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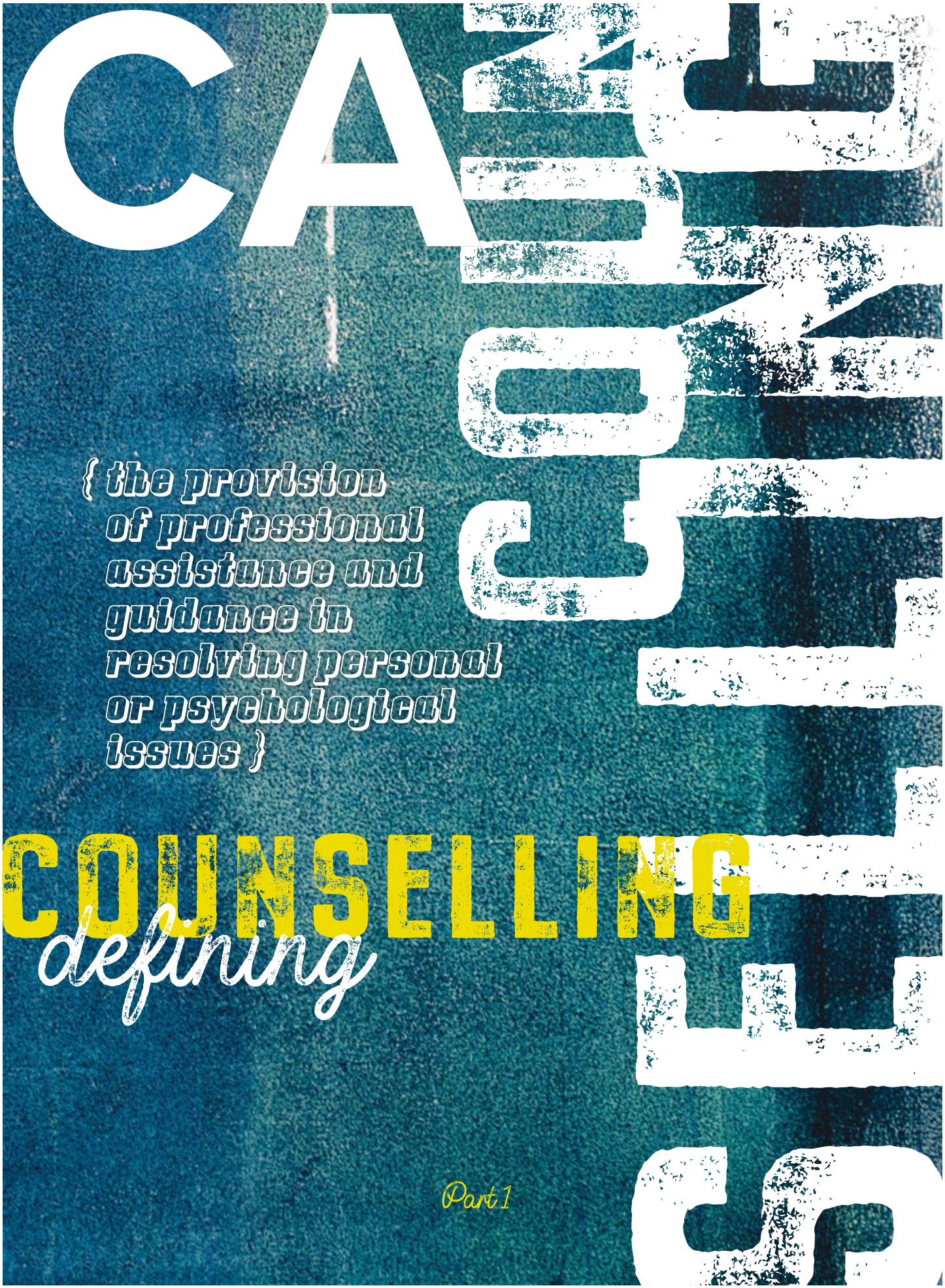

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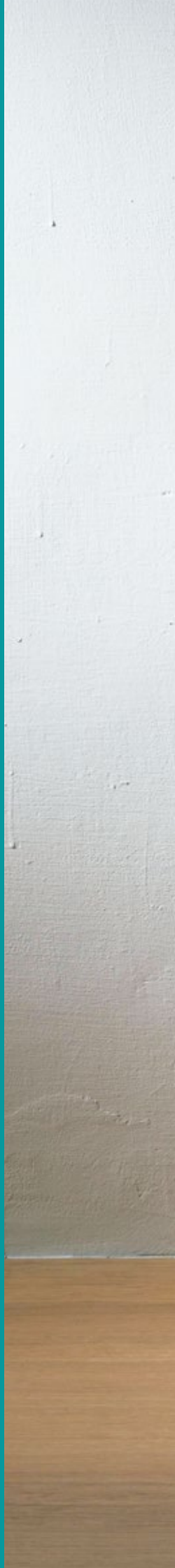

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REGULARS

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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:
The Editor
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See page 59 for peer-reviewed article submission guidelines.

Editorial

Building on the momentum of an election year

Philip Armstrong
Editor

As I write this editorial for the autumn edition of *Counselling Australia*, I, like many, am bewildered that we continue to face the challenges of COVID-19, more than two years since the pandemic reached us. While we cannot bear to hear words like 'unprecedented' and 'challenging times' anymore, we are nonetheless still living this reality.

Awareness of our profession, along with the health profession more broadly, is high. As more reports show the mounting toll of the pandemic on our collective mental and physical health, we are at the forefront of supporting the community. With the state of Australia's wellbeing in mind, coupled with the critical workforce shortage and upcoming federal election, ACA is launching the *Counsellors Care* campaign.

This campaign is an ACA-first initiative that aims to educate and encourage Australians to seek help from registered counsellors and psychotherapists. Equally important, our campaign proposes that Australians should be able to receive subsidised services from appropriately qualified registered counsellors and psychotherapists through the Medicare Benefits Schedule under the Better Access Initiative.

We believe every Australian should have access to readily available, high-quality, Medicare-subsidised mental health services. Our registered counsellors and psychotherapists are a ready workforce, dedicated to providing support, especially in rural and regional areas where there are often no easily accessible psychologists or psychiatrists.

The time to act on this disparity is now, to combat the need for more resources and support to help Australians who are struggling. We urge all to get involved; please visit www.counsellorscare.com.au to join the movement.

Industry benefits soar

The pandemic aside, there has been a sparkle of positivity to the beginning of year 2022: growth in industry benefits.

One of the most significant milestones was the recent partnership with Benestar Group, the leading provider of Employee Assistance Programs (EAPs) in Australia. Benestar now includes ACA registered professionals in its service provision and agrees that ACA counsellors and psychotherapists have an essential role in treating people across a broad range of life and work issues. This is a significant achievement for ACA, and the association's dedicated members, made possible by the industry's recognition of counselling, psychotherapy and ACA registered professionals alike.

This latest partnership means that there are now 15 recognised EAP providers, 11 private health funds and three state work cover regulatory bodies that accept contracts from ACA members.

What is counselling?

As 'counselling' is a verb and a noun, it is amorphous and can create uncertainty in people's minds. Depending on where counsellors work – schools, universities, technical institutions, community health centres or private practice – and with whom they engage – psychologists, psychiatrists, CEOs, the British or Americans – the definition changes, and with this perceptions of the profession's value.

As ACA ignites debate about the counselling profession, and the case for change, there's no better time to nail our own definition of what it actually is. I hope you enjoy part 1 of this special series, 'Defining and driving the counselling profession'. ■

We believe every Australian should have access to readily available, high-quality, Medicare-subsidised mental health services.

UPCOMING EVENTS 2022

Purple Day for Epilepsy

26 March

Purple Day is an international grassroots effort dedicated to increasing awareness about epilepsy worldwide. Every year on 26 March, people around the world are invited to wear purple and host events in support of epilepsy awareness. Last year, people in more than 85 countries on all continents participated in Purple Day.

For more information, visit www.epilepsy.org.au/fundraise/purple-day

Pay It Forward Day

28 April

Kindness spread in 2020, when the pandemic first hit – global choirs sang and volunteer armies came together. Amid uncertainty and fear, community hope and acts of kindness matter to support our own emotional wellbeing. Pay It Forward Day is a global initiative that exists to make a difference by creating a huge ripple of kindness felt across the world. Small acts, multiplied by millions of people can change the world. Join us in paying it forward, and help spread the word about this important day.

For free flyers, cards, school kits and other information, please visit https://payitforwardday.com.

IASP 10th Asia Pacific Conference

3 to 5 May

The International Association for Suicide Prevention (IASP) is dedicated to preventing suicidal behaviour, alleviating its effects and providing a forum for academics, mental health professionals, crisis workers, volunteers and suicide survivors.

This is a key regional opportunity to share expertise, knowledge and insights among peers within the field of suicide prevention. It will take place at the Gold Coast Convention & Exhibition Centre.
For more information, visit www.iasp.info/apac-home.

National Sorry Day

26 May

National Sorry Day is about remembering and acknowledging the mistreatment of Aboriginal and Torres Strait Islander people who were forcibly removed from their families and communities – known as the Stolen Generations. It is also about strength of Stolen Generations Survivors and reflecting on how we support the healing process.

Reconciliation Week

27 May to 3 June

The dates 27 May and 3 June commemorate two significant milestones in the reconciliation journey – the successful 1967 referendum and the High Court Mabo decision.

Reconciliation must live in the hearts, minds and actions of all Australians as we move forward, creating a nation strengthened by respectful relationships between the wider Australian community and Aboriginal and Torres Strait Islander peoples.

For more information, visit www.reconciliation.org.au/our-work/national-reconciliation-week.

Wear White at Work Day

29 May

Each year thousands of Australians (men, women and children) die by suicide – leaving families and communities suffering unimaginably. Wear white to work and donate a gold coin to show your support for mental illness sufferers and families of suicide victims.

The White Wreath Association provides 24-hour support for anyone who is in need, by providing advocacy, assistance and support to both families and individuals who have been affected by a mental illness or suicide. Together we can continue to provide families and individuals with the support and care that they need in order to reduce suicide rates in Australia.

For more information, visit www.whitewreath.org.au.

The health services gulf that must be bridged

By **Philip Armstrong,**
chief executive officer, ACA

The great disparity in the provision of mental health services in Australia, particularly the location of this increasingly needed support, has been in plain sight in recent times.

Government policies behind the provision of mental health services are centred on psychiatrists and psychologists – with 86 per cent of psychiatrists and 82 per cent of psychologists live in major cities.

By comparison, a third of counsellors and psychotherapists live and work in regional and rural Australia, where there is a serious unmet demand for mental health services.

This disparity is an issue the Australian Counselling Association (ACA) continues to push tirelessly. ACA is Australia's largest single registration body for counsellors and psychotherapists, with more than 9500 members nationwide.

The clear solution to increasing access to mental health services is to utilise the trained, skilled, dedicated and underutilised workforce that exists among our members.

Australia's mental health crisis urgently requires as many tertiary-qualified mental health workers as possible, and this means – for the sake of consumer choice and accessibility – being supported by the Medicare Benefits Scheme (MBS).

ACA has given evidence to the Select Committee on Mental Health and Suicide Prevention to argue for inclusion into the Better Access initiative* and MBS.

Nearly 4000 bachelor and master-qualified mental health professionals, most with more than 10 years' supervised experience, could address the mental health crisis by supplementing the work that psychologists and psychiatrists say they cannot keep up with.

Our standards are in line with other health professions with MBS access. Counsellors already provide much of the Employee Assistance Program workforce, are registered with private health funds for rebates, are employed by Beyond Blue, Headspace and WorkCover, as well as provide telehealth services and contract with the National Disability Insurance Scheme. Medicare Provider Numbers would also allow counsellors to work for the Department of Veterans' Affairs.

The recent announcement of $2.3 billion in federal mental health funding is welcomed, but the issues are compounded, as the only way to increase services is through more professionals entering the system. As the majority of counsellors would bulk bill if possible, we know the poorest people who need the most help would get it. The cost and waiting times to see a psychologist are discouraging to people seeking immediate help when they need it.

As an example, if 3000 bachelor and master-trained counsellors entered the system, the cost would be, at most, about $224 million dollars a year. Compared to the budget for mental health, this is a negligible sum. Consider also the recent Productivity Commission report into mental health, which put the cost to the Australian economy of mental illness and suicide at $70 billion a year.

Over the past few months, ACA has met repeatedly with Minister for Health Greg Hunt and Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention David Coleman, as well as the Department of the Prime Minister and Cabinet, the Department of Health, and nearly every state and territory health minister's office. We are frustrated by the lack of progress towards this simple and cost-effective solution that would result in better health outcomes for Australians.

Additionally, our advocacy secured a letter of support for registered counsellors to access MBS. ACA is also recognised as Australia's only observer member of the World Health Organization's Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support in Emergency Settings. ■

The Australian Government's Better Access initiative gives Medicare rebates to help people access mental health professionals and care regardless of where they live. See: **www.health.gov.au/initiatives-and-programs/better-access-initiative*

DV-alert

Domestic and Family Violence Response Training

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Did you know that 1 in 6 Australian women have experienced physical or sexual violence from their partner?

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What training does DV-alert offer?

DV-alert offers nationally accredited 2-day or 3-day workshops, eLearning courses and specialist 1-day workshops to equip frontline workers with the knowledge and skills to provide responsive and appropriate support to diverse communities.

DV-aware workshops are also available to members of public.

Find out when the next workshop is in your location or online at **dvalert.org.au** or contact **training.dvalert@lifeline.org.au** for enquiries.

Learn how to:

RECOGNISE the signs of domestic and family violence

RESPOND confidently with appropriate care

REFER women and their children to appropriate support services

Benefits from DV-alert training include:

- Receiving a Statement of Attainment for the unit of competency **CHCDFV001: Recognise and Respond to Domestic and Family Violence** after successfully completing the accredited workshop
- Building knowledge and skills to become a confident first responder to domestic and family violence
- Developing further skills with additional specialist 1-day workshops
- Learning from highly-skilled, experienced facilitators
- The opportunity to network with other frontline workers in the community

Costs

DV-alert training is **free** for frontline workers.

Financial support for staff backfill as well as travel and accommodation is available on application.

Terms and conditions apply.

Training delivered by Lifeline Australia RTO 88036

Funded by the Australian Government Department of Social Services.
Go to **dss.gov.au** for more information.

Lifeline

Nationally Recognised Training

Technology Update

With Dr Angela Lewis

Shopping and staying safe online

COVID-19 and the various restrictions and lockdowns experienced in Australia has resulted in more people than ever purchasing items online. Below I've given a quick checklist of the key things you should take into account when doing so yourself. The most comprehensive resource around is on the Consumer Affairs Victoria website (www.consumer.vic.gov.au/products-and-services/online-shopping) – it is absolutely worth a read!

1. **Only shop on https sites.** This means check for a lock icon in the browser bar of a site – the URL should start with 'https' rather than just 'http'. Secure websites are configured to mask the data you share, such as passwords or financial information, and legitimate businesses who care about customer security will always do this. Only making purchases on secure sites reduces the risk that your private information will be compromised while shopping. As an extra safeguard, I like to do a quick Google review of the business (particularly if I haven't shopped with them previously or have never heard of them) to see what other customers say regarding their experience with the business.
2. **Never (and I mean ever!) shop on public wi-fi**. These networks often feature poor security and can be scanned by hackers looking for weak connections.
3. **Pick strong passwords.** This is something we should practice at all times, anywhere online – not just shopping, but also when banking or using email, social media and so on – as a strong password is like a secure lock that keeps cyberthieves out of the accounts where you store your private information. It is so important I have outlined some further password safety tips on the next page.
4. **Keep your browser updated.** Software updates often fix old vulnerabilities that hackers use to sneak malware into your system, so if you are prompted to install updates then you should do it – pronto!
5. **Make sure the online store is legitimate.** I know that sounds kind of obvious, but there are scammers out there who will try redirecting you to a wrong website – they do this by using a URL that sounds and looks, at a glance, to be the one you're after. You are most likely to come across this in an email containing an embedded link or by clicking a link in a social media site, so take a good look at the URL address before you start your purchase. For example, you might think you are buying a pair of runners from Reebok.com but find yourself at Rebook.net. If something like that happens, delete anything you entered and leave the site immediately. If ever in doubt, before you click a link, go to your browser and take yourself directly to the entity's webpage to be sure you are on their legitimate site.

Password safety

- Use a complex set of lower and uppercase numbers, letters and symbols (you have probably noticed that many sites, including banks, already insist on this); or consider a long pass-phrase, using numbers to make up a word, or make up a combination of words in another language that you can remember and others are unlikely to guess.
- Obviously, do not use personal information that is easy to guess or glean from your Instagram or Facebook posts – such your kid's birthdate or your dog's name – or, heaven forbid, your own birthdate.
- Never reuse passwords across sites. If you do, a data breach at one company could give criminals access to your other accounts.
- Consider using a password manager application. Basically, a password manager acts as a vault for all your passwords and you use one 'master' password to access it. I don't use one myself, but it is worth doing some research on utilising this service to see if it is right for you. This link from CNET lists a number of providers – www.cnet.com/tech/services-and-software/best-password-manager – otherwise do a Google search on the term for more information.
- It is probably not a good idea to keep a record of your passwords on your phone or iPad (e.g. in the Notes app), as this information can be accessed by others if the device is lost or stolen.

How to easily share weblinks

Until recently, when you shared a link on a website the recipient would be taken to the page, as opposed to a particular section. Now, there's a better way to send a link and ensure the recipient goes directly to the part of the page you want to share.

1. Go the webpage and highlight the text you want to share.
2. Right-click and select **Copy link to highlight**.
3. Paste the link to your preferred location; for example, into an email or message.
4. When the recipient clicks your link, they are immediately taken to the position you highlighted.

Microsoft Word quick tip

While there are a lot of ways to select text in Microsoft Word, one of the niftiest ways that works on almost any amount of text in any version is this:

- Click the mouse where you wish to begin.
- Hold down the **Shift** key.
- Click the mouse where you want to end your selection.
- The text is selected and ready to work on as needed (for example: cut, copy, format and so on).

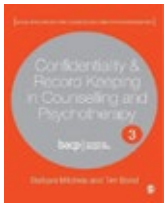
Online payment methods

While I use PayPal for taking payments (it offers business as well as personal accounts), I am no expert in this field, and there are many variables in how a person runs their business and what software may be in use for invoicing and so on. For this reason, I thought the best I could do is to point readers at a comprehensive and easy-to-read blog post I found online at www.linnworks.com/blog/online-payment-methods. I suggest you chat to your accountant or bookkeeper, as they will be more in touch with what is appropriate for your entity.

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



Confidentiality and record keeping in counselling and psychotherapy (3rd ed)
By Barbara Mitchells and Tim Bond

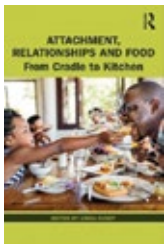
Reviewed by
Anne Gilbert

Every therapist will face issues regarding confidentiality and record keeping at some point in their career, but how up to date is our knowledge of the law that governs these areas? First published in 2008, with a second edition in 2015, the third edition of this book provides a wide-ranging whistle stop tour of the field. It aims to help therapists and trainees understand the legalities, values and ethics of confidentiality and record keeping. Basic issues – such as confidentiality from the viewpoint of clients and therapists, and how long records should be retained – are explored.

This edition encompasses recent legal changes, including the EU General Data Protection Regulation. In addition, it includes some of the changes to practice invoked by COVID-19, such as working online and storing data electronically, as well as recent changes in mental health and child protection law.
I particularly enjoyed section five, which deals with common dilemmas therapists might encounter in their practice. The authors pose pertinent questions to guide readers through a process of decision-making appropriate for complex situations.

Written in a clear and easy-to-digest style, the book is well organised and brimming with useful information. Numerous case examples and vignettes bring the text to life. There are also plentiful details of further resources, case law examples and check lists. No doubt trainees and many therapists will enjoy reading this book from cover to cover, but it's also an indispensable reference book for dipping into. I highly recommend it to anyone working in the field of therapy or allied professions such as coaching.

About the reviewer
Anne Gilbert is a gestalt psychotherapist and supervisor based in the UK.



Attachment, relationships and food: from cradle to kitchen
By Linda Gundy (editor)

Reviewed by
Dr Linda Hanson PhD

Certainly not a book for light reading, this is best read with pen and paper for note taking.
The nine chapters, individually authored, address many different perspectives of – as the title says – attachment, relationships and food from cradle to kitchen. While there are too many references to study in detail, the cited studies offer opportunities for exploration into the philosophy of attachment and food. The references are placed at the end of the appropriate chapter to avoid an overwhelming bibliography. There is also a comprehensive index.

The age-old necessity of feeding has altered drastically in relation to food itself, and how it is prepared and consumed (Chapter 3). Do these changes reflect or dictate the mental and emotional impact of attachment and relationships?
From birth to death, this book explores different perspectives of this most important attachment to food, the process and the outcomes.

Attachment is vital for survival. Acceptance into the group meant protection of the tribe (Chapter 40), a better chance at survival and a successful, reasonably safe and healthy life. Rejection meant death – being put outside the palisades and left to die from hunger or illness, and threatened by wild animals or hostile tribes (Chapter 1). Is it possible that attachment problems are the innate drive for survival? The generational memory is one of being rejected, triggering the fear of death; challenging the degree of confidence in being able to survive alone; or questioning the expectations of success or failure behind the palisades of being 'good' enough in order to stay loved and protected; living with the stress of always having to demonstrate certain behaviors to remain accepted and attached ... and safe.

Food, in all its aspects, tastes and purposes, has changed (Chapter 7). Previously, the flavour of the finished meal was only part of the eating process in community settings. All these once-familiar gatherings of family and friends have been relegated, somewhat reluctantly, to treasured memories in the current stressful environment of fear and separation (Chapter 4).

A significant number of family meals have been relocated from the warmth and aromas of family kitchens to restaurants and takeaway businesses. Intimate attachment has been transferred from the beloved home cook to the menus of different culturally based restaurants. Now, prospective diners recommend places, not people. No longer

are family and friends sharing the one meal; they are able to order different dishes for each individual – which may be a blessing these days, with so many culinary detours (allergies and preferences).

In many cases, eating out and internet recipes have usurped or broken the links of attachment for many, as the recipes handed down by Grandma and Mother are no longer treasured and replicated. The cooking for connection and belonging is lost in the convenience of not cooking (Chapter 7). The discussions tend to focus on whether everyone enjoyed their meal, the restaurant was nice or the waiters pleasant or rude. Getting value for money is a major consideration and often determines if the food was acceptable or not.

These chapters are essential to explore myriad types of attachment, ways of sabotage or, in fact, non-establishment. The first chapter begins with "Cooking is at once child's play and adult joy and cooking with care is an act of love", and the last chapter finishes by raising the question, "When we help others, is it for their benefit or for our own?"

The internal chapters investigate the many ways in which this essential act of love can be, has been and is still being sabotaged by emotions, culture or habits, or is being sustained by the treasured memories that nourish us.

It is promising to see reference to the positive acknowledgement of the role of food as medicine (Chapter 4), noting physical effects of food components on mind and body.

The chapters follow a distinct course through the manifestations of both healthy and unhealthy attachment and the changeable masks or complex disguises in dietary preferences, attitudes and actions toward food, self and others.

Part of Chapter 8 does pay tribute to the effect of COVID-19 and the disappearance of the traditional therapy room setting, replaced by virtual interaction with clients in their homes.

Offering insight for 2022 and the distressing rise in depression, anxiety and suicide, the theory of attachment and relationships to food explains the sense of loss, separation and abandonment where relationships are grounded in relationships to food and drink. The connection with entertaining and eating out with friends has been so brutally truncated by lockdowns, lockouts and separations, folk do feel a relational starvation, emotional deprivation and a loss of mental and emotional support. Without this social incentive and ability to meet and eat, many people have descended into a pit of depression and isolation because the essence of connection has been denied its material manifestations (Chapter 8). Through this love, children learn creativity, and also complex mathematics in weights, measures, liquids, temperatures, multiplication, division, subtraction and addition (Chapter 7).

This book is a cornucopia of information and insights either on a scholarly level or in the stories of clients. There are questions that will challenge personal memories and stories, question reactions and reasons, provoke introspection and upend long-held perceptions to the point where there is an answer to the question, 'When we help others, is it for their benefit or our own?'

About the reviewer

Dr Linda Hanson (PhD) is a Level 4 counsellor in private practice. She is also a homeopath (Bachelor of Health Science) and has a master's degree in counselling/psychology. She has been involved in many aspects of natural therapies since the late 1960s, as well as kinesiology and sound therapy, and she has many other skills and training to offer a well-rounded approach to physical, mental, emotional and energetic health.

DEFINING AND DRIVING THE COUNSELLING PROFESSION

By **Larissa Dubecki**

When Dr Sophie Lea arrived for her first session as a school counsellor 20 years ago, she found she had been given the cleaner's storage room as her clinical space.

"I remember it like yesterday. It really does show how they just weren't understanding the requirements that we need as therapists in the school space," she says. "I tried to liven it up by putting a pot plant in there and an Eminem poster to appeal to the kids. Not coincidentally, my PhD ended up being on therapeutic space design."

A Monash University lecturer in Counselling, as well as an adolescent and family counsellor, teacher, education wellness consultant and clinical supervisor, Sophie has witnessed significant changes in the counselling space over the past two decades. "It was very unusual back then for school systems to even have counsellors, and I could see it was all about having psychologists and being able to do diagnostics and funding applications," she explains.

She has encountered all the myths about counselling over her career – including the view that the counsellor's job is to 'fix' the client – but has cause for optimism after witnessing the profession assert its place in the allied health services while maintaining its own important identity.

"For me the core driver is around the gift and responsibility and privilege of being able to support others in their mental wellness journeys," she says. "Counselling is a dynamic and courageous exchange with people who are sometimes at their most vulnerable. In my opinion, counselling explores the 'how' and 'why' of human existence in a safe, accepting and supportive environment. As I say to my students, counselling is all about heads and hearts."

Counselling literacy

When differentiating counselling from other mental health professions to her students, Sophie asks them to envisage a triangle model.

"I place counsellors at the base of that triangle: we support clients with a wide variety of client issues such as relationships, aspirations of self-actualisation and, of course, mental health and wellbeing. Moving up the triangle, the client intervention becomes more specialised, with social workers and psychologists providing more targeted interventions, assessment and, when required, diagnosis. Finally, at the top of the triangle, we sit in the medical model, with psychiatrists and doctors able to assess and prescribe medication

Photo: Penny Stephens

"Counselling is a dynamic and courageous exchange with people who are sometimes at their most vulnerable. In my opinion, counselling explores the 'how' and 'why' of human existence in a safe, accepting and supportive environment. As I say to my students, counselling is all about heads and hearts." – Dr Sophie Lea

Photo: University of Queensland

or referral to specialist in-patient settings for clients who require it. But there's fluidity in that too; health care professionals may have training and experience on more than one level."

She also draws a distinction between counselling and psychotherapy. "In my experience, the clear definition of counselling and psychotherapy has at times seemed murky – partly because some therapists, such as myself, would view them as interchangeable. The simple distinction I make is that counselling is usually more short-term in its intervention, it supports clients with conscious events and emotions and has a present-day orientation and impact; I see it as more pragmatic in its design. Whereas psychotherapy is a deeper exploration of a client's life experience, it encourages further self-awareness and understanding of more entrenched patterns of behaviour and delves into uncovering unconscious understanding that empowers the client to facilitate lasting change."

The road to accreditation

For Sophie and many of her students, counselling is a deliberate choice over psychology. "There is not just depth but also breadth to the work we do, which is one of the reasons I love the work so much," she says.

A growing awareness and appreciation of counselling as an important part of allied health services is a heartening development for Sophie, but she finds all too often her Master of Counselling students are surprised that anyone in Australia can call themselves a counsellor.

"The lack of regulation in the counselling profession has created such a disservice to our profession over many years. It is something many counsellors have grappled with and been frustrated by. I am very grateful to have a membership to a counselling registration body, ACA, which sets required standards and champions our profession."

The mental health burden of the pandemic on top of the complexity of the modern era – the corrosive effects of social media, for instance – has added weight to ACA's call for qualified counsellors and psychotherapists to be included in the nation's Medicare Benefits Schedule.

"The short-sightedness is what gets me," says Sophie. "We have people who need support, who are suffering, and who don't have the means to go private. The bottom line is it's about humanistic intervention and support. It's about the responsibility of putting our profession in a space where it's recognised. There's also the critical responsibility of doing no harm to our clients … how can we guarantee that without adequate training and being able to adhere to ethical and professional guidelines? It's a no-brainer for me and it's completely antiquated."

Jim Schirmer (pictured), an associate lecturer with the University of Queensland whose research specialises in the professional identity of counsellors and counselling, argues that an advanced mental health system would recognise the complementary strengths of the range of professions involved. "In such a system, I think counselling would bring some distinctive theoretical, philosophical and practical strengths," he says. "Practically, counsellors not only deal with mental illness, but also are particularly well-trained in non-pathological areas of human difficulty. When I compare counselling training programs to other mental health and human service professions, counselling training includes not only mental health, but also common areas such as grief and loss, relationships and families, crisis counselling, domestic violence and health. In this way, counsellors have the capacity to see clients across a very broad range of human needs."

Clinical applications

This raises the question: should counsellors play a role in hospital and emergency department settings – and conduct diagnostic tests if they are appropriately trained?

"With the current pandemic, I remain concerned about the wait times clients are experiencing to be able to see allied health professionals. It's unacceptable, particularly when there are thousands of qualified and experienced counsellors willing and able to play a part in supporting our community."

For Sophie, the integration of counselling services in healthcare settings makes perfect sense in light of the current mental health crisis. "I think counsellors could play a vital role in this area, triaging clients and working alongside healthcare professionals to reduce the current demand for mental health services and implement much-needed mental health support in a timely manner," she says. "With the current pandemic, I remain concerned about the wait times clients are experiencing to be able to see allied health professionals. It's unacceptable, particularly when there are thousands of qualified and experienced counsellors willing and able to play a part in supporting our community."

Jim, however, cautions that formal diagnostic measures and tests might be at odds with the humanistic strengths of counselling.

"If the question is whether counsellors could conduct formal diagnostic tests, the answer would be a qualified yes. Currently, counsellors are rarely trained to conduct such assessments, but there would be no reason at all why they couldn't be trained and assessed as competent in any formal diagnostic measure," he says. "A diagnostic assessment can be valuable for its ability to provide a valid counterbalance to the counsellor's subjective judgements, as a system-recognised means of accessing support, and as a validating experience for the client's distress. That said, there are also several arguments for the limitation of diagnosis. Humanistic therapies would caution us from any reductionist account of our clients' experiences and postmodern therapies would remind us that any discourse is only one socially constructed version of reality. More broadly, though, there would be forms of helping that would be beyond our definition. Something may be helpful or therapeutic but still not be practiced by counsellors. Psychiatric medication would be an obvious example of this. Similarly, a musician or a remedial masseuse may bring about therapeutic ends, but we would not call them counsellors. Therefore, counsellors should be proud of their broad and effective scope of practice, but also happy to know the limits of this and be willing to acknowledge the therapeutic work that others do."

To the future

Ask Sophie where she would like to see the counselling profession in five years' time and the answer is simple: "I'd love us to be regulated, number one. I'd love governmental systems to be able to recognise the important role we can play in supporting us through and around these trying times globally … that we have a really strong skillset to offer."

So how is that achieved? Further resourcing in this space is crucial, enabling clients to access services in a variety of ways that might suit their individual requirements: "Not just in cities but in regional areas as well. Let's think about the telehealth space and how we can appropriately facilitate that, let's think about psychotherapists, let's think about creative arts therapists and animal-assisted therapy as well as counsellors – those different delineations of therapeutic support and intervention."

Overall, she hopes to see the counselling profession continue to commit to its professional standards and responsibilities, guided by a scope of practice and ethical guidelines, and not lose sight of the expert skill sets counsellors have in facilitating a safe and purposeful therapeutic relationship with a diverse range of clients.

"That's where I'd love to see our profession heading and I think we have the training opportunities, experience and passion to do it." ■

ASD: emerging from lockdown


Photo: Unsplash/Magnus Anderson

Enjoying lockdown and the struggle to re-emerge: a counterintuitive example of an adult male with probable undiagnosed high-functioning autism spectrum disorder. A case study of COVID-19 as at July 2021.

By **Dr Tom Edwards PhD**

Abstract

In 2020, being the opening phase of the COVID-19 pandemic, counsellors rightly concentrated their efforts on supporting people's mental health as governments 'locked down' communities, cities and even states. The present case study is a timely extension of the literature focusing on the counterintuitive example of an adult male who enjoyed being locked down but has since struggled to re-engage with his workplace. Interestingly, the client had no mental health history but returned a score of 31 out of 50 for the Autism Spectrum Quotient (AQ) inventory indicating the potential for high-functioning autism spectrum disorder (ASD). Beyond describing ongoing cognitive behavioural therapy (CBT) treatment for workplace-related anxiety, the present case study considers:

- the complexity of the COVID-19 'mental health picture';
- how COVID-19 has specifically affected adults with high-functioning ASD; and
- relevant professional/ethical issues.

All pandemics and epidemics come with significant mental health burdens. With respect to public health measures, Brooks et al. (2020) warned of the likely psychological impacts of quarantine even before the pandemic had been declared.

Introduction

COVID-19 was first reported in Australia in January 2020 (Hunt, 2020). In the last two years the nation has experienced the declaration of a pandemic alongside a cascade of socioeconomic shocks delivered via unprecedented public health measures (Australian Bureau of Statistics, 2021). Although effective, such measures have disrupted normal civic life in major and minor ways. Emblematic of this are a set of social restrictions, akin to community-wide quarantine, which have collectively become known as 'lockdown'.

With respect to lockdowns, Victoria fared worse than any other state. For instance, various levels of restrictions were a persistent reality for Victorians between March and early November 2020 (Storen & Corrigan, 2020; Timeline, n.d.). In addition, three brief lockdowns took place in 2021 (Timeline, n.d.). It is also worth noting that those living in Melbourne often had harsher restrictions than people living in regional Victoria. Given this, Melburnians have borne the greatest psychological load throughout the pandemic.

The present case study is concerned with the mental health effects of being locked down for considerable periods of time. More particularly, it represents a counterintuitive example of an adult Melbournian who did not find lockdown as difficult as re-emerging afterwards.

Lockdown-related mental health sequelae

All pandemics and epidemics come with significant mental health burdens. With respect to public health measures, Brooks et al. (2020) warned of the likely psychological impacts of quarantine even before the pandemic had been declared (World Health Organization, 2021). For example, they named those who would likely be most vulnerable, described the distressing nature of quarantine, and made the surprising observation that psychological distress could persist for months after quarantine's end.

However, by late 2020, such predictions could be replaced by COVID-19-specific data. Importantly, a nuanced picture of distress and resilience amid lockdown emerged. For example, Ahrens et al. (2021) found that despite there being some vulnerable people within their sample, "the vast majority … remain healthy or even improve their mental wellbeing [during lockdown], as everyday stressors are reduced". These positive findings were further supported by Prati and Mancini (2021) who, after analysing 25 studies, concluded only a small psychological impact of being locked down. Meda et al. (2021), in considering school students as a potentially vulnerable group, noted that their resilience remained high.

Nevertheless, other studies have reported greater impacts. Singh et al. (2020) reported that, "[Y]oung children show more clinginess, disturbed sleep, nightmares, poor appetite, inattentiveness and significant separation problems." Additionally, Fiorenzato et al. (2021) found changes to adults' sleep patterns, appetite and libido. They also noted subtle negative cognitive changes pertaining to "routine tasks involving attention, temporal orientation and executive functions".

As for those who have struggled the most during lockdown, we must now consider how common mental health disorders (such as depression and anxiety) have manifested within vulnerable groups. Yet such an analysis is no easy task. Not only must disorders be considered in light of cultural norms and local disease conditions, but also vulnerable groups may be large or small, homogenous or heterogenous, or even overlapping with respect to membership (Abbott, 2021; Fiorenzato et al. 2021; O'Connor et al., 2020; Pieh et al., 2021; Schmits & Glowacz, 2021; Wang et al., 2020).

One notable vulnerable group within the community are people living with pre-existing health problems. Indeed, 50 per cent of Australians live with a chronic health condition and may be assigned to this group (Australian Institute for Health and Welfare, 2018). Given its overwhelming size, any fruitful discussion of vulnerability must begin with a categorisation of the various chronic conditions found within the group. For parsimony, let us consider only those people living with a chronic mental/behavioural health problem. However, one in five Australians meet this criterion (Department of

Health, 2020). Therefore, let us be more specific and focus our attention on neurodevelopmental disorders – specifically autism spectrum disorder (ASD). ASD is of particular concern at the moment given its prevalence, affecting one in 150 Australians (Health Direct, 2020), and because affected people may struggle more than most with COVID-19-related changes to their daily routine.

Researchers were quick to identify some of the challenges faced by people living with ASD because of COVID-19 (Brondino et al., 2020; Colizzi et al., 2020; Smile, 2020). Although the emerging literature has predominantly focused on the needs of minors (Alhuzimi, 2021; Amorim et al., 2020; Chafouleas et al., 2021; Colizzi et al., 2020; Manning et al., 2021; Smile, 2020), a growing number of reports have now detailed the experiences of adults (Adams et al., 2021; Baweja et al., 2021; Brondino et al., 2020; Pfeiffer et al., 2021). Even so, much of this literature pertains to individuals with moderate to low-functioning ASD.

By contrast, den Houting (2020) has high-functioning ASD and has written of her lived experience through the early days of the pandemic. From her we learn of:

- "the sudden loss of my comfortable work routine" (p. 103);
- anxiety shaped by "constant media coverage of illness and death, global lockdowns and panic buying" (p. 103);
- the need for professional support;
- the difficulty in general coping alongside "a deep sense of uncertainty" (p. 104);
- the need for self-care; and
- imposed social isolation as both a boon and a burden.

This knowledge informs the case study below.


Photo: Unsplash/ Annie Spratt

Case study

A 38-year-old Melbourne man sought assistance, having had difficulty re-engaging face-to-face with his workplace following the city's protracted lockdowns of 2020. This was in spite of the fact that he was a skilled worker, experienced at his job and respected within his organisation.

The client's specific concerns were:

- annoyance at his employer's insistence that remote working be ceased without regard to his increased productivity when working from home;
- that he found the busyness and chatter of his workplace difficult to cope with; and
- a lack of change management by his employer such that workplace procedures were being adapted ad hoc without due consideration for service delivery.

In addition, the client confided, somewhat hesitantly, that he had actually "enjoyed lockdown". Ultimately, the client was experiencing a higher-than-expected level of distress each morning before work and a sense of relief at the end of each day. His distress had also lasted longer than three months.

The client's morning distress was evidenced by increased arousal levels observed as:

- feeling "rushed" and behaving in a "short-tempered" way;
- perfectionistic and negative

ASD is of particular concern at the moment given its prevalence, affecting one in 150 Australians (Health Direct, 2020), and because affected people may struggle more than most with COVID-19-related changes to their daily routine.

self-talk pursuant to the day's tasks; and
- resultant elaborate strategising to limit the risk of task failure.

In addition, while driving to work the client would actively manage his mood with music. He would also become frustrated if roadworks delayed him.

Throughout the day, the client would "put on [his] happy face" in front of colleagues and clients. His work preference was also to immerse himself in a task to have time pass quickly but, after lunch, would nevertheless begin to "watch the clock". Finally, he stated that he found himself relaxed during the evening drive home in spite of heavy traffic. The client's presentation was, therefore, prima facie, consistent with workplace-related anxiety.

In taking a detailed client history the author learnt that the client came from a stable, two parent household with traditional gender-based roles. The client described his father as domineering and his mother as emotionally distant. When reflecting on his school days he described himself as being a good student, rarely in trouble, but socially awkward.

Marrying at 28 years of age, and a little later than his peers, the client described his wife in positive terms and his marriage/family as fulfilling. He believed part of his happiness at home was related to the fact that roles and expectations were clearly defined. In addition, the client and his family were financially stable, owned their own house and had adequate social supports.

With respect to his workplace, the client stated that he found his work stimulating, his colleagues friendly and his employer fair. Curiously, such a description is not, of itself, consistent with workplace anxiety. However, when exploring the client's daily interactions with colleagues, alongside his work habits, a somewhat different picture emerged. For instance, the client admitted to "see[ing]" bad management decisions before others and speaking his mind in team meetings. Without regard for his team leader, the client believed his "contribution" created a helpful tension from which better workplace outcomes would result. While obviously perceptive, the client thus tended to reduce workplace complexities to simple dichotomous categories (such as right versus wrong decisions) and appeared naive to the various motives likely at play in his, and any, workplace. As for daily workplace tasks and time management, the client remarked that "as long as I keep to schedule, all's good".

Lastly, the client had no history of mental health problems but had, some years earlier, been cajoled by a close colleague to take an online "autism test". However, the outcome was negative.

Moving from client assessment to case conceptualisation, a minimalist approach to counselling may simply have sought to consider the client's anxiety, and this would not be incorrect – although perhaps unsatisfying given his particular "way of being". To capture the client's broader life context within the case conceptualisation, and putting aside the nebulous former ASD outcome, the author sought to explore the possibility of high-functioning ASD as a significant contributing factor to the client's workplace anxiety (American Psychological Association, 2013). This, as opposed to an adjustment disorder, was a reasonable line of investigation given the client's social awkwardness/naivety, cognitive style, preference for focused work, and his ability to cope well with the demands of lockdown (Autism Speaks, n.d.). This conjecture also had explanatory power in so much as the client's workplace anxiety could be directly linked to an increased cognitive load associated with:

- once again having to mask ASD-related behaviours;
- interacting with a variety of people in various roles;
- performing increased cognitive shifting throughout the day; and
- having to tolerate the increased sensory stimulation of a busy office.

It was also appropriate to pursue this line of investigation as, if correct, efficient and efficacious counselling, consistent with ethical counselling, would result. Helpfully, when the possible nexus between high-functioning ASD, the end of lockdown and the client's current workplace anxiety was mentioned, he was open to exploring this further.

The client agreed to complete the Autism Spectrum Quotient (AQ) inventory (Woodbury-Smith et al., 2005) which, although not

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[W]orking from home, however pleasant and productive, was not an option. Given this, we focused on the client managing the increased stress that would be part of his post-lockdown experience.

diagnostic, is a useful screening tool. The client's score was 31 out of 50, which was indicative of high-functioning ASD, being above a score of 26, but nevertheless below a score of ≥32, which identifies 80 per cent of people with ASD (Broadbent et al., 2013).

In subsequent discussion, this higher-than-expected score was found to be consistent with the client's lived experience. For example, as a young child he did not like to wear "prickly" clothes (for example, jumpers). In upper primary school he preferred to read in the library at lunchtime rather than play in the yard with his peers. In high school he and his peer group were described as "nerds". The client disliked subjects such as drama, but enjoyed mathematics, describing an aptitude for pattern recognition and himself as a "natural problem-solver". He also had a strong preference for schoolwork that was project-based, so that he could give it his full attention. As a young adult, and unlike his peers, the client had an intense dislike of loud music and small talk, which made dating difficult. Finally, the client succeeded at university but struggled to get work due to poor performance in job interviews. On this point he remarked that he never knew exactly what a prospective employer wanted and therefore how to present himself. Nevertheless, after some time he did gain employment with his current organisation and has remained with them for over 10 years. (This being a longer period of employment with the same organisation than expected in his industry.)

In light of the above information, a referral to a psychologist for diagnostics and treatment was considered. However, the client declined this offer given the cost, that he was mostly satisfied with his life and found our conversations productive. Ethically, this necessitated a discussion pertaining to the author's limited scope of practice and experience when compared to a psychologist specialising in ASD, and the dilemma of therapeutically engaging with ASD but lacking a formal diagnosis. Even so, the client wanted to proceed with counselling.

In discussing therapeutic interventions, it must be recognised that this case study is recent and treatment remains ongoing. As such, only a brief description is provided. Given that high-functioning ASD is only presumed and contextual, the focus of therapy was on the client's presenting issue of anxiety associated with his post-lockdown return to work. Nevertheless, the author did believe it was useful to present all interventions in an orderly, well-structured and evidential manner, as would be appropriate if the client had been diagnosed with high-functioning ASD.

Initially, it was necessary to acknowledge those "boundary conditions" imposed upon our work together, the main condition being that the client's employer expected staff would work onsite, albeit in accordance with Victorian law. As such, working from home, however pleasant and productive, was not an option. Given this, we focused on the client managing the increased stress that would be part of his post-lockdown experience.

Cognitive behavioural therapy (CBT) is a recognised modality for the treatment of anxiety and for working with people who live with ASD (Autism Speaks, n.d.). Given that many readers will be familiar with CBT, the author will only sketch his work with the client. Following psychoeducation related to CBT as an appropriate modality, the physiological basis of anxiety, and the nature of high-functioning ASD, several interventions were considered.

First, in so much as decreasing the client's physiological arousal was central to a successful therapeutic outcome, mindfulness breathing was taught and practiced. The technique chosen was one advocated by Ian Gawler OAM, which is notable because the user can implement it with their eyes open. It is, therefore, appropriate in the workplace.

Second, the client's dichotomous, negative and perfectionistic cognitions were challenged. These challenges primarily took two forms: (1) considering the past consequences of using such thinking; and (2) considering the 'fit', or otherwise, between current circumstances and presently limited cognitive options. Consequently, the client became motivated for change and began to learn to think in a more nuanced way. The long-term effectiveness of this work is, however, still to be evaluated.

Third, several ASD-aware, and anxiety ameliorating, workplace interventions were developed in collaboration with the client and then implemented. Yet the client


Photo: Unsplash/ Nik-shuliahi

Following psychoeducation related to CBT as an appropriate modality, the physiological basis of anxiety, and the nature of high-functioning ASD, several interventions were considered.

was not willing to inform his line manager of our work together, the implication being that all workplace interventions had to be discreet.

Usefully, the initial intervention of implementing a routine that would limit the client's morning arousal was home-based. Beginning the evening before, the client was to have sufficient fuel in his car to negate the need for an ad hoc delay on his way to work the following day. As he entered his home, the client was to leave his briefcase and car keys in one assigned place near the front door to prevent what he called a "search and destroy mission" in the morning. He and his wife were to discuss who would be responsible for the next day's family-related tasks. The client also prepared his next day's lunch before bed to limit the number of morning tasks he had to perform. As for each morning, an earlier waking time was introduced that provided ample opportunity to dress and have breakfast in a relaxed way. Most challenging for the family, however, was that ambient noise (such as TV) was to be kept low during breakfast. Finally, the client agreed to leave for work a few minutes earlier to prevent frustration due to local roadworks. This intervention has been largely successful.

At work, an eclectic set of discreet interventions were also implemented. Chief amongst these were to:

- clarify with his line manager their expectations for the successful completion of tasks, thereby off-setting any potential deficits in Theory of Mind and undercutting related perfectionistic cognitions;
- develop a disciplined workflow such that each task could be focused on individually as much as was possible, thus reducing the need for cognitive switching;

- take lunch offsite, and use so-called 'toilet breaks' during the day, to provide times of less stimulation, thus managing arousal levels; and
- to translate his line manager's newly updated procedures into a checklist with phone-based reminders, thus systematising his work, providing a sense of order and further reducing arousal levels.

Overall, the client has found these interventions to be helpful.

Finally, by way of future work and broader considerations, lockdown has caused the client to disengage from regular in-person socialisation. Although not a current therapeutic priority, it is expected that future work will have the client deliberately re-engage socially with colleagues and friends. This will include taking lunch in the workplace's common area and the resumption of weekly sport. In so doing, the client will likely have to relearn subtle social skills that will further aid his re-emergence into post-lockdown life.

Implications for practice and conclusion

The present case study is a useful and timely addition to the emerging COVID-19 mental health literature in several ways. For example, it acknowledges a specific post-lockdown window associated with people's emergence back into normal civic life and the struggles they may face. Extending this point, it also hints at the potential for a lengthy period of post-lockdown distress consistent with the predictions of Brooks et al. (2020). In addition, this case study is interesting for it is counterintuitive, being focused on a client who thrived during an extended period of lockdown but faced significant mental health challenges when returning to the workplace. Finally, the present case study may contribute important information on how adults with high-functioning ASD have coped with the demands of the pandemic. Put simply, a protracted period of significantly limited socialisation and low sensory stimulation, combined with the ability to create a workflow independent of the immediate demands of a workplace, may expose a masked ASD, and/or increase ASD severity. This may be manifested by the signs and symptoms of anxiety. The implication for counsellors with clients who have high-functioning ASD is that during future lockdowns simulated workplace routines and norms must be maintained, while anxiety ameliorating skills should be offered in advance of a lockdown's end.

More broadly, this apparently simple case study presented a number of challenges to the author's practice worthy of further consideration. For example, how does a counsellor uphold their duty of care to a client when working with incomplete knowledge of the case (that is, in this instance, a lack of a formal ASD diagnosis)? Alternatively, what are the ethics of working with a client when you have only limited experience with the presenting or underlying issue? Further, how does one discern treatment priorities when the presenting issue may be the tip of the iceberg? And finally, what is the relative importance of client assessment and case conceptualisation versus treatment? It is in relation to this last point that counsellors who favour an interventionist approach with clients should pause and reflect, for without considerable curiosity, treatment may fail.

The COVID-19 pandemic and its effects will likely challenge counsellors in ways that we are yet to fully grasp – and for a long time to come. As new issues and insights arise, it is important for the profession to share its collective knowledge. It is in this spirit that the present case study has been provided. Finally, and by way of a parting thought, alongside those necessary and sufficient qualities that make us effective practitioners let us now add one more – curiosity – for, as Bob Dylan said, "the times they are a-changin". ■

Postscript: Although the client "enjoyed" being locked down in 2020, by October 2021 mild depression was evident, and this became the focus of counselling. As at publication the client still struggles with switching between multiple workplace demands.

The COVID-19 pandemic and its effects will likely challenge counsellors in ways that we are yet to fully grasp – and for a long time to come. As new issues and insights arise, it is important for the profession to share its collective knowledge.

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Note-taking: the ins and outs

It is extremely important that professional supervisors have a good knowledge of what is appropriate and what is not with regard to note-taking. Not only do professional supervisors need to be aware of their own notes, but they also need to ensure their supervisees are keeping appropriate notes. Notes can be subpoenaed and, therefore, if they are not correctly written, the conduct of the supervisee and their professional supervisor will be brought into contention. Notes need to be legible, concise and accurate (Despenser, 2004; Presser & Pfrost, 1985).

For the supervisee, accurate notes are useful when debriefing with your professional supervisor, particularly if a difficult case was experienced several weeks before your professional supervision. Reading your notes the day after seeing a client can

Photo: Pexels/ Alex Green

also be enlightening – you may find you have been judgmental, or your own belief system is interfering with your objectivity. Read notes critically, but do not change them; learn from them (Despenser, 2004; Presser & Pfost, 1985).

Taking notes is a contentious issue. Should you take notes, and if so, how much should you document and how should you reflect statements? What words are appropriate and what words will leave us professionally vulnerable? There is no real answer; but consider: will your notes be adequate and not incriminating if you are called upon by a court to divulge them, and will your client sue you after reading them? It is a good idea for professional supervisors to critique their supervisees' notes, particularly those of new supervisees.

Clarity in documentation

The following is an excerpt taken from the American Counseling Association and written by Robert W Mitchell, ACSW. This document, entitled *Documentation in Counseling Records,* is relevant for any professional who is required to take notes (Mitchell, 2000; see also Armstrong, 2006).

Mark Twain once said to would-be writers, "As to the adjective, leave it out." His words have meaning to us today. He meant that when you write an adjective, for better or for worse, you give an opinion. Adjectives must be carefully chosen, or even replaced, if language is to be clear and precise.

Examples of the need for clarity and precision are the focus of this article. Your written words are the only record of a session you have with a client, and those will count for nothing, for your agency's purposes or in a courtroom, if you have not written them down accurately.

Let's take an example: *The sky is blue … no, the sky is generally blue … no, the sky generally appears to be blue … no, in some parts of the world, what is generally thought of as the sky sometimes appears to be blue*. We sometimes make things harder on ourselves when we go

Photo: Unsplash/ Julia Cameron

to extremes. All we need to say is the sky is blue. In many instances, the work we do is simple and very straightforward; we don't need to mystify it with complicated or confusing words.

Here's another example: *Jerry is exhibiting signs of depression … Jerry is depressed*. These sentences are grammatically correct, yet I am unsure what exactly is meant. An attorney would have a great time with either of those statements, saying the writer was judgmental, prejudiced. The client was simply a quiet, unassuming person whose behaviour produced unwarranted and false conclusions. To eliminate that possibility, all you need to do is add a simple clarifying phrase. If Jerry is depressed or showing depression, add something like 'because he lost his job'. If Jerry is repressing his emotions, add 'by not answering questions and by changing the subject'. What clues tell you Jerry is depressed? Add 'he said he has not been able to eat or sleep and is concerned about the crying spells'. Now your conclusions are supported with specifics.

Let's consider more examples:

- A favourite but inadequate phrase in records involves 'negative attitude'. Again, that is too vague and too judgmental. To make it clear, write something like: 'learn to discuss problems instead of throwing things'.
- A frequent goal is 'improve hygiene'. That's too vague because it doesn't tell you enough of a story. You must be specific. How about: 'brush teeth and shower each day'?
- Don't write: 'learn to become more independent'. What does that mean? Set up a business? Leave a husband? The specific goal could be: 'get up in the morning and report to job on time'.
- 'Increase self-esteem' is another favourite goal, but it's difficult to really sink one's teeth into such a phrase. How about: 'will not be critical of self or personal decisions about disciplining children'. See the difference?
- The record may read: 'client participated in chalk talk'. What does 'participated' mean? Will every reader understand that a 'chalk talk' in this instance is a chemical dependency lecture? Did the client talk? Cry? Take a swing at another client? Or at you? Someone can participate in an active or a passive way. So one word doesn't tell much. To clarify 'participate', add for example, 'client revealed examples of how he had fooled himself about the increasing use of drugs. He reported denying the importance of wife's complaints. The group encouraged his willingness to open up.'
- Since part of our topic concerns communication, let's take the phrase 'communication problem'. Again, what does this mean? Why not list the exact problem; for example, 'stuttering', 'speaking too fast' or 'talking around the subject'.
- Is your client withdrawn? How do you know that? Write instead, 'Suzanne is withdrawn as evidenced by the fact that she spends all her time in her room and refuses to even eat meals with her family.'
- To characterise someone as 'aggressive' is not enough. Does the client fight? Push? Scream? Kick? Do not leave room for interpretation. If the client described eventually takes you to court, the term 'aggressive' used alone could be interpreted by the attorney as a positive characteristic, not a negative one.
- If a client is unemployed, there may be more to the situation. Clarify your entry by adding something like 'has been fired from last three jobs for drinking and excessive absences'.
- You can define the term 'nervous' by writing something like 'not eating; sleep is not restful; screams at children'.
- Instead of 'feels bad', write 'history of high blood pressure and heart condition'. Remember: one can feel bad physically and/or emotionally. That holds true for another one-word problem: health. Enter something like 'asthmatic condition requires expensive medication, so the client does without'.
- When the client is ambivalent, you need to know why. So does a record user. Enter something like 'She cannot make a decision about continuing in a marriage with an abusive spouse'.
- We often think we are describing a behaviour when we say, 'Henry is lazy', or 'Laura is aggressive', or 'Karen is withdrawn'. These statements do not describe behaviours; they make undefined judgmental observations. That could be disastrous for a supervisee and the agency. What characteristics or symptoms give you cause to think the way you do? Write them down!

As you are choosing words, remember, it is a complex task. Your

choice could convey, deliberately or not, a view that tends to be too negative. Consider these examples and decide which is better: dumb or limited intelligence; cheap or economical. It is vital that your words be clear and precise to satisfy your profession, external auditors, your client and attorneys, should the need arise. It is necessary to substantiate your observations and give them authority. Remember: good entries are precise and current.

There is also the matter of timeliness. The word 'current' is a directive to record information immediately. Waiting even one day can blur accuracy. Those who wait until the last minute to write their entries often suffer from fainting spells, anxiety attacks and acute writer's elbow – a heavy price to pay.

Your client should be an active participant in setting goals, writing staff notes and plans and document client participation, perhaps including the client signature. Set goals the client will understand, agree with and accept. Objectives must be specific, measurable and meaningful to the client. Set a date for achievement of those goals. Define the methodology to be used in goal achievement. Do not create a reasonable doubt – that's a lawyer's job! Using words that are not specific or that create vague impressions could equate to an opinion, leaving room for reasonable doubt and the possible destruction of your credibility.

The writer's reasonableness and credibility can be assumed not only from the words but also from the readability and appearance of the record. Did you ever stop to think that a record's appearance affects a reader just as the appearance of a speaker affects a listener? There are several major factors that will influence the written word's credibility and clarity:

- Legibility. Scrawled, scratchy or sloppy handwriting, which is difficult or impossible to read, may make the writer appear irresponsible, fairly or unfairly.
- Spacing. Small writing that is crammed into a small space not only says something about the writer's concept of what is important but also frustrates the reader, who may already be looking for a way to use the record against you.
- Format. Disorganised filing, half-completed forms and a rambling assortment of ideas leave too much room for doubt.

Not taking care of the appearance of a document may be construed as an indication of disregard for the client and a lapse in professional accountability. ■

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Author: Robert W Mitchell, ACSW Series Editor: Theodore P Remley, Jr, JD, PhD

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BROACHING: HOW WE SUPPORT OUR CLIENTS TO TALK ABOUT RACE

By **Dr Stephani Stephens PhD**

At the time of writing, it has been exactly a year since the killing of George Floyd on the streets of Minneapolis, USA – in daylight and in public – and the resultant groundswell of global responses in cities around the world. In many respects, the violence, tragic injustice and horror of the nine minutes it took Floyd to die seem to have expressed what Indigenous people and people of colour have been trying to articulate for years: the othering, the different treatment, the racism that occurs for many every day. As journalist Stan Grant shares: "There, captured on video, was every person enslaved … In his cries, we hear the cries of hundreds of years and the unknown dead" (13 July 2020). Although the US is thousands of miles away, the cultural significance of real-time racial issues has made it uncomfortably close and has forced Australian circles to reflect on the treatment of our own people of colour and Indigenous community members.

At the same time as the George Floyd events, a group of Asian diasporans raised a delicate topic for discussion: the shortcomings of therapists in their own mental health journeys. The consensus was clear – participants were utterly frustrated at being unable to engage psychotherapists in addressing race as a place of pain in their lives. What became evident was that perhaps an immense gap between white therapists and their diverse clients remained unidentified, and that there was a very real and startling possibility that the professional community was not only failing to meet clients' needs, but in fact pivoting around them. By avoiding the discussion of race in the therapy hour, were therapists facilitating the same oppression and damage as what brought their clients to counselling in the first instance? As one podcast host shared:

"It's pretty messed up that so many of us actually need to go into the therapy room and try to advocate for ourselves around our lived experiences … and [then] have to teach our therapists how to treat us … like that is not (laughs) … that ain't right." (https://planamag.com/racial-trauma-and-therapy-ft-bryant-escape-from-plan-a-ep-109).

According to the Australian Human Rights Commission, a 2017 report found "about one-third of surveyed Australians … had experienced racism in the workplace" (Australian Human Rights Commission, 2019). Further, "around one in five Australians say they have experienced race-hate talk, such as verbal abuse, racial slurs or name-calling" and "more than one in 20 Australians say they have been physically attacked because of their race" (Australian Human Rights Commission). Given Australia's demographics, it is important to visit psychotherapeutic and counselling efficacy as it applies specifically to the varied multicultural community members who enter therapy. This population, although presenting with typical themes for counselling, might also harbour challenges around race, ethnicity and culture (REC), their

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> "...around one in five Australians say they have experienced race-hate talk, such as verbal abuse, racial slurs or name-calling" and "more than one in 20 Australians say they have been physically attacked because of their race..."

Despite work being done in professional associations, government bodies and training institutes to address multicultural awareness and competencies, there appears a misalignment in terms of the specific skills employed to demonstrate such awareness.

core identity and how they navigate a discernibly white Australia. This reality requires us as practitioners to listen for and assist in creating ways to talk about woundedness resulting from bigotry and prejudice, what Race Discrimination Commissioner Chin Tan identifies as "entrenched disadvantage, political exclusion, intergenerational trauma and ongoing institutional racism" (Tan, 2021).

Despite work being done in professional associations, government bodies and training institutes to address multicultural awareness and competencies, there appears a misalignment in terms of the specific skills employed to demonstrate such awareness. If multicultural awareness proved successful, racial concerns would be moot.

As Berman and Pardies (2008) note, "The absence of consistent anti-racism strategies as part of broader multicultural policies would be unproblematic if racism had been eliminated through the application of such policies. However, the limited available evidence would suggest otherwise."

Thus, there continues to be a very real issue between our collective understanding of multiculturalism as an accepting social and even professional attitude, and the very real daily experiences of microaggressions our clients of colour recount (Nadal, K.L et al., 2014, Sue, D.W., 2017). Further, professional development around a multicultural mindset needs to address the skills counsellors adopt to bridge the gulf between a mostly white profession and the clients of colour who make their way to therapy.

Meanwhile, the profession is making headway on how to translate multicultural competencies (Collins & Arthur, 2007; Tomlinson-Clark, 2013) to skills in the room (Day-Vines et al., 2021; Williams et al., 2018), yet there are still indications of hesitancy on the part of counsellors to broach race with clients of colour (Jones & Welfare, 2017, as cited in King, 2021). A sample study of 700 therapists found "less than half reported broaching racial/ethnic differences in cross-racial/ethnic dyads in the past 2 years" (Maxie et al., 2006). The conclusion? "Alarmingly, of dyads that did broach race/ethnicity, clients were equally responsible for beginning these conversations" (King, 2021). Thus, there is work to be done in increasing white practitioners' level of comfort to actively invite race into the therapeutic discussion.

This article challenges practitioners to reflect on their own opportunities with clients in this demographic and to evaluate how therapeutic efficacy might meet their clients' emotional, psychological and cultural needs. It attempts to discuss the importance of broaching as a skill; this is not exhaustive but rather focuses on exemplary practice. Since one of the scholarly core tenets of broaching is that it remains a counsellor responsibility (King, 2021) to that end examining closely the dynamic of a practitioner who models such responsibility is one of the goals here. In that vein, a look at the skill of broaching will give counsellors a specific focus toward building the skill, and thus the therapeutic alliance, while assisting to heal those places with our clients where racism has taken a toll.

Broaching

Broaching is an invitational skill that addresses a client's REC concerns "in an effort to develop strong therapeutic alliances" (Day-Vines et al., 2020). It also encompasses "the counsellor's ability to consider how sociopolitical factors such as race influence the client" (Day-Vines et al., 2007).

To broach racial difference is to attempt to bear the onus for articulating that difference, holding it for the client and enabling them through guidance to raise such REC issues. Therefore, we look to broaching to lean into those spaces where race might be a factor in our client's pain. The task is to ready the therapeutic process so clients can unburden around their daily struggles, including, perhaps, those with their white therapist. Practitioner Pat Ogden (8 June 2020) quotes an African American client on the importance of acknowledging race: "If you don't see my colour, you don't see me, and you certainly don't see how I see you." Ogden stresses, "we need to acknowledge that difference".

By not 'hearing' these themes with our clients, there is risk of "perpetuat[ing] a dominant cultural imperative" (Day-Vines, et al. 2020); simply put, we run the risk of being part of the problem. Bryant Tow explains, "When you are around white people and you can't address racism, you are really putting a

lot of yourself on the shelf … Our therapists are human and when our therapists are white … the same patterns that play out outside of the therapy room are happening right there, too." Most significantly, "When it's about racism and when it's about your white therapist needing essentially to interrogate his or her identity in order to help you develop yours … well, just, do the math" (https://planamag.com/podcasts, ep. 109, 28.30).

Therefore, with non-white clients, willingness alone falls short in grasping client context if counsellors are not ready to hold the burdens of articulating such pain. Broaching as an explicit skill addresses the ability to do so. As King (2021) notes, broaching requires acknowledgment of "the counsellor's own positionality and beliefs about the relevance of culture and power". With this, a radical honesty is needed to self-reflect about the structures we all live in, including those we take for granted.

As psychologist S. Sisko (2021) writes: "… Eurocentric knowledges have been privileged and assumed as core foundations to the [counselling] discipline, while all other perspectives are assessed as deviations."

Couples Therapy: DeSean and Elaine

To examine further best practice with respect to broaching, there often is, by default, a theoretical challenge for researchers; we often are left with speaking in generalities about work with clients. Fortunately, there is a seminal exchange by the

Photo: Unsplash/Simon Daoudi*

psychoanalyst Orna Guralnik in her deep work with coupled clients in the US TV show *Couples Therapy* (SBS), which deals directly with the race issue and serves the research well. It is worthy therapeutic work to explore in order to highlight how broaching race during the therapy session can unfold.

Guralnik is grounded in psychoanalytic theory and methods, which is evident in how she skilfully and attentively listens to what lies behind everything that is shared and how the couple relate, speak and commit to their coupling. The unburdening she often incites is attentive, compassionate and uncompromising as she allows her clients little room to shirk their responsibility to radical self-honesty, let alone honesty to other.[1]

One featured couple, Elaine and DeSean, are a mixed-race Puerto Rican–African American couple. Power imbalance and demanding behaviours are the issues that bring DeSean and Elaine to counselling and what they are hoping to improve as a couple. Over the course of their therapy, and concurrently just after the George Floyd killing, Guralnik found herself addressing race during the sessions. It is particularly useful to examine closely these exchanges because she demonstrates so well

1 What makes *Couples Therapy* so instructive for us professionally is being able to bear witness to the legitimate and honest therapy being conducted by real couples under real circumstances. The therapy room is a replica of Guralnik's own therapy space – down to the bookshelves and tables. This is done to accommodate cameras as intrusively as possible. I mention this here because normally there are issues around confidentiality, and so I offer this material for discussion with great respect for the work presented as well as for the honesty, hardship and bravery the couples demonstrate in offering to participate. As a result of the staging, which is meant to make couples feel as authentically engaged in the therapeutic process as possible, there are a few considerations to mention. Since couples were aware that their work would be broadcast, the confidentiality has limits if not pliancy, which professionally we are unaccustomed to. Also, the extent to which the footage was edited is unknown, and so we are left considering a narrative we assume is cohesive in its attempt to make sense as a story and is as true to the couples' issues as possible. In these exchanges, I am assuming that what resulted onscreen is a true representation of what happened. For the couple below, the veracity of what unfolded as the final presentation was confirmed in a separate interview.

> … awareness of the client's worldview falls largely to the therapist to gauge. The therapist needs to offer clients a language that matches their experience in order to pave the way for clients to begin to explore this often-marginalised part of themselves.

the skill of broaching and provides an example of how to acknowledge difference for therapeutic effect. Further, she conducts herself with a laudable level of self-reflection, which can assist practitioners who also contemplate raising these complex and layered tensions with their own non-white clients.

Couples Therapy: transcripts[2]

When we meet the couple, DeSean shares his background and his role outside of his relationship with Elaine. There are indications of his sense of being a black man connected in his community, as well as his position in a mixed corporate and primarily white world.

D: I'm very proud of where I come from. But I'm not the way I am when I'm here, in the corporate setting. I get along with everyone.
OG: So, you find a way to move between these different identities.

Guralnik not only paraphrases with a strength-based and trust-building reflection, but this is invitational and opens the space for Desean to explore later. With this, Guralnik affirms that both of his identities can be explored in the therapeutic space.

As the conversation between Elaine and DeSean begins, we learn that there is tension when Elaine wants to go out. She feels she needs to initiate, choose the restaurant, make the reservations and, in a sense, do all the work.

E: When I suggest we should go out, he says, 'Alright, tell me when and where and I'll be there' [*frustrated*]. I'm asking *you* to take *me* out, so if I have to plan it, you're not taking me out.

We learn the reason she needs to initiate.

D (to Guralnik): She likes these fancy restaurants, alright, and very expensive plates, I get treated very badly in a lot of these places. [*Elaine's facial expression here is doubtful, dismissive, perhaps annoyed.*]

OG: You get treated badly because these are like snooty waiters?

D: Yeah, yeah.

Here is where some psychotherapists might stop and consider what DeSean is saying at face value – that snobby waiters are not as attentive. Yet, Guralnik's instinct is to lean into what DeSean is not saying.

OG: Because they treat everyone badly?

D: No.

OG: They treat you badly because you are black?

D: Umm, I [*stutters*], I think [*wringing his hands*] … I felt like that very strongly (**OG:** uhum), very strongly (**OG:** uhum) and we are the only people of color in a lot of these places …

Guralnik is unafraid and broaches, simply to name what it is, and names what DeSean perhaps cannot. The broaching is clear, direct and shows her holding the question and its reality for them both. DeSean looks to Elaine, who is warming up to concede.

By calling out the issue of race, Guralnik has indicated to the couple that she is willing to explore this immense topic. Meanwhile, Elaine's look of doubt is unsurprising in its ease and readiness to dismiss her partner's experience. Or is it her desire not to engage in an awkward exploration of this woundedness? An important question is: would a therapist at this moment do the same – that is, pivot around the discomfort of this recognition?

E (frustrated): If you feel like they're snooty and you walk in feeling like, "Oh, this place is so snooty and I'm the only black person here", who cares? BE the only black person there, [*DeSean's expression shows he has shut down*] flaunt that like you know, like who cares? Who cares? Who cares? Why is that an issue for you? Honestly? *[Elaine's emphasis and tone of voice becomes more animated as she makes this point.]*

This is a significant moment and one in which people from dominant cultures might say, "I don't see this as a problem, why are you making this a problem?" There is often an assumption that race is an accessible topic between couples in their intimate lives. The work Guralnik does in later episodes with a white New York City police officer and his African American wife during the aftermath of the Floyd killing also brought home that the very public nature of racism and the arenas in which it often unfolds is brought into people's kitchens and even bedrooms.

Guralnik invites DeSean to respond and he makes the point that it is difficult to be in places where you are made to feel that

[2] These transcripts are amended from two sessions with the couple in episodes 6 and 10, as well as two supervision exchanges Guralnik attends to discuss the couple. It is recommended to watch these sessions to further study Guralnik's style and approach as she tackles this complex material.

"people don't like you". Again, it would be easier to leave this comment hanging or to pivot around this to land on a self-esteem tack. But Guralnik leans in to reframe.

OG: Don't like you or are scared of you?

With her choice of the word "scared", Guralnik highlights once again what DeSean is not saying or cannot. A counsellor not racially informed might let this go. DeSean has, in a sense, offered the therapist a way out (that is, some people don't like him), rather than taking the opportunity to pivot around to him being black. Here, DeSean in fact edits himself and curtails the full experience of being a black man. So, Guralnik takes the opportunity to lean in to gauge DeSean's response.

D: Or scared of you [*agreeing and turning to OG*] or intimidated for some reason or … I've been taken off accounts at work, uhh, they won't tell you why, but, I've been in meetings where you chalk it up at work, like listen this is business, but if someone doesn't like you for no particular reason, you know …

DeSean paints a picture of his very personal experience of racism.

Guralnik ends the session with the bravest and most seminal broaching question:

OG: Do you have any thoughts about what it's like to see a white therapist, like what's that like?

At first, the question does not find traction as Elaine and DeSean look at one another. We are left unsure if this is because no one has ever posed this question. Then they begin to laugh about the reference to the white therapist in the horror film *Get Out*. DeSean, laughing and rubbing his eyes, says, "If I see you with a teacup and a spoon, oh, man, we're going to have a problem"[3] . It is important to note how Guralnik uses the humorous moment to lean into the couple's suggestion of the film and to affirm the link they've made. The laughter between the three is a much-needed moment of relief, while not really addressing the important broaching question Guralnik posed. We are left to assume that Elaine's reaction is she had not really thought about Guralnik being white, and this might not be any issue at all for them at this time. The important point is Guralnik invited them to contemplate their experience with a white therapist.

Supervision I

Guralnik attends two supervision sessions in which she talks about her uneasiness in how she went about broaching. We get the impression that she feels frustrated, in doubt as to if she met DeSean's needs, let alone the presenting counselling concerns of them both.

OG: It was both fascinating actually and incredibly upsetting, very complicated discussion about race. [*Supervisor nods*.] It feels like we have to stop here and talk about like American history and talk about …

S: If you were telling me there's a false truth that he's living under, that needs to be unpacked, that would be one thing, (**OG:** uhum) but he's reporting the vicious facts of life, as lived by him, it doesn't sound as if he's one inch confused.

OG: No, he's not confused, [*pause*] he's muted, he's not confused, (**S**: yeah) he's muted.

While it is unclear whether the footage was edited at this point, we have a supervision response that echoes what we hear from many of our clients of colour who do not feel seen and heard with respect to their race: 'this is so big, there's nothing we can do'.

S: I really admire your ambitions for these sessions, but I think you're not getting that it is one session, a session in time, (**OG:** uhum) and not everything can happen (**OG:** yeah), and I know you know that, but you're left with a feeling like not good enough (**OG**: yeah).

We do not know the entirety of this supervisory session, and perhaps it went in a significant direction. The supervisor's response looks to refocus Guralnik and pivot around her real concern. The issue for Guralnik is that she cannot let this go and feels a deep sense of accountability for assisting DeSean to process his experiences.

Supervision II

After the murder of George Floyd, the protests and the concurrent lockdown, Guralnik checks in with Elaine and DeSean. She is aware that the outpouring of emotion after the Floyd murder has affected her clients and pushes DeSean to share his reaction. He is obviously stuck in his effort to communicate, and Guralnik tries to create space to lean in and support an exploration of what he could be going through. We see DeSean lost, unable to land anywhere in the conversation and unable to articulate what he is feeling. Instead, he retreats to the space he knows best – not addressing race. Whether due to this particular session with DeSean and Elaine or the confluence of events, Guralnik seeks out a different supervisor, Kirkland Vaughn, an African American who is very willing to explore Guralnik's concerns:

OG: DeSean kind of froze up, and for almost half an hour he couldn't speak really [***KV** nods*]. I was very conflicted because, on one hand, I felt like there is so much grief and anger that he's sitting with –

KV: Tremendous.

[3] The reference is particularly significant as in the film the stirring with a silver spoon was meant to hypnotise their black guest into the Sunken Place. See Sims, 2017.

OG: – tremendous, and he needs a space to say it. On the other hand, I felt like white people are confronted now with like 'stop asking us to speak' [*KV nods*]. Stop, it's just such a burden on the person of colour to speak and explain things to you. Like, I don't know, there's no right position from which to ask him to speak.

Guralnik is breaking down two points here: first, how to actually reach DeSean; and second, her real awareness of the cognitive burden of clients of colour teaching their (white) therapists how to treat them. Guralnick asks: how can – and should – she do this during such a socially and emotionally charged time?

KV: See, I think that's exactly the right position, acknowledging your position here, and how that might be experienced by him and wanting to therapeutically engage him around his trauma, (**OG:** yep) which means that he needed an opportunity to learn to be able to give it voice.

This is such an instructive turn here in that the supervisor suggests the broaching Guralnik has done – that is, raising being a white therapist – is the first step, and he further supports her attempts to broach. With this, he refocuses her to consider that DeSean needs support to join and experience the opportunity of the space 'to give it voice', because, after all, where is a black male client able to do that? The answer, hopefully, is with his (white) therapist.

OG (voiceover): Since that moment, my entire practice has been shaken … there's no one patient that kind of escaped this.

KV: Nobody gets out of here without taking some of this in, none of us are immune to this. And psychoanalytic therapy those are always dangerous waters that we walk, I don't think we can ever get around not enacting some racialised trauma … I think if we do get around an enactment it's because we are not there for them (**OG:** yeah) and so the treatment is bland, it's without substance and, therefore, does not stimulate growth, in my opinion.

The supervisor here was able to do for Guralnik what the previous one had not. With a racially informed focus, he addressed Guralnik's need to support DeSean in his potential reactions to the Floyd killing, vicarious or otherwise. By acknowledging Guralnik's own reaction to DeSean's muteness, and her feelings of inadequacy, the supervisor supported her to understand that clients might need guidance into exploring how racism affects their lives. The supervisor, too, paves the way so that Guralnik could recognise the value of her presence and her broaching skill.

Here we glean that if therapists do not broach, they risk the therapy failing, because their whole person and self is not being held in the room.

Concluding thoughts on implications

The importance of these sessional transcripts rests in examining how race often 'hides' beneath other client presentations. A skilled practitioner can hear those spaces and make conscious decisions around how to broach at significant moments (King, 2021). On several occasions, Guralnik's ability to broach supported DeSean to feel seen as she recontextualised his challenges within a race framework. Significantly, she did so on his behalf. The positive contribution Guralnik's examples offer is that broaching can be observed as an effective skill.

Although the context of the material is American, the implications for Australian practice are significant. Firstly, broaching can be seen as invitational, which is a part of all counsellors' alliance building. By considering the client's worldview and specifics of an invitational approach, the counsellor would be poised to hear not only the content but also the manner in which the client conveys their concerns. Phraseology that supports such invitation indicates to the client they are in a safe space for racial exploration (Williams, 2018; King, 2021), similar to Guralnik pointedly naming herself as a white therapist. Such directness also indicates the level of counsellor depth and awareness, which also contributes to alliance-strengthening.

White counsellors who work with non-white clients need to hold the client's social, psychological and racial identity concurrently. Explaining the client's worldview needs not be the client's cognitive burden to bear, nor should they need to ensure the therapist's understanding. Thus, awareness of the client's worldview falls largely to the therapist to gauge. The therapist needs to offer clients a language that matches their experience in order to pave the way for clients to begin to explore this often-marginalised part of themselves.

Broaching needs self-assurance to hold the invitation and then to consider it deeply. Collecting and sharing narratives that address work with non-white clients and their race experience would help to shed light on counsellor comfort levels with broaching skills. Sharing such accounts would not only make best practice more widely known, but also begin to reveal how broaching skills are becoming more effective. Further, not all broaching might be useful for all ethnicities, and thus accounting for cultural difference in broaching skills is an additional area useful to explore. The skill of broaching in itself is not difficult; feeling secure enough to use it is. ■

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UNDERSTANDING BOREDOM

Paula Brown explores the origins and impact of boredom in both clients and therapists.

By **Paula Brown**

"Boredom is not a problem to be solved. It's the last privilege of a free mind" (Devi, 2015).

As I child, I was the proverbial cardboard box player. I was lucky to have the kind of disposition that meant I could play for hours with a handful of stones or be found wedged for the afternoon halfway up a tree with some biscuits and a matchbox car.

However, even for me and the seemingly boredom-immune, the COVID-19 lockdowns were a stretch and ushered a new era of boredom. Both adults and children experienced varying responses to boredom, with some people shutting down while others set themselves goals, took up new hobbies or sought mindful activities. Even people able to amuse themselves with the merest of stimuli saw their reserves depleted as mind-numbing boredom gnawed at their existential cores.

What is boredom?

Interested to learn how people's responses to boredom to COVID-19 isolation might help us to understand more about the human condition, I set about researching. While there is no universally accepted definition of boredom, it has been described as "the aversive experience of wanting, but being unable, to engage in satisfying activity" (Eastwood et al., 2012).

Thus, boredom may be our response when our desired activities are thwarted, but it may also occur when we are forced into undertaking an undesired, monotonous or repetitive activity. During these unpleasant activities, or when there is simply 'nothing to do', we are left feeling unsatisfied and understimulated. We may be bored into creativity or begin to crave risky and dangerous behaviour.

However, boredom can be a deeper, more existential issue relating to a person's search for purpose and meaning in life. A valuable emotional state, it gives us the opportunity to be aware of (and perhaps choose) what we want to do, rather than what we 'should' do. Boredom extends an invitation to act without succumbing to mindless distractions or misery. Booker prize winner Anne Enright encapsulates it: "Boredom is a productive state, so long as you don't let it go sour on you." One way to relieve existential boredom is to somehow bring our desires in line with what is available in the present.

Boring activities may serve an adaptive function, helping us to

[B]oredom can be a deeper, more existential issue relating to a person's search for purpose and meaning in life. A valuable emotional state, it gives us the opportunity to be aware of (and perhaps choose) what we want to do, rather than what we 'should' do.

Photo: Pexels/Cottonbro

The boredom experienced during the COVID-19 pandemic might be linked more with anxiety, hopelessness or powerlessness.

go on autopilot, saving energy for focusing on threats or more useful, reinforcing activities. Boredom, as a state, may also help us switch off when we are overwhelmed. Crucially, it communicates our need for stimulation from others, helps us avoid discomfort and acts as a catalyst for action.

Studies show that boredom levels rise through childhood, peak in early adulthood then, generally, decline in midlife. Boredom is a feature of adolescence – associated with higher risk-taking – and in the elderly – speeding up ageing – and links depression to both groups.

Components of boredom

When working with clients who report feeling bored, we as counsellors might get curious and explore what kind of boredom it is they are experiencing – perhaps through language and metaphor. For example, the German word *langeweile* (meaning long-while) links with the sense of time dragging, while the French translation *ennui* (annoyance) resonates with boredom's lighter, irritating overtones. In Zulu, boredom and loneliness are represented by the same word, *isizungu*, which highlights how collaboration and connection can sometimes relieve boredom caused by solitude. The colloquial word *meh* encapsulates the emptiness felt during boredom or that resulting from sensory privation.

However, it can go deeper still. Ultimately, our clients may feel disengaged and dissatisfied, their lives may seem to lack meaning or purpose. They might find it hard to maintain attention, leading to malaise, apathy and depression. The boredom experienced during the COVID-19 pandemic might be linked more with anxiety, hopelessness or powerlessness.

Chronic boredom

Psychologists have come to see the dangers inherent in chronic boredom though there is no consensus around whether boredom is a high arousal state, like anger or frustration, or a low arousal state, like apathy. Researchers have begun to look at the differences between boredom as a trait (a person's proneness to boredom) and the state of boredom (judgments of the boringness of a task, activity or situation) as two separate factors.

Propensity to boredom is perhaps most relevant to therapy, as boredom-prone clients are at higher risk of physical, psychological and social harms (Ben-Zeev, Young & Depp, 2021). These might include relationship difficulties, aggression, poorer life satisfaction and increased risk-taking, as well as eating disorders and suicide ideation.

People with impaired executive functioning, attention deficit disorders or with lower levels of the neurotransmitter dopamine may get bored more easily and may even seek negative stimulus – even electric shocks and disturbing images – rather than being bored (Bench & Lench, 2013). Pervasive technology, as well as being offered excessive choice, can exacerbate boredom by damaging our ability to hold attention. These distractions inhibit our client's ability to answer the questions: What do I really want to do? What will really satisfy me?

Working with boredom

As a call to action, boredom presents us with a spectrum of ways to act. Healthy responses to boredom might include seeking out play or a challenge, or working on our self-control. Play theorist Stuart Brown proposes the opposite of play is not work but depression involving a chronic state of restlessness, distinct from laziness or lack of curiosity (Brown & Vaughan, 2010). Play, he says, is the cure for boredom and making games out of tasks helps to keep us motivated.

Secondly, responding to boredom by setting challenges that match skill levels can result in individuals experiencing what Csikszentmihalyi (2020) refers to as "flow" – a deeply satisfying state in which they are fully absorbed and, ultimately, happy.

People with better self-regulation often report being both less bored and less affected by the sense of time dragging during boring activities. They can move from tedious to satisfying activities more easily by making them playful or finding more meaning in the task. They also, therefore, refrain from simply avoiding the activity. This both relies on and creates a sense of agency in the individual.

As a play therapist, I might begin by considering whether a client presenting as "bored" is having their basic needs met. This


Photo: Pexels/Cottonbro

might mean auditing whether they are eating, sleeping, moving and socialising appropriately. Boredom is a call to action and that action might be something as simple as movement, sleep or rhythmic activities.

I would be mindful that, as their therapist, it is not my job to rescue my client from boredom, but rather to observe it and reflect on it, reassuring the client that it's okay to be bored in the therapy room. We can delight in the new brain connections that novel experiences, activities, thoughts and conversations in the therapy room might create for the client. Creating a low-stress environment can help foment creativity.

Mindfulness

As Danckert and Eastwood (2020) state, when we are "constantly carried along by a fast-moving stream, we can forget how to swim for ourselves". The cult of boundless productivity and of constant 'shoulds' leaves little time for watching clouds or smelling roses. Technology inhibits opportunities to daydream our way, with eyes soft-focused, through the tedium of standing at bus stops or waiting in a phone queue. This may ultimately inhibit creativity as people have been shown to think more divergently after doing a boring activity (Mann & Cadman, 2014). Essentially, mindfulness reminds us to experience what is rather than lamenting what is not. Ironically, or maybe logically, the rise of endless distractions has also led to a boom in the mindfulness sector.

The therapy room is perhaps a place for 'standing and staring', providing clients with precious time for metacognition (thinking about thinking) and for meta-emotion (feeling about feeling). Constructive boredom allows clients to attune to their inner states, to follow trains of thought and see where they lead them, to ruminate, to freewheel. Allowing a client to deal with the discomfort of boredom and reset their inner gyroscope helps them engage with the world and avoid stagnation.

Ultimately, therapy involves problem-solving, limit-testing and collaboration. These are difficult things, but rarely boring.

Boredom and the nervous system

Sensing a client's boredom or feeling our own boredom with a client gives us a great deal of information. Synergetic play therapist Lisa Dion (2016) proposes that boredom may be a felt experience corresponding with the dorsal parasympathetic activation of the nervous system, often as a response to threat. We may feel hypo-aroused, bored or sleepy, and

Examining our own nervous system and locating what energy we do have can be useful. We might take a deep breath in and a shorter breath out to stimulate the sympathetic nervous system.

this may manifest in the sensation that we cannot feel things, that we cannot connect to ourselves or others. We might experience a collapse response as a result of our own overwhelm or perhaps tap into the sensations our client is somatically feeling. We might find it hard to connect with the client, to 'feel' them.

Examining our own nervous system and locating what energy we do have can be useful. We might take a deep breath in and a shorter breath out to stimulate the sympathetic nervous system. We might open our chest and shoulders and ground our feet, anchoring ourselves in the present, perhaps using our senses such as by observing something we can smell, see, hear and touch. This can help bring us back to the process but also models this to the client. Dion (2016) advocates describing this to the client by saying, "I'm feeling a little fuzzy right now," rather than the shame-inducing, "I feel bored".

Boredom and dissociation

Scott (2017) talks about boredom in the therapy room as a derailment of the therapeutic process and as an opportunity for therapists to explore how the dissociated parts of their psyche are in secret conversation with dissociated parts in their clients.

Winnicott and Phillips (1988) suggest that being bored forces us into contact with an inner reality we might describe as our core self. This core self might either lead to a rich internal world that fosters creativity, vitality and inventiveness or to a terrifying, fragmented non-existence. In the latter case, boredom becomes a defence against feelings and experiences we deemed unsafe, experiences that are perhaps pre-verbal and expose our vulnerability, distress or helplessness. It becomes an avoidance.

Boredom in the therapy room, Scott suggests, is an unconscious mutual agreement where therapist and client have shut down to defend against the difficult unconscious material of each. The therapeutic dialogue breaks down and an impasse is reached (Stern, 2010). Becoming aware of this uncomfortable situation, recognising split-off parts of both oneself and the client – perhaps in supervision – is the first step in restoring the therapeutic dyad. Trusting and sitting inside the boredom allows exploration of the dissociation that lies beneath. ■

THE BORED THERAPIST

Therapists experiencing professional burnout often cite boredom with work as a symptom that may belie something else such as stress, sadness, anger or overwhelm. Children, for example, often declare a task 'boring' by which they mean it is too difficult. Regular auditing of our own levels of engagement or burnout – through supervision, professional questionnaires, self-reflection and consideration of our client-load – should, of course, be done regularly. Finding oneself bored of therapy work might, however, indicate a need for an urgent and more in-depth examination of our practice.

Boredom in our careers might indicate a crisis of meaning or it may simply mean that we need to diversify our interests or extend our skills. Personal therapy may be needed to work through issues, or we may consider developing a gratitude practice, undertaking activities that inspire awe or take up campaigning for social justice issues to revitalise our practice.

Ultimately, Dion (2016) reminds us, when we work with clients, they seek out the twinkle in our eye, the sense that we are fully engaged, inspired and grateful to be there. If we do not seek to constantly engage and re-engage with our work, they may not find it. ■

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Photo: Unsplash/Dylan Fout

Pornography consumption or addiction and its treatment

By **Ireni Farag**

Arguments exist regarding the validity of the term 'pornography addiction' and whether or not such a condition exists. However, for clients presenting to therapy wishing to cease or limit pornography consumption, therapists need to provide therapeutic interventions that address the concerns of the client. This article outlines the characteristics and risk factors of pornography addiction. It invites therapists to consider acceptance commitment therapy (ACT) for working with clients presenting with pornography consumption concerns. It will also provide a critical analysis of ACT in comparison with other treatment methods, such as structural family therapy or psychoeducation.

Introduction

Addictions are grouped into two broad categories: substance and behavioural. Common among both forms of addiction are the building of tolerance, withdrawal symptoms (such as increased levels of anxiety, hyperarousal or compulsion), unsuccessful bids at cessation or reduction and the impairment of normal function within areas of the addict's life (American Psychiatric Association, 2013). The behavioural addiction to pornography has been shown to have a detrimental impact on individuals and relationships (de Heer, Prior & Fejervary, 2020; Doran & Price, 2014; Peter & Valkenburg, 2016). While there is disagreement about whether addiction to pornography is real or only perceived by clients due to their own moral beliefs (Gola et al., 2017; Grubbs et al., 2018), therapists are still required to provide appropriate support for those clients who seek help regarding their use of pornography. It is, therefore, important that therapeutic interventions aimed at assisting individuals struggling with pornography consumption are sensitive to the ethical and moral guidelines of clients while addressing its psychosocial, emotional and cognitive impacts.

Description and features

Exposure to pornography has been demonstrated to impact individuals in a variety of ways throughout their life. Adolescents' level of exposure to online pornography has been shown to correlate with their views of women as 'sex objects' (Peter & Valkenburg, 2007) and their tendency to be sexually aggressive (Brown & L'Engle, 2009; Dawson et al., 2019; Shin & Lee, 2019). These impacts continue into early adulthood: one study found that male American college students who frequently watch pornography that included male-dominant roles are more likely to

Photo: Unsplash/Daniel Gregoire

use sexual force (de Heer, Prior & Hoegh, 2020). It has also been found that women who regularly watched pornography are 2.7 times more likely to become victims of sexual violence than those who do not, the likelihood increasing further with the consumption of alcohol. It is hypothesised that this trend is due to the minimisation of sexually aggressive behaviours within pornographic materials and prolonged, repeated exposure leading to delayed or inhibited response to aggression from victims rendering them more susceptible to victimisation (de Heer, Prior & Fejervary, 2020). Anxiety, depression and sexual dysfunction have also been shown to co-exist with frequent pornography consumption (George et al., 2019).

These issues also have a flow-on effect on individuals' relationships. Although some studies suggest pornography consumption has the potential to positively impact intimate relationships between adults (Kohut et al., 2017), others have noted it has been found to increase in likelihood of extramarital affairs and divorce, cause unrealistic sexual expectations and personal insecurity, and decrease levels of marital satisfaction, overall happiness and interest in sex (Doran & Price, 2014; Kohut et al., 2017).

The pre-existence of impaired psychological wellbeing and excessive sexual interest were found to be predictors of problematic pornography use among boys (Doornwaard et al., 2016). These conditions often continue as the individual engages in problematic pornography use (Fong et al., 2012). With frequent exposure to pornography, neurological changes occur. These include alteration to how sexual excitement is reached and the building of tolerance, thus generating a craving for more explicit forms of pornography, followed by stages of binging and withdrawal. These occurrences mirror those of addiction cycles found in substance addicts (Love et al., 2015). Furthermore, Gola et al. (2017), using functional magnetic resonance imaging, found that men who were seeking treatment for problematic pornography use presented similar results to those observed in substance and gambling addicts. They conclude that problematic pornography consumption is a behavioural addiction and, therefore, behavioural interventions would be most helpful for those clients seeking therapy.

Despite these risk factors and associated issues, some researchers argue that pornography addiction is only a perceived addiction and that distress caused is due to incongruence with the individual's morals (Grubbs et al., 2018). However, even if the claim – that it is a violation of a person's values or beliefs when viewing pornography that causes shame, guilt and a pathological view of self as an addict – is true, the self-perceived addict still requires therapeutic assistance when sought (Fisher et al., 2018; Grubbs et al., 2018). In fact, treatment that addresses behaviours, underlying beliefs and values, informed by individual client assessment, is more likely to be effective for those whose pornography usage issues are due to shame and guilt or those who exhibit cyclical addiction behaviour in their consumption of pornographic materials.

Acceptance commitment therapy and pornography

Pornography addiction requires a therapeutic intervention that addresses both the ethical challenges and the behavioural issues faced by clients (Twohig & Crosby, 2010). Acceptance and commitment therapy (ACT) does so by placing emphasis on mindfulness, acceptance and compassion to form the third stage of the evolvement of cognitive behavioural therapies (Craske, 2017; Harris, 2019; Hayes, 2016).

Within ACT, the therapeutic relationship is an egalitarian one, which invites the client to be open and honest in the present moment. The honesty of the client is met with an empathic, reflective response by the therapist (Harris, 2019; Hayes, 2016). Building the therapeutic process on such a relationship provides pornography addicts, who may be struggling with feelings of shame, guilt and self-loathing, with a safe, non-judgmental environment within which to explore their struggles.

It is important to note that by allowing the client to openly explore their experiences and thoughts, the ACT therapist can undertake a client assessment in a non-invasive manner suitable for pornography addicts who may not be ready to expose their experiences with the therapist. This is achieved through asking open questions about the client's hopes, such as 'If I could perform magic

and these thoughts were no longer in your way, what would your life look like?'. Such questions are non-threatening and provide information about the client's thoughts, hopes and struggles (Harris, 2019).

ACT therapists are able to guide clients struggling with pornography usage to lessen the impact of their inner thoughts and experiences on their external behaviours. This is coupled with helping clients choose to increase the effect of those inner thoughts they deem helpful (Harris, 2019; Twohig & Crosby, 2010). To do so, the therapist would invite the client to identify the purpose that pornography usage serves in their life, rather than focus on the frequency or form of usage (Hayes, 2016). This approach begins the process of diffusion, helping the client detach from their thoughts, ultimately weakening the pull towards the cyclical addictive behaviour (Harris, 2019; Love et al., 2015).

Having achieved distance from intrusive thoughts, clients can then choose acceptance of those painful thoughts. For pornography addicts, thoughts can include memories of experiences, emotions or urges that may have existed prior to their engagement with pornography. Through the opportunity to accept rather than resist them, the client is empowered to choose to allow those thoughts or emotions to pass by instead of acting on them (Harris, 2019).

Through use of therapeutic interventions, such as the client writing their own eulogy or tombstone, ACT therapists emphasise values and invite clients to articulate their own core values. By clarifying them, clients can then choose actions they would commit to in order to ensure that their behaviours are aligned to those values (Fraumeni-McBride, 2019; Hayes, 2016). For clients seeking help with pornography consumption, this provides the opportunity to address the underlying beliefs that contribute to their self-concept as shameful addicts (Fisher et al., 2018), as well as those external behaviours that are misaligned with their core beliefs.

Initial studies in the effectiveness of ACT in treating pornography addiction have provided promising results. In their first study, Twohig and Crosby (2010) reported an 85 per cent reduction in pornography viewing and improved quality of life among participants. Another randomised trial for the use of ACT with pornography addicts had similar results, with a 93 per cent decrease in pornography viewing (Crosby & Twohig, 2016). These findings confirm the effectiveness and appropriateness of ACT for the treatment of pornography addiction.

Critique

Although ACT has been demonstrated to be effective in the reduction of pornography viewing, it has provided inconsistent results regarding its ability to help improve the quality of life of pornography addicts (Crosby & Twohig, 2016). It is also important to note that ACT, through its focus on changing how individuals respond and interact with unhelpful or painful thoughts, has only been found to be effective in the short term with pornography addicts (Crosby & Twohig, 2016; Twohig & Crosby, 2010). Further study is required to ascertain if the theoretical approaches of acceptance of thoughts and commitment to actions aligned with values produce long-term improvement for this client group.

Another weakness of the ACT model presented for this client group is that it is based on individual work of the client, disregarding the relational impact of the issue of pornography usage. A more holistic therapeutic approach may invite others impacted by the issue to the therapeutic process. Eliciting a couple's ability to navigate through and solve the issue of pornography use within structural therapy provides the pornography addict with the support of their family structure. It also allows the couple to form a coalition, a partnership against the pornography, and improve their strained alliance by doing so (Ford et al., 2012).

ACT relies on the client as being the expert on their own experiences and life. However, in the case of pornography addicts, information regarding the impact of prolonged exposure to pornography are not as readily available to them as information about other addictions, such as nicotine or online gambling. The role of psychoeducation has been shown to have positive impacts on adolescents whose parents provided information about pornography prior to their viewing it (Shin & Lee, 2019). It is also likely that psychoeducation would aid the work of the ACT therapist in providing information regarding the addiction cycle and its impact on the brain and behaviours. Such information would be used to support the client's commitment to actions, potentially providing added incentive and thinking to their decision to choose actions aligned to their values.

Despite the shortcomings of ACT, its theoretical underpinnings of acceptance, commitment and values address the vast majority of issues that have been found to result from pornography addiction. The establishment of a strong therapeutic alliance provides clients with the opportunity to be vulnerable and honest within the safety of the empathic and humble presence of the ACT therapist as they explore an issue that is typically accompanied by guilt and shame.

Summary

Pornography addiction has been demonstrated to have detrimental impacts on several areas in an individual's life. These issues range from a greater likelihood to engage in sexual aggression, to being more likely to be to be a victim of sexual aggression. It is also linked to, relational issues and sexual dysfunction. The impacts have also been shown to vary throughout the lifespan of individuals, the common attribute being that pornography addicts often felt trapped within the addiction cycle.

Although some studies provide evidence that pornography consumption may have an impact similar to that of substance addictions, others argue that pornography addiction exists only in the client's perception due to their moral evaluations. Despite these differing views, ACT has been shown to be an effective therapeutic model for those struggling with pornography addiction. The implementation of therapeutic interventions within ACT is dependent on the therapeutic relationship. The therapist has the opportunity to build a therapeutic relationship that respects the autonomy of the client and their individual ethical views regarding pornography.

Through examining the purpose of pornography within their life, differentiating between helpful and unhelpful thoughts, identifying values and committing to actions aligned to those values, clients have been able to achieve significant reduction in their pornography usage. However, it is argued that ACT interventions can be more effective if coupled with psychoeducation regarding the impact of prolonged pornography usage. ■

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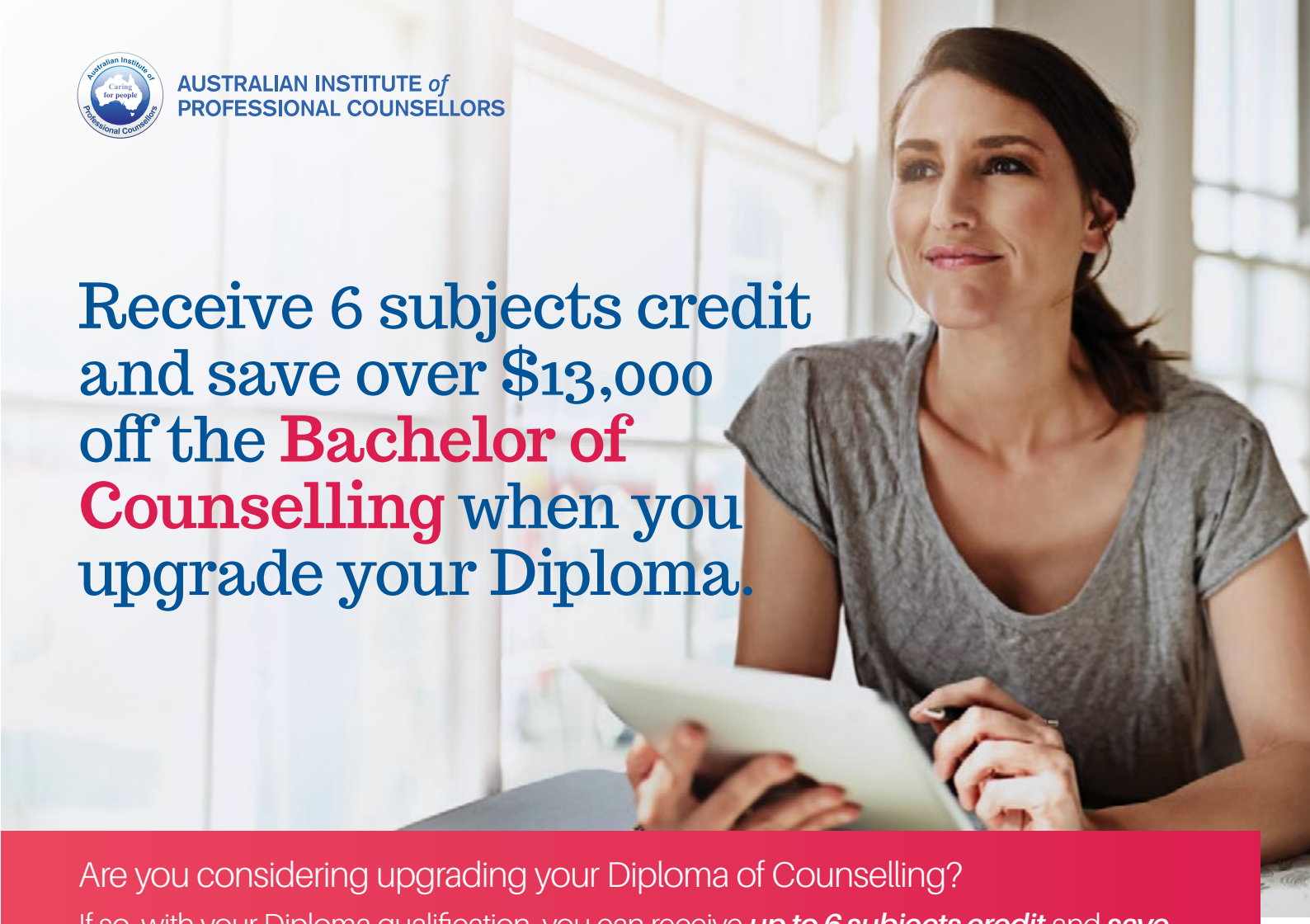

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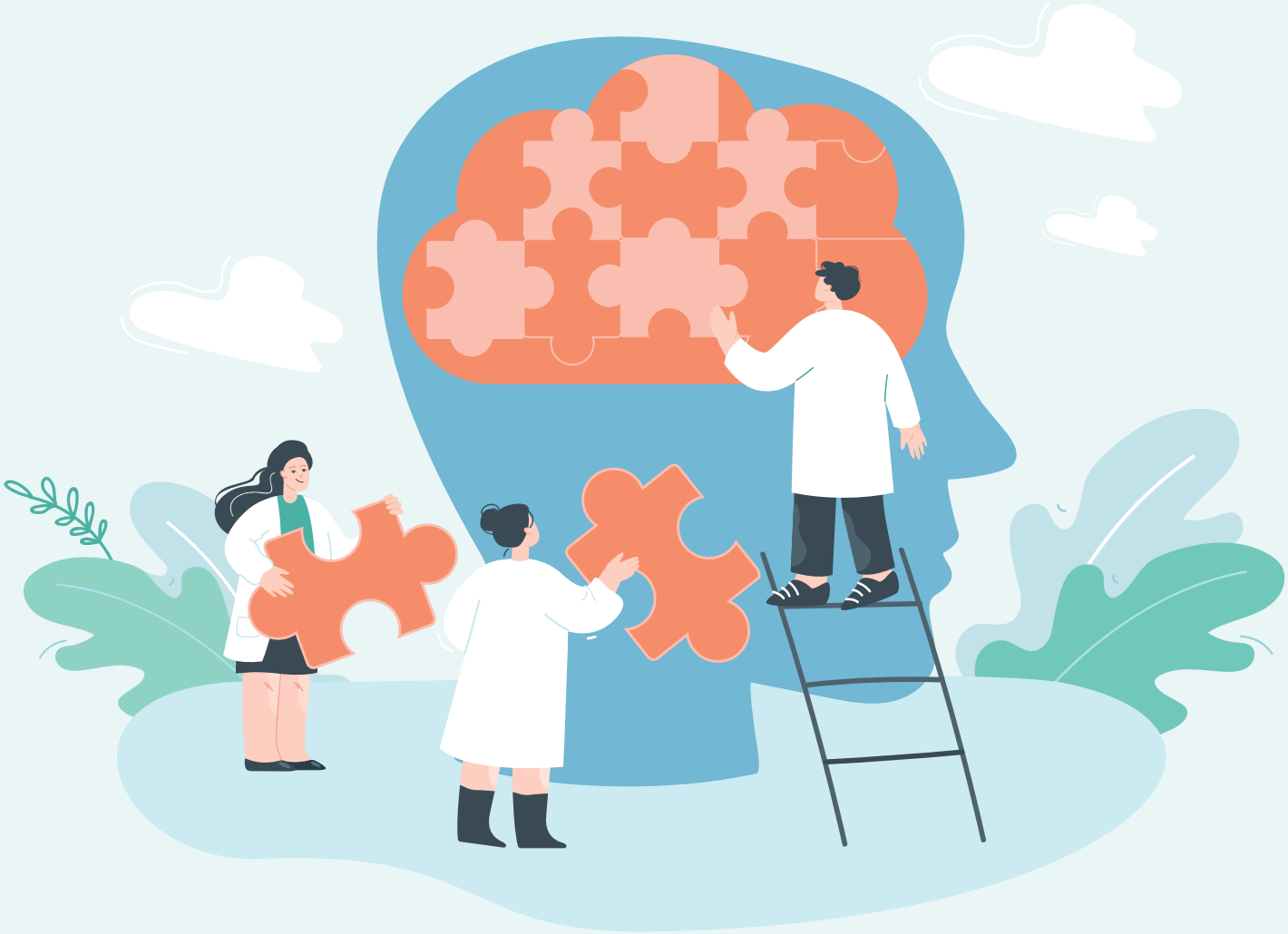
About the author

Ireni Farag
Ireni is a counselling lecturer at Excelsia College and Western Sydney University with over 15 years of counselling experience in school settings and private practice. She is also a PhD student at Queensland University of Technology. She is interested in the conversations between therapists and clients, particularly those which occur at the start of therapeutic interactions. She has been involved in research which examined checking-in as a therapeutic conversational tool. Her interests include the co-construction of a safe therapeutic environment by therapists and clients, therapeutic attachment and the use of practice-based research to inform therapist training.

Illustration: 123rf



WHY SUPERVISORS AND SUPERVISEES NEED THERAPY

Have you ever sat in session, listening to your client explain why they were struggling with an issue, only to find that you experienced a rising panic and sense of helplessness because you, too, were dealing with the same issue?

Have you ever finished a session with a deeply depressed client, only to find that you then felt very down, even though you were okay before the session?

Both examples constitute sound reasons to engage a consummately helpful yet infrequently discussed aspect of professional self-care: therapy for the therapist. Carl Jung suggested that "a good half of every treatment that probes at all deeply consists in the doctor's examining himself, for only what he can put right in himself can he hope to put right in the patient" (Plata, 2018).

Being the 'wounded healer' is controversial

This question of acknowledging the 'wounded healer' in ourselves is important, and does not come without controversy. There is first the question of whether therapists can even practice ethically if they do not do their own therapy, which is said to be "far more informative than any graduate class or textbook" (Latham, 2011). As therapists, of course we wish to be ethical, but there is the accompanying question of what it will cost us. Some writers have commented on the reality in our associated helping professions that, while there is an acknowledgement that we are human, it is also true that there is still a stigma associated with having psychological distress – especially as a mental health professional – and having 'vulnerability' is not necessarily seen as a strength.

Many counsellors fear professional repercussions if they acknowledge present or former psychological struggles (Plata, 2018). Certainly, it is the case for some professionals that they must state on their annual registration forms sent to the regulatory agency whether they have had any mental health issues. Some Australian doctors, for example, have expressed serious concern that they would be on the radar of the Australian Health Practitioner Regulation Agency by making such an admission, and choose to leave it out (personal communication to author, 2019).

Other health writers note that, while some clients are comforted to know that their therapist has had therapy, others are disconcerted by it (Latham, 2011). Yet therapy is important. Let us examine why you are strongly recommended to engage in your own therapy as part of your helping work.

To prevent burnout

Burnout and compassion fatigue are rife in the helping professions. A study of mental health professionals in Panama found that 36 percent of this cohort had suffered from burnout at one point or another in their careers (Plata, 2018). Personal support as found in counselling helps prevent the problem.

For greater empathy and understanding

We can be more empathetic with clients if we have had experience in 'the other chair', as we can anticipate unstated feelings more readily than therapists without that firsthand knowledge. For example, can you recall a time when you told a client you were going on holiday and they protested that they didn't know how they would make it without you for three whole weeks (or whatever length your holiday was)? If you have done therapy yourself, you personally know the sense of loss and disruption when your regular therapist is away.

Illustration: 123rf

Concepts such as transference are more easily understood experientially than from textbooks. Even for those therapists who are non-psychodynamic, being able to recognise transference and other 'real-time' emotional reactions (because they've had them themselves) gives therapists who have had therapy an advantage in terms of rapport, compliance and other aspects (Reidbord, 2011).

To process clients' thoughts and feelings

Hearing about heavy issues such as abuse, addiction, trauma and other mental health challenges can weigh on a therapist. We can preserve our own mental health better by processing through therapy our reactions to what we hear (Forte, 2018). In terms of the transference, we note that those practicing psychodynamic therapies use transference and countertransference as essential treatment tools; it takes self-knowledge – acquired by dint of hard work in our own sessions – to use these tools therapeutically, because without self-knowledge we cannot sort the client's issues from our own (Reidbord, 2011).

> Many counsellors fear professional repercussions if they acknowledge present or former psychological struggles (Plata, 2018).

To deal with our own issues

A recent Antioch University of Seattle study found that 81 per cent of psychologists studied had a diagnosable psychiatric disorder (although a large percentage of these were mild), including substance abuse, mood disorders, depression, anxiety, eating disorders and other personality dysfunctions (Plata, 2018). In doing therapy, we are forced to look at our own base instincts, neuroses and 'blind spots' – not always easy. The same study found that 43 per cent of psychologists struggled to see the mental illness and psychological distress within themselves (Latham, 2011). In therapy, we get to confront our issues, learn to accept feedback and strengthen our professional identity, thus reducing the risk that we will act out in ways that harm our clients (Reidbord, 2011).

To destigmatise therapy

When clients know that we, too, have had therapy, it normalises it. Apart from reducing the errors based on unexamined transference, our stint of therapy – acknowledged judiciously to clients – encourages humility and decreases hubris. It may very well strengthen the therapeutic alliance for the client to see that you, too, have human needs, challenges and issues.

In the final analysis, ours is a profession in which we use our own perceptions and reactions as sensitive instruments of therapeutic helping; thus it makes sense to take care of that equipment, by taking therapeutic care of ourselves. Besides, we are always there for others, listening with great attention and concentration to their woes. Isn't it a nice thought that there can be a professional listener out there for us as well?

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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.

Georgina Bedford

What inspired you to move into counselling as a profession?
I was working in a welfare child protection role when I was approached by a family therapist and encouraged to support a young woman and her child. From this experience I then wanted to help other people in a therapeutic way, so I started a counselling course that became an ongoing journey of work, more study and learning.

What is the greatest reward about being a counsellor?
Counselling is my 'must do in life' – and out of that I have the privilege to use the professional relationship of connection to help other people find ways to overcome or manage adversity. I think this helps them to discover their own, meaningful must do in life.

What is the biggest challenge of being a counsellor?
American psychologist Carl Rogers outlined personal growth alongside professional growth as a life task, and I think this is one of the first challenges for a counsellor. Honouring the growth and development of myself in life tasks is an ongoing endeavour – to be able to present 'self' as authentic and congruent.

Name the highlight of your ACA membership.
To be able to call myself a counsellor – as a registered professional. I remember I felt when I joined, as I do now, very proud to be part of a body that is bound in ethical standards and practices. This is something I hold up to myself and others. It is what I believe in and endeavour to fulfill.

How would you like to see the counselling profession change in the future?
I would like to see counselling continue to change, alongside the health profession generally, as it adapts to a changing society and environment. The profession is growing rapidly, as are the population and social issues. It is increasingly important we all present ourselves as a dedicated, united front in facing health politics.

How many clients do you see each week?
This depends on aspects of practice such as if I need to travel, the type of therapy I am offering and clients' particular needs. In private practice it is my choice, unlike when working in organisations that may have other specialist guidelines and include other duties. So the numbers can vary, though in these COVID-19 times my current caseload from employed and private work is around 20 clients, which is a manageable and ethical number for me with how and where I provide counselling.

What do you love most about running your own professional practice?
I can usually be more flexible and creative with how I offer my skills and resources, and I appreciate being available for a wide range of presentations. I love to create a beautiful space for people, beyond the more clinical environment usually found in organisations utilising buildings that serve multiple purposes.

Describe a valuable learning experience.
Years ago, I obeyed the rules of 'do not touch your clients'. I allowed a woman to die without holding her hand, without giving physical comfort, because I kept space – and I felt terrible. That experience taught me to value the care of people with human decency, to trust my own professional judgement and act accordingly.

What pearl of wisdom would you offer a student counsellor or colleague?
Ensure you have a good mentor and supervisor who will help you to maintain courage, ethical practices and confidence in your work. ■

Want to be published?

Submitting your articles to *Counselling Australia*

About *Counselling Australia*

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

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

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

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

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

Do you have a definition of counsellling to share? We'd like to hear it. Email the editor aca@theaca.net.au

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.

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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.
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- References are required to support both arguments and personal opinions and should be listed alphabetically.
- Case studies must be accompanied by a signed agreement by the client granting permission to publish.
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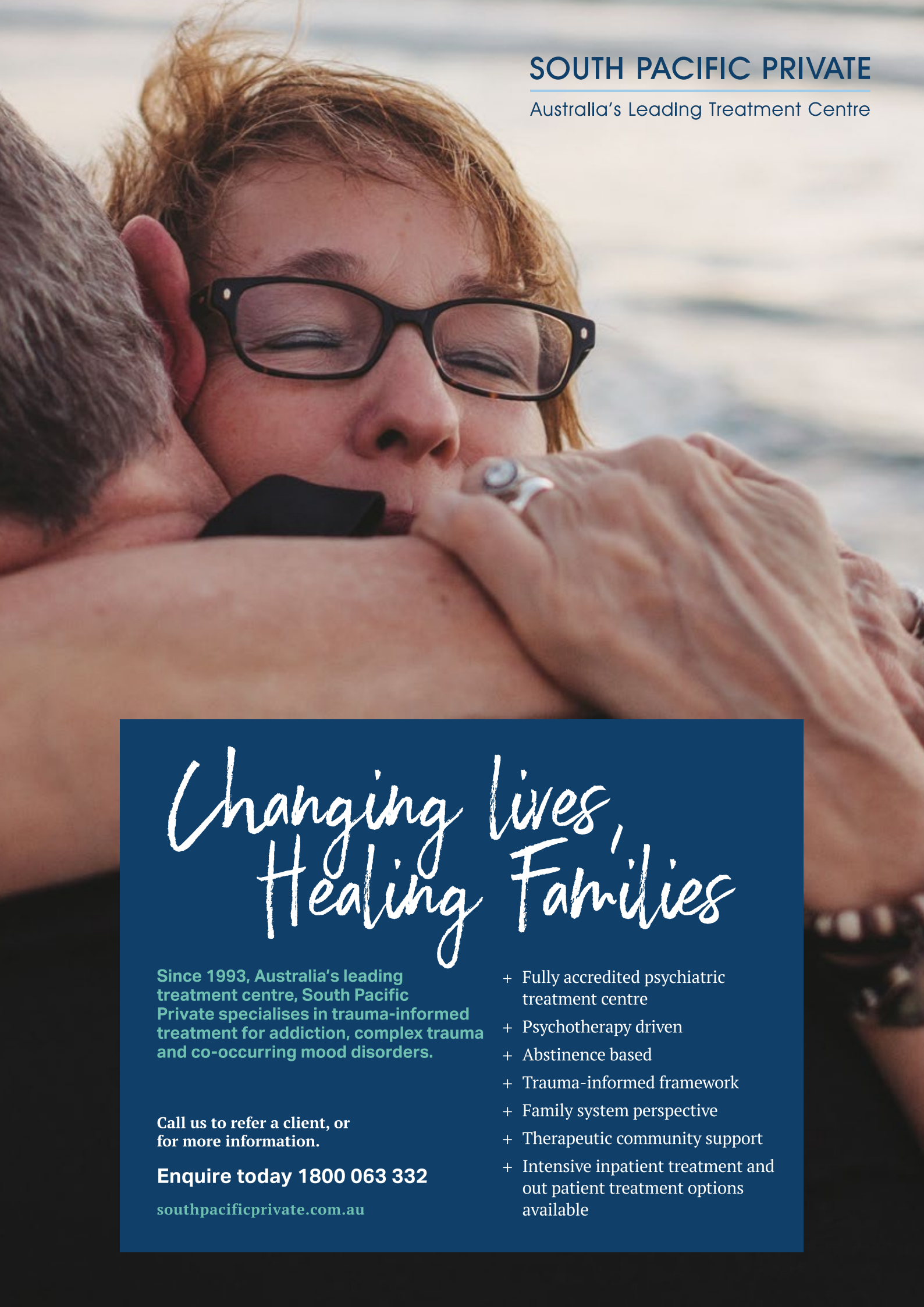
- Only original articles that have not been published elsewhere will be peer reviewed.
- *Counselling Australia* accepts no responsibility for the content of articles, manuscripts, photographs, artwork or illustrations for unsolicited articles.

Deadline

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



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