, before normal medical aid can arrive. In a life-saving circumstance, knowledge of basic First Aid is incredibly important.

In everyday situations, First Aid could be needed in situations as simple as accidentally cutting yourself on a sharp kitchen knife or falling down the stairs. But in a crisis situation, First Aid could be as drastic as giving medical aid to people in war-zone countries or areas hit by natural disasters, such as tsunamis and earthquakes.

Wherever you are in the world, First Aid is essential for all human life. This truly makes World First Aid Day an important global event.

For more information, please follow the link www.twinkl.com.au/event/world-first-aid-day-2021.

Technology Update

With Dr Angela Lewis

After prison support

I recently came across the Australian Community Support Organisation (ASCO), a not-for-profit located in Melbourne (www.ACSO.org.au) whose work is focused on helping those who are at risk of going to prison or who need help transitioning from the prison system. As an organisation, it focuses on helping people reintegrate into the community, as well as providing diversion programs to help prevent them returning to crime. It also provides assistance with safe and affordable housing (in Victoria only) and counselling, and works alongside young people to help them find the right job and with employers to find the right person to join their business.

Most states in Australia have comprehensive online services to support released inmates:

Victoria:
www.corrections.vic.gov.au
Queensland:
https://corrections.qld.gov.au
New South Wales:
www.crcnsw.org.au/services
Tasmania:
www.justice.tas.gov.au/prisonservice/iom
Western Australia:
www.correctiveservices.wa.gov.au
Northern Territory:
https://justice.nt.gov.au/correctional-services

Support for veterans

For anyone who missed the media campaign, Open Arms – Veteran and Family Counselling is a new online service founded by Vietnam veterans to provide help and support to all veterans and their families, and it is now live. Services include general advice on living well (food, sleep, alcohol and so on), counselling, a 24-hour helpline, crisis intervention and suicide prevention. This is really worth a look: **www.openarms.gov.au**.

Hiding photos in iPhone or iPad albums

Handing your phone to a friend or colleague to show them a photo means you take the chance they may also look at others, which you may not be willing to share. Luckily, protecting personal photos is simple:

- Open the **Photos** app and locate the photo/s you wish to hide.
- Tap **Select** at the top right of the screen, then tap each photo you want to hide – you will see a blue tick appear on the selected photo/s.
- Tap the **Share** icon (the square box with an up arrow) in the bottom left of the screen.
- In the menu choices that appear, tap **Hide** (you may need to scroll down a little to see this).
- Tap **Hide Photo** to confirm the action.
- Note: after selecting Hide on your chosen photos, they will only be found in the Hidden album.

To view your hidden photos:

- Open the **Photos** app, then tap **Albums**.

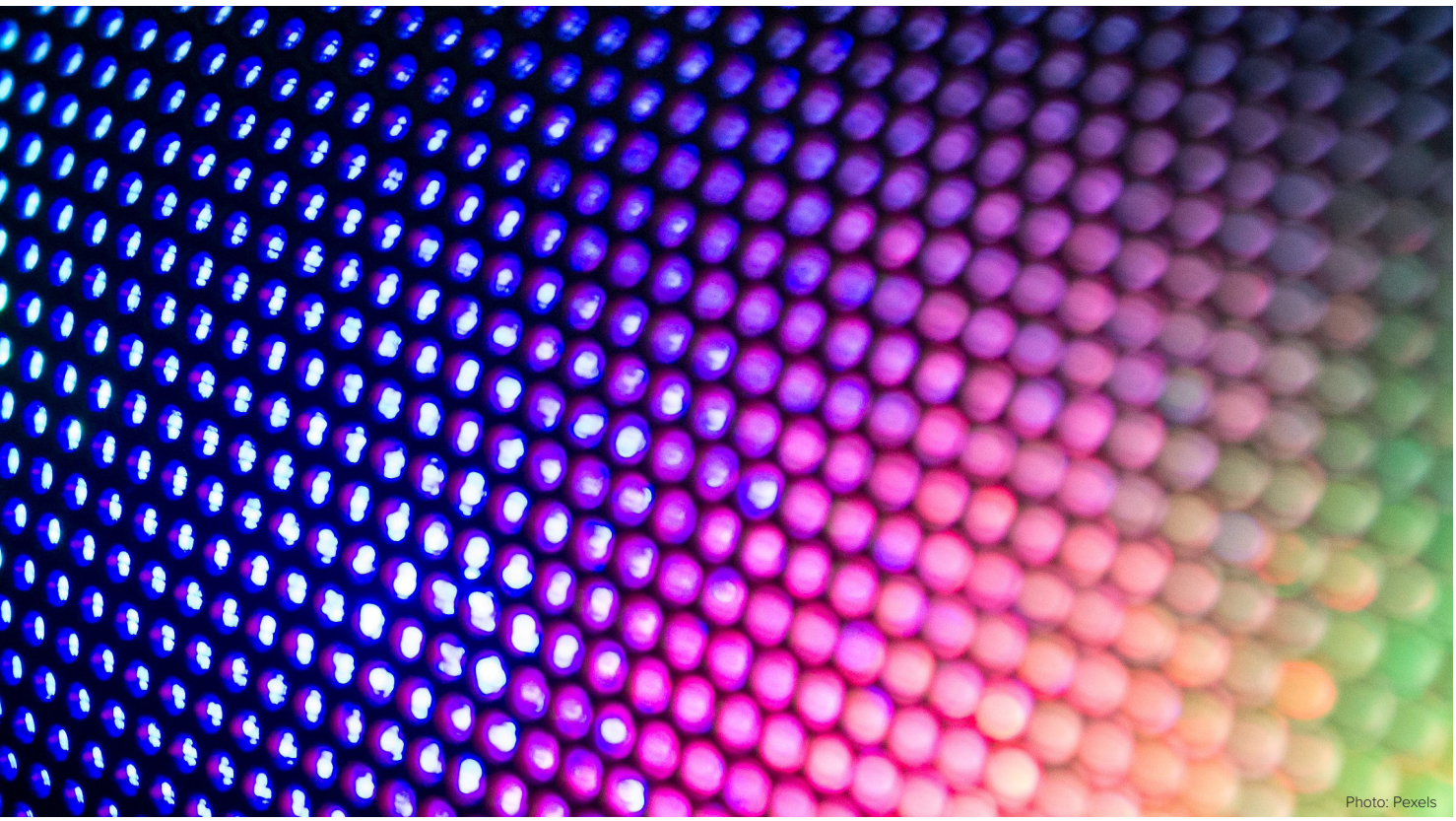


Photo: Pexels

- Scroll to down to **Utilities**, then tap **Hidden**.

To undo hiding a photo:

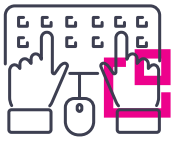
- Open **Photos** and locate the photo/s you wish to 'unhide'.
- Tap **Select**, tap the **Share** icon, then tap **Unhide**.

What are NFTs?

NFT stands for non-fungible token and is proof of ownership for a digital item. Software, electronic books, MP3 music and podcasts are examples of digital items as they are accessed online in a digital format. The tokens are unique asset identifiers that are considered to be non-fungible because they cannot be forged, replicated or divided. (The opposite of non-fungible is fungible, meaning that something – a good or asset – can be exchanged for something of the same kind. Money is a good example of fungability, as you can swap a $10 note for two x $5 notes). Some common things currently sold as NFTs are the digital forms of trading cards, art, music, images, video clips and games, but NFTs can function as a non-duplicatable digital certificate of ownership for any assigned digital asset.

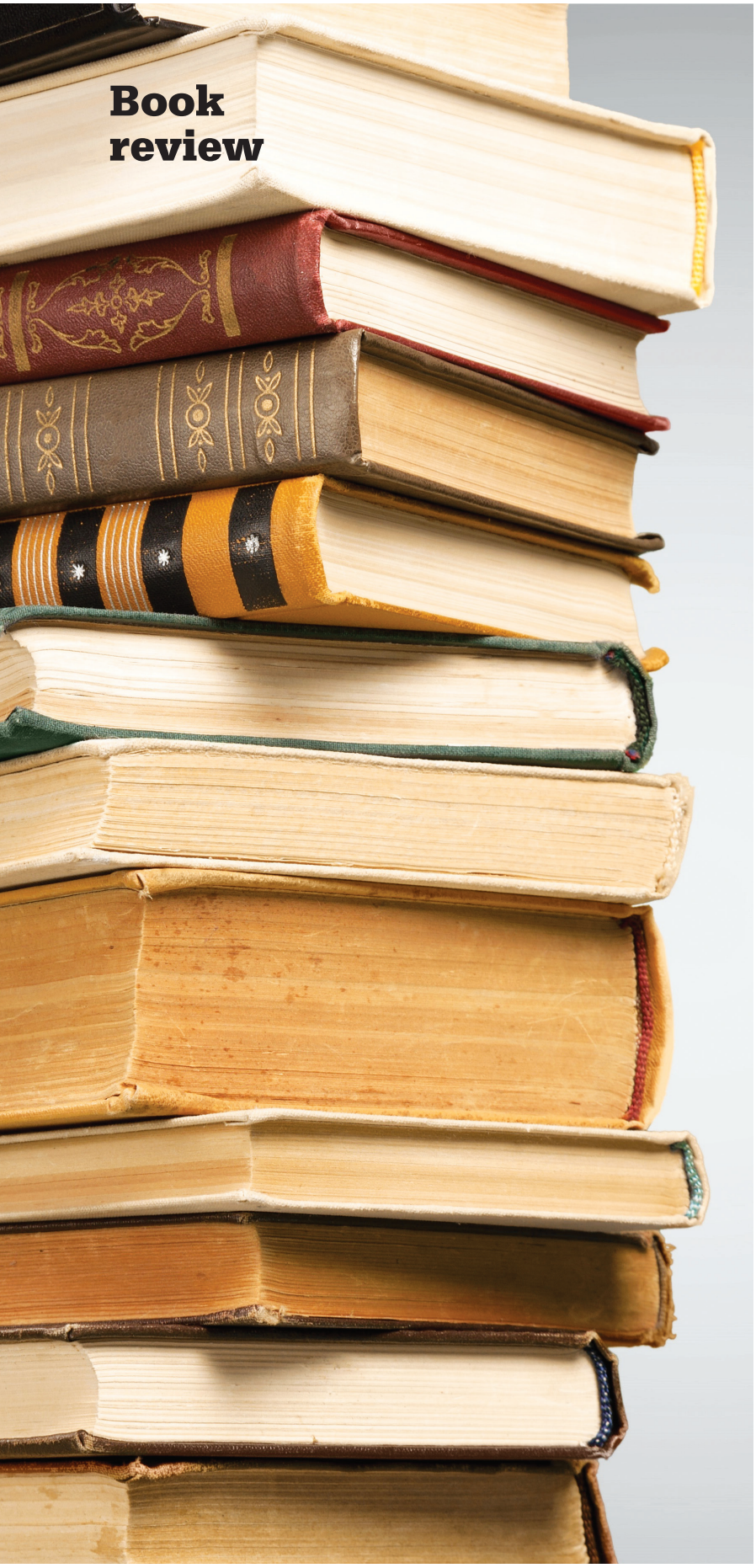
To use an example, if a person buys an original painting in digital form, they receive it online rather than taking delivery of a physical canvas to be hung on a living room wall. To ensure ownership, they receive an NFT, which proves the purchased digital file is the original. There can only be one owner of an item once it has been sold using an NFT, and the owner's private crypto key proves proprietorship of the item. Similar to bitcoins, NFTs contain ownership details for identification and easy transfer between token holders, and like cryptocurrencies, an NFT's value comes from the market's perception – for example, Twitter's founder transformed his first tweet into an NFT and sold it for $2,915,835.47.

If the concept of digital ownership and sales interests you, please do your research thoroughly (Google has a wealth of information) and ensure you understand the crypto marketplace first. ■

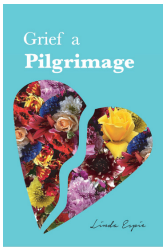


As always, all website addresses and user instructions supplied were correct at time of submission and neither the ACA nor Dr Angela Lewis receive any payment or gratuity for publication of any website addresses presented here.

Photo: 123rf



Book review



Grief a pilgrimage
By Linda Espie
Reviewed by Liz Antcliff

Grief a pilgrimage is written from Linda Espie's lived experience of death, loss and grief and, as she is a grief and bereavement counsellor and psychotherapist, with the wisdom of professional knowledge and practice. This little book is 99 pages in length and tells the story of the journey with grief, and the validation of the human experience, after the death of a loved family member. Espie is an Australian author and practitioner, and *Grief a pilgrimage* is her fifth publication on grief and bereavement.

We follow the personal account of the author as she recounts the experience of her sister's death. This journey with grief mirrors the metaphor of walking a pilgrimage trail; those such as the Camino demand physical, psychological and spiritual tenacity, forging change within oneself. Throughout the book, Espie reflects on her and her sister's relationship spanning their shared life as children, into adulthood and her sister's illness and decline toward her death.

Through the story, Espie presents the physicality of grief, the emotional work of memories and the processing of the significance of relationship. She writes about finding gratitude in memories, the realisation of personal growth through pain and suffering, and about accepting new understandings and perspectives that she calls "gifts and discoveries" (p 93).

We are taken on this journey as Espie shares selected journal entries. She includes beautiful quotes at the opening of every chapter that provide a salient point for the words that follow. By quoting mystics and philosophers, such as Thomas Merton, Meister Erkhart and Joseph Campbell, she brings a spiritual texture to her reflections. Also interspersed throughout the text are lines of poetry written by Espie. While it is a deeply personal account, there is also the thread of knowing, of wisdom that is shared, which I suspect is born from Espie's experience as a grief and bereavement counsellor.

Grief a pilgrimage is a small book in size. The chapters are often a few pages in length, the writing style is easy to read and it has a deeply personal tone. However, reading this little book also offers validation of the human experience of grief and normalises grieving as an ongoing process. The experience of loss is revisited as the relationship with the loved one changes, reflecting the absence and the sense of the continued importance of the deceased in the lives of those still living.

This book is suited as a resource for those who are experiencing grief and bereavement, and for those who are seeking ways to find meaning in their experience. By characterising grief as a pilgrimage, Espie gives us a sense of the spiritual, emotional and psychological gifts to be gained through suffering loss and grief.

About the reviewer
Liz Antcliff, Ma Coun; B. Sc App Psych; Phd Grad researcher (CAMTRU/ UOM)

Photo: Unsplash

REGIONAL COUNSELLORS' PERSPECTIVES ON THEIR SELF-CARE NEEDS

By Marta Bloom and Dr Mark Pearson

Abstract

This study identifies the self-care perspectives of counsellors across the Sunshine Coast, Queensland, Australia. This qualitative, grounded theory study identifies how counsellors in regional Australia perceive their needs for self-care, and the activities they use. This study gathered self-reports on self-care attitudes and behaviours from five participants who are actively working as counsellors. The results show regular engagement in self-care-related behaviours, and that these activities are valued as important. Peer support has been nominated as the most sought activity. Surprisingly, clinical supervision was deemed as a technical requirement and not a support for self-care. The findings indicate a need for future research to develop a model for establishing region-specific self-care activities or programs, and further investigation of the qualifications and agency roles of clinical supervisors.

Introduction

Self-care is considered a type of behaviour in which counsellors can improve health, development and wellbeing and support healing (O'Halloran & Linton, 2000). Self-care serves the purpose of supporting optimal functioning and growth on a personal and professional level, and it is being increasingly recognised as a necessity for those who aim work in the helping professions (McLeod & McLeod, 2011; Norcoss, 2000). Considering the context of their profession, counsellors who, according to Skovholt (2011), feel the constant pressure of giving to others first, may eventually face

the urgency of their own needs being met. It appears that a cycle of uncertainty, guilt and, finally, burnout may follow, as counsellors have been taught how to be attentive and sensitive to the needs of others, but not so much to their own needs.

Barlow and Phelan (2007) claim that although, historically, looking after one's own health and wellbeing has been discussed in theoretical terms, execution in real-life settings was always less successful. Indeed, the common reasoning of students who are preparing for mental health professions seems to be that supervision alone will suffice as a form of self-care that will protect them from burnout or compassion fatigue (Thompson, Frick & Trice-Black, 2011). O'Halloran and Linton (2000) have identified self-care as vital and urge professionals to prescribe it for themselves as much as they prescribe it for their clients. Characteristically, the wellbeing of a mental health practitioner impacts severely on the therapeutic relationship, and has been found as one of the main contributing factors that impact on the successful outcome of therapy (Bradley et al., 2013; Friedman, 2017).

This study reviews the self-care perspectives and efforts of counsellors in the regional community of the Sunshine Coast (SC), Queensland. In the UK, Barton (2020) claimed therapist self-care is a vital area, as it has implications not only for therapists but also for their clients, yet it is under-researched. No studies have gathered data from Australian regional counsellors. Generally, counsellors on the SC have limited access to professional development workshops and seminars without significant travel and accommodation costs. Keeping up to date with professional expertise and increasing professional self-understanding have been identified as factors in preventing burnout (Skovholt, Grier & Hanson, 2001). Professional development is often an inspirational source contributing to preventing burnout, yet there are many regional and rural counsellors with limited access to in-person events that may also contribute to social inclusion and networking. Of course, the COVID-19 restrictions and cautions have seen an explosion of online professional development offerings.

Although workshops offer new opportunities for learning and networking, they can only ever be effective if attainable within a realistic scope of time and travel. Residents of the SC need, on average, two hours' driving time to reach Brisbane city, so joining a seminar for a whole day can become problematic if time is of the essence. Research on the contribution of online seminars to self-care and decreasing of burnout has yet to be conducted. It may be that the missing elements of socialising and networking reduce the self-care impact.

Adding to the fact that counsellors have been faced with social distancing rules and travel restrictions due to the COVID-19 pandemic, training opportunities designed as seminars or workshops have often been postponed until further notice or, regrettably, cancelled. Consequently, already limited offerings of self-care seminars have been further restricted and, therefore, impacted negatively on counsellors' opportunities for self-care training. Counsellors on the SC have been finding fewer opportunities to exchange experiences and reunite with industry colleges and trainers, who also participate in self-care courses. There appear to be repercussions among counsellors when left to their own devices to negotiate when, where and how to self-care effectively (Schechter et al., 2020).

Nevertheless, in a constantly changing world the pursuit of previously functional professional development habits will need to be transformed and adjusted to the reality of counselling during and after global pandemics. New skills for using technology are being urgently taught, as counsellors are being pressed to quickly grow their professional skills, readjust and keep pace with the evolving industry. Counsellors' levels of stress escalate correspondingly (Bard, 2020; Shiozawa & Uchida, 2020).

Historically, whenever there are additional demands placed on counsellors (for example, further training), self-care activities are neglected in the process of balancing work and free time (Effiong et al., 2020). The self-care of a counselling professional appears to be low on the list of priorities, despite its direct impact on the quality of the therapeutic relationship, and, therefore, the success of therapy outcomes (Bradley et al., 2013; Friedman, 2017).

Overall, due to geographic restrictions, the limited number of

Photo: Toa Heftiba/Unsplash

available workshops on the SC, and an increased psychological impact due to additional educational demands, it appears questionable that online seminars alone would suffice as a self-care contributors for professionals in regional areas. During times of global adjustment, individual solutions for effective self-care strategies may be sought more than ever.

Hence, it was relevant to investigate the self-care behaviours of regional counsellors, and possibly develop a framework, or a description of how self-care phenomena is practised and perceived within the community of counselling professionals. An aim of this study was to identify useful recommendations that develop out of the specifics of participants' attitudes and behaviours. In practical terms, this means providing recommendations to develop individually tailored activities and programs within this the regional area.

Literature review

The literature shows that the extensive research on burnout in the helping professions does highlight the problem when severe signs and consequences are obvious, yet individually tailored self-care strategies within area specific possibilities have not been investigated (Arvay, 2001; Bimrose & Hearne, 2012; Lawson, 2007; Myers & Sweeney, 2008). That is, the literature tends to fail to explain how people in the helping professions can actively engage in wellbeing in the first place. Only a small percentage of the counselling literature explores self-care, but this is explored theoretically, and without specific examples that are relevant to everyone (O'Halloran & Linton, 2000; Patsiopoulos & Buchanan, 2011).

Studies on burnout point to the negative consequences on work quality due to insufficient self-care strategies (Sharpio, 2007; Thompson, Frick & Trice-Black, 2011). Counsellors' burnout negatively impacts wellbeing and quality of work. Gutierrez and Mullen (2016) suggest that counsellors are especially susceptible to burnout and that counsellor-specific activities should be implemented in the workplace. Burnout can emerge within the first year of practice, and then counsellors' interest in connecting with clients on deeper levels shrinks rapidly, which, in turn, negatively affects the success of therapeutic outcomes (France, 2014). McMahon, Wilding and Palmer (2013) warn against neglecting to take sufficient breaks during client work and highlight the positive outcomes from engagement in self-healing strategies.

Research on therapy outcomes demonstrates that the

counselling relationship is one of the main factors contributing to successful outcomes and, while the counsellor's wellbeing is crucial to effective practice, it cannot become the last element to be considered (Lawson, 2007). Furthermore, leaving self-care as last on the list gets exacerbated through community demands and group acceptance, highlighting the expectations of being resistant to work stressors (Cooper, Quick & Schabracq, 2009).

The ACA Code of Ethics (ACA, 2019) notes that in situations of personal or emotional difficulty, excessive tiredness or illness, counsellors will monitor the point at which they are no longer competent to practice and act accordingly. This section in the Code indicates consequences of burnout that will become problematic once they affect a counsellor's work, yet decisions on self-care may be left to the individual. Furthermore, studies on personality traits show how counsellors with more rigid personality types could face higher degrees of burnout if they are not aware enough to make adjustments (Moate et al., 2011). Further contributors to increasing burnout among counsellors are ethical dilemmas, transference trauma and additional work stressors (Landrum, Knight & Flynn, 2012; Mullen, Morris & Lord, 2017; Seymour, Smith & Chambers, 2003). Some studies highlight the vulnerability of counsellors due to imperceptibly developing compassion fatigue, and advise future research to focus on improvement of self-care activities. Without active and specifically tailored measures in place, counsellors are more likely to suffer from the effects of burnout and typically retreat into a forced timeout from work when it is long overdue (Skovhollt & Trotter-Mathison, 2011). Meanwhile, a healthy balance between work and life appears to contribute to greater job satisfaction and allows counsellors to effectively engage in their work (Friedman, 2017; Payne, 1989). Keeping up to date with professional expertise and increasing professional self-understanding have also been identified as factors in preventing burnout (Skovholt, Grier & Hanson, 2001).

Studies on self-care indicate that mindfulness training can be an appropriate choice for burnout and compassion fatigue prevention (Friedman, 2017; Sharpio, 2005). Additionally, the importance of self-compassion practice and recognition of early warning signs as self-care behaviours have been highlighted, along with encouragement for practitioners to understand the positive impact of self-care on their professional and personal wellbeing (Arvay, 2001; Boellinghaus, Jones & Hutton, 2014; Christopher & Marris, 2010; Myers & Sweeney 2008; Norcross, 2000).

Examining practitioner attitudes to, and practice of, self-care could help identify the most effective self-care strategies on an individual level. Overall, research suggests a crucial

Photo: Avrielle Suleiman/Unsplash

role for self-care in the helping professions, while counselling professional bodies clearly call attention to the necessity of self-care practice in their codes of ethics (ACA, 2019; PACFA, 2015).

Methodology

Grounded theory (GT) was the method used for this examination of counsellors' perspectives and behaviours regarding self-care. As defined by Glaser and Strauss (1976), GT is a method for exploring perspectives on human behaviour in a specific context and is useful when gathering participant meanings that can lead to the emergence of theory (Engward, 2013). The process of hermeneutic interpretation of data helped establish meaning from both the participant's explanation of the phenomenon and the researcher's understanding. Constructive interpretation of empirical research evoked results embedded from the direct experience of the participants (Age, 2011). This study identified a number of themes or categories that together provide the participants' perspectives.

Participants

Five qualified, practicing counsellors located on the SC participated in the study. There were three females and two males. Participants' ages ranged from 39 years to 50 years.

Data collection

Data collection was through individual recorded semi-structured interviews. It was a circular process that began with the first semi-structured interview, using open questions. The transcript was then analysed, revealing data for categories that were then expanded through subsequent interviews. The process ended when theoretical saturation was reached (Goulding, 2002).

Five interviews allowed enough material to achieve saturation of themes. Due to the pandemic crisis, utilising online resources for recruitment and interviews were optimal options. Interviews were audio recorded and transcribed. The interviews were

semi-structured, which enhanced participants' disclosure of specific perspectives, activities and roles connected to their experiences of self-care.

Data analysis

Data analysis followed the steps of GT: coding and comparing, and memo-writing (Glaser, 1992; Goulding, 2002). Relevant statements were coded via open, axial and selective coding, and the formed codes were interpreted, compared and bundled into concepts and categories. The aim was to build an overview, adding themes or categories to the process until saturation occurred (Glaser, 2007).

The responsibility of the researcher was to reflect on their own role in the development of theory and to convert the complexity of individual perceptions into an overall schema. The researchers wrote journals and self-reflected throughout the process. The process of examining the researcher's own perspective (social constructionism) relies on the existing knowledge and experience of the researcher and becomes central for theory development (Flick, 2007). Emerging thoughts and comments of the researcher were documented throughout the whole process to enhance objective interpretation.

Results

Analysis of the interview transcripts revealed two main categories: general positive attitudes to self-care and self-care through interpersonal connections, with four self-care subcategories: physical activities, preventative activities in the workplace, time out and cognitive stimulation, and least-useful activities. Three other connected themes that emerged were attitudes towards supervision, impact of COVID-19, and a time frame for neglect of self-care.

Positive attitudes towards self-care

The value of self-care in participants' lives has been consciously appreciated and respected. Participants responded to the idea of self-care with enthusiasm and gratification. It was reported as an essential part of their daily routines. One participant described self-care as part of her value system, being truthful and authentic towards oneself. Participants all agreed on the idea that self-care is an ongoing monitoring process and that it contributes vitally to their mental health.

"I think it is important. Not just in terms of work but also with coping in general with life. And I always notice when I am busy, I neglect self-care." – *Brian*

"I think self-care is vital. I guess it is about having those moments of recuperating and revitalising my energy."– *Jane*

Self-care is employed to avoid burnout and compassion fatigue, and also to enhance general wellbeing. Self-care activities are chosen tailored to the individual's preference. Self-care included social interaction with peers and colleagues and was seen as a support for dialogue with oneself. A healthier working life was seen as being fostered through self-care strategies. All participants acknowledged actively engaging in self-care and were clear about how they use it to their advantage.

Regular engagement in self-care has been a long learning process and there appear to still be some gaps in how to effectively utilise it for optimum benefits. In accordance with research studies on counsellors' self-care, the current findings include an appreciation of the importance of wellbeing (Norcross, 2000; O'Halloran & Linton, 2000).

While not discussed in the current study, mindfulness practice, which has been found to increase awareness of the need for self-care among counsellors in training (Dye, Burke & Wolf, 2020), may be useful as an in-service training to enhance counsellors' future self-care.

The findings of awareness of the importance of daily self-care rituals, and the variety of activities that counsellors benefit from – especially those activities that provide relaxation, energy regeneration and positive mental wellbeing – would not be surprising to counsellors.

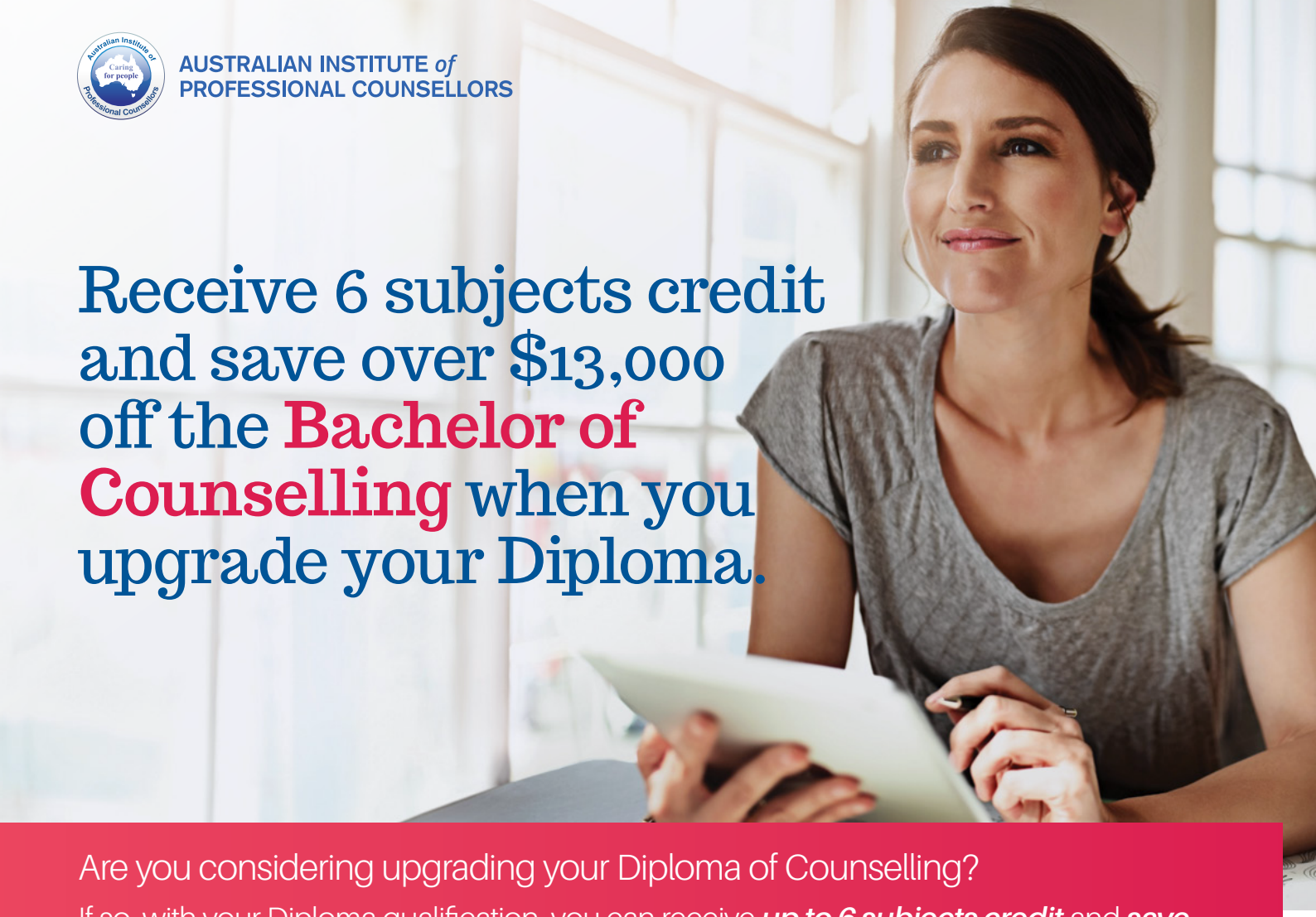
Self-care through interpersonal connections

Participants' statements demonstrated a strong orientation towards interpersonal connections. Peer support appears to be highly valued. Peer support in the form of 'friendly chats', 'relaxed get-togethers' and in a 'having a laugh' atmosphere were seen as contributing to mental wellbeing and energy recharge.

"Firstly, it is very important to have good peer support". – *Steven*

"Socialising with my peers and talking about stuff that has nothing to do with therapy is good for my self-care." – *Jane* **(continued page 16)**

AUSTRALIAN INSTITUTE *of* PROFESSIONAL COUNSELLORS



Receive 6 subjects credit and save over $13,000 off the Bachelor of Counselling when you upgrade your Diploma.

Are you considering upgrading your Diploma of Counselling?

If so, with your Diploma qualification, you can receive ***up to 6 subjects credit*** and ***save over $13,000*** off your Bachelor of Counselling.

AIPC's Bachelor of Counselling is one of the most flexible programs available:

- Learn in highly supported, personal cohorts
- Study externally from anywhere in Australia, even overseas
- Residential Schools available in **Melbourne, Sydney, Brisbane and Perth**
- Start with just 1 subject
- Receive 6 subjects credit from a Diploma of Counselling (CHC51015, CHC51712 or CHC51708)
- Move up to Level 3 ACA membership with a Bachelor of Counselling
- Open up additional employment and career opportunities.

And being **FEE-HELP approved**, you start now and pay later.

What some of our graduates are saying...

"Studying with AIPC is a really good thing to do because of the flexibility you have when choosing courses and you are very limited with the amount of time you have to stay away from work or family to attend residential schools. It is a very practical and specific course tailored for counselling to give you all the practical skills you need to be successful when you embark on your career."

Michael, AIPC Bachelor of Counselling Graduate

"If you are thinking about considering studying I would definitely go through AIPC. They have helped nurture me, made it easy to keep progressing and it is really rewarding."
Danielle, AIPC Bachelor of Counselling Graduate

"The tutors are wonderful. You can contact them at anytime during business hours or via email. If you have any issues the tutors will help you through and support you to find the solution."
Lois, AIPC Bachelor of Counselling Graduate

"I really enjoy doing the degree because it allows me to study at home. Having children also at home, I have been able to work my study around other things I need to do which has given me a lot of flexibility."
Colette, AIPC Bachelor of Counselling Graduate

Support is always close...

Sydney | Melbourne | Perth | Brisbane | Adelaide | Regional QLD | Gold Coast | NT/Tasmania

Learn more here: www.aipc.net.au/degree

All participants appeared to feel connected and supported through human interconnections. Safety and a sense of release were provided through peer support. There was a need to be socially engaged. Attachment with colleagues is formed over time and valued continuously.

"You find a group of people and peers that understand your work and you can support one another."– *Sarah*

Peer support was regarded as most valuable and has been identified as crucial for mental wellbeing and positive energy recharge. Participants rate these activities as more important than physical activity or any type of preventative practice at their workplace. The current findings are supported by the literature, which also shows that peer support does appear to elicit a positive effect on mental wellbeing (Barlow & Phelan, 2007; Bowman, 2007; Connors et al., 2020).

However, at the time of the interviews, participants' views seemed influenced by the impact of the COVID-19 restrictions on social gatherings. Social distancing rules restricted face-to-face connectivity with peer groups and potentially altered social connections to a point where peer connectivity seemed more attractive or desirable than ever before. Nonetheless, participants acknowledged possible modifications to their perception due to the COVID-19 situation.

Impact of COVID-19

Social distancing was seen to diminish the quality of peer relationships. Challenges meeting with support groups and friends accelerated pre-existing difficulties of arranging a time and place to see peers face to face. The reports were united: online meetings do not substitute for human contact. The reality of social restrictions impacted negatively on the counsellors' wellbeing, as they felt more isolated, and gatherings with friends were hard to manage:

"It is with peers that self-care works best, but because of COVID-19 everything is more isolated, that makes it hard at times." – *Steven*

"Meeting up with friends worked very well before COVID-19, but not now with Zoom. It does not work so well." – *Brian*

Physical activities

All participants emphasised the positive effect of daily activity, especially outdoor activities that include movement. Their awareness of the benefits of physical movement was apparent. Participants ffound that engaging with their selected form of exercise grounded them and gave them a reconnection to self.

"I enjoy running and going for a swim in the morning." – Steven

"Yoga and physical things help me get back to my body." – Jane

"I like to walk and cycle. I find exercise good for my self-care." – *Mary*

This theme is in line with a range of contemporary evidence on the value of physical activity in supporting wellbeing (for example, Murphy, Sweeney, & McGrane, 2020; Vert, et al., 2019; Wright, 2018). The current findings indicate that physical activity helps counsellors to reconnect with self and revitalise mind and body. It also allows for the release of negativity and work-related stresses. Movement and being in and deeply breathing fresh air are useful strategies that, when implemented regularly, can optimise health (Coon et al., 2011). Furthermore, medical research emphasises that moving the body regularly is crucial for our fitness and health (Black et al., 2015; Hawker, 2012). It appears pivotal that those working in a 'sitting profession' do take regular breaks for exercise, and ideally include outdoor activities (Iwuala et al., 2015).

Preventative activities in the workplace

Participants have established a variety of individually tailored strategies to prevent burnout, such as taking on fewer clients, reducing hours of work or taking time off work. These methods are effective at their workplace because they allow for some control and autonomy in decision-making about self-care. Participants reported that they learned from their own experience. There appears to be a need for self-management when it comes to structure at work. They see that the responsibility lies with the counsellor and not management. Participants paid attention to their own requirements, prioritising these over agency requirements.

"I used to be like five days a week, six or seven clients each day. I cannot do that anymore." – *Mary*

"I ask my manager for two days off or plan time off from work." – *Sarah*

Photo: Brian Gordillo/Unsplash

These findings indicate a similar trend evident in previous research, which supports the idea of preventative strategies at work to support self-care. Participants also all reported flexibility in how they arrange their working hours. They stated benefits of this strategy such as having additional spare time and feelings of being more energised for future therapy sessions. In this regard, self-management of working hours and setting of strict boundaries around availability are active measures participants engage in, in the hope for minimalising risk of burnout.

Burnout has often been identified as the main reason counsellors skip work, experience compassion fatigue or do not come to work anymore (Landrum, Knight & Flynn, 2012; Lee et al., 2010; Sangganjanavanich & Balkin, 2013). Therefore, it appears reasonable that counsellors have options to reduce hours of work and to remain unreachable to clients in their free time. These behaviours seem to help prevent counsellors burning out and correspond with studies claiming that a satisfactory work–life balance is key to optimal functioning (Shanafelt et al., 2015). Furthermore, research agrees with participants' claims and confirms that a reduction of workload does seem to increase productivity and work satisfaction (Kelliher et al., 2011).

Time out and cognitive stimulation

There appears to be in counsellors a longing for time away from work and holidays or weekend getaways in another place other than their hometown. The wish to physically remove oneself from routine spaces was distinct:

"I love taking holidays and try to take weekends away." – *Steven*

"I plan different things along the way, perhaps a weekend away." – *Brian*

Participants also search for cognitive stimulation, such as further training, study, seminars or courses within their industry. Nevertheless, training offered in different states has been noted as challenging to attend due to time and cost. A wish for local training was expressed:

"I like some sort of training, having a few days away and doing new techniques." – *Oliver*

"We once had a day together with colleagues on the Sunshine Coast. It brought everyone closer together." – *Steven*

Participants enjoy breaking the routine of being in one place for too long. This correlates with the literature, which states that time off work often results in a reset of cognition and a rewiring of brain functions, especially when people

Burnout has often been identified as the main reason counsellors skip work, experience compassion fatigue or do not come to work anymore.

change their location for a while, leading to positive impacts on mood and quality of life (Strandberg et al., 2017). Counsellors who report signs of fatigue and exhaustion benefit from holiday time (Wilson, 2012). The literature supports the current findings, showing that higher work satisfaction correlates with regular time off work and shorter working hours (Hurley, Orazem & Miller, 2000; Lopez, Madrigal & Pagez, 2010).

Participants reported awareness of benefits of additional training in staying cognitively sharp. As research suggests a link between higher education and life satisfaction, it appears reasonable that counsellors do enjoy keeping their skills up to date and expanding their professional knowledge (Koilias, Tourna & Koukouletsos, 2012; Mathur & Mehta, 2015). It is possible that further research could reveal that these strategies are somewhat situation or time specific.

Least useful activities

Several participants expressed a concern about engaging in less helpful self-care strategies, such as watching TV, drinking alcohol and emotional eating. These behaviours seemed to be sought out especially when participants reported feeling tired, passive and lazy (not energised):

"I like to sometimes just stay at home and watch TV, but that is something I do not allow myself to do too much because I know, for my self-care, it is always better to get out and do something." – *Sarah*

When considering the literature, these least useful strategies do not come as a surprise, as compassion fatigue, burnout and potential suicide have been identified as risk factors (Ahola et al., 2006; Heger, 2007). These least optimal solutions for battling feelings of tiredness or emotional drain are viewed by health practitioners as damaging in the long run. Reaching for alcoholic beverages appears to be a short-term strategy that seems to mend fractured moods, and mental health practitioners are not immune to these needs (Kumar, 2011).

Participants reported using emotional eating as a way of coping with unpleasant feelings after coming home from work. This type of coping strategy has been of interest to research in the fields of eating disorders and obesity (Khodabakhsh & Kiani, 2014; Rotella et al., 2018). Research into the association between feeling hopelessness, tiredness or anxiety and reaching for food seems to show that people do this in order to either fill a void or to use comfort food to literally try to swallow the unwanted feeling (Deroost & Cserjési, 2018; Sangganjanavanich & Balkin, 2013). While these unhealthy coping strategies were recognised by participants as not ideal solutions, continual engagement in these behaviours can act as warning signs for the risk of compassion fatigue.

Attitudes towards supervision

Clinical supervision was portrayed as a necessity. The requirement for clinical supervision was felt as a technicality and appeared not to fulfill the participants' needs for support. Supervision was seen as having a mostly cognitive nature, meaning advice-taking for different therapeutic approaches.

"For me supervision is not always useful, it is not the same as sharing, talking and having a laugh with friends". – *Jane*

"We do need formal supervision, but if I was feeling really burned out, I don't know if I find that as good as sharing with my friends". – *Mary*

"It is with peers that it works well, with supervision it is more a formality." – *Steven*

However, responsibility for a counsellor's wellbeing was not attributed to the supervisor, but self-care was acknowledged as an individual task.

"It is actually just me who is involved in the decision-making process of engaging in self-care." – *Brian*

"Self-care is totally my own responsibility." – *Sarah*

"It is not the clinical supervisor's responsibility to deal with that what I am supposed to do on my own." – *Jane*

Participants approached supervision through a lens of obligation. They reported a lack of relationship and an absence of trust in the interpersonal aspects of supervision. However, the functional aspect of the cognitive exchange on therapeutic interventions and procedures between counsellor and supervisor was experienced as convenient.

Reflecting on these unexpected findings leads to an assumption that some counsellors may be unclear on the different aims of clinical supervision and of lighthearted social interactions and connection. Nevertheless, participants identified that they would prefer to discuss their personal challenges and difficulties with peers rather than with their supervisors. This theme

Photo: Alysha Rosly/Unsplash

could lead to the question: what defines optimal supervision?The literature suggests that effective supervision can lower burnout and improve mental wellbeing (Bergen & Baltrinic, 2020; Edwards et al., 2006; Hyrkas, 2005). However, the question could be considered whether some counsellors on the SC are currently experiencing effective supervision, and whether that is in-house supervision by managers or confidential external supervision. Hence, it may be crucial to identify what may inhibit participants from being supported in a way that engenders connectivity, empathy and experiences of non-judgement.

Time frame for neglect of self-care

This theme revealed a continuum of one day up to three months for neglecting self-care. Participants usually engaged daily in some sort of self-care; however, some participants did not. Overall, all participants engaged in some form of self-care from daily activities to monthly, scheduled ones. Self-care is viewed as a learning process that along the time continuum changes with experience, trial and error and becomes individually tailored to suit the busy schedule of the counselling professional.

Implications for counsellors, counselling educators and agency management

The findings suggest that the participants do regularly engage in some sort of self-care-related behaviours and value these as important in their lives. Counsellors having peer support is crucial for mental wellbeing and is a central preference among self-care-related activities. Agency managers may increase workplace wellbeing through the organisation of time and activities that generate experiences of peer support.

There appears to be a discrepancy between expectations and theories on clinical supervision and the realities playing out in the field. Clinical supervisors may need to reflect on their style of supervision; managers may need to ensure confidential external supervision is provided; and definitions of supervision may need to be expanded to include some focus on individuals' needs for connections. These findings may become valuable to those who teach counselling or are involved
in counsellor's supervision within the industry.

Barton (2020) also gathered the self-care experiences of five experienced UK therapists, showing that self-care concerns for counsellors may be universal. Overall, this study showed that the self-care concepts of regional counsellors hold these areas as central: peer support, physical activities and preventative strategies at the workplace. In this regard, when teaching about and establishing personalised and region-specific self-care activities, recognition of these strategies should be considered for optimum workplace wellbeing and burnout prevention. The findings indicate a need for future research to develop a model for establishing region-specific self-care activities or programs, and further investigation of the qualifications, experience and agency roles of clinical supervisors. ■

Resources

Ahola, K., Honkonen, T., Pirkola, S., Isometsä, E., Kalimo, R., Nykyri, E., Aromaa, A., & Lönnqvist, J. (2006). Alcohol dependence in relation to burnout among the finnish working population. *Addiction*, 101(10), 1438–1443. https://doi.org/10.1111/j.1360-0443.2006.01539.x.

Age, L. (2011). Grounded theory methodology: positivism, hermeneutics, and pragmatism. T*he Qualitative Report*, 16(6), 1599-1615. Retrieved from nsuworks.nova.edu/tqr/vol16/iss6/8.

American Counselling Association (2014). ACA code of ethics.

Arvay, M. J. (2001). Secondary traumatic stress among trauma counsellors: What does the research say? *International Journal for the Advancement of Counselling*, 23(4), 283-293. doi: 10.1023/A:1014496419410

Bard, T. (2020). COVID-19 and a New Normal? *The Journal of Pastoral Care & Counseling*, 74(2), 81–81. doi.rg/10.1177/1542305020926831.

Barlow, C., & Phelan, A. (2007). Peer collaboration: A model to support counsellor self-care. *Canadian Journal of Counselling*, 41(1), 3–15. http://search.proquest.com/docview/195802401/.

Barton, H. (2020). An exploration of the experiences that counsellors have of taking care of their own mental, emotional and spiritual well-being. *Counselling & Psychotherapy Research*, 20, 516-524. doi: 10.1002/capr.12280

Bimrose, J., & Hearne, L. (2012). Resilience and career adaptability: Qualitative studies of adult career counseling. *Journal of Vocational Behavior*, 81(3), 338-344. Doi: 10.1016/j.jvb.2012.08.002

Boellinghaus, I., Jones, F. W., & Hutton, J. (2014). The role of mindfulness and loving-kindness meditation in cultivating self-compassion and other-focused concern in health care professionals. *Mindfulness*, 5(2), 129-138. Doi: 10.1007/s12671-012-0158-6

Black, S., Cooper, R., Martin, K., Brage, S., Kuh, D., & Stafford, M. (2015). Physical activity and mental well-being in a cohort aged 60-64 years. *American Journal of Preventive Medicine*, 49(2), 172–180. https://doi.org/10.1016/j.amepre.2015.03.009.

Bloom, J. (2012). How does a vacation from work affect employee health and well-being? *Psychology & Health*, 26(12), 1606–1623. https://doi.org/info:doi/.

Bowman, J. (2007). Dealing with job stress: peer support, time management, and self-care are key. *Professional Case Management*, 12(5), 252–253. https://doi.org/10.1097/01.PCAMA.0000291422.69234.3e.

Bradley, N., Whisenhunt, J., Adamson, N., & Kress, V. (2013). Creative approaches for promoting counselor self-care. *Journal of Creativity in Mental Health*, 8(4), 456–469. doi.org/10.1080/15401383.2013.844656.

Charmaz, K. (2006). Constructing Grounded Theory. *A practical guide through qualitative analysis*. London: Sage.

Charmaz, K. (2008). Constructionism and the grounded theory method. In: J. A. Holstein & J. F. Gubrium (Eds), *Handbook of Constructionist Research* (pp.397-412). New York: The Guilford Press.

Christopher, J. C., & Maris, J. A. (2010). Integrating mindfulness as self-care into counselling and psychotherapy training. *Counselling and Psychotherapy Research*, 10(2), 114-125. Doi: 10.1080/14733141003750285

Cooper, C., Quick, J., & Schabracq, M. (2009). *International handbook of work and health psychology* (3rd ed.). Chichester, UK: Wiley-Blackwell.

Connors, C., Dukhanin, V., March, A., Parks, J., Norvell, M., & Wu, A. (2020). Peer support for nurses as second victims: resilience, burnout, and job satisfaction. *Journal of Patient Safety and Risk Management*, 25(1), 22–28. https://doi.org/10.1177/2516043519882517.

Coon, J., Boddy, K., Stein, K., Whear, R., Barton, J., & Depledge, M. (2011). Does participating in physical activity in outdoor natural environments have a greater effect on physical and mental wellbeing than physical activity indoors? A systematic review. *Journal of Epidemiology and Community Health*, 65(Suppl 2), A38–A38. https://doi.org/ 10.1136/jech.2011.143586.85.

Effiong, A. I., Nseobot, I. R., Simeon, I. I., Ette, U., Ahmed Soomro, M., KM, D., Edet, A. U., et al (2020). Counselling for COVID-19 patients: implications for social well-being. *American Journal of Social and Humanitarian Research*, 1(3), 1-8.

Engward, H. (2013). Understanding grounded theory. *Nursing Standard* (Royal College of Nursing, Great Britain), 28(7), 37–41. doi.org/10.7748/ns2013.10.28.7.37.e7806.

Flick, U. (2007). *Designing qualitative research*. London: SAGE Publications.

Friedman, K. (2017). Counselor self-care and mindfulness. *Contemporary Buddhism*, 18(2), 321-330. doi.org/10.1080/14639947.2017.1373437.

Glaser, B. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.

Glaser, B. (2007). Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods*, 1(2), 1–38. https://doi.org/info:doi.

Goulding, C. (2002). *Grounded Theory*. In Grounded Theory. United Kingdom, London: SAGE Publications. doi.org/10.4135/9781849209236.

Gutierrez, D., & Mullen, P. (2016). Emotional intelligence and the counselor: Examining the relationship of trait emotional intelligence to counselor burnout. *Journal of Mental Health Counseling*, 38(3), 187–200. doi.org/10.1774/mehc.38.3.01.

Hawker, C. (2012). Physical activity and mental well-being in student nurses. *Nurse Education Today*, 32(3), 325–331. https://doi.org/10.1016/j.nedt.2011.07.013.

Hegerl, U. (2007). Burnout - alcohol problems - risk of suicide. role reversal: The doctor as patient. *MMW-Fortschritte der Medizin*, 149(27-28), 26–27.

Hurley, T., Orazem, P., Kliebstein, J., & Miller, D. (2000). Work environment, time off lead job satisfaction list. *National Hog Farmer*, 45(6), E16. http://search.proquest.com/docview/197632849/.

Hyrkäs, K. (2005). Clinical supervision, burnout, and job satisfaction among mental health and psychiatric nurses in Finland. *Issues in Mental Health Nursing*, 26(5), 531–556. https://doi.org/10.1080/01612840590931975.

Iwuala, S., Sekoni, A., Olamoyegun, M., Akanbi, M., Sabir, A., & Ayankogbe, O. (2015). Self-reported physical activity among health care professionals in south-west Nigeria. *Nigerian Journal of Clinical Practice*, 18(6), 790–795. https://doi.org/10.4103/1119-3077.163275.

Landrum, B., Knight, D., & Flynn, P. (2012). The impact of organizational stress and burnout on client engagement. *Journal of Substance Abuse Treatment*, 42(2), 222–230. https://doi.org/10.1016/j.jsat.2011.10.011.

López, B. F., Madrigal, L., & Pagés, C. (2010). Part-time work, gender and job satisfaction: Evidence from a developing country. *The Journal of Development Studies*, 46(9), 1543–1571. https://doi.org/10.1080/00220388.2010.492864.

Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., Fothergil, A., & Coyle, D. (2006). Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses. *Journal of Clinical Nursing*, 15(8), 1007–1015. https://doi.org/10.1111/j.1365-2702.2006.01370.x

Kelliher, C., Anderson, D., Kossek, E., Lewis, S., & Hammer, L. (2010). Doing more with less? Flexible working practices and the intensification of work. *Human Relations*, 63(1), 83–106. https://doi.org/10.1177/0018726709349199.

Koilias, C., Tourna, E., & Koukouletsos, K. (2012). Job satisfaction of higher education graduates. *Operational Research*, 12(3), 421–437. https://doi.org/10.1007/s12351-010-0099-6.

Kumar, S. (2011). Burnout and psychiatrists: What do we know and where to from here? *Epidemiology and Psychiatric Sciences*, 20(4), 295–301. https://doi.org/10.1017/S204579601100059X.

Landrum, B., Knight, D., & Flynn, P. (2012). The impact of organizational stress and burnout on client engagement. *Journal of Substance Abuse Treatment*, 42(2), 222–230. https://doi.org/10.1016/j.jsat.2011.10.011.

Lawson, G. (2007). Counselor wellness and impairment: a national survey. *Journal of Humanistic Counseling*, Education and Development, 46(1), 20–34. doi.org/10.1002/j.2161-1939.2007.tb00023.x.

Lee, S., Cho, S., Kissinger, D., & Ogle, N. (2010). A typology of burnout in professional

counsellors. *Journal of Counselling & Development*, 88(2), 131–138. https://doi.org/10.1002/j.1556-6678.2010.tb00001.x.

Mathur, A., & Mehta, A. (2015). Factors affecting job satisfaction among employees of higher education: a case study. *Journal of Strategic Human Resource Management*, 4(1), n/a. https://doi.org/10.21863/jshrm/2015.4.1.006.

McLeod, J., & McLeod, J. (2011). *Counselling skills a practical guide for counsellors and helping professionals* (2nd ed.). Maidenhead: Open University Press.

McMahon, G., Palmer, S., & Wilding, C. (2013). *The essential skills for setting up a counselling and psychotherapy practice*. East Sussex, UK: Routledge.

Moate, R., Gnilka, P., West, E., & Bruns, K. (2016). Stress and burnout among counselor educators: Differences between adaptive perfectionists, maladaptive perfectionists, and non-perfectionists. *Journal of Counseling & Development*, 94(2), 161–171. https://doi.org/10.1002/jcad.12073.

Myers, J. E., & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. *Journal of Counseling & Development*, 86(4), 482-493. doi: 10.1002/j.1556-6678.2008.tb00536.x

Mullen, P., Morris, C., & Lord, M. (2017). The experience of ethical dilemmas, burnout, and stress among practicing counselors. *Counseling and Values*, 62(1), 37–56. https://doi.org/10.1002/cvj.12048.

Murphy, J., Sweeney, M. R., & McGrane, B. (2020). *Physical activity and sports participation* in Irish adolescents and associations with anxiety, depression and mental wellbeing. Findings from the Physical Activity and Wellbeing (Paws) Study. Physical Activity and Health, 4(1), 107 – 119. DOI: 10.5334/paah.58

Norcross, J. (2000). Psychotherapist self-care: practitioner-tested, research-informed strategies. *Professional Psychology: Research and Practice,* 31(6), 710–713. https://doi.org/10.1037/0735-7028.31.6.710.

O'Halloran, T., & Linton, J. (2000). Stress on the job: Self-care resources for counselors. *Journal of Mental Health Counseling*, 22(4), 354–364. http://search.proquest.com/docview/198792954/.

Patsiopoulos, A. T., & Buchanan, M. J. (2011). The practice of self-compassion in counseling: A narrative inquiry. Professional *Psychology: Research and Practice*, 42(4), 301-307. doi: 10.1037/a0024482

PACFA (2005). Code of Ethics. Psychotherapy and Counselling Federation Australia.

Payne, L. (1989). Preventing rehabilitation counselor burnout by balancing the caseload. *Journal of Rehabilitation*, 55(4), 20-24. search.proquest.com/docview/236263571/.

Rotella, F., Mannucci, E., Gemignani, S., Lazzeretti, L., Fioravanti, G., & Ricca, V. (2018). Emotional eating and temperamental traits in eating disorders: A dimensional approach. *Psychiatry Research*, 264, 1–8. https://doi.org/10.1016/j.psychres.2018.03.066.

Sangganjanavanich, V., & Balkin, R. (2013). Burnout and job satisfaction among counsellor educators. *Journal of Humanistic Counseling*, 52(1), 67–79. https://doi.org/10.1002/j.2161-1939.2013.00033.x.

Schechter, A., Diaz, F., Moise, N., Anstey, E., Ye, S., et al. (2020). Psychological distress, coping behaviours, and preferences for support among New York healthcare workers during the COVID-19 pandemic: *General Hospital Psychiatry*, 66, 1-8. doi: 10.1016/j.genhosppsych.2020.06.007

Seymour, R., Smith, D., & Chambers, T. (2003). Beyond burnout: When the counselor needs help. *Journal of Psychoactive Drugs*, 35(3), 410. search.proquest.com/docview/207973233/.

Shapiro, S. (2005). Mindfulness-based stress reduction for health care professionals: results from a randomized trial. *International Journal of Stress Management*., 12(2), 164–176. doi.org/info:doi/.

Shiozawa, P., & Uchida, R. (2020). An updated systematic review on the coronavirus pandemic: Lessons for psychiatry. *Brazilian Journal of Psychiatry*, 42(3), 330–331. doi.org/10.1590/1516-4446-2020-0975.

Skovholt, T. (2011). *The resilient practitioner: burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals* (2nd ed.). New York; London: Routledge.

Skovholt, T. M., Grier, T. L., & Hanson, M. R. (2001). Career counselling for longevity: Self-Care and Burnout prevention strategies for counsellor resilience. *Journal of Career Development*, 27(3), 167-176.

Shanafelt, T., Hasan, O., Dyrbye, L., Sinsky, C., Satele, D., Sloan, J., & West, C. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clinic Proceedings,* 90(12), 1600–1613. https://doi.org/10.1016/j.mayocp.2015.08.023.

Strandberg, T., Von Bonsdorff, M., Strandberg, A., Pitkälä, K., & Räikkönen, K. (2017). Associations of vacation time with lifestyle, long-term mortality and health-related quality of life in old age: The Helsinki Businessmen Study. *European Geriatric Medicine*, 8(3), 260–264. https://doi.org/10.1016/j.eurger.2017.03.003.

Thompson, F., Frick, M., & Trice-Black, S. (2011). Counselor-in-training perceptions of supervision practices related to self-care and burnout. *The Professional Counselor*, 1(3), 152–162. doi.org/10.15241/eht.1.3.152.

Thornberg, R. (2012). Informed grounded theory. *Scandinavian Journal of Educational Research*, 56(3), 243–259. doi.org/10.1080/00313831.2011.581686.

Vert, C., et al. (2019). Impact of a riverside accessibility intervention on use, physical activity, and wellbeing: A mixed methods pre-post evaluation. *Landscape and Urban Planning*, 190, p.103611. https://doi.org/10.1016/j.landurbplan.2019.103611

West, W. (2001). Beyond grounded theory: The use of a heuristic approach to qualitative research. *Counselling and Psychotherapy Research*, 1(2), 126–131. doi.org/10.1080/14733140112331385168.

Wilson, M. (2012). Work characteristics and employee health and well-being: Test of a model of healthy work organization. *Journal of Occupational and Organizational Psychology*, 77(4), 565–588. https://doi.org/info:doi/.

Wright, A. (2018). Exploring the relationship between community-based physical activity and wellbeing in people with dementia. *Ageing and Society*, 38(3), 522-542. doi: 10.1017/S0144686X16001124

About the authors

Marta Bloom
B.Arts (Psych & Counselling); M.Couns.

Marta holds a Bachelor of Psychology and Counselling and a Master of Counselling. She has been successfully running her private practice in Caloundra for some time now.

Dr Mark Pearson
PhD., MEd(BEM), Dip T.

Mark is a senior lecturer in counselling at the University of the Sunshine Coast. While no longer in practice, he has over 30 years of experience as a counsellor and supervisor. He specialises in teaching expressive therapies.

INTERRUPTING WITH INTENTION: UNDERSTANDING INTERRUPTING WITHIN A COLLABORATIVE THERAPEUTIC RELATIONSHIP

By Abigail Boukogiannis

Abstract

Despite the vast amount of research on the therapeutic relationship, little is known about the role interrupting plays in the building and maintaining of the relationship between counsellor and client. Interrupting is often part of everyday dialogue, as well as part of the discourse in therapeutic settings. This paper investigates the author's experiences as a counsellor using the intervention of interrupting and uncovering what role intentionality plays. This autoethnographic study considers that from a social constructionist lens, which holds the view of a collaborative approach to therapy, there might be an alternative view of this intervention. Data was collected and compiled over a 10-month period, detailed in the form of written reflective journals and vignettes. The autoethnographic methodology was made possible by the author's experiences in a counselling clinic, working with individuals and couples using a social constructionist lens and comparing those experiences to what literature presents on the topic.

Introduction

Interrupting has long been part of my conversational life. Growing up in a predominately Latin culture in Miami, Florida, it was simply part of the dominant communication style. I never thought too deeply about the ideas surrounding interruption until I stepped foot into a room where I was the primary counsellor. Taking into consideration the framework I was studying and planning to use in sessions, I took pause. When working as a counsellor, I endeavoured to offer a social constructionist framework to my clients, making sure I was in alignment with this framework when it came to using appropriate interventions. This framework is a therapeutic process that is a collaborative between client and counsellor, and allows space for co-construction of alternative possibilities and multiple perspectives (Dickerson, 2010). I began to consider interruptions as more than just part of conversations. I started to ask myself questions about why, how and when did I use this intervention? Did I even have an awareness of when it was happening in these therapeutic

Photo: Pexels/Jopwell

conversations? Were these even important questions to be answered?

Goldberg (1990) asserted that interruptions are attempts to gain control of the discourse and put pressure on the speaker to relinquish control. These ideas were furthered by Tannen (1994), who suggested that interrupting is a form of dominance and power, especially when a person repeatedly interrupts. These two studies alone solidified that not only was this a topic worth exploring, but also it was a topic that would shine light onto my own habits, thoughts and assumptions about interruptions. Focusing on interruptions, which for some counsellors might seem a minor intervention, may help to uncover their overall intent and whether or not their intentions are congruent within their framework of practice. Practicing from a social constructionist framework, one that recognises that humans generate meaning together largely though language, means that it is important to place a magnifying glass over even the smallest forms of language (Gergen, Gergen & Ness, 2019).

This study encompasses my own experiences with interruptions within the counselling context,

introducing the idea of a social constructionist lens on interruptions and uncovering that intention plays a vital role for me. Considering that autoethnographic research is not solely focused on the self but also about searching for an understanding of others through the self, it exemplifies the social constructionist idea that there are multiple perspectives about how interruptions can be used and perceived (Burr, 2015; Chang, 2016a). From my experiences, as well as from reading the literature, the research question I found myself asking was this: because there can be many elements that contribute to someone choosing to use the intervention of interrupting, what are mine? The following study unfolded from focusing directly on interrupting, allowing for a multifaceted view of how intentionality came to play a crucial role in how and when I utilise this intervention.

Choosing autoethnographic research

Ellis and Adams (2014) describe autoethnographic research as research writing, stories and methods connecting the autobiographic and personal to the social, cultural and political – an approach that considers personal experiences as important sources of knowledge and insight into the broader cultural experience. Autoethnography opens a wider lens to the world, by avoiding a rigid definition of what constitutes meaningful and useful research; it seeks to unite the ethnographic (the outward story beyond the self) with the autobiographical (the inward story of the self) (Le Roux, 2017).

Within this type of research there is an emphasis on personal experiences. This sits well within the framework used to conduct this study. The experiences I had with interrupting may be vastly different from those of other counsellors, so looking at this topic from multiple views and perspectives is necessary. The embracing of personal experience allows for the dual identities of the academic and personal to be displayed in order to tell stories of one's experiences (Ellis & Adams, 2014).

This type of research suits me well as an emerging counsellor who aims to work from a social constructionist lens that privileges multiple perspectives and stories. For this study the perspective is my own.

My intent is to consider my experiences in comparison and in contrast to what the literature presents on the topic of interrupting and intentionality within the scope of the therapeutic relationship. My hope is that in sharing my learned knowledge on interruptions, I can help to generate meaningful conversations and break down some of the stigma around the assumption that society perceives interrupting as rude, with some counsellors even being trained to avoid interrupting for this reason (Dryden, 2018). More knowledge about the intervention may make way for interruptions to be used in thoughtful and intentional ways for emerging counsellors.

Methods

A reflective journal kept over a period of approximately 10 months was used as the data source. In these journals were reflections on both primary counsellor experiences, as well as group experiences, while being part of a reflecting team in a clinical setting within a university. Reflections were focused on the experiences I had within these two roles. The autoethnographic method focuses on the inward journey, exposing the vulnerable self, while considering the outward implications of the personal experience, both socially and culturally (Ellis & Adams, 2014).

An analysis of the data was done by reading through the journal entries and assessing the parts that were pertinent to this autoethnographic study. Through this analysis, there were prominent themes and ideas that were present and expanded throughout the clinical experience. It was important to consider that the reflections written in the journals were not about trying to decipher how clients responded to being interrupted but rather what the experience was like from my perspective and the questions I found myself asking.

To give a richer picture, vignettes of some experiences are included. The three vignettes in this study give a glimpse into how interruptions feel in a face-to-face counselling session with one individual, in an online counselling session and, finally, in a couples counselling session. These were included in the hope that more questions and considerations could be generated from my observations and experiences for other counselling professionals and students.

The results of this study indicated that many factors are present when making the decision to interrupt during a counselling session, many of which are dependent on the

Photo: Pexels/Vlada Karpovich

A reflective journal kept over a period of approximately 10 months was used as the data source. In these journals were reflections on both primary counsellor experiences, as well as group experiences, while being part of a reflecting team in a clinical setting within a university.

counsellor's framework of practice. For myself, intentionality was the most vital factor; that is, making sure that my intentions were congruent with the framework of a social constructionist counsellor.

Review of the literature

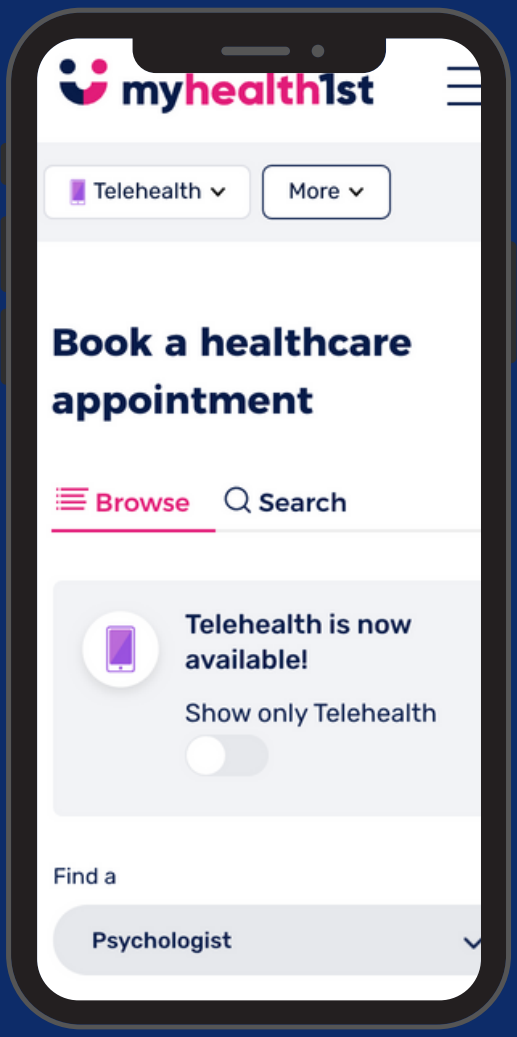
In my early journal entries, I asked myself questions focused on the therapeutic relationship. Why did initial sessions feel easier when subsequent sessions felt harder for me? I realised that in those first sessions, I focused on developing a rapport with my client. Research has consistently shown that the therapeutic relationship is a significant predictor in the outcome of therapy, thus there has been an abundance of research in understanding how the relationship is built, maintained and strengthened (Howgego et al., 2003).

For the purpose of this study, looking at the therapeutic relationship through a social constructionist lens is most relevant. The epistemological stance within this framework is that a client is the central piece to the process. The framework is collaborative and allows for the co-construction of alternative possibilities and promotes a bottom-to-top analysis of power (Dickerson, 2010). As previously stated, this framework relies heavily on language as it recognises that through language meaning is generated, and that meaning and action are intertwined (Gergen et al., 2019). Villatte (2016) points out that language is the building block for the therapeutic relationship, as it is language that provokes insight, teaches skills and concepts, allows for the expression of

(continued page 28)

myhealth1st

Are you doing everything you can to drive bookings and ensure that clients have the best experience possible?



Let Australia's most trusted online booking service

help your practice thrive in an increasingly digital world.

To learn more, visit:
www.myhealth1st.com.au/mentalhealth

myhealth1st

Metcalf (2017) claims that when a client begins to open up about the problem they have brought to therapy, counsellors often feel that they need to jump in, offering their assistance too quickly. This is based on the belief that if they do not do so, the client might falter.

empathy, and guides any therapeutic exercises. He goes on to say that all interventions rely on language, even silence. This means that interruptions are a type of intervention that can be used within therapeutic conversations. Therapeutic conversations will involve a variety of interventions, and often the interventions seen are dependent on the framework used. Within a social constructionist framework, an intervention is meant to be used in service of the client since they are central to the process and their knowledge and ideas should be privileged above those of the counsellor.

Language style matching, or LSM, is one interesting way to understand how language plays such a vital role in the therapeutic relationship as well as in interrupting. In a 2011 study, researchers measured the degree to which two people sometimes subtly match one another's speaking style (Ireland et al., 2011). A correlation was seen between LSM being high and heightened attunement to the other person. Borelli (2019) scaffolded the ideas from this study analysing LSM within a therapeutic context, finding that higher LSM between clients and counsellors may be reflective of superior therapeutic relationships. This higher attunement between counsellor and client may result in the client feeling more understood by their counsellor and becoming willing to engage in the therapeutic work, resulting in superior outcomes.

How does interrupting fit into the counselling session?

Metcalf (2017) claims that when a client begins to open up about the problem they have brought to therapy, counsellors often feel that they need to jump in, offering their assistance too quickly. This is based on the belief that if they do not do so, the client might falter. It is possible then to say that interruptions may happen often in a counselling session for this reason. Whereas some experts felt that this intervention was used as an attempt to gain control over the discourse and put pressure on the speaker to give up control, others did not see it as a challenge to the speaker's right to finish speaking (Goldberg, 1990). As such, interrupting might be an intervention that is looked at with more scrutiny because within a society it can often be perceived as rude.

As language plays an integral role for a counsellor using a social constructionist framework of practice, it is an important part of how they engage with clients during sessions. Because of their focus on the language, counsellors using this framework might be able to observe and acknowledge the power of and influence of the words they choose within therapeutic conversations. This knowledge may allow them to interrupt in ways that are backed by thoughtful and client centred ways of speaking in therapeutic conversations.

Looking at LSM, there is a possibility there could be a correlation between matching a client's way of speaking in terms of interruptions. If a client feels comfortable being interrupted or interrupting their counsellor, it may allow for the intervention to be used within a therapeutic conversation.

Counsellors will not always remain a silent listener in sessions. There are a number of interventions that can be used within a therapeutic conversation. Some of these include reframing, the use of humour, relabelling, language changes and active listening (Watts & Carlson, 1999). My study would like to add interruption to that growing list. A shift from active listening to actively engaging in the therapeutic conversation may come in the form of an interruption. To look at this with more specificity during a session, a counsellor using solution focused therapy may make the decision to stop a client from going into too much detail about the problem story they have brought to therapy (Trepper, 2012).

Some view interruptions as rude, or as a display of dominance and power. A social constructivist counsellor would likely agree that interruptions are a display of power, and avoid them. These counsellors view clients as the experts in their own lives, and would probably want to share power with clients as much as possible (Dickerson, 2010; Guiffrida, 2015; Metcalf, 2017; Tannen, 1994).

To be consistent within a social constructionist framework, there must be consideration on what society's view on interrupting is while also knowing that there is no subjective reality since there are multiple perspectives and realities

Photo: Pexels/cottonbro

Metcalf (2017) claims that when a client begins to open up about the problem they have brought to therapy, counsellors often feel that they need to jump in, offering their assistance too quickly. This is based on the belief that if they do not do so, the client might falter.

(Presbury, 2008). With that thinking in mind, interruptions can be used and perceived in many ways within this framework because there is no single version of how events happen (Burr, 2015). Nelson (2012) echoes this by stating that interruptions can show a speaker's enthusiasm or support, while at other times they can be seen as disruptive.

The possibility that interruptions can be used gently and with transparency about why the interruption happened can still be in alignment within the overarching epistemological viewpoint of a social constructionist counsellor. This stance is that the therapeutic process is client centred, collaborative and co-constructed, where power is as equal as possible (Dickerson, 2010). With this idea in mind, interruptions might make possible a redirection of a client's focus from negative thoughts or language. It could also be used in order to help refocus a client and get them back on task, if there seemed to be a struggle to keep focus (Dryden, 2018; Lipchik, 2011).

Emergence of intentionality

When I first began to look closely at interruptions, I had to ask myself, "Why do I interrupt?". The simple answer at the beginning of this exploration is that I had absolutely no idea. I had never thought to consider if I had any intention or reason behind it. Was I using this intervention in ways that aligned with my own epistemology or was I simply just wanting to share my ideas and thoughts? As an emerging counsellor who aims to work within a social constructionist framework, I needed to assess whether my interruptions were in service of myself or if they were in the service of my clients. My reflective journal helped to uncover questions and ideas I had throughout the 10 months, which helped solidify that when I interrupt during counselling sessions, I want to do so intentionally.

Counsellor intentionality has been researched for many years, dating back to the 1970s (Gersten et al., 2013). Narrative therapy is described as an intentional and dynamic dialogue between client and counsellor where new meaning is created (Suddeath, Kerwin & Dugger, 2017). Narrative therapy is part of the overarching social constructionist framework and it is clear that intentionality is part of the fabric of this framework. For interruptions to happen in congruence with a type of therapy, a counsellor must have an awareness of their intention to use or not use it. Gersten (2013) points out that counsellors in the early stages of training at times lack intentionality. He asserts that it can manifest in two ways: the complete absence of intention or not recalling the intention. This study also found that trainees demonstrated this non-intentionality by only identifying

the skills used, not the intention behind them, and by the inability to articulate their intention. This is why it is so important to evaluate if there is intentionality behind interventions. This can be done with any intervention, including interruptions.

To put this in context for this paper, understanding a few things about ways in which a social constructionist counsellor may use interruptions intentionally is helpful. A social constructionist counsellor might choose to interrupt with the intention to use externalising language in reference to a client's problem, so they can help the client separate their identity from their problem (Payne, 2006). Another way a counsellor can be intentional with an interruption is by using transparency. This way, a counsellor may choose to be honest about why they interrupted in order to give their clients that knowledge and open up a collaborative discussion about it (Anderson, 2016). If a counsellor has awareness about the importance of intention, there might be space in supervision to go over this to unpack what it means for them, in order to gain clarity on whether they are being intentional or unintentional during their sessions.

Intentionality was continually highlighted for me when looking at interruptions. It became clear that, for me personally, the intention far outweighed the response from clients. If they had responded badly, I could be transparent and walk them through the intention behind my interruption and why it might have been beneficial for me to use this intervention. From there, I believe an open dialogue could be generated and the collaboration between myself and my clients around the interruptions would be possible.

I can say, within my own practice, it was not until I called into question if I had any intention to interrupt that I could then ask these kinds of questions in the larger scope of my practice. I think if we can begin to bring intentionality into our practice on these micro levels, we can then begin to see a clearer picture of where our epistemology stands and if it is indeed congruent with our way of engaging with clients. The questions around intentionality can be asked about any part of our practice as counsellors, from how we greet our clients to wrapping up and terminating the therapeutic relationship. If I can be more intentional about my interruptions, what would that make possible for the therapeutic relationship I build with my clients? (continued page 32)

Ethical implications

Although autoethnographic research is focused primarily on the self, there are still ethical issues to be considered. An autoethnographer still must keep in mind that other people will always remain present in self-narratives, either actively participating in the story or as an associate in the background (Chang, 2016a). The most important of the ethical principles and guidelines I want to adhere to is respect for person, meaning that I treat each person involved in the research with respect, by not including details that would identify them in any way (Adams, 2015). The choice to de-identify the clients in this study is important to keep their privacy and confidentiality in place. I also made the decision not to identify the clinical setting by name as to further protect client anonymity. Chang (2016b) drives this point home, saying that in telling our stories there is a need to be sensitive and intentional in implementing strategies that protect the rights of those implicated in our stories. This was especially poignant for me as a researcher because intentionally was brought into focus through doing this autoethnographic study. I wanted to keep a close eye that I did not do this research simply to improve in my own practice. I personally do not think that would be ethical. I did not want to use clients to benefit only myself. I wanted to make sure that there was something to learn for anyone who chose to read this article.

The other important piece to consider in terms of ethics was how much to disclose about myself. What is revealed about the autoethnographer can have serious implications for how they are viewed. These views include social, professional and personal contexts (Chang, 2016b). Because of this, researchers need to be cautious about what is revealed, being wise about what they disclose and how they are presented in their stories (Chang, 2016b; Chatham-Carpenter, 2010). Keeping this in mind, I made sure that when I wrote my vignettes, I was careful with my use of language not only about my clients but also with how I portrayed myself in the retelling of these stories.

Vignette one

This counselling session took place within a university clinic. The client was a female in her 20s. This particular client had come the previous year to the same clinic but had seen a male counsellor. I was the primary counsellor, with a reflecting team situated behind a mirror. This particular session was my first session with this client as a primary counsellor. For me, an initial session with a client is hugely important in building rapport in the therapeutic relationship. I aim to make clients feel heard, safe and comfortable. The client came to the session to talk about the anxiety she had been experiencing and had previously enjoyed the sessions with a reflecting team.

She brought with her a support worker, so although it was a conversation between her and I, there was also another person in the room. The conversation seemed to me to be going well; I felt comfortable and saw that I was allowing my own genuine personality to shine through. It was not until I interrupted her that I saw something in her demeanour change. She seemed not only startled by my interruption but also apologetic in her language. My heart sank a bit because I really felt like I had made a misstep. I honestly cannot remember why I interrupted, and after the session I could not recall the exchange that took place – only that my client had responded in a way that I perceived as negative. Had I let too much of myself in the room? I feel comfortable interrupting in my own life with people I have close bonds with, but had I forgotten that this conversation may need me to be more measured?

The feedback from the team was positive and not one person asked me about this interaction. This perplexed me. Did no one on my team notice this? It felt so big for me within the session that I was surprised no one picked up on it. Was it not a big deal? Was I thinking about this too hard or in too much depth?

I ruminated on this for a long time post-session. I had felt good overall about the session, but this one interaction made me begin to consider how interruptions might cause ruptures within the therapeutic relationship. After discussing this with my supervisor, she reminded me that in the social constructionist framework, the relationship is collaborative and that, possibly, I was looking at this from a psychodynamic lens. She challenged me to reframe this idea of rupture into something that aligned more closely with the type of counsellor I wanted to become.

I took on this challenge and began to question myself and those

around me about my interruptions. In the end, it was clear that I had seen interruptions as part of discourse in my own life, as part of the culture that I grew up in, and I had ceased to consider how this may be perceived within a counselling context. My research question was in its infancy here, but I knew that there was much more to uncover.

Vignette two

I saw this same client in person for three sessions before COVID-19 hit and the clinic shut down. We had a few weeks off before we were able to provide counselling services for clients in a telehealth format. My client had come back to continue with counselling in this new format of online video sessions.

The rapport and therapeutic relationship we had built over our three sessions felt to me as if it had a good foundation. I had been very measured with interruptions after that interaction in the initial session. I used a softer voice and thought much more intentionally about how and why I would interrupt her in a session. Telehealth felt different.

I did find that the therapeutic relationship was back to the beginning and that rapport needed to be built up again. I think that the time off from meeting, plus the new format of telehealth, played into this quite a bit. I also thought of this as a brand-new start, one where I could really be intentional about my interruptions and be in alignment with the social constructionist framework.

Interrupting in a telehealth session felt much harder than it had in a face-to-face session. I found myself sitting back and listening much more. As I reflected on this, I think there were many factors contributing to active listening being the dominant intervention. I could not feel as much of a 'vibe' for my client's comfort levels in a telehealth session. There were times I felt the pull or need to interrupt but stopped myself because online video sessions already had so many factors that make it more difficult. Things like internet speeds, internet dropouts, bad computer microphones and delayed buffering certainly interrupt the flow of a session. Interrupting felt like it would make taking turns speaking, which was already more difficult, even more so.

It is also important for me to reflect on what this format made possible for me. Upon reflection, I believe that it allowed me to acknowledge and see that listening and not interrupting is equally as useful as interrupting. I do not feel as if I was non-influential in the telehealth sessions I had when I did not interrupt. I think it allowed me to listen to the full speaking turn of my client and write down notes and ask questions when they finished speaking. Although there were times when I felt like interrupting may be helpful for things such as gaining clarity, refocusing the conversation or keeping my client from delving too much into her problem story, remaining silent had its own benefits. I think it allowed for my client to be in more control of the conversation, speaking about the things she found important and finishing when she was ready.

Vignette three

This was an initial session with a couple. They came in seeking help to strengthen their marriage and communicate better. I thought this would be a fantastic opportunity to witness how interruptions may play out within a couples counselling context. I noticed early on that one of the clients was the more dominant speaker. I wanted to make sure that both had enough space to speak and make sure I was not engaging with one more than the other.

This was tricky. In order to give the other space to talk, I found that interruptions were needed. This session came after I had done a majority of the literature review, so I was much more conscious of intentionality by this point. My intention in interrupting the speaker was to make sure that there was shared space within the conversation. My other intention was to show that interruptions within conversations can be done thoughtfully. With me demonstrating that within a conversation, interruption can be done tactfully and intentionally, it might make way for a parallel process to happen that focuses interruption during a conversation between them and without me present.

I noticed that within a couples counselling context, interruptions felt more present, not only me interrupting my clients, but also interruptions between the two clients. It made me wonder if, because I was seeing these two clients interrupt each other and being okay with it, that it then made it safer and more acceptable for me to interrupt them as well. It also had me thinking that the more

people there are in the room, the more possibilities and opportunities interrupting has to be present. This might mean that within a family counselling session, interrupting happens much more frequently because there will be many different communication styles within the group.

Discussion

The research has shown that there is a correlation between a strong therapeutic relationship between counsellor and client and reaching good outcomes. Less is known about how interrupting plays a role within building and maintaining a strong therapeutic relationship, and there is clear division between those who see it as helpful and those who think it is hurtful. Some will see interruptions as beneficial when used to keep clients on track, or when showing enthusiasm for a client's ideas and thoughts (Dryden, 2018; Nelson, 2012). Still others see interrupting as disruptive and a cause of power imbalance in the therapeutic relationship.

There is little research that considers what role intentionality plays in when and how interruptions are used within a counselling context. One conclusion that can be drawn is that if a counsellor's intention behind interrupting is in alignment with the overarching epistemology, they are more likely to be using the intervention with the client's best interest in mind. This will vary and be dependent on how the counsellor views the therapeutic relationship based on their specific framework. For me – a counsellor aiming to stay within the stance of social constructionist practice – my intentions for using interruptions are to keep my clients central to the process, refocusing their attention, reframing ideas, getting further information if there is a misunderstanding, and externalising in order to separate the identity of my client from their problem.

Implications for practice

The main purpose of this study was to address the lack of research about how and when interruptions are used with intentionality within the social constructionist framework. This was done using an autoethnographic method, using reflective journal entries written over a 10-month period, providing data particular to interrupting.

The major practical contribution of the present research is that seeking to understand a counsellor's intentionality behind an interruption is a first step in using the intervention more effectively within the counselling context. This can be done through reflective journalling, as done in this study, or within a supervision context. There is also room to determine approaches for looking at this intervention from a client's perspective, for example through a questionnaire or simply open dialogue with the counsellor.

I believe this research is especially meaningful because interrupting can be prominent within any type of conversation. Because of this fact, looking at it more specifically from a counselling context is important for any counsellor who wants to investigate ways in which their communication style might affect the flow or overall feeling of conversations with clients.

Limitations and future research

The major limitation to this research, and that is often seen throughout all autoethnographic research, is that the findings are biased toward myself and my experiences. The framework I used when conducting this research was social constructionist, which privileges multiple perspectives. Although I endeavoured to keep in mind the multiple perspectives when looking at interruptions, the experiences and reflections were through my personal lens. Lapadat (2017) acknowledges that autoethnographic research potentially narrows down subjects of study to university-trained researchers and students in training. Because of this, stories can be constrained to this population, which is true of this current study. This research is specifically through my lens and personal experiences, and because of this there can be no clear or absolute truth about the intervention of interrupting. Further research is needed to analyse interruptions not only from other frameworks, but also from the perspective of clients.

Conclusion

Interruptions happen; they happen in daily life and they happen in a counselling context. Generally, they are seen as simply part of a conversation. There seems to be a need for further investigation in a couple of different areas – specifically two of special interest to the topic of this paper. One area would be to see if there is truly a correlation between knowing one's intention behind the intervention and whether that

helps its efficacy. A second area would be, when working from a social constructionist framework, holding the epistemological stance of a client centred practice. Investigating this intervention from a client's perspective may shed new light on how it is used and accepted or not during a counselling session.

The question I asked myself in this study was about the elements that contribute to my decision to interrupt during a counselling session. Although there are many factors that can be involved in making this choice to go from listener to interrupter, the element that became more prominent for me was intention. I believe there is merit in the idea that intentionality plays a vital role with interruption, especially when using the social constructionist framework. As a counsellor aiming to be in alignment with that stance, I am invited to be critical of the idea that my observations of the world are absolute truth, and the stance causes me to constantly question my assumptions (Burr, 2015). Within this framework, where knowledge is co-constructed, there is a need for investigation on both sides – for a counsellor to understand their intentions of interrupting, and for a client to discover how they feel about being interrupted. This means that what will and will not work will vary from client to client, so there also needs to be room for reflection and reflexivity around the intervention of interrupting. ■

References

Adams, T. E. (2015). *Autoethnography*. New York, NY: Oxford University Press.

Anderson, H. (2016). Postmodern/poststructural/social construction therapies: Collaborative, narrative, and solution-focused. In T. L. Sexton, J. Lebow, T. L. Sexton, & J. Lebow (Eds.), *Handbook of family therapy*. (pp. 182-204). New York, NY, US: Routledge/Taylor & Francis Group.

Borelli, J. L., Sohn, L., Wang, B. A., Hong, K., DeCoste, C., & Suchman, N. E. (2019). Therapist–client language matching: Initial promise as a measure of therapist–client relationship quality. *Psychoanalytic Psychology*, 36(1), 9-18. doi:10.1037/pap0000177

Burr, V. (2015). *Social constructionism* (3rd ed. ed.). Hove, East Sussex: Routledge.

Chang, H. (2016a). *Autoethnography as method*. London: Routledge.

Chang, H. (2016b). *Collaborative autoethnography*. London: Routledge.

Chatham-Carpenter, A. (2010). "Do Thyself No Harm": Protecting Ourselves as Autoethnographers. *Journal of research practice*, 6(1), M1.

Dickerson, V. C. (2010). Positioning Oneself Within an Epistemology: Refining Our Thinking About Integrative Approaches. *Family Process*, 49(3), 349-368. doi:10.1111/j.1545-5300.2010.01327.x

Dryden, W. (2018). *Very brief therapeutic conversations* (First edition. ed.). Milton Park, Abingdon, Oxon: Routledge.

Ellis, C., & Adams, T. E. (2014). The purposes, practices, and principles of autoethnographic research. In *The Oxford handbook of qualitative research*. (pp. 254-276). New York, NY, US: Oxford University Press.

Gergen, K. J., Gergen, M., & Ness, O. (2019). Social Construction and Therapeutic Practices. In J. L. Lebow, A. L. Chambers, & D. C. Breunlin (Eds.), *Encyclopedia of Couple and Family Therapy* (pp. 2687-2694). Cham: Springer International Publishing.

Gersten, A. H., Mears, G. F., Baldwin, C. L., Roberts, S., Gaertner, D., & Bartley, J. L. (2013). The Development of Intentionality: Training and Supervision Implications. *The Clinical Supervisor*, 32(1), 70-89. doi:10.1080/07325223.2013.780877

Goldberg, J. A. (1990). Interrupting the discourse on interruptions: An analysis in terms of relationally neutral, power- and rapport-oriented acts. *Journal of Pragmatics*, 14(6), 883-903. doi:10.1016/0378-2166(90)90045-F

Guiffrida, D. (2015). A constructive approach to counselling and psychotherapy supervision. *Journal of Constructivist Psychology*, 28(1), 40-52. doi:10.1080/10720537.2014.922911

Howgego, I. M., Yellowlees, P., Owen, C., Meldrum, L., & Dark, F. (2003). The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian & New Zealand Journal of Psychiatry*, 37(2), 169-183. doi:10.1046/j.1440-1614.2003.01131.x

Ireland, M. E., Slatcher, R. B., Eastwick, P. W., Scissors, L. E., Finkel, E. J., & Pennebaker, J. W. (2011). Language Style Matching Predicts Relationship Initiation and Stability. *Psychological Science*, 22(1), 39-44. doi:10.1177/0956797610392928

Lapadat, J. C. (2017). Ethics in Autoethnography and Collaborative Autoethnography. *Qualitative inquiry*, 23(8), 589-603. doi:10.1177/1077800417704462

Le Roux, C. S. (2017). Exploring rigour in autoethnographic research. *International journal of social research methodology*, 20(2), 195-207. doi:10.1080/13645579.2016.1140965

Lipchik, E. (2011). *Beyond Technique in Solution-Focused Therapy Working with Emotions and the Therapeutic Relationship*. New York: Guilford Publications.

Metcalf, L. (2017). *Solution focused narrative therapy*. New York, New York: Springer Publishing Company.

Nelson, A. (2012). *The gender communication handbook conquering conversational collisions between men and women* (1st ed. ed.). San Francisco: Pfeiffer.

Payne, M. (2006). *Narrative therapy an introduction for counsellors* (2nd ed. ed.). London: SAGE.

Presbury, J. H. (2008). *Beyond brief counselling and therapy : an integrative approach* (2nd ed. ed.). Upper Saddle River, N.J.: Pearson Merrill Prentice Hall.

Suddeath, E., Kerwin, A., & Dugger, S. (2017). Narrative Family Therapy: Practical Techniques for More Effective Work with Couples and Families. *Journal of Mental Health Counselling*, 39(2), 116-131. doi:10.17744/mehc.39.2.03

Tannen, D. (1994). *Gender and Discourse*. Cary: Oxford University Press.

Trepper, T. S. (2012). Solution-focused brief therapy with families. *Asia Pacific Journal of Counselling and Psychotherapy*, 3(2), 137-148. doi:10.1080/21507686.2012.718285

Villatte, M. (2016). *Mastering the clinical conversation*. New York, New York ;: The Guilford Press.

Watts, R. E., & Carlson, J. (1999). *Interventions and strategies in counselling and psychotherapy*. Philadelphia, PA: Accelerated Development

About the author

Abigail Boukogiannis is an ACA level 2 counsellor. She holds a Master of Counselling degree from Queensland University of Technology and a Bachelor of Science from Florida State University. She is practicing from a social constructionist framework and has a special interest in working with mothers and families. Currently she is working as a foster and kinship care practitioner with Anglicare Southern Queensland.

Childhood trauma: its impact on mind, brain and body development

By Chloe Wells

Introduction

There is a growing body of evidence to show that trauma experienced in childhood can have long-term consequences. Traumatic experiences are far-reaching and do not discriminate in terms of age, gender, ethnicity, race or sexual orientation, and they can be a result of a single event (acute) or repeated exposure over time (chronic) (Dye, 2018). It is important to clarify what is meant by the term 'trauma'; for the purposes of this paper, any event that is an emotionally or physically harmful experience is considered trauma; this includes, but is not limited to, abuse, neglect, violence, loss, accidents, disasters and war (Dye, 2018; Hannan, 2016).

This paper will discuss how the experience of trauma in childhood affects the mind, brain and body of a child and how it can lead to a range of trauma-related behaviours.

Childhood trauma

Trauma is usually defined as any event that causes physical and/or psychological damage. Traumatic events that occur in childhood are not only becoming increasingly prevalent, but they also have pervasive implications for a child's level of functioning as they move through the developmental stages (Mahajan, 2018). Traumatic experiences can range from abuse and neglect through to loss, accidents and disasters. Exposure to these experiences has been shown to increase the potential for a child to develop an array of physiological and psychological illnesses and exhibit trauma-related behaviours (Roche et al., 2019). In addition to this, childhood trauma has also been found to place individuals at greater risk of developing post-traumatic stress disorder (PTSD), with symptoms including low self-concept, poor emotional regulation and disturbed relationships (Danese & Baldwin, 2017).

Impact on development

That childhood trauma has a negative impact on the mind, brain and body is well established (Kelleher et al., 2013; Heim et al., 2008). Research has shown that childhood trauma is a potent risk factor for developing psychological morbidities later in life (Heim et al., 2008; Cross et al., 2017).

Brain

Exposure to childhood trauma can impact brain development over time, with research showing that it can lead to changes in the structure and functioning of areas of the brain that are stress-sensitive, such as the hippocampus, pre-frontal cortex (PFC) and the amygdala (Cross et al., 2017). During normative development, the hippocampus receives and organises perceptual information, the 'who and what', and contextualises it into the 'when and where'. The PFC is then responsible for future recollections and attributions, which becomes the 'why' (Cross et al., 2017). Additionally, the PFC works together with the amygdala and the hippocampus to facilitate the consolidation of emotional and perceptual information (Cross et al., 2017; Jaworska-Andryszewska & Rybakowski, 2019).

When a child has had adverse experiences, the individual and interconnected functions of the hippocampus, amygdala and PFC are negatively impacted. This can result in inappropriate associations between perceptual, contextual and attributional information regarding traumatic events (Cross et al., 2017; Quidé et al., 2017). In addition to this, the brain's capacity for consciously managing recollections of traumatic events and managing the fear associated with them is negatively impacted (Cross et al., 2017; Quidé et al., 2017).

It is important not to negate the impact that childhood trauma has on executive functioning. Executive functioning refers to a set of processes, supported largely by the PFC, that facilitate the awareness and adaption of external and internal stimuli and goals (Cross et al., 2017). In a neurotypical brain, this means that context-appropriate, flexible and goal-oriented emotional and behavioural responses are produced (Cross et al., 2017). Executive functioning also comprises working memory, cognitive flexibility, inhibitory control and the ability to think abstractly (Cross et al., 2017; Quidé et al., 2017). Exposure to trauma in childhood, especially early childhood, has been shown to cause relative impairment to each of these processes and subsequently create a predisposition to an array of psychological morbidities later in life (Cross et al., 2017).

Photo: Pexels/pixabay

Mind

There is strong evidence to suggest that traumatic childhood experiences are linked to poor emotional regulation. Emotional regulation is comprised of various strategies to manage cognitive, behavioural and physiological responses to emotion by practicing awareness, acceptance and understanding of said emotions (Cross et al., 2017). As these processes are typically developed through modelling by parents and other supportive adults, when a child has suffered trauma, this process is interrupted or missing completely (Cross et al., 2017). Unfortunately, as a large portion of child maltreatment is abuse, neglect or violence in various forms from a primary caregiver, a child is not able to learn the appropriate emotional labelling or regulatory behaviours and, therefore, may develop deficits in these areas (Cross et al., 2017; Heim et al., 2008).

The current literature highlights a strong correlation between childhood trauma and the onset of various psychological problems later in life, such as major depressive disorder, schizophrenia and bipolar disorder, to name a few (Kelleher et al., 2013; Mrizak et al., 2016; Karatzias et al., 2016; Zavaschi et al., 2006). Among various environmental factors, childhood trauma is one of the most important predictors of psychological disorders. A study conducted by Jaworska-Andryszewska and Rybakowski (2019) found that in a group of adult bipolar sufferers,

63 per cent of them had experienced childhood trauma in any of its forms, compared to the 33 per cent of those in the neurotypical control group. The same research found that experiences of childhood trauma not only had an impact on the development of psychological disorders, but also impacted the clinical course of the disorder (Jaworska-Andryszewska & Rybakowski, 2019; Roy, 2010). For example, those who suffered from bipolar disorder had an earlier onset of the illness as they experienced physical abuse as a child; additionally, there was postponement in receiving a proper diagnosis and seeking appropriate treatment. These patients also experienced rapid-cycling of their symptoms with both the manic and depressive episodes being greater in intensity (Jaworska-Andryszewska & Rybakowski, 2019; Roy, 2010).

Experiences of childhood trauma is not just responsible for causing bipolar disorder; much of the literature has shown that there is a variety of mood disorders and psychiatric illnesses that can develop because of trauma (Jaworska-Andryszewska & Rybakowski, 2019; Cross et al., 2017).

Body

Perhaps the most widely discussed physiological impact of childhood trauma is the effect it has on the neuroendocrine system and the hypothalamic-pituitary-adrenal (HPA) axis (Danese & Baldwin, 2017). These pathways are responsible for the biological adaptation to stress. Childhood trauma experiences have been shown to alter the development of the HPA axis and, therefore, impact its functioning later in life (Danese & Baldwin, 2017). What research has found is that those children who have experienced trauma have chronic activation of the HPA axis and, therefore, have an elevated baseline cortisol level and a higher HPA axis reactivity to new stressors. Increased cortisol levels and hyperactivity of the HPA axis can be toxic to the developing brain, therefore having long-term impacts on brain functioning (Danese & Baldwin, 2017).

In addition to the impact on the neuroendocrine system, those who have experienced childhood trauma have been found to have an elevated level of inflammation in the body. Elevated inflammation is common amongst bipolar, schizophrenia and PTSD sufferers (Danese & Baldwin, 2017). Raised inflammation has been associated with poor treatment outcomes and diminished immune response (Danese & Baldwin, 2017).

Trauma-related behaviour

Childhood trauma is related to an array of risky, unhealthy and problematic behaviours. These behaviours vary across the developmental life span. For younger children, one of the main indicators is trouble with self-regulation and impulsivity (Williams, 2020; Kim & Choi, 2020). Self-regulation plays an important role in personal agency through its impact on thought, affect, motivation and action. Additionally, high impulsivity is a predictor of problematic behaviours later in life (Roche et al., 2019; Kim & Choi, 2020).

A study conducted by Roche et al. (2019) found that college students who had been exposed to trauma in their childhood were significantly more likely to engage in risky behaviours such as excessive alcohol consumption, tobacco use, drug use, restrictive eating, binge eating, risky sexual behaviour and self-injurious behaviour. Childhood trauma appears to also have a direct dose–response relationship with various types of problematic health behaviours; furthermore, these behaviours appear to be comorbid. For example, a high proportion of those who engage in excessive alcohol consumption also have a nicotine dependence (Roche et al., 2019). Similarly, those who engage in substance abuse can also experience bulimia nervosa and binge eating, and self-injurious behaviour has been associated with disordered eating (Roche et al., 2019).

While each of these behaviours is unique, research has posited that they are similar in function. What this means is that these behaviours are specific in that they are termed 'experiential avoidance behaviours' (Roche et al., 2019). These are attempts to avoid contact with internal experiences such as emotions, thoughts, memories or bodily sensations. While these behaviours may provide short-term relief of unpleasant internal

Photo: Hassan/Vakil

Childhood trauma is related to an array of risky, unhealthy and problematic behaviours. These behaviours vary across the developmental life span.


Photo: Pexels/ AllanMas

experiences, engaging in them can have negative long-term consequences. For example, engaging in long-term avoidance can result in increased exposure, intensity and duration of unwanted stimuli, as well as causing greater psychological distress, therefore being a paradoxical extension of an unwanted experience (Roche et al., 2019; Kim & Choi, 2020). Research has posited that a potential antidote to experiential avoidance behaviours could be mindfulness and acceptance, a willingness to embrace psychological experiences without any attempt to change them. This has been associated with more favourable outcomes following traumatic experiences (Roche at al., 2019).

Conclusion

Traumatic events that occur in childhood are not only becoming increasingly prevalent, but they also have pervasive implications for a child's level of functioning as they move through the developmental stages (Mahajan, 2018). Research over the years has found that childhood experiences of trauma can impact not only the brain, but the mind and body as well. Those who have experienced childhood trauma are also more likely to engage in unhealthy and problematic behaviours (Roche et al., 2019).

This paper has discussed the potential detrimental impacts of childhood trauma on the structure and function of the brain, in addition to the impact on mental and physiological health and the long-term implications of trauma-related behaviours. ■

Traumatic events that occur in childhood are not only becoming increasingly prevalent, but they also have pervasive implications for a child's level of functioning as they move through the developmental stages (Mahajan, 2018).

References

Cross, D., Fani, N., Powers, A., & Bradley, B. (2017). Neurobiological development in the context of childhood trauma. *American Psychological Association* (APA). https://doi.org/10.1111/cpsp.12198

Danese, A., & Baldwin, J. (2017). Hidden Wounds? Inflammatory Links Between Childhood Trauma and Psychopathology. *Annual Review of Psychology*, 68(1), 517–544. https://doi.org/10.1146/annurev-psych-010416-044208

Dye, H. (2018). The impact and long-term effects of childhood trauma. *Journal*

of Human Behavior in the Social Environment, 28(3), 381-392. https://doi.org/10.1080/10911359.2018.1435328

Hannan, T. (2016). Childhood trauma and the developing brain. *Australasian Science*, 37(7), 41. https://doi.org/10.3316/ielapa.571248077059492

Heim, C., Newport, D., Mletzko, T., Miller, A., & Nemeroff, C. (2008). The link between childhood trauma and depression: Insights from HPA axis studies in humans. *Psychoneuroendocrinology*, 33(6), 693–710. https://doi.org/10.1016/j.psyneuen.2008.03.008

Jaworska-Andryszewska, P., & Rybakowski, J. (2019). Childhood trauma in mood disorders: Neurobiological mechanisms and implications for treatment. *Pharmacological Reports*, 71(1), 112–120. https://doi.org/10.1016/j.pharep.2018.10.004

Karatzias, T., Howard, R., Power, K., Socherel, F., Heath, C., & Livingstone, A. (2016). Organic vs. functional neurological disorders: The role of childhood psychological trauma. *Child Abuse & Neglect*, 63, 1–6. https://doi.org/10.1016/j.chiabu.2016.11.011

Kelleher, I., Keeley, H., Corcoran, P., Ramsay, H., Wasserman, C., Carli, V., Sarchiapone, M., Hoven, C., Wasserman, D., & Cannon, M. (2013). Childhood Trauma and Psychosis in a Prospective Cohort Study: Cause, Effect, and Directionality. *The American Journal of Psychiatry*, 170(7), 734–741. https://doi.org/10.1176/appi.ajp.2012.12091169

Kim, J., & Choi, J. (2020). Influence of childhood trauma and post-traumatic stress symptoms on impulsivity: focusing on differences according to the dimensions of impulsivity. *European Journal of Psycho traumatology*, 11(1), 1-11. https://doi.org/10.1080/20008198.2020.1796276

Mahajan, M. (2018). Neurobiology of trauma and its implications for therapy. *Indian Journal of Health and Wellbeing*, 9(6), 849-853. https://www.iahrw.com/index.php/home/journal_detail/19#list

Mrizak, J., Trabelsi, R., Arous, A., Aissa, A., Ben Ammar, H., & El Hechmi, Z. (2016). The relationship between childhood trauma and theory of mind in schizophrenia. *European Psychiatry*, 33(S1), S259–S259. https://doi.org/10.1016/j.eurpsy.2016.01.660

Quidé, Y., O'Reilly, N., Rowland, J., Carr, V., Elzinga, B., & Green, M. (2017). Effects of childhood trauma on working memory in affective and non-affective psychotic disorders. *Brain Imaging and Behavior*, 11(3), 722–735. https://doi.org/10.1007/s11682-016-9548-z

Roche, A., Kroska, E., Miller, M., Kroska, S., & O'Hara, M. (2019). Childhood trauma and problem behavior: Examining the mediating roles of experiential avoidance and mindfulness processes. *Journal of American College Health*, 67(1), 17–26. https://doi.org/10.1080/07448481.2018.1455689

Roy, A. (2010). Combination of family history of suicidal behavior and childhood trauma may represent correlate of increased suicide risk. *Journal of Affective Disorders*, 130(1), 205–208. https://doi.org/10.1016/j.jad.2010.09.022

Williams, A. (2020). Early Childhood Trauma Impact on Adolescent Brain Development, Decision Making Abilities, and Delinquent Behaviors: Policy Implications for Juveniles Tried in Adult Court Systems. *Juvenile & Family Court Journal*, 71(1), 5–17. https://doi.org/10.1111/jfcj.12157

Zavaschi, M., Graeff, M., Menegassi, M., Mardini, V., Pires, D., Carvalho, R., Rohde, L., & Eizirik, C. (2006). Adult mood disorders and childhood psychological trauma. *Revista Brasileira de Psiquiatria,* 28(3), 184–190. https://doi.org/10.1590/S1516-44462006000300008

About the author

Chloe Wells is a final year Bachelor of Counselling student at the University of Notre Dame, Fremantle, Western Australia. She has a keen interest in promoting emotional resilience throughout the developmental lifespan. Chloe hopes to conduct further research in the area of grief and trauma counselling and psychotherapy.

Have you made a clinical will?

Photo: Unsplash

You think it is never going to happen to you, but in the event of your death, somebody is going to have to attend to the clients, supervisees, trainees and colleagues you leave behind.

By Sally Despenser

We have probably all heard of people who never got round to writing a will and, on their death, left a mess for others to sort out. It is not hard to see why many of us put off making a will. Unless you are already facing imminent death, you probably think it is never going to happen to you, and in any case, talking about it might make it happen. Freud (1957) put it like this: "Our unconscious … does not believe in its own death; it behaves as if it were immortal." It does not take a lot to imagine the

impact on clients, trainees and colleagues when a practitioner dies unexpectedly. It is much worse when none of the survivors has access to basic essential information: where to find the diary and how to contact clients, students and colleagues (with due regard to confidentiality), as well as information for sorting out business in the long term.

In our professional capacities we commit to offering clients, students and supervisees "as much care as is reasonably possible" (BACP, 2018). Consequently, we should have an advance plan in place for others to act on in case of sudden disaster. I shall call this advance plan a 'clinical will'. A clinical will consists of detailed arrangements to be carried out in the event of your death, and aims to leave as little mess as possible, with as little damage for clients, staff and colleagues as can be managed. The suggestions given here can be adapted to meet a wide range of professional situations. Other situations where an ending – temporary or permanent – is imposed by external circumstances (for example, fitness to practise, moving premises) will need to be taken into account.

Why is it necessary to make an advance plan?

As professionals (counsellors, trainers, supervisors, managers) in counselling settings, we know that arrangements for ending should be incorporated into the beginning of both therapeutic and business relationships. By explicit contracting we observe the ethical principles of fidelity and autonomy, beneficence and non-maleficence.

In essence, it is more ethical to say, 'We will do what we can to prepare for the end' (and then get on with making plans) than to do nothing, saying, 'We cannot face thinking about it.' However, knowing what we should do and doing it are different matters. 'Given the temptation to deny our mortality, we may delay making these arrangements and leave a difficult mess behind.'

This article presents a template for writing a clinical will, listing tasks, responsibilities and arrangements to make before it is too late. Please note, the clinical will is not intended to be a legal document.

Vignette

Joe and Chris are business partners running a counselling and training consultancy. Chris has just heard that Joe died last night in an accident abroad.

How would you/your practice/your training program respond in a circumstance such as this? Do you have a 'disaster plan' to guide your response? Unless the business partners have prepared a clinical will in advance, there is no guarantee that Chris will be able to 'pick up the pieces'. It cannot be assumed that colleagues in other settings (for example, a group of counsellors) will, without specific arrangements, have the necessary means. The need is perhaps even more pressing in solo practices.

Consequences

Apart from the personal and emotional impact on the survivor, she/he/they will be faced with obligations to the following interested parties:

- clients, trainees and supervisees;
- counsellors, colleagues, trainers and support staff;
- those who may have financial, contractual or other dealings with the business; and
- professional bodies and referring agencies.

They will also be faced with a complex array of needs, demands and feelings:

- a sudden death is likely to create panic and paralysis;
- it may be difficult to provide adequate 'holding' for self, clients and staff;
- there may be an absence of information (or limited information);
- limitations may have to be faced and repercussions managed as the situation unfolds;
- a sense of powerlessness and uncertainty may arise, as well as the need for a 'parental' figure to take charge;
- there may be feelings of anxiety about vulnerable clients, security of contact details and client records;
- getting in contact with people may be frustrating;
- there may be financial consequences to consider for the business and individuals;
- there may be fear that the reputation, standing and viability of the business may suffer;

A clinical will consists of detailed arrangements to be carried out in the event of your death, and aims to leave as little mess as possible, with as little damage for clients, staff and colleagues as can be managed.

- there may be unfinished emotional business for the therapist to consider (such as their perfectionism); and
- there may be unfinished emotional business for clients (such as other losses evoked, feelings of disappointment and rage, and the impulse for flight or intrusion).

In the example given above, the tasks may last an indeterminate length of time and require the input of several people. They may need to:

- liaise with the next of kin of the deceased;
- identify who has the power to make decisions on behalf of the business and who implements these decisions;
- decide who will be in charge of day-to-day responses;
- determine who to notify and in what order;
- identify people to carry out immediate tasks;
- decide who holds clinical responsibility;
- negotiate appropriate access to diary and client contact details;
- make confidential data and details secure;
- contact clients (current clients and waiting list);
- contact all staff (support staff, counsellors, supervisors, students);
- prepare an agreed publicity statement and make this available to staff, support staff and clients;
- appoint a spokesperson to field enquiries;
- arrange an appropriate way for all staff to keep in touch;
- source and offer other forms of support/counselling for clients (referring on);
- consider referring some future work to other practitioners;
- maintain appropriate contact with clients; and
- notify referring agencies, placement contacts, holders of relevant databases, course providers, professional association, insurers and fundholders.

Choosing an executor

An advance plan can provide a framework for responding to the consequences of such an event – clinical/professional, financial and administrative. Implementing the plan requires a willing, available, confidential and competent helper to carry out the various tasks, some of them delicate, others weighty and perhaps time consuming. It is unlikely to be appropriate or sensible to appoint a relative. You might want to choose your supervisor (if willing and geographically well placed), or have a mutual arrangement with a colleague. In any case, it needs some thought and discussion with potential candidates for the task.

The arrangement with an executor

Above is an example of a clinical will, which takes the form of an arrangement with the person appointed to carry out your wishes (the clinical executor). It can be modified to meet various professional circumstances.

Summary of clinical tasks and responsibilities

The following lists summarise the clinical tasks and responsibilities applicable to a wide range of practice, including agencies and the voluntary sector. There is some overlap of functions and shared responsibilities in these lists. Where an individual therapist is making these arrangements, the tasks may be assigned to the same individual, if that is acceptable to them. In all circumstances, the location of paperwork and information mentioned below will need to be made clear in advance, without compromising either security or confidentiality. It is vital to have a system for keeping this information up to date.

1. An executor for clinical/ professional tasks:

- has access to contact details for clients, supervisees, agencies and training agencies, and contacts these appropriately;
- deals with current clients and waiting list, decides who will contact them and formulates what to say;
- deals with clinical notes and records in accordance with policies, client contracts and the ethical framework;
- liaises with (clinical) referring agencies; and
- informs academic contacts about teaching/writing/ reviewing commitments.

2. An executor for financial tasks:

- pays bills, collects debts, cancels subscriptions (journals, libraries, memberships);
- notifies banks;
- notifies landlord, utilities, local council;
- takes care of wages, rent, insurance, tax, pensions, leftover funds;
- winds up trust, business, charity;
- notifies Charity Commission; and
- closes accounts with businesses and services (such as accountant, stationery supplier, cleaner).

3. An executor for administrative tasks:

- notifies funders and Charity Commission;
- liaises with (clinical) referring agencies;
- informs other signposting agencies, for example, Citizens Advice, Social Services, libraries, Medicare or NHS referrers;
- cancels advertisements;
- cancels telephone/email accounts; and
- issues a publicity/press statement if appropriate.

Conclusion

In writing these guidelines I have struggled to prepare for an event that cannot be avoided and for which the timing is unknown. Since completing it, every time I go away from home, I wonder if I have left everything in order. My clinical will exists, but writing this has shown me that it needs improvement. I need both to relinquish the wish for a perfect ending and acknowledge the curious feeling that by writing it all down I have somehow tempted fate. ■

References

Freud S. *Thoughts for the times on war and death*. London: Hogarth; 1957:296.

BACP. *Ethical framework for the counselling professions*. Lutterworth: BACP; 2018.

See also Good Practice in Action resources: GPiA 104 on clinical wills and digital legacies; 072 on unplanned endings and 078 on fitness to practise, www.bacp.co.uk/gpia.

Note: This article was originally published in Therapy Today, *September 2008, membership journal of the British Association for Counselling and Psychotherapy, here updated 2021.*

About the author

Sally Despenser is a BACP accredited counsellor and supervisor.

EXAMPLE OF A CLINICAL WILL

Dear
On [date] you agreed to be my clinical executor in the event of my death or sudden illness. By clinical executor, I mean the person who takes care of some professional tasks when I die. Specifically, you agreed to:

- contact my clients and supervisees;
- discuss with them appropriate onward arrangements;
- shred and dispose of my remaining case records;
- notify agencies (or EAPs) for counselling and supervision work; and
- notify X and Y who will distribute my workbooks as they see fit.

So that you can carry out the above tasks, with your permission:

- I have given your contact details to my next of kin, and they also have a copy of this document;
- you were shown where to find the folder of contact details, the office diary and the up-to-date list* of my work as counsellor, supervisor and trainer – the location of these is also known to my next of kin;
- I committed to keeping these records up to date;
- I have arranged that you will be reimbursed for any expenses incurred in carrying out the terms of this agreement, so please keep a list. My next of kin will carry out any other outstanding financial tasks; and
- we agreed that I would ask to renew this arrangement between us annually on my birthday.

Thank you very much.
[Signature]

***Example of up-to-date list of my work (updated week/month commencing ...)**

Contact details for:

- current private clients and supervisees;
- other current contracts for counselling and supervision;
- other referring agencies;
- training course at ...;
- workshop at ...;
- publications currently writing for ...;
- professional bodies including ...; and
- professional insurance.

UNPACKING THE SUITCASE

Migration, whether chosen or forced, has huge ramifications on a person's mental health. One ACA member reflects on how it affects people – and how it felt for her.

By Liz O Muganda

Many times when we think of travelling or relocating to a new country, state or even a village or town, we get so thrilled. Many of us find joy in what we can take with us or what we can leave behind. The things we cherish, and the attachments that come along with them, means space has to be created.

Sadly for some, it may be the opposite – they may be confronted with sadness, sorrow and fear of the unknown, depending on the circumstances surrounding the move.

'Unpacking the suitcase' may mean different things to different people, and in this article I will primarily focus on two groups of individuals: refugee young people and families, and student migrants (both high school students and their families and mature age students).

I personally migrated to Australia as a mature age student to further my education, as a 'dream come true', and I remember having a discussion with my father on his hospital bed. He was retired and he was facing a health battle with diabetes, but I reassured him not to worry that all would be okay. Upon my arrival in Melbourne, when I was starting to 'unpack my suitcase', I was hit with the emotion that most people would call 'homesickness'. Take a moment to picture yourself unpacking your suitcase, and the feelings you have when doing so. I had tears rolling down my cheeks with thoughts of missing all my eleven siblings (even being the eighth in line) and of not seeing my elderly grandmother, who had always been there for us since my mother had passed when I was only five years old and my father when I was a teenager. I was filled with doubt about whether any of my family members or my friends would also relocate and how I would survive in a foreign country, and had many more thoughts. That initial excitement was gone, and I started to ask if I made the right decision or not.

Well, I decided to put my doubts and worries aside and focus on the main purpose, why I chose to get on the flight and come to Australia. I took time to analyse my feelings and realise that I had made it to this moment so that meant I could go far.

In saying that, not many people will have the same experiences. Over the past 16 years I have worked with young offenders and

Photo: Unsplash/Ross Sneddon

young people and their families, and this has not only expanded my knowledge and skills but it has also been a space where I have shared their journeys and learnt so much from each of my clients: young students, families, elders and communities.

For migrant young people and, in particular, those who relocate without choice (due to humanitarian grounds or political reasons), many if not all of them will go through the experiences of not only 'unpacking the suitcase', but also unpacking the loss and grief they may have experienced along the way through refugee camps or transit countries. Some will be unpacking violence and trauma that they may have witnessed, and its impacts on them, such as the fear it might have caused. Many may be mourning for their loved ones they may have been forced to leave behind due to visa/migration requirements. Above all is the loss of self-identity – who I am, based on culture and ethnicity – and the lack of sense of belonging that accompanies this. Loss is not just experienced in death.

There are also migrants who may be relocating as students in primary or high school. With these groups of students, the decision is always made by their parents due to work or the need to better their education or for quality of life or greener pastures. The experience for them of 'unpacking the suitcase' is mainly the loss of their parents' guidance at a very young age, the fear of letting their parents down if they do not meet their expectations, the fear of being in a new environment and a new culture, the uncertainty of how to deal with freedom without misusing it, and the doubt of having to start networking and forming new friendships.

For the last group – mature age students (of which I was a part in my time) – the decision to leave their homeland is dependent on the person and, consequently, the experience of 'unpacking the suitcase' is hugely reliant on the individual. This may include feelings and doubts of ever being successful and accepted in a career, upon completion of their studies, and of becoming part of a whole new society. Additionally, individuals in this group will often question while 'unpacking' if they should go back home after graduating or if they should stay and gain some work experience. In reality, these are questions that may take days, weeks or months to find answers to, but it all depends on how individuals integrate and travel on their personal life journeys.

So, how can we support individuals, families, adolescents, communities, ourselves and everyone around us to 'unpack the suitcase'. It is our responsibility to bring that feeling of togetherness, connectedness and empathy, sharing our journey and trying to understand the person next to us without being judgmental. 'Unpacking the suitcase' is not just about the physical removal of clothes and personal belongings from a suitcase, it is deeply emotional and personal and a lot more complex than we think. ■

Photo: Unsplash/Matese Fields

About the author

Liz O Mugunda is an ACA member level 4. She holds a Postgraduate Degree in Counselling and Child and Maternal Health and a Master of Social Change and Development. Liz has always had a passion working with young people in her career.

Want to be published?

Submitting your articles to *Counselling Australia*

About *Counselling Australia*

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

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

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

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

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

Editorial policy

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

Previously published articles

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

Articles for peer review (refereed)

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

Conditions

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

Deadline

Deadline for articles and reviewed articles is 25 January, April, July and October. The sooner articles and papers are submitted, the more likely they are to be published in the next cycle. ■

SOUTH PACIFIC PRIVATE

Australia's Leading Treatment Centre

Changing lives, Healing Families

Since 1993, Australia's leading treatment centre, South Pacific Private specialises in trauma-informed treatment for addiction, complex trauma and co-occurring mood disorders.

- + Fully accredited psychiatric treatment centre
- + Psychotherapy driven
- + Abstinence based
- + Trauma-informed framework
- + Family system perspective
- + Therapeutic community support
- + Intensive inpatient treatment and out patient treatment options available

Call us to refer a client, or for more information.

Enquire today 1800 063 332

southpacificprivate.com.au