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CA

Supervision in counselling
a national report on the practice, content and value of supervision

Lockdowns measure the uncertainty principle
personal stories from counsellors in NSW

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Letters to the editor should be clearly marked and be a maximum of 250 words. Submissions and letters may be addressed to:
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See page 51 for peer-reviewed article submission guidelines.

Editorial

Building on the momentum of an election year

Philip Armstrong
Editor

As we head into an election year and the country reopens, now more than ever is the time to be noisy, to connect and to drive action to ensure every Australian can access affordable, high-quality counselling services.

ACA's growing influence

ACA's advocacy efforts have soared over the last few months, as multiple bills were introduced to the Victorian Parliament to get counsellors and psychotherapists added to the list of mental health practitioners in Victoria. Sadly, the bills were voted down, with the last bill only defeated by a single vote.

In positive news, ACA was able to speak directly to Department of Health officials and form relationships with decision-makers who can influence policy.

The future of counselling and psychotherapy will be limited only by the effort we, as the peak body, make – or fail to make – to influence decision-makers and grow awareness of this issue in the public and government spaces.

Perhaps the greatest accomplishment and evidence of our efforts to build influence to date is the sole invitation that I received to represent counsellors and psychotherapists in the Stakeholder Engagement Group (SEG). This group provides input into the evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative.

ACA's advocacy work benefits all counsellors and psychotherapists. A simple step you can take is to get involved with the ACA Facebook community, where we all can contribute to advocating for, and advancing, the profession of counselling and psychotherapy. www.facebook.com/theacainc

COVID-19 vaccinations

With the easing of restrictions across the country, we are receiving many questions about COVID-19 vaccinations. As Australia's largest single registration body for counsellors and psychotherapists, we strive to keep members up to date with the latest information regarding COVID-19 and vaccination requirements.

However, as public health orders are often unclear and inconsistent in relation to counsellors and psychotherapists, ACA cannot provide blanket advice. Each state and territory has its own requirements and guidelines for vaccination, which can quickly change.

We advise all members to follow guidelines given by your respective state or territory government health sites on COVID-19 vaccination requirements.

Currently, it is up to each individual whether to vaccinate against COVID-19; however, ACA does encourage members to be vaccinated to protect their clients.

For members who are employed, we highly recommend you speak to your employers on the vaccination policy for your workplace.

ACA is in constant contact with the Allied Health Professions Australia and the chief allied health officers of each state and territory to coordinate effective and accurate information.

ACA is seeking legal advice so that we can properly inform members in private practice of liability considerations.

For more information, read our latest COVID-19 update at www.theaca.net.au/download-documents.php.

World Health Organization (WHO) Mental Health Forum 2021

ACA joined key international stakeholders for part one of the World Health Organization (WHO) Mental Health Forum 2021. This year's forum focused on how we can create better opportunities and systems to respond to a growing demand for mental health services around the world. We thank WHO for the opportunity to exchange ideas, collaborate and learn.

Collaborative research

An important collaborative research paper is published in this edition of *CA* on the impact of professional supervision and on understanding its elements, as well as on reviewing supervision models and the effect of supervision on supervisee performance.

The results indicate that supervision is a widespread practice and that participants recognise that supervision contributes to professionalisation. The survey identified some predominant themes in the format, content, benefits and methods of supervision practice in Australia.

Still, even with some common ground, the results showed a wide spectrum of responses, indicating that supervision structure and practice can vary based on the individual needs and characteristics of the supervisee. Implications for practice, research and policy are presented on page 24.

Special feature

This time last year you may recall we invited Victorian members to share their experiences of dealing with the impacts of COVID-19, especially the prolonged lockdowns and social isolation. In this edition we have invited NSW practitioners to share their experiences and responses. As with our Victorian members, counsellors and psychotherapists have had to balance a rapid escalation in demand for their services with finding creative new ways to engage with clients. It has been an extraordinarily challenging two years and many counsellors report they have found some positive new approaches and methodologies to take into the future.

ReturnToWorkSA on board

ACA is delighted to report that ReturnToWorkSA now recognises registered counsellors and psychotherapists to deliver services. ReturnToWorkSA agrees that ACA counsellors and psychotherapists have an important role to play in treating workers with a work-related injury or illness and its impacts.

The relevant authorities in NSW and Queensland are also on board and the ACA is continuing to work with remaining jurisdictions.

World Mental Health Day 2021

ACA was proud to partner with Mental Health Australia on the 2021 World Mental Health Day campaign 'Look after your mental health, Australia' on 10 October. The campaign aims to reduce stigma, connect communities and encourage Australians to share how they are looking after their mental health, through prompts to make a mental health promise. I was honoured to take part in a video for Mental Health Australia and share what I do to look after my mental health. Catch the video on our Facebook page.

Decembeard | Decembhair

1 to 31 December 2021

Bowel Cancer Australia's hair-raising fundraiser encourages you to get beardy or hairy. A virtual Decembeard can be applied easily via your Facebook profile picture frame.

International Day of Persons with Disabilities

3 December 2021

IDPwD is aimed at increasing public awareness, understanding and acceptance of people with disability.

World Cancer Day

4 February 2022

A positive global movement led by the Union for International Cancer Control to raise awareness of and improve education about cancer.

Ovarian Cancer Awareness Month

1 to 28 February 2022

Ovarian Cancer Awareness Month is held each year in Australia to raise awareness of the signs and symptoms of ovarian cancer.

febfast

1 to 28 February 2022

For the month of February, individuals can pause for a cause by giving up alcohol, sugar or another vice of choice to support disadvantaged youth in Australia.

Red Feb

1 to 28 February 2022

Be it a lipstick, dress, shoes or accessory, wear your brightest reds and focus on cardiovascular risks and diseases.

National Day of Action Against Bullying and Violence

3 March 2022

This day is Australia's key bullying prevention initiative, connecting schools and communities to find workable solutions to bullying and violence.

World's Greatest Shave

10 March 2022

Get sponsored to shave, colour or cut your hair and help families facing blood cancer.

International Day of Happiness

20 March 2022

Established by the United Nations General Assembly in 2012, the International Day of Happiness aims to help people understand the importance of happiness and wellbeing in their lives.

Technology Update

With Dr Angela Lewis

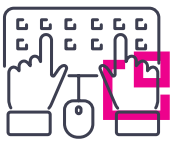
Cybercriminals and their latest tricks

Cybercriminals have been quick to take advantage of situations such as COVID-19 and the fact that most Australians have needed to spend more time online than ever before, working, schooling and shopping and keeping up contact and relationships with friends and family. The Australian Competition and Consumer Commission's (ACCC) service Scamwatch reports that consumers lost more than $166 million to scams in the first seven months of 2021. Some of these scams are related to COVID-19 vaccines, so we should be aware of emails, texts or even calls related to booking in for a vaccine, queue jumping for a jab appointment or clicking a link to confirm an upcoming vaccine appointment. Scammers are also impersonating the Australian Taxation Office (ATO), Medicare and most major supermarkets, inviting people to clink links and be tricked into handing over personal information such as passwords or banking details.

Here are some red flags to watch out for:

- The email address of the sender bears no resemblance to the organisation it is representing; that is, it consists of nonsense words or spelling.
- The country code in the message is something like .ru or .de – somewhere clearly not in Australia.
- The message sounds terribly urgent and suggests something serious might happen if you don't follow the instructions.
- The message is full of typing and spelling mistakes.
- A password notification arrives, such as "Your account has been comprised; click here to reset your password".
- A request to click a link or "click here" to claim your voucher or prize.
- A notification to unsubscribe from a mailing list.
- An invitation to click a link and jump the COVID-19 booking line.
- Emails or texts with a link to claim a refund or overpayment.

Remember: banks, the ATO and other government bodies and agencies will never send unsolicited emails or texts that request your personal information. If in doubt visit www.scamwatch.gov.au. ■



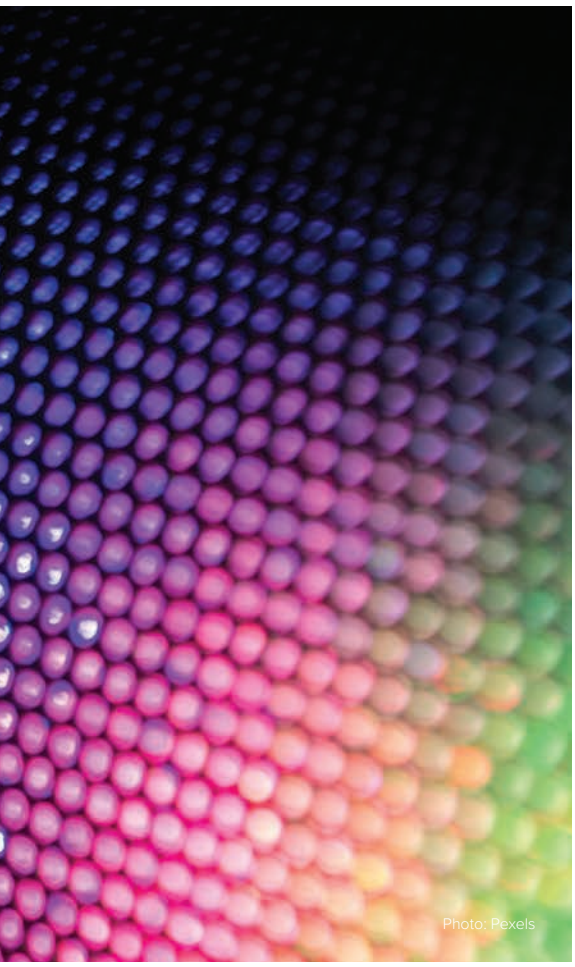


Photo: Pexels

Online pornography and children

According to a 2020 report on pornography and young people, authored by the organisation Our Watch, 30 per cent of children see pornography online before they are 12 years old. The full report is available as a downloadable PDF from www.ourwatch.org.au and is located by clicking their search tool icon and using the term 'pornography'. Our Watch is supported by the Commonwealth and state governments. The organisation also receives financial support, donations and in-kind support from individuals, and corporate and non-government organisations.

There are also a number of valuable resources around online safety for children and young people available at www.esafety.gov.au/kids. ■

Women's shelters

Women's Community Shelters is an Australian charity set up on a social franchise model to provide emergency accommodation for homeless women in NSW, in partnership with local communities. It addresses support for women and children experiencing homelessness and family violence, and it works to provide transitional housing for those at risk. It is based on government, philanthropy, business and the community collaborating to fund, establish and operate shelters. Find out more at www.womenscommunityshelters.org.au. ■

***Warning: content may disturb some readers**

Stillbirth resources

A close friend of mine in the Netherlands recently gave birth at full term to a stillborn daughter, and the hospital organised for her to take the baby home in a specially designed clear box with a built-in cooling system to stop deterioration. The intention is to give grieving parents time with stillborn babies that they may not have gotten otherwise.

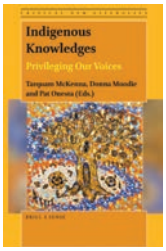
My friend, her husband and their son then spent a week with the baby girl in their home before she was buried. I believe something similar, known as a 'cuddle cot', is also available from some hospitals in the UK, but not currently in Australia.

The University of Queensland's Centre of Research Excellence in Stillbirth (www.stillbirthcre.org.au) is a source of research papers, workshops and community education. Its vision is to reduce the devastating impact of stillbirth for women, their families and the wider community in Australia and across the globe by improving care to reduce the number of stillborn babies. ■

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 reviews



Indigenous Knowledges – Privileging Our Voices
Edited by Tarquam McKenna, Donna Moodie and Pat Onesta
Reviewed by Loretta A. Bennett

The cover illustration by Deanne Gilson, Cultural Tree of Knowledge, immediately draws one into the journey of cultural exploration. This is an ideal metaphor for the way the book explores how cultural knowledge can engage students, honour past practices, and build an education system that is inclusive and links non-Indigenous and Indigenous practices. It challenges Western education systems on the approaches used to engage students, conduct research, analyse data and develop education that is enhancing both teachers' practice and students' outcomes.

This book is a self-study of academic practices for the improvement of teaching and learning, but it also provides much more. It is a reflective look at how to explore different ways of creating an engaging, relevant and interactive education experience for Aboriginal and Torres Strait Islander peoples. There is much that all learning institutions could gain from the insights and reflections in this book. It gives voice and a place for Indigenous people to be heard, respected and understood. This book explores real-life examples of the programs at Deakin University and NIKERI Institute, and the experience of students to explore what is being done and gives hope for the future of change.

This is an advanced academic text that highlights ways in which education systems can draw on Indigenous knowledge to provide an environment that respects the roles of students within their communities, and also creates a relationship between student and teacher and student and system. I particularly enjoyed the chapter on examining the relationship between teachers and students, which recognises the importance of teachers providing a space to build a relationship with students and its impact on student learning and outcomes. It also highlights the challenges faced when systems aren't embedding cultural practices that are culturally safe and draw on its richness of Aboriginal and Torres Strait Islander knowledge.

This book provides a narrative of carefully holding the place of culture in learning and recognises the importance of drawing on Indigenous voices of both the past and present to create a space where learning is considered, celebrated and honoured for the richness. It recognises the challenges students face and draws them in to feel that they belong, are valued and are supported to achieve.

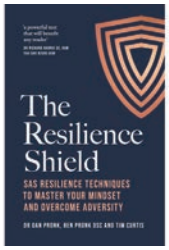
Importantly, the book explores how rich learning can be when those practices are embraced, explored and integrated into pedagogy. Each chapter builds on the one before to explore education from all perspectives and give insight to the experiences and challenges that occur, and the changes that need to.

The narratives in this book give understanding of the racism, shame, discrimination and powerlessness experienced by Aboriginal and Torres Strait Islander peoples, and the impact on them engaging in, or feeling culturally safe within, the education system. It is written in a way that creates awareness and provides a framework for moving forward, building connection and clarity between challenges in the Western system and embracing a different way of doing things.

Understanding comes with the sharing of narratives, the recognition of what has gone and what can be done now to shape the future. I am most grateful for the voices of those who shared their knowledge, experience and foresight within this book; their narratives I hope will encourage others to explore, challenge and look differently at how we understand learning and growing together and collaborate more to create culturally rich spaces.

The book gives voice to cultural safety and to how Western education systems have failed to weave rich cultural knowledge and practices into learning frameworks. This, in turn, has alienated and disengaged Indigenous students. The authors explore how creating a safe and culturally positive space to expand the learning outcomes for Aboriginal and Torres Strait Islander students will at the same time enable non-Indigenous people to learn and grow with understanding and develop knowledge.

In reading this book I valued the honesty, vulnerability and the challenge to re-evaluate the educational experiences for Aboriginal and Torres Strait islander peoples. It is a rich and comprehensive background for teachers, social workers, politicians and academics on how to embrace Indigenous knowledge and enhance learning outcomes throughout the education system.



The Resilience Shield
By Dr Dan Pronk, Ben Pronk and Tim Curtis
Reviewed by
Melissa Anderson

At a critical juncture in our world's history, when countries are learning to live with COVID-19 with resilience and grace, comes a book timed with precision.

The Resilience Shield compellingly submits that human resilience is made up of six layers – the innate, the mind, the body, the social, the professional and the adaptation layers – which protect us. The authors, Dr Dan Pronk, Ben Pronk and Tim Curtis, liken resilience to the timeless, exquisitely woven rugs of the Afghans. Like the rugs, it is knotted with strength and durability, with mastery passed through the ages, and the finished product can withstand the rigours of life. They insist that resilience is not static – on the contrary, resilience is something we can learn, build, courageously course-correct and master using the strategies and techniques documented in this superb book.

All three authors share their experiences in the Special Air Service (SAS) on missions across the globe. Their poignant and often harrowing experiences and observations forced them to hone their mental strength. Their vulnerabilities and self-doubt in the moment, and their willingness to grow beyond the most challenging of circumstances, is both humbling and instructive.

Coming out the other side of any life challenge generates humility and gratitude – in most people. Learning from the inevitable challenges in life requires self-awareness, grit and, often, deliberate intervention by a trusted, sage guide. The authors dig deep into this critical area for all human beings known as post-traumatic growth.

Neuroscience has begun to tackle the question of what resilience looks like in the brain. The hope is that understanding the neurobiological mechanisms that contribute to resilience in humans will lead to better-targeted, more potent interventions. In particular, the authors note how, with training, the prefrontal cortex (the most advanced part of the brain compared to all other species) can remain in charge of the cortisol and adrenaline-filled brain, despite attempts by the amygdala to highjack our courage, our clarity of thought and our critical thinking skills.

Vital human concepts are discussed at length, including understanding our locus of control (internal versus external); finding meaning (aka the sixth stage of grief); 'dark leaders' who can cause you to feel disgruntled, undervalued and demotivated; and 'transition stress' in forging new identities, particularly when changing careers.

Most pertinent to our world at present is the immense and powerful value of "stress inoculation" by training for specific stressors – small, manageable doses of challenge, ideally while young, which can fortify and empower us.

Too often we shy away when something is painful or fear-inducing instead of recognising it as an opportunity to grow. Too often we are manipulated to side with fear, driven by the influences of social media and group think, rather than using critical thinking skills, rationality and fact-based, unbiased decision-making.

The authors remind us that life is difficult and unfair – and to revel in its complexity. The key is to start developing resilience early in life, if possible, prior to brain maturity (the human female brain is regarded as mature at 24 to 25 years and the male brain at 25 to 26 years).

The authors' powerful strategies to build resilience are practical and immediately applicable to the challenges we face, including the often-hidden pitfalls of 'safetyism' (a belief system where safety has become a sacred value), reliance on technology, obesity, increasing levels of depression and anxiety, increasing polarisation within democracies, and the epidemic of loneliness.

The book wisely and strongly encourages the reader to find purpose in what one is doing, and if you cannot, to "make purpose". "And the beautiful thing is that when seeking virtuosity becomes a habit, it is automatically transferable to all other aspects of your life. It becomes part of who you are, of your identity."

The authors note, "The conclusion from our research is that resilience is dynamic, multifactorial and modifiable. That is, it changes with time and circumstance, is comprised of many different components and – crucially – can be improved by deliberate intervention." And this gives us all hope, no matter what our age.

This book is a must-read, particularly for students of psychology, those running a business, those in high-performance sport, those in the fields of mental health, those navigating a life-changing event, and indeed any human being committed to ongoing and tenacious development of the best version of themselves.

About the reviewer
Melissa Anderson is a Level 4 ACA counsellor, a pharmacist (retired), has a music degree (opera) and is the director of SHINE Leadership and Resilience Academy for Girls and LONGFORD & FRASER Leadership and Resilience Academy for Boys.

Supervision in counselling: a national report on the practice, content and value of supervision

By **Jim Schirmer and Sonia Thompson**

BACKGROUND

Counselling is an emerging profession within the Australian human services context and is currently growing rapidly in both the number of practitioners and scope of services being offered. Counselling supervision provides an essential system for quality assurance and professional development of registered counsellors and psychotherapists, which, in turn, holds the potential to deliver better outcomes for clients. Supervision provides a mechanism for registered counsellors and psychotherapists to review caseloads with an experienced practitioner and to develop the best therapeutic outcomes for the client, to discuss any concerns or ethical issues that may arise, and to reflect on the impact of the client work on the counsellor in an effort to improve self-care (ACA, 2018; PACFA, 2020).

Supervision is valued for the role it plays in enhancing the professional practice of those working in the areas of mental health and psychosocial care and is recognised as having an impact on improved client outcomes in professions including counselling and psychotherapy, psychology, psychiatry, social work and mental health nursing (Barletta, 2017). In recognition of the potential value of supervision to practice, professional bodies in Australia have specified supervision as an obligatory requirement of maintaining professional membership and registration.

While the purpose of supervision is clear, the research evidence regarding the optimal way to achieve this purpose is inconclusive. Firstly, while there have been a number of studies that have demonstrated robust evidence for the influence of supervision on client outcomes (for example, Bambling et al., 2006), the majority of supervision outcome studies have not had the same rigour of evidence (Watkins, 2019). While over 50 models of supervision have been identified in the research literature – containing a vast spectrum of elements and emphases – none have been established to have empirical superiority (Simpson-Southward et al., 2017).

While the specific mechanisms through which the purpose of supervision may be achieved have not yet been conclusively established (Kühne et al., 2019; Watkins, 2019), the strength of the supervision alliance has proven to be a more robust predictor of outcomes across several dimensions (Callahan et al., 2019; Wilson & Lizzio, 2017; Ladany et al., 2012). This finding has reaffirmed the relational foundation of supervision. In turn, this has prompted researchers to explore the needs, experiences, practices and opinions of the stakeholders more thoroughly in order to identify potential variables or mechanisms that might affect outcomes.

Illustration: Vecteezy

Furthermore, there is need for more supervision research that is sensitive to context. The majority of current research in the field emerging from specific cultural contexts (especially the USA) focuses on supervision of trainee counsellors and is conducted in structured rather than naturalistic settings. Therefore, there is a distinct lack of knowledge on how supervision is used by qualified counsellors in the context of their current practice in their particular national context (in this case, Australia) (Mallinckrodt, 2011; Schofield & Grant, 2013).

In light of this background, this study aims to contribute to the research, policy and practice of supervision through describing the opinions and experiences of counsellors and supervisors in the context of their professional practice in Australia.

METHOD

Research, aims and questions

This study aims to contribute to the knowledge on the role of supervision in the professional practice of counselling in three ways. Firstly, this study aims to generate accurate data on how practicing counsellors in Australia use supervision in the naturalistic setting of practice. Secondly, the study looks to identify active processes of supervision in order to generate a research agenda for future investigations into effective supervision practices. Finally, this study seeks to address gaps within the existing literature by capturing the perspectives of both participants (that is, supervisee and supervisor) on the experience of supervision.

To this end, the study addressed a number of concurrent research questions:

1. How does supervision practically operate in the context of the counselling profession in Australia?
2. How is supervision time practically used by counsellors?
3. What purpose and value do counsellors ascribe to the role of supervision in their professional practice?
4. What similarities and differences occur between supervisors and supervisees in relation to their opinions and experiences of supervision?

This current article reports the results relating to the first three research questions. Results relating to the fourth research question on the comparison between supervisee and supervisor results can be found in Schirmer and Thompson (2021).

The study targeted two key populations: (1) professional counsellors who engage in professional supervision for their practice, and (2) supervisors of professional counsellors.

Informing methods

Survey research has particular utility as a research method for studies that aim to describe experiences and opinions of a sample that can be considered representative of the wider population under investigation (Robson & McCartan, 2016; McBeath, 2019). By providing a description of a cross-section of a large sample of a demographic, surveys hold the potential of providing a reliable picture of the views, experiences and behaviours of that population. In this way, this method was an effective fit with this study's central aim of establishing the practices and attitudes toward supervision across the population of Australian counsellors.

Recruitment

The study targeted two key populations: (1) professional counsellors who engage in professional supervision for their practice, and (2) supervisors of professional counsellors. In order to ensure that there was some consistency in the population being studied, an inclusion criterion was that participants must be eligible for membership with a professional counselling organisation (such as the Australian Counselling Association (ACA), the Psychotherapy and Counselling Federation of Australia (PACFA), or the Australian Register for Counsellors and Psychotherapists). Trainee counsellors who were still students but who might have been accessing supervision as part of their practicum or internship experience were excluded from this study, due to supervision requirements and uses being different at this early career stage (Rønnestad et al., 2019).

The survey was advertised through the ACA, the Australian Register for Counsellors and Psychotherapists, and related networks. Notification of the survey was primarily through online channels, such as website, social media and email subscription lists. Given that many counsellors are employed within human services organisations, the survey was also sent to the organisations that most commonly employ counsellors, as outlined by Parker (2017).

Materials

Given the exploratory nature of the research and the specific topics being addressed, the survey instrument was custom designed for this study, as is common in survey research (McLeod, 2015). The authors designed the initial instrument from a review of the literature. The face and content validity was then reviewed by three consultants considered experts in this field of research. Finally, the survey was reviewed by the ACA members of the research team to ensure consistency with, and relevance to, the industry. The final survey was also piloted to ensure usability for participants.

The final survey contained a total of six sections covering the following broad topics:

- demographics;
- practical elements of supervision;
- use and content of supervision;
- purpose and value of supervision; and
- influential experiences of supervision.

Data collection

The survey was delivered through the online survey tool Qualtrics. The online tool was chosen in order to maximise the reach of the survey to as many participants as possible, to aid in ease of access and completion for participants, and to ensure anonymity for participants. The survey was open for a period of four weeks from 20 May to 19 June 2020.

Data analysis

Responses were first organised according to section and question. Data was analysed according to the type of question asked. Quantifiable data was aggregated and tabulated to be analysed through a descriptive analysis, such as standard categories of distribution, central tendency and dispersion. The nature of the study did not allow any inferential statistics; however, this was not necessary for the scope of this study. Any qualitative data such as reflective statements or open text fields were analysed through a thematic analysis (Braun & Clarke, 2006). The process involved initially categorising and coding the data descriptively. A secondary coding named and defined patterns of themes that best described the categories of responses. This process was reiterated in conjunction with re-reading of the data to ensure precision and accuracy.

Ethical approval

The project was designed to comply with the National Statement on Ethical Conduct in Human Research and was

granted approval through the Human Research Ethics Approval processes of the University of Queensland (Approval Number 2020000744).

RESULTS

Description of sample

This section reports on the characteristics of the sample surveyed, including (a) participant details; (b) counsellor/supervisee demographics; and (c) supervisor demographics.

Participant details. A total of 1041 participants completed the survey. This sample included 839 (80.6 per cent) who predominantly work as counsellors and thus completed the survey from the perspective of a supervisee. The remaining 202 (19.4 per cent) participants predominantly worked as a supervisor and therefore completed the survey from that perspective.

The sample size is sufficient to give confidence that the results represent the wider body of practitioners. Using the Australian Government Job Outlook 2020 estimate that there are 31,200 counsellors working in Australia, a sample of 1041 practitioners allows a margin of error of ±3 per cent at a 95 per cent confidence interval. Therefore, we can be 95 per cent confident that a percentage finding within this study is within ±3 per cent of what would be found if the study had surveyed the whole population. (On some questions the number of responses was lower than the total number of participants. Whenever this is the case, this will be noted in the results.)

The sample included representation across the states of Australia, as displayed in Figure 1 (above). Responses for the 'Other' category included counsellors practicing in Cambodia, Canada, Hong Kong, India, Macau, Malaysia, New Zealand, Norway, Singapore, Thailand, Tokyo and Vietnam, as well as remotely Australia-wide and online. The sample also included a representation of various locations of practice, as displayed in Figure 2 (above).

Figure 1: In which state or territory do you currently practice?

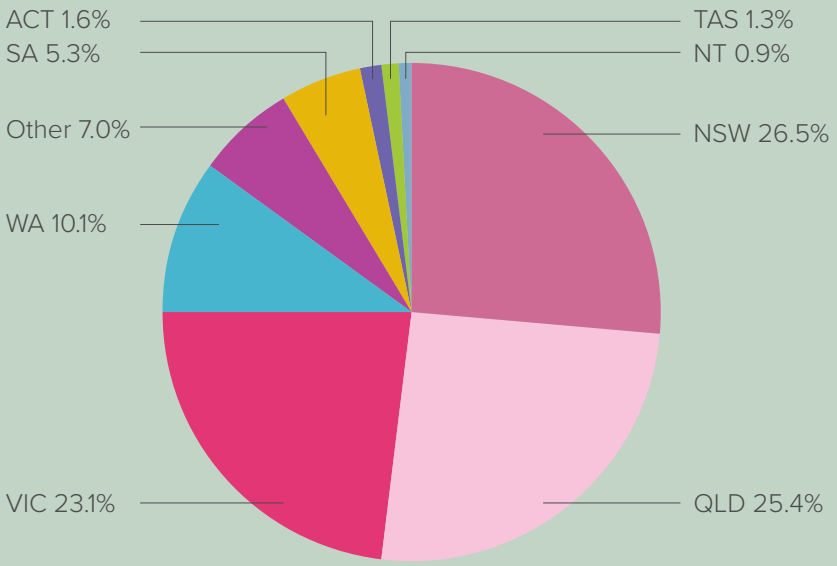
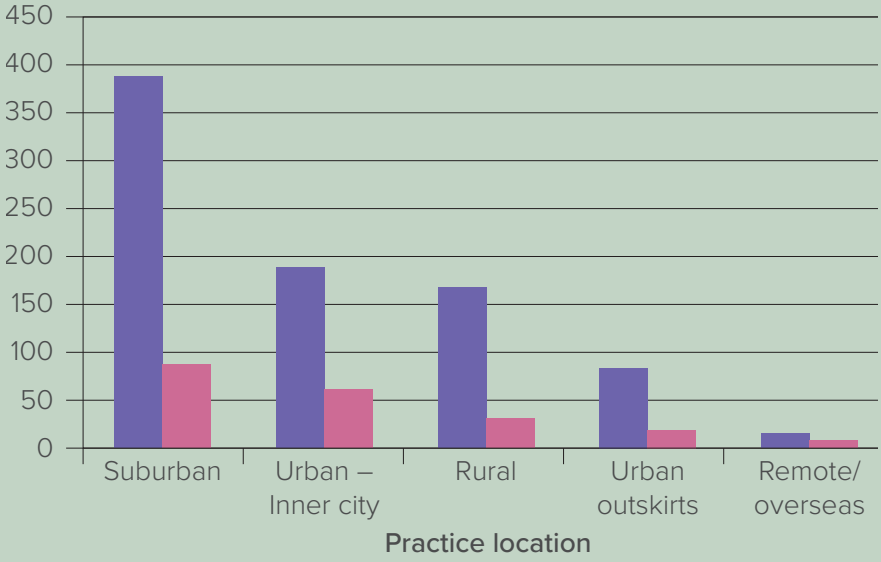


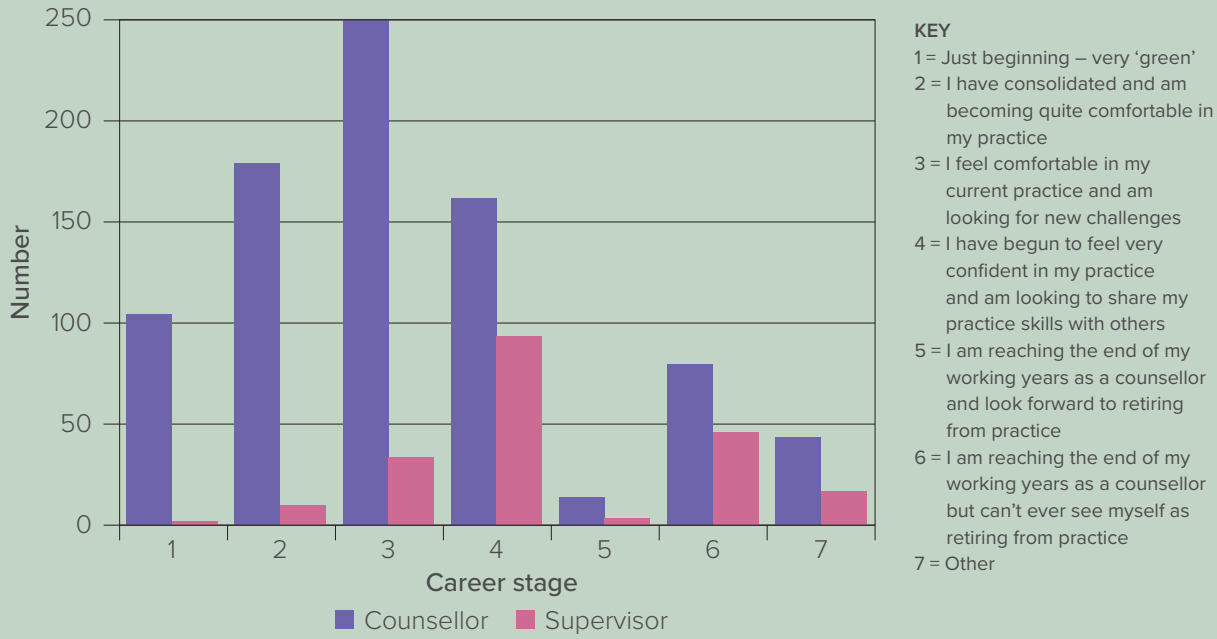
Figure 2: How would you describe the location of your counselling practice?



Counsellor demographics. There was a broad range of experience levels represented among the 839 counsellors who responded to the survey. Across the participants, there was a mean of 9.22 years of practice as a qualified counsellor; however, there was considerable spread in the data (SD = 7.75; Range = 45).

A majority of the sample held a master's degree (n = 297) or bachelor's degree (n = 221) as their highest qualification in counselling, with most of the remaining participants holding a diploma (n = 302). 98.4 per cent of the sample were registered with a professional counselling

Figure 3: Which statement best describes you in your career at the moment?



association. The remaining participants were either eligible to be registered with an association or were members of a related association (such as the Australian Psychological Society (APS) or Australian Association of Social Workers (AASW)). Participants were most commonly registered with ACA, but the sample included numerous other accrediting bodies both from Australia and overseas, and a considerable number of the sample (n = 240) did not nominate which body they were registered with.

Consistent with the spread of years of experience, the counsellor participants saw themselves at a variety of stages in their career. As Figure 3 (above) shows, participants most commonly saw themselves as "comfortable in my current practice and am looking for new challenges", followed by "I have consolidated and am becoming quite comfortable in my practice" and "I have begun to feel very confident in my practice and am looking to share my practice skills with others". However, there was also representation across the other categories.

Supervisor demographics.

Compared to the counsellors in the study, the 202 supervisors who participated were, on average, more experienced. The supervisors had been practicing in the field of counselling for a mean of 14.69 years, though again there was considerable variance within the group (SD = 8.26; Range = 44). Further to their years of experience as a counsellor, the sample of supervisors had been practicing as supervisors for a mean of 6.33 years, again with a considerable variance across the group (SD = 6.64; Range = 44.5).

In contrast with the counsellor participants, the supervisor participants most commonly nominated their career stage to be "I have begun to feel very confident in my practice and am looking to share my practice skills with others". Figure 3 shows the comparison of career stage between counsellors and supervisors.

Regarding their qualifications, supervisors were most likely to hold a master's (n = 93) or bachelor's (n = 38) degree as their highest qualification in counselling. Compared to the counsellor samples, supervisors were less likely to hold a diploma (n = 40) and more likely to hold a doctorate (PhD or professional doctorate) (n = 23) as their highest qualification in counselling.

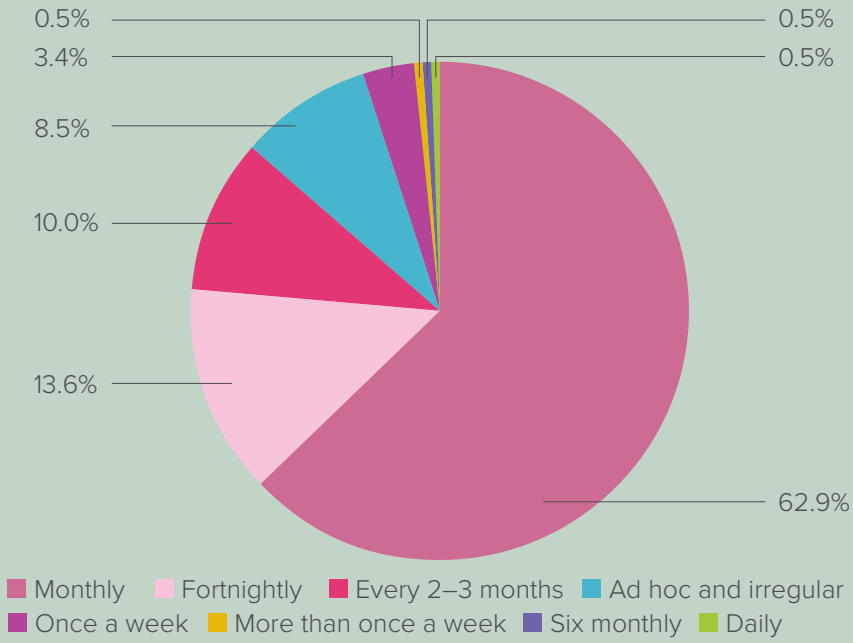
Ninety-six per cent of the supervisor sample were registered with a professional counselling association. The remaining participants were either eligible to be registered with an association, or were members of a related association (such as APS or AASW). Participants were most commonly registered with ACA, but the sample included numerous other accrediting bodies both from Australia and overseas, and a considerable number of the sample (n = 65) did not nominate which body they were registered with.

Practice of supervision in Australia

The section reports on the pragmatics of the practice of supervision in Australia. It includes results pertaining to:

- rate of usage;
- frequency and duration;
- cost and payment;
- format;
- choice of supervisor;

Figure 4: How often does your supervision occur?



- training in supervision; and
- supervisor motivations.

Usage of supervision. A total of 96.3 per cent of survey respondents currently access supervision for their practice. Counsellors most commonly reported that they access supervision because it was required for professional registration (79.6 per cent), with a further eight per cent doing so as part of their employment, and eight per cent said that they did so voluntarily. The 3.7 per cent of the sample not accessing supervision nominated that this was due to cost or time constraints, or because they were not currently practicing as a counsellor at a level to warrant supervision.

On average, the participants in the survey had accessed supervision for their counselling practice for 6.98 years, although there was a wide variance across the group, most likely owing to the range of experience levels in the sample (SD = 5.89; Range = 34.5).

Frequency and duration. Nearly two-thirds (62.9 per cent) of the sample accessed supervision on a monthly basis, with a further 13.6 per cent attending fortnightly supervision. A small number of participants reported having supervision more than once a week or more (4.4 per cent) and conversely nine per cent said that supervision occurs less frequently (that is, every two to three months or more). Appropriately 10 per cent of the sample accesses supervision on an ad hoc or irregular basis (Figure 4).

The majority of those sampled (51.5 per cent) had sessions that lasted, on average, 60 to 90 minutes. A further group of 36.5 per cent had session durations of an average of 30 to 60 minutes. For some participants, the average supervision session was longer than 90 minutes; however, it was very rare for sessions to be shorter than 30 minutes.

Cost and payment. The majority of participants paid for their own supervision costs (64.9 per cent). Of the remaining participants, a significant proportion of the sample had their supervision costs financed by their employer, either through the employer providing supervision within the workplace (16.5 per cent), or through the employer paying (9.4 per cent) or reimbursing (3.3 per cent) the costs of supervision. A small proportion (5.8 per cent) had a supervisor who did not ask for payment. Of those who paid for supervision, there was a spread of costs, though most commonly supervision costs fell between $50 and $150.

Format. The data showed that a range of formats was utilised by counsellors to access supervision, with the most common being individual sessions that occur in an office setting. More broadly, individual supervision (either in-person, online or by phone) was the predominant mode in which counsellors accessed supervision, followed by group supervision (whether in-person, online or in association meetings).

When asked about preference of formats, a standout number of participants nominated their preference for individual supervision (n = 232), preferably in an in-person setting (n = 179). Smaller numbers of participants nominated other supervision formats (including group supervision, and online or by phone) to be preferred, indicating

Illustration: 123rf

that these are formats that may be favoured by a portion of the professional population.

Notably, when asked to identify which of the formats provided the least benefit in supervision, a significant number of participants did not respond (n = 344). Of those who did respond, a group nominated that this did not apply to them (n = 91), with another group saying that they found all formats to be beneficial (n = 62). Of those who did nominate a format of supervision that was least beneficial, the standout responses were group formats (including professional association groups for supervision) (n = 184), followed by phone (n = 82) and online formats (n = 42). Additionally, a proportion of respondents identified that they found all supervision formats to be equally beneficial.

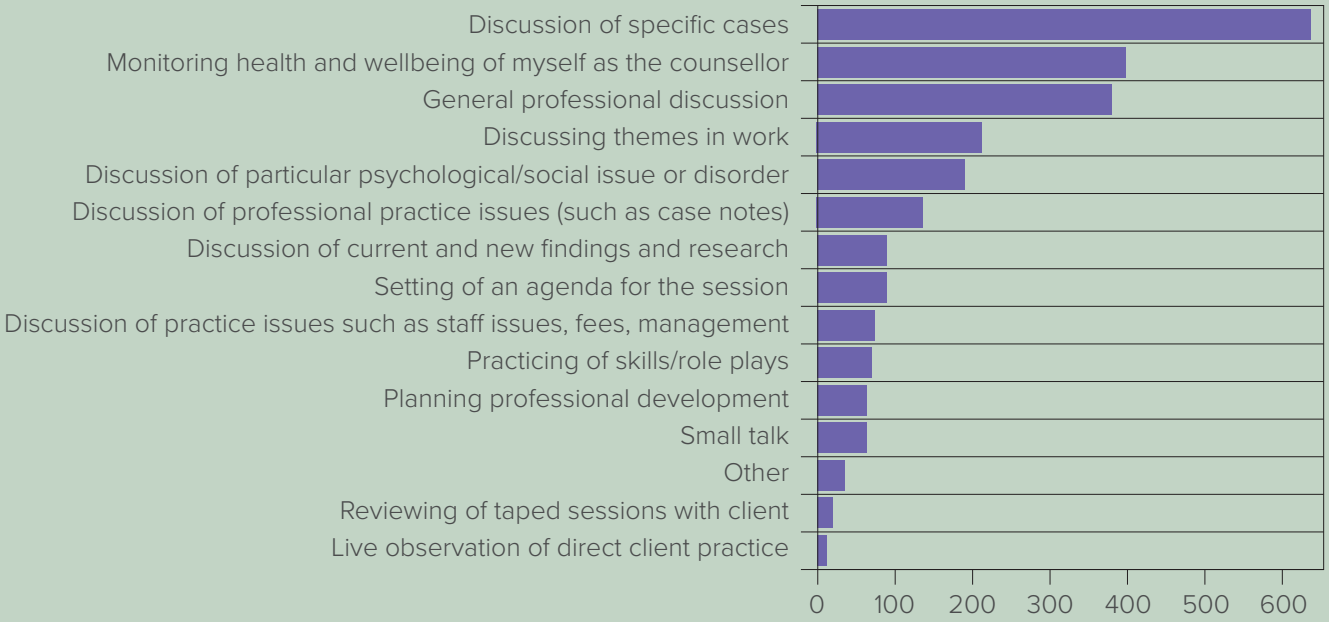
The factor that most frequently impacted the choice of supervision format was related to the supervisor that counsellors wanted to work with. Other significant factors included accessibility, cost and time, with a proportion of the sample having no choice (most commonly because it was the employer's decision). A further influence on the format would be that the survey took place during the COVID-19 pandemic, and some participants specifically mentioned COVID-19-related issues as having been influential in the format that supervision took (for example, not having access to in-person sessions).

Choice of supervisor. Survey participants came to use their particular supervisor in a variety of ways; however, the most common was to find a supervisor on a professional organisation's list. Among the 'Other' responses, the only major theme was that the supervisor was known to the supervisee through a professional context (for example, training or a previous work connection). A proportion had no choice in their supervisor as they were assigned by their workplace. However, taken together, these results indicate supervisors seemed to be known to counsellors before they came to work with them.

Training in supervision. Of the supervisors surveyed, 86.9 per cent were registered as an accredited supervisor with a professional association, while 13.1 per cent were not registered in this way. Of the 202 participating supervisors, registering bodies varied; however, the largest proportion were registered with the ACA (n = 119). Over 90 per cent of supervisors accessed their own supervision specifically for their supervisory practice.

A majority of supervisors had undertaken training that was accredited with one of the counselling industries bodies (79.8 per cent specifically mentioned their training to be

Figure 5: What are the most common elements of your supervision sessions? (supervisee responses)



accredited with ACA and 4.2 per cent with PACFA). Some participants (6.2 per cent) had undertaken a stand-alone qualification or a unit within an accredited program. In examining responses from the remaining 8.8 per cent of participants who chose 'Other', the majority of these responses fell under accredited trainings.

A large number of supervisors also identified that they had been trained in a particular model (68.2 per cent), with 20 per cent saying they had not been trained in a particular mode and 11.8 per cent being unsure. The models included counselling theory-based (such as CBT, narrative and so on), issue-based (such as trauma), and models specifically developed for supervision (such as RISE UP, seven-eyed model, reflective practice, and so on).

When supervisees were asked whether they had received training in being supervised, close to 70 per cent of participants said they had experienced training in how to use supervision/how to be supervised. Most commonly, training had occurred as part of a counsellor training program or was done post-training while the participant was practicing as a counsellor. However, 30.6 per cent said that they had not received any training in being a supervisee and had learned along the way.

Supervisor motivations.

Supervisors nominated a spectrum of reasons for choosing to become a supervisor. For most, the nominated reason was to be able to give back to the profession in the way of supporting counsellors (n = 120) or to increase the professionalisation of counselling in Australia (n = 90).

It was noted that supervisors' reasons for continuing to be supervisors paralleled these categories both in regard to both the top and bottom categories. Top reasons selected were that they enjoy sharing their experience and expertise, and interacting with other counsellors, while the reasons related to the expectation of the workplace for them to be supervisors were selected less often.

Use and content of supervision

This section of the study explores how supervision time was used by practicing counsellors. It covers:

- elements of supervision sessions;
- control over supervision session content;
- evaluation of counsellor practice;
- application of supervision; and
- evaluation of supervision.

Elements of supervision.

When considering the most common elements of supervision

Figure 6: What are the most common elements that occur in your supervision sessions with counsellors? (supervisor responses)

sessions, the standout category counsellors identified was the discussion of specific cases, followed by the monitoring of the counsellor's health and wellbeing, and more general professional discussion. A relatively equal distribution of further categories was noted; however, the least common elements of supervision sessions were the review of direct client work (live or recorded) (Figure 5).

When asked about whether there were other elements that they would prefer to be spending time on in supervision, 82.2 per cent of counsellors who answered said that there were no such elements. For those who did have a preferred area of focus, the responses covered a spectrum of topics. Still, there was some commonality in the responses such as: case studies (n = 23); the topics self-care, wellbeing and burnout (n = 22); skills development (n = 16); and exploring current and new findings in research (n = 13). A significant portion of the sample did not to respond to the question (n = 267).

Similar to responses of supervisees, most supervisors said that discussion of specific cases was the most common element in supervision sessions. The top responses of supervisors were similar to those of supervisees, although in a different order (Figure 6).

Control over supervision sessions. Of those who responded to the question regarding who has most control over the content of the supervision session, 49.2 per cent of supervisees considered that there was mutual control over the content covered in supervision. A further 42.3 per cent identified that it was the supervisee who had most control. Counsellors identified that the workplace or organisation had little control over the content that was covered in supervision (1.3 per cent) and only 7.2 per cent identified that supervisors had most control over the content of supervision (Figure 7).

Participants were also asked who has most control over the interactions in supervision. Consistent with the findings on content, 63.8 per cent believed that there was mutual control over the supervision interactions, with 20.5 per cent indicating it was the supervisee who has the most control, with only 11.2 per cent stating the supervisor had control over the interaction.

Similar to supervisees, the supervisor respondents largely indicated that the content of the session was either controlled by the supervisee or there was mutual control between the two parties (Figure 8). However, the ratio of these two elements contrasted with supervisees' responses, with 66.5 per cent of participating supervisors indicating that there was mutual control over the content of supervision sessions, whereas only 24.6 per cent identified that the supervisee has most control. Similarly, only 7.3 per cent of counsellors said that the supervisor has most control and 1.6 per cent stated that the workplace had most control.

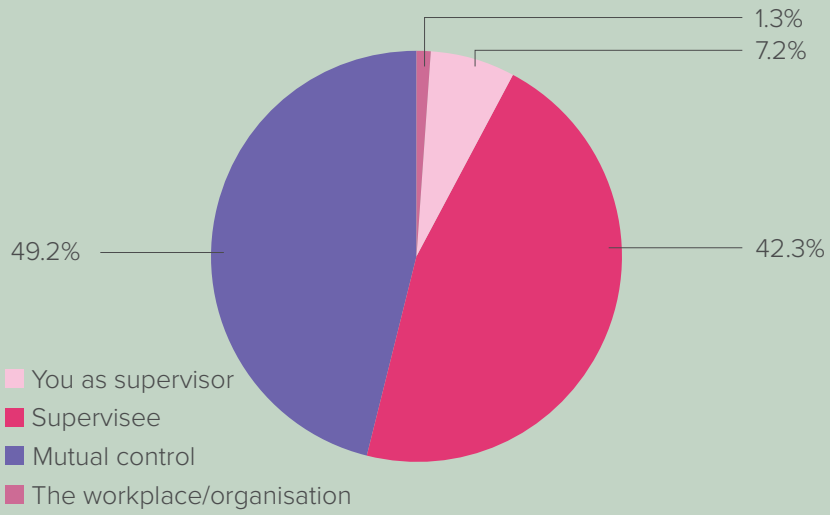
Evaluation of counsellor practice. Over 63 per cent of counsellors who responded stated that their supervisor does not evaluate their

practice, leaving 36.1 per cent of supervisees having their practice evaluated by their supervisor (Figure 9). Predominantly, these supervisees experienced the evaluation of their practice through informal means (such as feedback, discussion, supervisor questions, and so on). Some participants noted experiencing more formal evaluation including review of live or recorded sessions, reviewing case notes, client data, or the use of reports, surveys and rating scales. These more formal evaluations were rare.

Fifty-five per cent of participating supervisors said they evaluate counsellors' practice, with 44.7 per cent stating they do not evaluate counsellor's practice. Those who said they evaluate counsellors' practice identified a variance in the frequency with which this occurs, from sessional reviews of practice to regular reports at distinct intervals (for example, quarterly or annually). Methods described included both formal and informal evaluations, ranging from supervisee reports and discussion, review of tasks set in supervision, use of structured assessments or reports, live and recorded observation, and client data (for example, the session rating scale). Notably, there was a significant contrast in responses about evaluation of practice when compared to supervisee's responses, where over 63 per cent of counsellors stated that their supervisor did not evaluate their practice.

The impact of practice evaluation was largely considered to be positive, with the noted themes being that supervisors identified there to be improvements for the supervisee (e.g. ongoing learning and reflection; professional development); quality control for the client (e.g. ethical practice and accountability; work outcomes); improvement in the supervision

Figure 7: Who has the most control or influence over what content is covered in the supervision session? (supervisee responses)



Note: Missing: n = 263

Figure 8: Who has most control or influence over what content is covered in the supervision sessions? (supervisor responses)

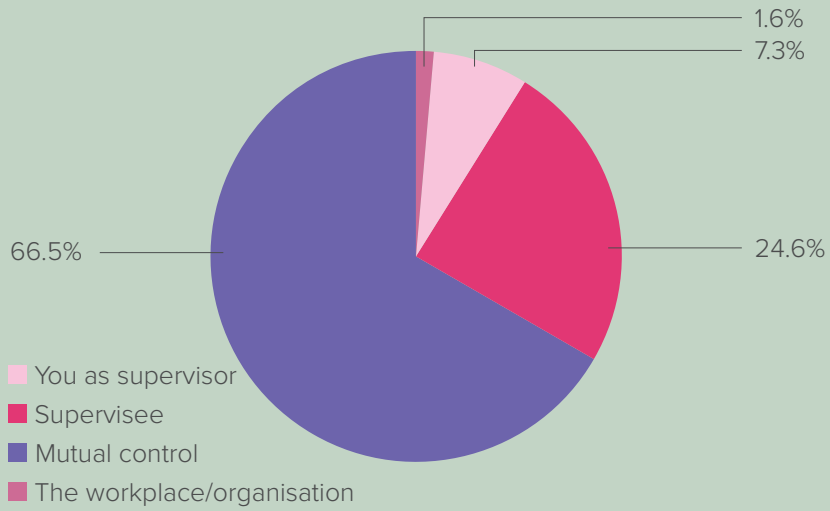
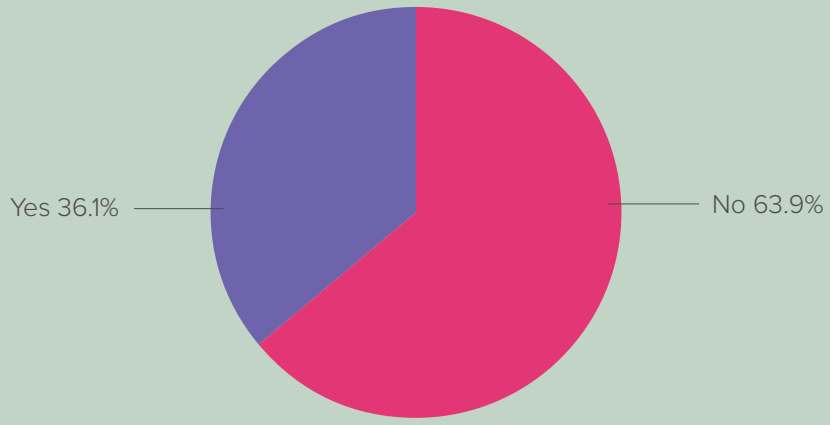
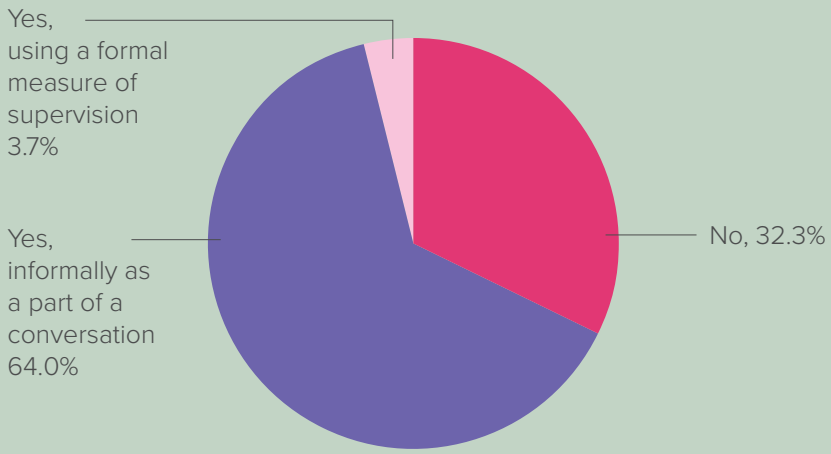


Figure 9: Does your supervisor evaluate your practice as a counsellor?



Note: Missing: n = 263.

Figure 10: Do you and your supervisor ever evaluate the process of supervision?



Note. Missing: n = 263.

process and alliance (e.g. improves supervision process; feedback to improve process; strengthens relationship; enhanced clarity and goal setting). An additional benefit noted was that supervisors also identified that they benefited from evaluating counsellors' practice as it helped them in their role as a supervisor and was seen to be part of their own professional development. Conversely, it was also noted that some supervisors saw that evaluation could either have little impact or could limit the effectiveness of supervision.

Application of supervision.

The majority of supervisee participants saw that they were able to apply what occurs in supervision to their practice with clients, with only a very few respondents (n = 15) saying that they were not able to apply supervision to their clients. Counsellors nominated a variety of ways in which this application takes place, though most commonly it was through the application to specific cases, followed by an overall increased knowledge of the therapy process.

Nearly all supervisors nominated that counsellors apply what occurs in supervision in some form to their work with clients, with only one respondent nominating that they did not see supervisees apply supervision in this way. There was no predominant method through which supervisors said their supervisees applied what they had learned. Rather, results covered a spectrum of mechanisms, such as through improved confidence, application to specific cases discussed in supervision, handling ethics dilemmas, and increasing knowledge of the therapeutic process, therapeutic interventions or skills needed to build the therapeutic alliance.

Evaluation of supervision.

When asked if the process of supervision was evaluated with their supervisors, 64 per cent of respondents said it was informally evaluated as part of a conversation with a further 3.7 per cent saying that it was evaluated using a formal supervision measure (Figure 10). Just under a third of those who responded (32.3 per cent) said they did not evaluate the supervision process with their supervisor. Notably, there was a significant number who elected not to respond to the question (n = 263).

A majority of supervisors (78.9 per cent) indicated that they and their supervisees informally evaluate the process of supervision. An additional 19.5 per cent said they use formal measures to evaluate supervision through use of published and supervisor-developed measures, surveys and tools. Conversely, however, only 3.7 per cent of counsellors identified that supervision was formally evaluated, and 64 per cent said it occurred informally. Most notably, only 1.6 per cent of supervisors said that they did not evaluate supervision, whereas 32.3 per cent of counsellors had said supervision was not evaluated.

Purpose and value of supervision

This section explores the results relating to the purpose and value that supervisees and supervisors ascribe to supervision. These include:

- the importance of supervision;
- benefits of supervision; and
- factors hindering supervision.

Importance of supervision.

When asked about the value of supervision a high proportion of participants (60.5 per cent) indicated that it was 'extremely important' with a further 34 per cent saying it was 'important' or 'very important'; 3.3 per cent were not sure of its value, while only 2.2 per cent found it 'limited', 'not important' or 'detrimental'.

Of the supervisors, 90 per cent saw supervision as being 'extremely important' to counsellors. This response is even more positive than the response of supervisees (60 per cent of counsellors rated supervision as

'extremely important'). A further 8.9 per cent of supervisors considered it 'very important' or 'important', with only one percent of supervisors identifying supervision to be of limited importance or being unsure of its benefit to counsellors.

Benefits of supervision.

As displayed in Table 1, the results suggest that there is a broad spectrum of benefits that are perceived and experienced by supervisees, with some strong correlations between potential and experienced benefits. When asked to identify the potential benefits of supervision, supervisees nominated a spectrum of benefits. Still, the most commonly nominated potential benefits were assistance with difficult cases, advanced practice skills, care of the therapist as a person, increased self-awareness and evaluation of current practice.

There was a strong correlation between the potential and experienced benefits for supervisees. In regard to the most common benefits that supervisees personally experience from supervision, the top five responses contained many similar categories to the potential benefits; namely, assistance with difficult cases, increased self-awareness, advanced practice skills, care of the therapist as a person and altered perspectives on practice.

When asked to nominate which of the experienced benefits was most important, supervisee participants again most frequently nominated assistance with difficult cases (n =1 56), followed by advanced practice skills (n= 73),

... the most commonly nominated potential benefits were assistance with difficult cases, advanced practice skills, care of the therapist as a person, increased self-awareness and evaluation of current practice.

TABLE 1: BENEFITS OF SUPERVISION

Category	Supervisee responses	Supervisor responses
Potential benefits of supervision – five most common responses	Assistance with difficult cases Advanced practice skills Care of the therapist as a person Evaluation of current practice Increased self-awareness	Assistance with difficult cases Care of the therapist as a person Evaluation of current practice Increased self-awareness Advanced practice skills
Experienced benefits of supervision – five most common responses	Assistance with difficult cases Increased self-awareness Advanced practice skills Care of the therapist as a person Altered perspectives on practice	N/A
Potential benefits of supervision – five least common responses	Greater flexibility Time management skills Research skills Managerial skills Other	Time management skills Managerial skills Research skills Personal therapy Other
Experienced benefits of supervision – five least common responses	Greater flexibility Time management skills Research skills Managerial skills Other	N/A

increased self-awareness (n = 69), and altered perspectives of practice (n = 65). Most supervisees (93.4 per cent) believe that their supervisors would agree with the benefits received from supervision, most commonly due to a collaborative relationship with their supervisors (for example, that they had shared discussion or agreement, regular check-ins and goal setting).

When asked to consider the primary ways that supervision can benefit counsellors, supervisors saw a wide range of potential benefits. The top five responses were assistance with difficult cases, care of the counsellor as a person, evaluation of current practice, increased self-awareness and advanced practice skills.

In addition, when asked which of the potential benefits were most important, supervisors said increased self-awareness and care of the counsellor as a person were the top potential benefits of supervision. Over 90 per cent of supervisors believe that their supervisees would agree with the benefits they gain from the supervision, responding that they knew this due to feedback and regular check-ins with supervisees.

Factors hindering supervision. In addition, when asked if there were any possible factors that hinder supervision, supervisees nominated areas that the supervisor was unable to offer that related to time constraints, and factors that hinder the alliance (such as different practice styles, lack of shared goals and the supervisor not checking in). When asked about possible factors that hinder supervision, supervisors saw a number of factors potentially hindering supervision. However, unlike with supervisees' responses, there were no standout categories. Both counsellors and supervisors considered that a hindrance to adequate supervision was when the 'supervisor [was] not able to offer aspects or aspects at the level needed' as a significant factor; however, a number of other factors seemed to be rated differently by the two groups, and of importance were issues such as 'sufficient time', 'good fit' or 'structure too rigid'.

DISCUSSION

Major findings

How does supervision practically operate in the context of the counselling profession in Australia?

The results of the survey found that supervision is used extensively by practicing counsellors for registration, employment and professional reasons. Counsellors most commonly attend supervision fortnightly or monthly, though some attend sessions more or less frequently. A vast majority of sessions last between 30 and 90 minutes. On average, where supervisees paid for sessions, the cost of supervision falls in the range of $50 to $150.

Supervision sessions are conducted across a range of formats and settings. The individual face-to-face format is both the most common and the most preferred format. However, this does not diminish the variations in both use and preference of formats, with some going so far as to say all formats could be beneficial. While some had no choice in the format of their supervision, for many the format of supervision was of secondary importance to the choice of supervisor and what they had access to (such as cost and time).

Overall, supervisors had attended accredited training, were registered as accredited supervisors, and received ongoing supervision for their supervision practice. A range of motivations were given for having become a supervisor, with wanting to give back to the profession, increase the professionalisation of counselling, and a passion for talking with counsellors about the practice of counselling being given as the predominant motivations. Most counsellor participants indicated that they have received some training in how to use the process of supervision to be supervised, though just under a third said that they received no formal training and had learned about being supervised 'along the way'.

How is supervision time practically used by counsellors?

Although a broad spectrum of activities was reported across the sample, both supervisees and supervisors reported the most common element covered in supervision was the discussion of specific counselling cases. Other common activities included monitoring the health and wellbeing of counsellors, discussing themes in work, general professional discussion and professional practice issues. The results suggested that these common activities were aligned with what participants wanted to spend time on in supervision.

Most supervisees and supervisors considered that there

Illustration: 123rf

was either mutual control or that supervisees had the most control over the choice of content of the session (though the ratios varied between the two groups). Supervisor or workplace control over content of sessions seemed to be a minority experience.

It was unclear from the findings whether supervisors formally evaluate the counselling practice of their supervisees as there were differing reports between the two groups. It was also unclear how commonly the process of supervision is evaluated. Supervisors almost unanimously said that it was regularly evaluated (either formally or informally); however, close to a third of supervisees said that supervision was not evaluated in their experience.

Across the sample, there was a clear opinion by supervisees that they applied what they did in supervision to their client work, with very few participants suggesting that they could not apply what was discussed in supervision. Still, there was no conclusive method of application to client work, with a spectrum of possibilities selected across the sample, and with some difference between how the two groups saw this was achieved.

What purpose and value do counsellors ascribe to the role of supervision in their professional practice?

There was a clear valuing of supervision across the population surveyed, with almost all participants rating supervision as important, very important or extremely important. The idea that supervision was not important or detrimental seems to be a minority opinion and experience. Furthermore, supervisees largely felt that supervision had met or exceeded their expectations.

Participants across the study noted a broad spectrum of potential benefits that supervision provides to counsellors. Supervisors and supervisees agreed on the most common potential benefits (though with some difference in order between the two groups). These common potential benefits were assistance with difficult cases, care of the counsellor as a person, evaluation of current practice, increased self-awareness, and development of advanced practice skills. Counsellors most commonly nominated that the most important benefit of supervision is gaining assistance with difficult cases, whereas supervisors most commonly said the most important benefit was increased self-awareness.

For counsellors receiving supervision, there was a strong alignment between the potential benefits and the benefits they experienced. Similarly, supervisors also nominated that it was rare that there were potential benefits that they could not offer. Both supervisees and supervisors nominated that they believed that there would be agreement in their supervision relationship about the

Illustration: 123rf

benefits of supervision, commonly citing the collaborative relationship and feedback opportunities as leading them to this conclusion.

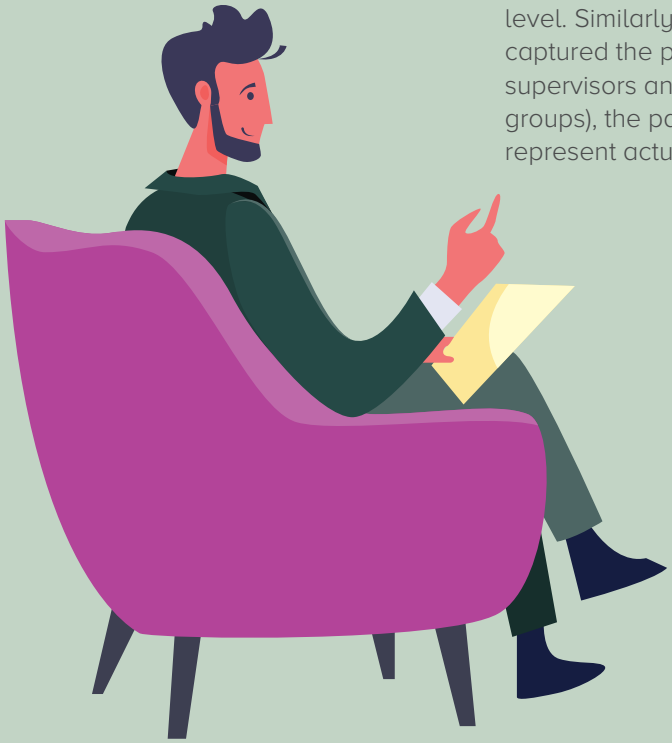
What similarities and differences occur between supervisors and supervisees in relation to their opinions and experiences of supervision?

A further research aim informing the study was to investigate the comparison between supervisor and supervisee responses. The results of this aspect of the study are reported in Schirmer and Thompson (2021).

Strengths and limitations

This study represents an initial step to expand the research literature on supervision in counselling. Specifically, it provides a descriptive study of the current practice of supervision amongst practicing counsellors in the Australian context. Furthermore, it captures the perspectives of both supervisees and supervisors on the same phenomenon. The high response rate enables a high degree of confidence in the results.

Nevertheless, these results need to be taken in the context of their limitations. As is common with survey research, the standardisation of the format and delivery does not allow for answers to be explored, and therefore the researchers have no mechanism to clarify how participants have interpreted the question. Furthermore, while the value of this study was to provide an initial descriptive snapshot, this resulted in most results primarily representing what was most common among the sample. Therefore, more subtle variables influencing the picture were not captured. As such, the results can only comment on what is most likely at a group level, but this should not be inferred to be predictive at an individual level. Similarly, while the study captured the perspectives of both supervisors and supervisees (as groups), the participants do not represent actual supervision dyads, and therefore the comparisons and contrasts should not be taken to represent what is going on in any particular supervision relationship. Further research, with different methodologies, would be needed to draw these sorts of conclusions in these areas.



IMPLICATIONS

Implications for practice

Consistent with the study's conclusion on the importance of the supervision alliance, there is scope to attend to the need for greater consistency between supervisees and supervisors. This could be achieved through a range of initiatives, such as more consistent training for supervisees on how to use the process of supervision (for example, as a standard part of counsellor training), and placing an emphasis in supervisor training on the importance of negotiating the goals and tasks of the process. While there were some themes to the use and content of supervision, the results also identified that supervision covers a wide variety of formats, content, benefits and methods of application. While the data showed themes at the collective level, supervision is delivered at the individual (or small group) level. Therefore, each supervision relationship and session could contain an idiosyncratic combination of these variables. As such, practitioners of supervision need to be trained and competent in the flexibility and complexity needed for such a bespoke task.

Such variability also demands best practice processes for setting the agenda (that is, the goals and tasks) for gaining feedback to evaluate the supervision process. Given that this study showed scope

... this study has identified how key participants in supervision perceive the processes, benefits and application of supervision.

for more clarity on the processes of evaluating supervisee practice as well as evaluating the process of supervision, this seems a major issue to be addressed in practice. In short, supervisors and supervisees should regularly be asking themselves: what is the best use of our time? And how do we know this is working?

Of course, the most influential (yet also complicating) variable in this is that supervision is a process between two parties for the benefit of a third party: the client. Therefore, the answers to the above questions cannot exist in a closed system between supervisees and their supervisors. Even though the task has multiple complexities, there is scope for practitioners to investigate and innovate ways of ascertaining the practice and development needs of supervisees beyond supervisees' self-reports.

Implications for future research

As a piece of inductive and descriptive research, this study has identified how key participants in supervision perceive the processes, benefits and application of supervision. Still, this self-report data could be further supported by more objective or observable data on the activities and outcomes of supervision. There is also scope to not just understand what is working in supervision but also how supervision is working; that is, there could be process research to differentiate the active factors that contribute to successful supervision. Given the relational element of the practice, this should not only include supervision method or techniques, but also factors in the supervisor, supervisee and the supervision relationship.

The major consideration for research in this area again relates to the complexity of the phenomenon being observed (that is, a process between two parties for the benefit of a third party). Consequently, a thorough research program on supervision would likely need to include many elements, such as mixed methods of quantitative and qualitative data collection, longitudinal studies, and dyadic (or even triadic) studies.

Implications for policy

As part of the process of professionalisation, professional counselling bodies have put in place clear requirements around supervision for counsellors, and standards for the accreditation of supervisors. The positive results in this study suggest that such a step has been and remains to be important for the profession of counselling. Supervision is used and valued across the profession, and many participants attest to the benefits of it. Supervisors are trained, accredited and monitored in their practice.

Such standards should not be taken for granted. For instance, in some countries, supervision is not mandatory after training. Given that this study describes the use of supervision across a naturalistic sample of practicing counsellors, the finding that supervision holds a high number of benefits with very few apparent detriments indicates the importance of maintaining supervision standards within professional counselling bodies (such as described in the ACA Supervision Policy).

Still, given that supervision constitutes one of the major strategies used to ensure the quality of the profession, there is further scope to ensure a consistency between policy and practice. For example, the ACA Supervision Policy recommended that counsellors receive "one hour of supervision for every 20 hours of client contact time or one hour every working week for counsellors with a full-time case load"; however, the results of this survey suggest that practitioners are not meeting these targets and raises questions about how this recommendation aligns to practice.

Similarly, the policy recommends that supervision consists of evaluation, education, support and administration. As previously mentioned, it is unclear how regularly and with what rigour the 'evaluation' activities are occurring. Given the importance of the evaluative function, but equally cognisant of the ethical complexities and potential

inadvertent effects on counsellor wellbeing, there is scope to identify or develop effective, efficient and (importantly) supportive mechanisms through which counselling practice can be more directly evaluated within supervision. In identifying these mechanisms, the expectations of professional bodies regarding supervision as a means of quality assurance may need to be defined with more precision and could be emphasised more in supervisor training and standards.

CONCLUSION

In summary, the survey identified the widespread usage of supervision in the counselling profession as well as themes in its usage and perceived and experienced benefits for the practice of counselling. As counselling seeks to further establish and expand its presence in the Australian mental health context, the practice, research and policy regarding supervision needs to develop at the same rate. As such, supervision is the business of all members of the profession – practitioners, researchers, educators and leaders – to collectively commit to continual improvement for the sake of the clients we serve.

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LOCKDOWNS MEASURE THE UNCERTAINTY PRINCIPLE

In December last year, Victorian counsellors shared with CA their COVID-19 lockdown experiences. A year later, the hoped-for end to the pandemic had not happened. Here, NSW counsellors talk about how they responded to these challenging times.

By Brad Collis

Mark Mahemoff sounds incredulous: "If you'd told me a year ago that I'd be counselling couples sitting in their car talking to me via video on their phones, I just would not have believed you," he says.

"But these have been exceptional times."

Mark, a Drummoyne-based relationship therapist, echoes the experiences of many counsellors and psychotherapists, particularly in New South Wales and Victoria, in having to adjust to escalating demand for their services at the same time as they, and everyone else, endured prolonged and enforced lockdowns.

For Mark, it broke all his rules, mainly his belief in the need for structure and formality around counselling sessions to establish a clear sense of purpose.

"My office had suddenly become my bedroom from which I was entering people's homes, or consulting with them sitting in cars or on park benches."

The danger, he felt, was that the online interaction would become a relaxed conversation without the focus that is counselling needs, risking the credibility of the process.

"It was an interesting challenge, given I really had no choice … and I have to say now that I think it has improved my work. I was always reluctant to do telehealth-type work, but I've now come to see it can be quite effective."

"However, it was the new reality and I had to adjust if I wanted to continue to work."

Mark's first move was quite simple: just blurring the background of his own Zoom location to separate his professional life from his private life. Another technique was to start a session by asking if the client was in a place with sufficient privacy to talk.

"It was about setting a tone, setting boundaries, without being too hard-line about it," he says. "It was an interesting challenge, given I really had no choice … and I have to say now that I think it has improved my work. I was always reluctant to do telehealth-type work, but I've now come to see it can be quite effective."

Mark says it has been interesting to reflect on where forced choices can lead: "You start out being frustrated about the restrictions you are working and living under, but then you discover capabilities and possibilities that you didn't think you had."

He says that while it was a challenging process professionally, the anxiety created by the lockdowns for many of his clients, not being able to travel or see family and friends, has had serious impacts.

"I'm mainly a relationships counsellor, but found myself becoming more and more a lifeline for people. That was certainly a change for me, and I sense for many others in the community. That's a good thing, but how we move forward remains complicated. Some people can see opportunity in things like more flexible work arrangements, but a lot of people are still really struggling."

Back to school

When Amanda Dounis realised online consulting was going to become the new norm for counsellors during the height of the COVID-19 lockdowns, she also realised it meant learning new skills and techniques to make sure the counsellor–client relationship was not compromised.

She had already observed how some schoolteachers were struggling to stay connected with students in online classes, so she knew that maintaining effective therapeutic relationships involved a lot more than knowing how to use Zoom.

Based in the Sydney suburb of Wolli Creek, Amanda undertook several online courses to better equip herself for operating in a virtual consulting room.

"It's a whole new relationship online. Some people think it is not face-to-face, but it is actually an even more intense face-to-face engagement. It requires new techniques and approaches and, contrary to initial misgivings, I found the experience very positive," she says.

"I found we could do so much more. We could access online resources, work on mindfulness, do some hypnosis, even some drawing. If you were prepared to be creative, so many options opened up."

Amanda says when clinic visits resumed after the first lockdown, some clients opted to retain their online sessions. "Some became more motivated and more engaged as a result of not having to spend hours travelling.

"I also started doing group sessions online and they were great. This also extended to more networking with colleagues – sharing knowledge and experience."

In terms of the pandemic's impact on clients, Amanda says the biggest change was more parents reaching out for their children.

"The kids really struggled from the disconnection from friends and social isolation … the build-up of negative thoughts, low self-esteem, lack of focus and concentration, and fear, because they were constantly hearing conversations about uncertainty.

"Even the opening up was daunting. By the time the lockdown was lifted, 'I can't wait to see my friends' had become 'do I still have friends?'"

Moving forwards, Amanda expects online consulting will have an ongoing role in counselling, especially where it facilitates greater flexibility.

Illustration: 123rf

Caught in the middle

For Byron Bay counsellor Julia Ford, work and life during the lockdowns was one simmering pressure cooker: people seeking out counselling because of existing disconnection, finding themselves further isolated by arbitrarily imposed and enforced restrictions. In her area, this was exacerbated by schisms in the community over vaccinations.

The herd mentality that aggravates an individual's feeling of isolation and disconnection, and consequences like addictions, was amplified during lockdowns. It was traumatic for a lot of people, she says.

"People were coming to me with issues I'd not encountered at the same level before … workplace bullying stemming from different approaches to directives. The bullying and harassment were made worse by perpetrators feeling they were empowered by government.

"It was in conflict with the way I've always practised. I try to rip down fear, deconstruct anxiety and then say, 'OK let's weigh up the risks of facing the issue. Let's not be frightened. Let's find your strengths.' During lockdowns it was more necessary than ever for people to be able to make decisions feeling like they had some control … but they didn't. And this was very hard to navigate.

"As a professional counsellor I have to be neutral because you are there for the person who has come to you. But people were looking for answers, for certainty, from a healthcare system unable to provide this."

Julia admits to starting some days crying, but she had a job to do. People's need for support, for some glimmer of solid ground on which to stand in the future, had never been greater.

She now looks to the future with her own questions: "People are talking about a new norm. What does this mean? Some people are moving on, and that's great. But many can't. So where does that leave our community?"

The question of autonomy

Sydney psychotherapist Dr Antonia Saunokonoko says the loss of personal autonomy threw up some of the hardest challenges for people – for clients and counsellors alike in the sense that everybody was affected.

"As a counsellor I deal with people with addictions, who have complex trauma

Illustration: 123rf

in their history, and for whom a sense of powerlessness is already part of their makeup. So to be presented with a real, living situation where their autonomy is removed and where authority is much more in their face than would ordinarily be the case, could be very triggering."

She, like Julia Ford, found the issue of vaccinations being raised frequently in sessions: "'Where is the boundary for who has control over my body?' The issue of 'what goes in my body' comes up with eating disorders and addictions, and so triggered strong reactions to vaccinations."

Antonia says the pandemic clearly increased her workload, but she says there have also been positive outcomes.

"Yes, it heightened many people's difficulties, but it also eased some people's circumstances – removed social pressures, removed some of the relationships that were problematic for them.

"It also raised community awareness of mental health. Workplaces that didn't even broach the subject are now trying tentatively to implement measures to support people. The conversation about mental health is much easier to have than it's ever been before."

Antonia believes one of the most crucial lessons learned by many is how important 'connection' is to wellbeing and to healing.

"People do best in connection, they heal in connection. It is the spiritual space between people that needs to be nurtured and protected because that's where we all do best."

As the lockdown lifted, Antonia was looking forward to once more being in the same room as her clients.

"I enjoy the face-to-face. It's part of the reason why I choose this profession. I like working with people in this way. And I missed it."

About the author

Julia Ford
Julia has worked across a broad spectrum of mental health services, including government and NGOs, and as counsellor for Mindstar for the past 18 years. She is currently in the midst of joining my practice with Primal Release, a holistic healing centre. She is passionate about meeting the diverse needs of clients and understanding life's challenges uniquely affect everyone. Her academic and practical experience using strength-based practice has been paramount to ensuring clients can recover to the best of their unique abilities. Julie currently lives and works in sunny Byron Bay, where she and her husband raise their twin daughters.

My story 2021

Julia Ford

I assume, for most, when COVID-19 hit, the uncertainty was surreal and horrific. Many of us were trying to manage work and home life, keeping it together so to speak. As a counsellor I can't remember being so busy. For me, panic set in followed by a frantic attempt to take control of the situation. I admit to panic buying overpriced masks, stocking up on hand sanitiser, then praying for the best. I'd managed my anxiety for years successfully, but this situation pushed my limits.

My husband is an emergency doctor, so I dreaded watching him head off to work. Daily he'd come home, his clothes stuffed in an acid yellow bag marked 'hazardous waste' – a harsh reminder of the disaster unfolding. In the past, we'd weathered work crises, like a needle stick injury by a suspected HIV-positive patient. It was terrifying, but practical responses were in place to deal with it. COVID was different; it saw my husband treating patients with no proper PPE (personal protective equipment), and processes that changed minute by minute. Health workers seemed to be thrown into the frontline as some sort of fodder. Work life was stressful, but home life was too.

As borders shut and families separated, my twin daughters moved home.

We took in a young woman who was in a DV (domestic violence) relationship with nowhere safe to go. My plate was full, I was mentally exhausted and lives were in chaos ... but as they say, 'the show must go on'.

My work is predominately online, so I was confident and comfortable with the process. This time was different though; I'd never experienced such a heavy load of clients all sharing the same fears, including my own. Yes, there were differences in how COVID affected individuals, but fear of the unknown doesn't discriminate. The stories differ but the effect is the same. Fear, helplessness, hopelessness, desperation and frustration were common themes.

My struggle to understand the government's response to this crisis

remains the hardest stumbling block. I find the measures quite draconian. For me, a society where the state decides who can or cannot be by the side of a dying loved one will never make sense. Perhaps it's because my beloved uncle died alone in the UK, his family kept from him. And I'm continually prevented from seeing my mother, who suffers dementia, at the whim of government lockdowns.

I work hard to leave personal feelings aside. My focus is to remain a vessel for my clients, to be a safe place for their worries to fall. My approach has always been to walk beside my client. Shared experiences can allow for a deeper understanding and, although it's not always possible, I believe most humans can relate to varied life situations.

The challenge for me as a counsellor lies in the idea of 'the new normal'. It simply clashes with my core beliefs, conflicting with the very framework I build with clients for a healthy, happy life. After all fear keeps people locked in DV situations, it stops addicts asking for help when they need it most, it stops people living life to the fullest. When the government advertises that the measures are "keeping us safe" and yet I hear about the devastation they cause, it's frustrating to say the least. I have no expertise in living in this system of the new normal. It is a path the client and I must walk together, but this time I am leading in the dark.

As counsellors we must be constantly aware of our personal beliefs. Clients ask my opinion on what they should do regarding vaccines. I try to stress the importance of making informed decisions not based on conspiracy theories, or the media hype that does not fit with the reality on the ground. Some clients are panicked, unable to access vaccines fast enough; others call with anxiety after taking the vaccine. I've learned to stick to a script regarding this, advising them to visit their GP if they're worried. I'm no expert; at the end of the day the effects are unknown. My opinion may only serve to alienate my client and exacerbate their anxieties. The truth is, in this period of time, no one has the answers; there is no immediate cure for the world we now live in.

This past year I have had to learn to sit comfortably with uncertainty and found there are greater issues than the worry of any virus. I've heard stories of people losing their homes and life savings, women locked in DV situations with no way out, families trapped in tiny apartments with newborn babies and husbands freshly out of work, relatives from overseas all crammed in with nowhere to go. These stories weigh on me. There's no easy solution at hand, but it's

my job to help clients survive as best they can. For me, the critical measure in managing all this is to connect with my supervisor regularly. Bless my supervisor, she is my rock!

I've learned that the most powerful mindset is so very basic. We must search for the gifts we have and bless them with gratitude. We must learn to let go, accepting the things we cannot change. It all starts with our breath. If we can centre ourselves and become present, we can start to look at the things we can embrace. For some it's spirituality; for others, it's creating a network of support. One thing's for sure, we must grieve our old lives, so it's best we make our peace and learn to adapt as best we can. COVID is here to stay, and the government measures to deal with it are ever changing. We must be able to help clients find ways forward in this new normal, all the while grasping the gravity of navigating the unknown.

Being a counsellor during COVID-19 restrictions in Sydney in 2021

Sudhir Dean

I'm sitting in an N95 mask with plastic goggles on, facing a counselling client, who has no phone to be able to do phone counselling. He tells me of his hair-raising history and his present-day dilemmas, homelessness being one of them. I certainly never foresaw such physical constraints being put on the counselling relationship. Still, we manage an affecting and deeply touching therapeutic exchange.

A few months ago, I was sitting opposite a client who not only had a surgical mask on but chose to wear sunglasses as well. At this point I wondered at the absurdity of life, thinking that perhaps laughter really is the best medicine. Still, we got to tears of recognition, acceptance and openness. The humbling nature of the counselling moment seems to shine through no matter what works at getting in the way of it.

I am employed as one member of a seven-person counselling unit at the Kirketon Road Centre (KRC) in Kings Cross. KRC is a free, walk-in, primary healthcare service offering medical, counselling and harm-minimisation services, with no appointment needed. One can attend KRC without a Medicare card and without giving one's real name, if needed. Confidentiality is assured.

KRC is staffed by a team of doctors, nurses, counsellors and health education officers, backed up by an admin support team. In more normal times, KRC's brief is to offer wrap-around healthcare to marginalised communities, young people, sex workers, injecting drug users, people from the LGBTQIA+ community, the local Indigenous community, people experiencing homelessness and more. In these less-than-normal times we are also heavily involved in offering COVID-19 testing and vaccinations to these same communities, mostly in outreach settings.

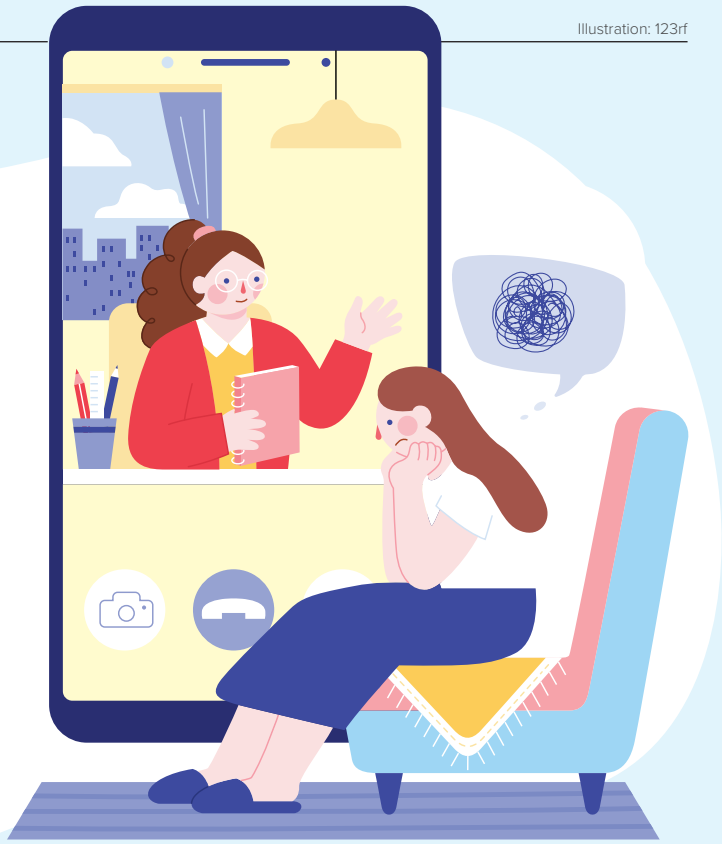
Counselling at KRC is a wild ride. It is simply impossible to foretell what issues people will bring into the counselling room. In this community they are more varied than I had ever imagined. COVID has added a whole new selection to the list. One has to be prepared to respond to the unexpected in every session, every day. We regularly see people who are homeless. During the first lockdown we had a wave of sex workers who were suddenly unable to work or pay rent. We case manage intravenous drug users who are on our in-house opioid agonist program. People walk through the door with the full spectrum of mental and emotional health problems. I have seen soldiers whose PTSD has left them adrift, and women and men dealing with domestic violence, gender abuse, racial abuse, sexual abuse and more.

None of these people are judged for who they are, or what they are doing. KRC has a culture of respect that has been 30 years in the making. Everyone is treated as a human being. This starts the moment they are greeted at the door. There is a functional hierarchy at KRC to make sure the place runs smoothly, but there is no siloing between teams. I can call a doctor into a session, if that's what is needed. The doctors and nurses know to call on the counsellors to come into their consults when needed, too.

It is clear from the conversations we have with our clients that they often have underlying histories of adverse experience, frequently beginning in childhood. Once I hear a person's history, their behaviour generally makes perfect sense. This extends to their experience of homelessness, substance use, incarceration, mental health and more.

There was a time when as counsellors we used to spend a lot of energy looking for trauma-focused follow-up services to refer our clients to. We discovered that

Illustration: 123rf



if one has no money, such services are as rare as hen's teeth. To this end, we have been working on up-skilling ourselves so that we can approach our clients' underlying trauma safely, compassionately and effectively, in-house. We also have allies in the health system who can help us with peer support and expertise when we need it. We have been able to make this a priority in these days of lockdown.

There is also a research arm at KRC. This year the counselling team presented the results of a research paper *Confronting the obvious – acknowledging and addressing trauma: an evaluation of the Adverse Childhood Experiences (ACE) questionnaire in the KRC setting* at the Network of Alcohol and Drug Agencies conference 2021. This paper would never have happened but for the support of the KRC Consumer Participation Group.

Over the last year, our counselling work has mostly moved from seeing people face to face to working on the phone. Not all our clients have phones, so this is not always possible. Our nursing colleagues have educated us thoroughly in the art of personal protective equipment and infection control. Phone counselling seems to work better for some clients than others. For some, the visual anonymity adds to their willingness to be open and engage. For others, it's just clunky.

As people have been dealing with the isolation inherent in lockdowns, so our work has intensified. With fewer distractions and nowhere to go, people's feelings surface, along with all their various – not always healthy or legal – coping mechanisms. Our clients are nothing if not resilient; however, anxiety and depression, suicidality and domestic violence seem to have increased.

As we have become more focused on testing for COVID and rolling out vaccinations for homeless people and people living in social housing, so as counsellors we have found ourselves seconded onto the outreach bus and to the vaccination hubs, interacting with people choosing to get tested or vaccinated, helping to find them accommodation in which to isolate, or providing safe injecting equipment. These shifts take place in multiple locations and are sometimes done at night. Each interaction is a potential opportunity for a counselling moment. The simple act of being patient, friendly, non-judgemental and reassuring has a powerful effect. One never knows the results of seeds sown.

2021 has been, and continues to be, a powerfully therapeutic existential adventure.

About the author

Sudhir Dean
Sudhir is a counsellor, author and newspaper columnist living and working in Sydney. He is presently working for the Kirketon Road Centre (NSW Health). He is passionate about contemporary trauma research and practice. He is currently training to be a counselling supervisor.

My experience as a counsellor during the COVID-19 restrictions

Amanda Dounis

As I write this article in July 2021, the COVID-19 pandemic journey has certainly challenged me as a counsellor. But this challenge has also progressed me toward new skills, and this in itself is a blessing.

But before you read on, I know that COVID restrictions have also negatively impacted some counsellors, and I truly feel for them and wish them a great recovery. I understand that each professional has their own experience, and here is mine ...

My office now has a large perspex barrier that divides me and any future clients who enter my space. I think investing in this was wise and that, post-restrictions, I will keep it. It's transparent and it offers a sense of safety, as we know particles from our breath (including from sighs, coughs and sneezes) cannot reach one another.

To be honest, knowing how to use Zoom is not enough to allow you to do great and effective therapy online. Every professional should invest in a professional development course to ensure they learn the best way deliver therapy.

For me, COVID restrictions have landed me opportunities for technical and digital resource growth. They have actually turned me into a better therapist. Who would have thought? I never would have predicted that. But having proper procedures and policies in place to ensure confidentiality, reliability, access and compliance are absolutely essential. This takes time and commitment.

I have had to convince some clients that online can be just as (if not more) effective than being present inside my clinic. My clinic has a separate therapy/cosy room that offers a beautiful scent, lighting, comfortable recliner and a therapeutic experience, and my clients were not happy to give this up, but after each online session we do a quick evaluation and, truth is, online is rated right up there.

I have been able to master online techniques to deliver EMDR (eye movement desensitisation and reprocessing), meditations, mindful activities, sharing of digital resources and more. It's been quite fun doing professional development courses to learn to deliver a variety of modalities online. In fact, creativity on my part has been very helpful.

Even when there are no stay-home orders, I have been able to place wireless headsets on clients who physically come in (with disposable ear hygiene protectors) and I have been able to do short, guided visualisations from a distance, and even the next room, using an app that serves as a microphone. It is a personal experience with a reassurance of safety.

It's these small adjustments that we need to keep us all safe and still have effective sessions. I guess where there are systems in place, then your practice will be successful. Plan to succeed and to move with the times.

Being generous has really helped me stay connected with my clients. Offering specials during school holidays for online sessions with kids has also been seen as a treat and perhaps a new experience for them.

It's amazing how we can be so giving with resources. This applies to all ages – kids, teens, adolescents and adults. Wellness tools, meditation audios, inventories, tips, YouTube videos and more. This helps maintain rapport with our clients.

COVID has also changed how I work, as I always check in with clients to see how they are coping with the current situation at the beginning of our session.

No doubt the pandemic and its restrictions and consequences have had quite an impact on mental health. It has become important that I cover this with clients at the beginning of each session. I check in with their safety, sleep, exercise, mindset, employment and more.

Supervision is now online and this has proven to be a success. Again, it has turned me into a very generous supervisor, where I have embraced networking with other colleagues. We share and support each other. It's so easy to hop online and connect.

I'm grateful that my clinical practice has evolved to deliver great therapy to suit these trying times. I found great confidence in being a professional online and COVID-safe therapist.

This has been my experience with lockdown restrictions. One thing that I have not enjoyed is having AirPods in my ears for so many hours. It's so nice to have them out at the end of the day.

I hope my account has been able to offer a positive outlook for anyone who is reading this. Where there is a will, there is a way.

About the author

Amanda Dounis
Amanda is the founder of four early learning centres (Banbury Cottage, Rainbow Cottage, Little Dolphins and Babyland), all located in Sydney. She is director of the Dounis Group and founder of the Positive Thinking Clinic (psychotherapy: hypnotherapy, counselling and neurolinguistic programming master).

Reflections on my experiences during COVID-19

Phillip Halstead

I read with interest other counsellors' experiences during these challenging times. I also looked at volume 22, number 2 edition of *Counselling Australia* journal, referring to research and the application of self-care for therapists as presented by Marta Bloom and Dr Mark Pearson, detailing the perspectives of regional counsellors.

I have a private practice in Corrimal, a suburb of Wollongong, NSW, two hours south of Sydney. We are, at the time of writing, still under COVID restrictions. During the lockdown, I have noticed that referrals have increased but, at the same time, 'no-shows' have increased.

Overall, the time has been full of ups and downs, just like most other people's experience in times of uncertainty. As counsellors, we know the research and lessons explaining resilience, and I have drawn on these methods of building and maintaining resilience. In the main, I have resorted to humour in the face of adverse conditions, maintaining a sense of control and downplaying situations that might otherwise cause frustration and anxiety.

I reminded myself of the things I talk to clients about to help them to overcome, manage and learn from difficult situations and to take a long-term view of seemingly overwhelming problems. Strength-based counselling, positive psychology and lessons from humanistic psychology and other modalities have proven valuable allies during these COVID times.

'Expect the unexpected' and 'improvise, adapt and overcome' are sayings used by many who find themselves facing adversity. In the military, it can help soldiers better handle changes in battle. In construction or mining, where tasks are planned meticulously by project managers, it allows for some contingency planning to consider what may change and what to do when things take an unexpected turn. Similarly, in other areas of life, like conducting a counselling practice, we need contingency plans and to have the right attitude to accept what happens and adapt.

I remembered the locus of control theories, where we all need some degree of control over our lives and our surroundings and to exercise a degree of perspective in order to make sense of our environment.

I find that I am taking more time to reflect on my practice and supervision, which is proving to be very valuable time spent. I am actually enjoying the time I take to review, with a critical eye, what I am doing with each client and how they are progressing, and also to better plan strategies. This review is helping me to devise questions and week-by-week detailed guides to therapy, and to take more time to check in on more counselling methods that could be used to drive progress.

The no-shows I put down to people forgetting (being too preoccupied or distracted by life events), home schooling or balancing their working-from-home activities. So, I always look at these very probable reasons rather than assuming people just don't care or are inconsiderate' ... catastrophic thinking and cognitive distortions.

All in all, the COVID-19 lockdown situation has allowed me to be more introspective and critically reflective of all aspects of my counselling work – from marketing, clinical supervision and staffing to technology, telehealth and counselling methodologies. It has also provided more time for study, albeit online, which I learned to adapt to by necessity. I became more creative and resourceful, and viewed things from a different perspective, which provides positive change.

Another positive is that I am spending more time with my family, which is great for my mental health and wellbeing and for my family's. We are enjoying everyday things and appreciating those things we often take for granted.

Essentially, I want to say that such challenges can be useful to reflect and seek improvements in life and in our counselling practices. Specifically, if we allow ourselves to review and respond with a positive view to accept changing circumstances and use solution-focused strategies, we can make the best of a bad situation.

About the author

Phillip Halstead
Phillip is a counsellor in private practice specialising in **mining employee assistance programs**. This comes from his extensive dual career in mining and counselling, having worked as a coalmine deputy in NSW and Queensland and as an army reserves officer in the Australian Army Psychology Corps. He also is an NMAS-accredited mediator, providing alternative dispute resolutions to workplace conflict.

Counselling mid-pandemic

Mark Mahemoff

Before COVID-19 arrived to change life as many of us knew it, I found the idea of having a serious and meaningful counselling session via video dubious, annoying and counterintuitive. The whole reason I became a counsellor some 25 years ago was so that I could meet with people – couples by and large – and talk to them, in the flesh, about their hopes and dreams. At the beginning of my counselling career at the age of 31, I found it a particularly nerve-wracking experience when a couple in their mid-50s walked in wanting to discuss their failing marriage and the effect of their tribulations on teenage children when I was single and childless. But as I clocked up 'flying miles', what was once worrying soon became enjoyable; what started as trepidation became anticipation. From the moment I first saw my clients in the waiting room I would study them. I would notice if they were sitting next to each other or at opposite ends of the couch, whether they were talking to each other or reading. And then, as they entered my room and took their seats, I would watch how they each responded to each other's comments, their facial expressions – or lack of them – and their body language.

Then the pandemic hit. Overnight my house became my workplace and my son's bedroom my makeshift office. It felt a bit like starting all over again, but this time I would have to become accustomed to a technology that I didn't trust, let alone have the faintest idea how to use. I was forced to learn words like 'Zoom' and experienced a new type of tiredness I'll call 'screen fatigue'. The waiting room I had, which once contained solid books and furniture, was now a virtual one, and I had the power to let clients in or keep them in virtual limbo. And then, when I was meeting an individual or a couple for the first time, we were all suddenly transported to each other's houses. This doesn't often happen on a first date let alone in a therapeutic context. Fortuitously, this led me to discover virtual backgrounds. I realised that, not only were the bookcases some clients were sitting in front of identical, they also didn't actually exist in the timber and paper sense of those words. So now I find myself endlessly browsing for the perfect background the way one might browse at IKEA. Today I might prefer a simple shaker desk and potted plant. Tomorrow, well, that ubiquitous bookcase.

However, 18 months on I can truthfully say I find video another efficacious way to deliver counselling, in conjunction with the telephone and sitting face to face in a physical counselling room. I must admit, while I still prefer having whole people in front of me to seeing them from the neck up, now I have a greater appreciation for its convenience. Clients without cars, who are geographically remote or who are housebound for whatever reason, can roll out of bed and sit in front of their computer. Late cancellations happen less often as people can avoid traffic and just quickly log on when running late. While this can sometimes lead to a lack of the formality that is often useful – indeed necessary – in setting and maintaining boundaries, I must remind myself that I am sitting in my child's bedroom, attempting to be a professional while wearing an ill-fitting pair of tracksuit pants, and my briefcase resting on a redundant box of Lego.

After all, I must admit there is something incredibly refreshing about seeing one or two strangers suddenly become visible on my laptop monitor and then diving headlong into forming a therapeutic relationship. While I'm excited for the pandemic to be over, I am also more than comfortable with this way of counselling. I'm confident it will remain a permanent part of my repertoire.

About the author

Mark Mahemoff
Mark is a Sydney-based relationship therapist and poet. He has published four books of poetry and his work is represented internationally in journals and anthologies. He also regularly reviews psychotherapy and poetry literature and conducts poetry workshops. He works as senior counsellor and clinical supervisor in the not-for-profit sector and has a small private psychotherapy practice.

Eight ways to a better coupling with your partner during COVID-19 restrictions

Law Ortovent

As a relationship counsellor, I have seen many couples struggling during lockdown. As the sudden new 'normal' has made them stay all day and night together under the same roof, with many restrictions,

for a long period of time. It has been particularly difficult for those who have been working or living independently prior to the pandemic.

The time and space a couple spend together can be pleasurable and meaningful if they have already established a strong and connected relationship, physically, emotionally and sexually. However, if the relationship was difficult, problematic or abusive, one partner or both may find themselves in a more stressful situation, when they have no choice but to be confined with their partner. Even in a healthy relationship, it can be challenging to cope or manage day-to-day living in an extended lockdown, like we had Sydney.

Here are some general tips for how to live well with your partner during lockdown restrictions:

1) Take time to explore unfulfilled wishes

Take this time for things you've been wanting to do or explore as a couple when you didn't have the time. No more excuses for you and your partner not to fulfil the promises you made before, or any wishes that you've always had about enjoying each other's company. It can be as simple as exercising, singing or dancing together, or exploring different kinds of homemade cuisines. My partner and I have created a home karaoke just by simply connecting the smart TV with a quality speaker and microphone. We search karaoke songs on YouTube and sing like pros, and above all, have lots of fun and enjoyment.

2) Give space to each other

The fact that you are staying home with your partner doesn't mean that you can't have your 'me' time. If that's how you feel in moments of stress, communicate well with your partner and express your feelings. Couples who find themselves in a pattern of arguments, criticism or negative feelings and emotions should call a 'time out' before things spiral down. This can happen fairly quickly during this tough time. You may even structure your 'me' time each day or week to fulfil your needs so that your partner can understand and allow that time and space for you.

3) Focus on what you can control

With the restrictions that have been put on us, we need to go easy on everything. This is not a good time to try to resolve all the problems that have been accumulated from the past. Focus on small tasks or things that you can do better. If you find yourself not coping in the relationship, seek help. Call somebody you can trust or find the professionals who offer telehealth.

4) Structure the 'we' time

Even though you are spending the whole time together, it's reasonable to make the 'we' time that you both agree on. To show you both respect and treasure this common time, make it as special as it can be. No matter if it's spontaneous or planned activities, be creative and attentive – try ideas such as dating at home, cosplay, play a new game etc.

5) Show gratitude

Be grateful you have each other during this tough time and you are not alone. Look out for each other; be each other's support rather than enemy. You are together to make this difficult time a bit more acceptable, easy and fun. Open your mind, for it can be the time for your relationship to transform.

6) Recognise needs and feelings

You don't need to sugar-coat how difficult it is for both of you; instead, validate each other's feelings. Recognise your own needs as much as your partner's needs. Learn how to communicate well with each other.

7) Stay connected

Be mindful of the present, do not drill into the past or worry too much about the future. Tune in to yourself and to each another. Limit your time with media or devices, as they not only can bring more stressors with the news, but also they can divert you from precious moments with yourself or with your partner.

8) Expand your sexual pleasure

Seize this time to indulge yourself and your partner with longer foreplay, sensual touch and communication. Learn each other's bodies, connect to each other's feelings, expand your vocabulary or expression, and explore how to pleasure each other. Perhaps try something different rather than following the same old routines. It can be as simple as a new position, play with a new sex toy, doing role play, giving each other an erotic massage, creating a new atmosphere, and so on. You and your partner's imagination can run wild even in a confined situation. A good start will be to open that dialogue to each other. Be present and curious!

About the author

Law Ortovent Law is an accredited counsellor, psychotherapist, sexologist and dance therapist. She has extensive clinical experience in helping people affected by complex trauma, addictions, life transitions, anxiety, depression and relationship and sex-related issues. For more information, please visit her website **https://www.lawmaycounsellor.com.**

Illustration: 123rf

The disconnection connection: working with addiction in lockdown

Dr Antonia J. Saunokonoko

As Sydney was plunged into lockdown, bracing itself against the invisible enemy of COVID-19, I found myself in a curious position.

I am a psychotherapist specialising in addiction. Since connection is the antidote to addiction, my challenge was to help clients find recovery in unusually disconnected times.

I work with clients who live with alcoholism, eating disorders and a variety of behavioural and substance addictions. My clients are seeking a specific outcome from therapy. They want and need to stop using. Their difficulties usually emerge from complex traumatic experience in childhood. The addictions they develop are unconscious responses to attachment disruption, relationship failures and interpersonal betrayal. The greater role played by government and authority in the COVID crisis, including restrictions on movement, increased isolation and punishments for non-compliance with rules, were at times very triggering for this group of clients. The consequence for me was that it created even more pressure to facilitate a successful therapeutic relationship: one that could form the basis of the recovery journey.

My clients are not people who have learned to lean on others for help. Their experience is that others cannot be trusted. Reaching out to a therapist is often a sign all other routes to wellbeing have been tried and found lacking. Clients arrive at my door (or computer screen) with tales of betrayal and abuse at the hands of family, friends, partners and, all too often, members of the therapeutic, psychological and psychiatric communities.

Therapy often constitutes a vital component in a recovery journey – but therapy in the COVID era has brought both benefits and challenges.

Wearing a mask wouldn't be acceptable in my work. My clients struggle with existential fear, poor mentalisation skills and abuse issues. For them, wearing 'masks' is par for the course and part of their problem. So, I moved all my sessions online, where my clients could see my expressions fully and I was able to assure them of their own visibility to me.

Building a strong therapeutic relationship is essential, so working online brought with it tricky moments that had always to be addressed. If the internet connection was interrupted during a session, or the Zoom link failed, my clients could experience strong feelings of abandonment and anger. This had to be acknowledged and worked through in order to maintain trust and avoid disengagement from the work.

On the upside, I found very few clients missed sessions in lockdown. This reflected the important connection provided by the therapeutic relationship, but also the positive consequence of fewer everyday distractions. At times, those living with addiction can find it hard to focus on themselves and their needs. It can be a challenge in their day-to-day lives to not be thrown off course by their belief that they have to acquiesce to the needs and demands of others. With a more restricted lifestyle came fewer temptations to abandon self-care.

Building and modelling intimacy skills is an important aspect of working with addiction issues, and this had to continue in the online therapeutic format. During one session, a client wanted to keep her camera turned off. She was feeling shame at her recent behaviour and this translated into a desire to hide. The early part of the session focused on the exploration of intimacy, achieved by revealing oneself to another as imperfect. Turning her camera back on and experiencing unconditional acceptance was a powerful therapeutic outcome for her.

Regarding other aspects of intimacy, clients revealed fragments of themselves online that would not normally be disclosed in the traditional consulting room setting. I have conducted sessions where my clients are sitting in bed, without make-up on or in their pyjamas. Importantly, I am able to glean snapshots of their home surroundings. In some instances, clients revel in the informality and the lack of need to leave home or put their 'game face' on. For others, contact via a screen denied them the privacy and/or physical proximity they found reassuring in face-to-face sessions. Discussing and unpacking the meaning made by clients of these departures from session norms provided valuable therapeutic content.

Creating a safe space for exploring new possibilities of connection is imperative when working with issues surrounding addiction. Yet working remotely creates distinct challenges for structuring and managing the personalised and multimodal treatment approach suitable for addressing the consequences of complex traumatic experience. Some things were not possible in the online experience. I couldn't use certain exercises drawn from art therapy, such as body mapping, which require me to be with my client in person in the room. I could not do walking meditations with clients, and some of the useful trauma-focused resources I would ordinarily bring to my clients' attention could not be accessed temporarily. But there were many alternative ideas and techniques I was still able to use to positive effect. All that was required was flexibility and a bit of imagination.

Alongside talking therapy, many somatic techniques translated well to online implementation, as did meditative and mindfulness exercises. There were trauma-sensitive yoga resources available, free for clients to access via YouTube. Breathing exercises worked well to address anxiety and emotional overwhelm, and techniques inspired by focusing facilitated greater emotional tolerance.

My experience as a therapist working in lockdown was that my role in creating a secure base for my clients was heightened. Further, being comfortable offering and adapting a range of techniques and utilising in-depth knowledge in my area of specialisation was paramount in being effective. Understanding how to implement a truly integrative approach was more important than ever.

There is no doubt that COVID-19 has posed challenges for therapists and clients alike. But it absolutely has been possible to build a positive and stable therapeutic relationship capable of effecting beneficial change in clients' lives. In the process of evolving my own practice to meet new demands, I also noticed personal growth in myself in terms of creativity, adaptability and careful observation in the interest of my clients. It continues to be an experience for which I am happy to remain present.

About the author

Dr Antonia Saunokonoko
Antonia is a psychotherapist working in private practice in Sydney. She specialises in helping people recover from eating disorders and all substance and behavioural addictions. Her research has focused on the condition of bulimia nervosa, exploring its relationship to complex trauma, family relationships and treatment options. She has written master's courses in psychotherapy and continues to contribute to her field by authoring articles for peer-reviewed and mainstream publications.

How can I live with a monster behind the wall?

Mehdi Bina

In counselling sessions, we often hear couples say, “we have lost our love” and “I want a divorce”. In times of disaster, we often find that, by probing deeper during sessions with them, a functional family has changed to become dysfunctional. It means that some elements, such as the quality of the relationship, boundaries, rules and power, do not work well. With regard to the couple’s biological and genetic vulnerability, some mood instabilities will be formed. The intimacy between the two will start to diminish and, eventually, this can end in both emotional and legal divorce. The stressor alone is not enough to cause the disorder; the response to the traumatic event must also involve intense fear or horror (Kaplan, 2015).

Counselling providers have different approaches for their treatments. Working on preventing family mental health issues is the best strategy. Therefore, it is necessary we change our philosophy of life about protection, working on elements that form our functional family, and rebuild intimacy by using the new techniques learned.

Changes in relationships between family members or relatives can shape the phenomenon of the triangle, according to Jenny Brown (1999) and Murray Bowen (1978). The effects of COVID-19 can be an angle between a couple in their triangle, and a negative result can influence the quality of intimacy between them. In the clinic, this phenomenon will reveal itself in emotions, thoughts and behaviours (Webster, 2021). Then the psychopathology will come up.

Fear of death can shape the physical, sexual and emotional distance between a couple – and the final stage is the absence of intimacy. In these conditions,

The greater role played by government and authority in the COVID crisis, including restrictions on movement, increased isolation and punishments for non-compliance with rules, were at times very triggering for this group of clients. The consequence for me was that it created even more pressure to facilitate a successful therapeutic relationship: one that could form the basis of the recovery journey.

counsellors are not expected to find stability in elements of functional couples. Adjustment disorders are characterised by an emotional response to a stressful event. It is one of the few diagnostic entities in which an external stressful event is linked to the development of symptoms. Typically, the stressor involves financial issues, a medical illness or a relationship problem (Kaplan, 2015). The effects of precipitating factors, such as social distancing and lockdown conditions, need to be evaluated epidemiologically.

In situations like COVID-19 and lockdown, our thoughts can have specific negative effects on our behaviour. Ideas about being free from lockdown or the danger of vaccines are frequently heard.

Disasters will come and are inevitable, and they have catastrophic effects. To follow societal rules for establishing social health are crucial. To be in lockdown and to accept any vaccination trial will be lifesaving. Trying to establish a functional family, building good communication and undoing triangle matters are important. In professional counselling, there are many techniques that come from different schools of couples therapy, and research has shown their beneficial effects for forming true intimacy and love. Some of these beneficial techniques include:

- repairing listening skills through couple talk, drawing and sculpting from emotion-focused therapy (Webster, 2021); and
- couple dialogue, holding exercises and encouraging imagination using imago relationship therapy (Hendrix, 1980).

By empowering their relationships and applying love, the pain of the couple's old wounds will reduce and become tolerable, and then they can better tolerate the difficulties of this disaster. As a provider, you can hear the voice of couple: "We threw out the monster from our relationship. It is still behind the wall, but we have decided to change the old map of our life to a new one. Now we are free and happy." ■

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About the author

Medhi Bina
Mehdi has over 50 years' experience in the field of mental health as a psychiatrist. After retiring from the National Medical University in Iran, he works in Australia as a counsellor in marital therapy.

SCHOOL-BASED COGNITIVE BEHAVIOURAL THERAPY FOR PREVENTION OF DEPRESSION IN ADOLESCENTS

Dr **Nicola Santarossa**

Depression is currently the leading cause of disability worldwide, affecting more than 264 million people of all ages (Ma et al., 2020). Efforts are being made to reduce this figure and to prevent future cases from emerging. Intervening in childhood and adolescence to prevent the initial onset of depression is likely to be the most effective strategy to reduce the risk and severity of adult episodes and to prevent the negative outcomes and disability associated with the disorder (Hetrick, Cox & Merry, 2015). Longer-term outcomes associated with depression include interpersonal relationship difficulties, poor vocational attainment and achievement and increased risks of self-harm and suicide (Lewinsohn, Rohde & Seeley, 1998). A number of prevention programs currently exist, and many have been trialled to test their efficacy. Programs can be delivered universally or to targeted or selected populations, and the benefits and drawbacks of both of these approaches will henceforth be discussed. The number of sessions, the person who delivers the content and gender also contribute to overall efficacy of program implementation.
The purpose of this literature review is to examine the empirical evidence relevant to school-based interventions that target youth depression, to discuss the discrepancies in the literature and to consider ways to further decrease depression rates in adolescents.

Cognitive behavioural therapy (CBT) is the most studied type of intervention for preventing depression and there is evidence to suggest that it is effective in reducing the risk of youth developing a depressive disorder, particularly in selective high-risk populations (James, Soler & Weatherall, 2005). CBT is a collaborative, problem-focused therapy that aims to rewrite predisposing and maintaining factors that lead to the child's distress (Crawley et al., 2010). Other therapeutic approaches employed include interpersonal therapy and although initial results appear promising, further studies need to replicate its effectiveness across a wider demographic (Murphy et al., 2017). This review will therefore be focusing on the cognitive behavioural approaches to prevention programs run within schools. It has proven challenging to determine the specific components of CBT that have

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led to results in treatment effects, largely due to inconsistent reporting of the skills and techniques used (Stice et al., 2009). Another meta-analysis supports this notion claiming that overall, the content of the programs is similar; however, there are difficulties in accurately conveying the nuances given unstandardised descriptions and variable terminology (Hetrick, Cox & Merry, 2015). Most interventions, however, focus on a combination of cognitive restructuring to address maladaptive thinking, behavioural activation to break cycles of avoidance and inactivity, effective problem-solving and social skill development (Mychailyszyn et al., 2011).

Prevention programs are either delivered universally, meaning they target whole group populations, or selectively/targeted when programs are delivered to students at risk, based on the presence of identifiable risk factors such as having a parent with depression (Ginsburg et al., 2008). The evidence that selective or targeted programs are more efficacious than universal delivery is incontrovertible, and this finding is consistent with previous meta-analyses of youth depression prevention programs (Horowitz & Garber, 2006; Stice et al., 2009). Merry et al. (2012) undertook a Cochrane review that included 68 randomised controlled trials of depression prevention programs for adolescents. Their findings indicated a small but significant effect in reducing depressive symptoms and future episodes of depression for up to 12 months after the intervention was delivered for selective programs, but for only three to nine months for universally offered programs. There are a number of factors that contribute to these results. Firstly, participants who volunteer in these selected groups have a higher baseline rate of depressive symptoms, therefore a higher percentage of participants are likely to show quantifiable improvements over time. Stice et al. (2009) suggest that the distress which characterises individuals from these selected groups could provide motivation to engage in the program more effectively, leading to greater symptom reduction. Secondly, these programs tend to be conducted in smaller groups and are often led by people with mental health training (Murphy et al., 2017).

However, there are a number of drawbacks to implementing these programs to targeted youths. Although there is no available data to determine whether adolescents at risk for depression are less likely to participate, the literature indicates that depressive symptoms such as hopelessness and suicidal ideation are related to low rates of help-seeking in general (Rickwood et al., 2005) and data collected from other youth development programs suggest that higher-risk youth are less likely to participate (Keller et al., 2005). It has also been noted that many young people who may benefit from selective programs fail to participate in the screening process, which ranges

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from 19 per cent for a program that was to be conducted outside of class times to 51 per cent for a program that was planned for in-class delivery (Murphy et al., 2017).

The efficacy of universally offered programs tends to be consistently less than the selectively offered programs and require much larger sample sizes to adequately detect small treatment effects (Wolfe et al., 2008). Merry et al. (2012) conducted an absolute risk-reduction analysis as part of evaluating a universal delivery program, which found that 33 students needed to receive the intervention in order to move one student from the moderate/severe level of depressive symptomology to the minimal/mild level. However, universal interventions have the capacity to provide whole population psychoeducation and skill-building without singling out high-risk individuals, which minimises the risk of stigma that may make some individuals reluctant to participate (Ma et al., 2020). This suggests that the selected method of intervention may be a cost-effective and relatively successful strategy to reach high-risk youth; however, larger numbers of both high and low-risk youth who might not otherwise seek help may benefit from a universal approach that is more readily implemented in classroom settings (Wolfe et al., 2008). Hetrick, Cox and Merry (2015) conducted a meta-analysis that found little difference between universal and selective approaches. These findings should impart caution in assuming the superiority of one approach over another, particularly because selective interventions are often more laborious to implement and risk missing large numbers of adolescents who may benefit from its delivery. Interestingly, Stice et al. (2007) found that a wide range of interventions were equally effective, and Merry et al.'s (2012) Cochrane review showed no difference between depression prevention programs and active comparison groups or placebo, highlighting the concern that there may be a placebo effect in operation.

Another factor affecting outcomes was the number of sessions delivered during the programs, which proved to be in contention. Indeed, some large-scale meta-analyses supported the notion that a greater number of sessions would produce a greater reduction in depressive symptoms, both for universally delivered and selected programs (Mychailyszyn et al., 2011; Hetrick, Cox & Merry, 2015); however, other studies indicated that fewer sessions tended to be more efficacious (Stice et al., 2009; Ma et al., 2020). A number of theories attempted to explain this effect. Limited sensitivity due to the lower statistical power was suggested by Stice et al. (2009) as being a contributing factor. It has also been presumed that longer programs may deter adolescents, causing greater rates of attrition and attenuated intervention effects (Murphy et al., 2017).

Photo: Pexels

Ma et al. (2020) inferred students are already juggling multiple classes, including health-related syllabus, and may simply just get bored with the program. Further investigation into number of sessions needs to be undertaken and may include asking the students, through a survey, how many sessions they would prefer the content to be delivered in.

Inconsistencies also exist when considering who delivers the program content. Mychailyszyn et al. (2011) and Hetrick, Cox and Merry (2015) concluded that program outcomes do not appear to be influenced by the level of mental health training of the person who delivers the program and that upon direct comparison of universally delivered programs, mean effect sizes did not differ between programs run by teachers and those run by trained professionals. Another earlier meta-analysis observed that programs delivered by professional interventionists did not improve program outcomes initially; however, it appeared to improve outcomes at follow-up (Stice et al., 2009). More recent meta-analyses have supported the delivery of content by trained professionals. Ma et al.'s (2020) meta-analyses of 38 controlled studies concluded that programs led by professional interventionists produced larger effects at follow-up, while the effects of programs run by school personnel dropped significantly at follow-up. This effect is likely explained by the combination of the education and training professionals delivering the course content have; their experience with the logistics of program delivery; and fewer competing demands for their time (Stice et al., 2009). While hiring trained professionals may not always be feasible, providing training and supervision to school personnel may be a way forward.

Up to one in four adolescent females experiences an episode of major depression, which is at least twice the rate found with adolescent males (Wolfe et al., 2008). It would therefore be a logical prediction that inherent gender differences exist within the literature, purely because depression tends to affect females more than males, but again this proves to be contentious. Earlier meta-analyses (Horowitz & Garber, 2006; Stice et al., 2009) found that depression prevention programs were more effective when delivered to samples comprised of a larger portion of females than to males. One plausible explanation for this is that because females tend to report higher levels of depressive symptoms, they would be more motivated to engage in the program, thereby making prevention efforts more apparent (Stice et al., 2009). Wolfe et al., (2008) also found that this gap widened when comparing females

Of the 40 per cent of adolescents with a psychiatric diagnosis who are accessing services, only about one in five are receiving mental health care from a specialist.

in late versus earlier adolescence; however, more recent analyses did not replicate findings of significant gender differences (Ma et al., 2020). However, there may still be merit in tailoring gender specific programs. The literature has indicated that females may find important discussions of issues pertaining to romantic relationships and sexual issues easier among their female peer group (Murphy et al., 2017). Stice et al. (2009) also suggested that adolescent females may be more likely to discuss sensitive issues influencing their mood (such as body image concerns) in gender-specific groups.

The literature has indicated that empirically supported interventions are rarely successfully transported through to community settings (Wolfe et al., 2008); therefore, strategies to enhance program sustainability should be considered. But once depressed youth are identified, one must consider what sort of ongoing care they should receive. Regrettably, a considerable number of adolescents never receive any kind of mental health care (Murphy et al., 2017). Of the 40 per cent of adolescents with a psychiatric diagnosis who are accessing services, only about one in five are receiving mental health care from a specialist. (Mychailyszyn et al., 2011). Wolfe et al.'s (2008) study on adolescent females found that out of 807 females, 93 scored within the diagnostic range on the depression measure at baseline, post and/or at six-month follow-up and agreed to undertake a diagnostic review. Of those 93, 43 females met diagnostic criteria for major depressive disorder, dysthymia, or both, and unfortunately, most of them declined further referral or treatment pathways (continued page 48)

despite assurances of availability of services (Wolfe et al., 2008).

One such method to maximise access to high-risk adolescents is if the school were to provide a setting in which they could access mental health services (Murphy et al., 2017), which would decrease logistical issues for parents and carers (Storch & Crisp, 2004). Another advantage of having mental health care available in schools is that the learning environment is one of the major settings in which at-risk adolescents display the impairments they may be suffering as a consequence of depression (Ginsburg et al., 2008). Many other situations at school may force the individual to display symptomology on a daily basis, including conflict within friendship groups or academic underachievement (Crawley et al., 2010). School administrators are therefore in a unique position to encourage students to practice their skills and techniques learned in the very situations that led them to distress, and treatment effectiveness would then be realised in a clinical and practical way that brings meaning to the everyday lives of adolescents (Mychailyszyn et al., 2011). With regards to the future delivery of program content, online delivery may help avoid many of the logistical issues of removing students from classes or having them attend school early or remain behind on days they seek help (Hetrick, Cox & Merry, 2015). This research is still in its infancy, but the preliminary results on trials of online CBT indicate potential benefits for treating busy adolescents; however, larger population studies need to be undertaken to test the efficacy of this mode of delivery (Murphy et al., 2017).

Times are changing; however, stigma surrounding mental illness largely still exists. Research indicates that many parents and adolescents are reluctant to seek help because of the stigma associated with mental illness (Wolfe et al., 2008). Sheffield et al. (2006) found low rates of stigma for both universal and targeted programs; however, the delivery of the targeted program was associated with greater overall perceived stigma, including complaints of embarrassment and bullying as a consequence. Universal programs delivered to all students may therefore minimise the risk of stigmatising factors that may make high-risk individuals reluctant to partake in the selected programs (Ma et al., 2020). In their meta-analyses, Mychailyszyn et al. (2011) found statistically significant increases in reported stigma in the selected groups, but that the effect size amounted to very little, which may be a small price to pay when, perhaps more importantly, those targeted adolescents reported much greater satisfaction with the program than the students receiving the universal intervention. Adolescents may also feel less stigmatised if depression prevention programs can be delivered by non-mental health professionals (Wolfe et al., 2008).

As school-based depression prevention programs largely target internal protective factors for depression, there are many external factors still impacting the adolescent within their school, larger family and community (Hetrick, Cox & Merry, 2015). Risk factors such as parental depression, punitive parenting styles, parent–child conflict and school bullying are also associated with the development of depression in adolescents (Calear & Christensen, 2010). Thus, depression prevention programs addressing some of these other factors may enhance the program

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efficacy (Ma et al., 2020) and reduce depressive symptoms in adolescents. There is a large amount of variability and lack of clarity in the literature over what determines a prevention and intervention effort and how they are distinguishable (Collins & Dozois, 2008). It becomes unclear at times whether the intervention goal is to prevent the onset of depression or to reduce existing depressive symptoms. Therefore, an important way forward to effectively implement school-based mental health programs would be to arrive at a consensus on how these two terms differ and how to determine the goals one should be striving for in each adolescent population (Kutash, Duchnowski & Lynn, 2006). Thankfully, having mental health workers in the school environment is becoming more accepted and less stigmatising for the students seeking help. Now is the time for schools to take responsibility to reduce rates of depression in their adolescent students, and the negative consequences and disability associated with it. For example, they can include strategies for coping with life's difficulties in their syllabuses. (Hetrick, Cox & Merry, 2015). ■

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About the author

Dr Nicola Santarossa originally worked as a medical officer and is now non-practising and completing a Master of Counselling through the University of Queensland, graduating in 2021. She is currently on clinical placement at the Institute for Urban and Indigenous Health, Brisbane. Qualifications: Bachelor of Medicine/ Bachelor of Surgery in 2016. and currently completing Master of Counselling.

Counselling perspectives

In this feature, CA interviews a counsellor and ACA member about their profession, their journey and what they've learned along the way.

Grahame Smith

Vicarious trauma is always sitting in the background while helping [people with unresolved trauma], so it needs to be kept at bay by having a strong sense of self-awareness and seeking help when I need it.

What prompted you to move into counselling as a profession?
While I was working in the public service in New South Wales, I was responsible for large numbers of staff and critical incident management. Over time, it became clear people involved in dealing with critical incidents suffered mental health issues and needed help. This is when I started training in workplace counselling, which led me to helping people out in the community with mental health difficulties and relationship issues.

What is the biggest reward in being a counsellor?
Seeing people achieving their counselling goals and improving their quality of life.

What is the biggest challenge in being a counsellor?
I am involved in a lot of trauma work as a result of people suffering from a wide range of unresolved traumatic experiences. Vicarious trauma is always sitting in the background while helping these people, so it needs to be kept at bay by having a strong sense of self-awareness and seeking help when I need it.

Name a highlight of your 20-year ACA membership.
ACA establishing, over time, its colleges for supervisors, clinical counsellors and Christian counsellors. This opened the door for me to be registered with a wide range of employee assistance program (EAP) organisations and government departments to supply mental health services.

How would you like to see the counselling industry change in the future?
Acceptance of counsellors and psychotherapists widened so it is fully recognised by all private health funds and government, and thus being registered under Medicare.

How many clients do you see each week?
I'm at the stage of life where I now work part time and I see about 10 clients per week. These are a combination of practitioners requiring supervision services, and I have a mix of EAPs, government clients and clients from out in the community.

What do you love about running your own professional practice?
Having worked in government and having to meet managers' expectations, I now love to be my own boss and the independence it provides me.

Describe a valuable learning experience?
If you are in private practice, don't expect clients to come to you. Often, they do not. I found out very quickly you must market yourself and your practice continually as today's work may not be there tomorrow and new work must be found.

What 'pearl of wisdom' would you offer to a student counsellor or colleague?
Firstly, know your limits in your skill sets. There will always be clients who will be beyond your capacity to help, so don't be afraid to refer them on. Additionally, lifelong learning is really important for us as practitioners, so please expand your qualifications and skill sets. Then place these learnings into your daily practice as opportunities present themselves. ■

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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.
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- Clients must not be identifiable in the article.
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