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Editorial

Volume 15, Issue 2 - 2021. Dr Ann Moir-Bussy

Welcome to this final issue for 2021. What a year it has been for so many. However, it is heartening to see the research and creativity that is brought to us in these articles, and I'm sure you will enjoy the variety and the wisdom that has been shared.

We begin with the first article by Alison Howarth who explores a systematic review of both evolving and emerging themes on vicarious trauma. As we know, vicarious trauma is not always easily recognised, and Alison has looked at the impacts of such trauma including personal protective factors, and personal risk factors, the contributing factors of professions and organizations and the exploration of post traumatic growth and vicarious resilience. This is timely research given the trauma suffered by so many as a result of COVID.

Carolyn Cousins, a clinical supervisor, has contributed to the journal before, and she again brings an extremely informative article on safety and potential dynamics in line managed supervision. Examining the dual roles of management and supervision, and how to create a reflective practice, is indeed challenging and Cousins offers useful ways of dealing with these dynamics.

Katarina Linder is a registered counsellor who now works in the Northern Territory as a Child and Family Counsellor in a remote Indigenous Community over 300 kilometres from Katherine. In her research she explores culturally appropriate clinical practice and what needs to be done to develop a counselling model of therapy which embeds Indigenous views and perspectives.
The next article comes from India and Savee Bhuvaneswari and Vasuki Mathivanan show us the significance of ancient Indian wisdom and its relationship to professional supervision. It is indeed enlightening to see how Sri Krishna, an avatar of God in human form, enable the warrior Arjuna "to see the absolute point of view, the fairness of war, the Duties of a warrior, the need for attached detachment, and the ultimate realization of the connection between mind and soul".

This reminds us of how important it is to be culturally aware in all our counselling and supervision and to be prepared to dig deep into the myths and stories of cultures with whom we work.

We then have another cultural exploration in a comparison of depression in Australian and Indian University students. Nigar Khawaja, Sibnath Deth and Janine Lurie from both Queensland University of technology and Pondicherry University in India examined the depressive experiences of Indian and Australian students, highlighting for us the differences in both their expression of depression and their coping mechanisms. From this study they draw the implications for allied health professional in both countries and the need for tailored support.

And the next article is from Peter Smith, the founder of the Institute for Quantum Consciousness based in Melbourne. Peter's article was first submitted to Nexus Magazine and it is with their and Peter's permission, we are able to reprint it here. Peter looks at Anxiety – a rapidly worsening epidemic and asks "Are we looking in the right places for the source, or are we only treating the symptoms? Given the increasing levels of anxiety in so many people with Covid and the lockdowns and all the issues that have arisen from this, the article is timely and very helpful. And thank you to Peter for sharing these insights with us.

Editors

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Our final manuscript is from Jarrod Clarke, a student at UNISA who explores the different reactions to grief, and what events and responses may make the grief complicated. Jarrod looks at traditional models of grief and contemporary models of grief and finally a multidimensional model. He offers some suggestions for clinicians.

So, as we come to the end of the year, the editors wish you a blessed and happy Christmas and New year. Thank you to all our contributors throughout the year and to all our readers too. Please don't be afraid to offer contributions. Research, practical case studies, reflective pieces on your counselling experiences, varying forms of therapy and so on. It is great to see in this issue, articles on hypnotherapy. We would love to see manuscripts on telehealth, creative arts therapies, drama therapy and many more cross-cultural contributions exploring the influence of your culture on your work.

Also, if any of you are interested in joining our Editorial Board, you would be most welcome, so please do get in touch with us.

Dr Ann Moir-Bussy
Editor

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A systematic literature review: exploring evolving and emerging themes in vicarious trauma research from 1990 to 2021

Alison Howarth

This study is a systematic literature review of research into vicarious trauma / vicarious traumatisation. The aim was to examine emerging and evolving key themes over time since 1990, when vicarious trauma was first named in a research title. All pieces of research and literature which included vicarious trauma or vicarious traumatisation were on the original inclusion list. Only the abstracts or descriptions of each piece were used in the analysis. The literature was explored using thematic analysis with a semantic lens.

The primary themes which emerged for exploration were vicarious trauma impacts; personal protective factors and personal risk factors; professions and contributing professional factors; organisational protective factors and organisational risk factors; exploration of post traumatic growth and vicarious resilience, and issues found in the body of research. Themes which remained relatively steady over time with little change were the impacts of vicarious trauma and contributing professional factors. Themes which evolved to become more nuanced over time were in personal risk factors and personal protective factors, and in post-traumatic growth and vicarious resilience factors. Perhaps the biggest evolution was the expansion of professional bodies being studied for their exposure to vicarious trauma risk, and an emerging dissatisfaction with the concept definitions and methods used in vicarious trauma research. Future areas for research are discussed.

Keywords: *Vicarious trauma; vicarious traumatisation; vicarious resilience; professional risk; inter-personal trauma.*

Introduction

This systematic literature review examined the existing literature and research about vicarious trauma and its impacts. The current body of work was initially explored from a broad perspective and then a narrower focus was used to analyse the themes which have emerged over the past 31 years. This gave a high-level view of the research to date and indicates potential avenues for further exploration.

Vicarious trauma has appeared in research since it was first named as such in 1990 by McCann and Pearlman in their article: “Vicarious traumatization: A framework for understanding the psychological effects of working with victims”. Since then, there have been relatively few studies in which vicarious trauma or vicarious traumatisation is named in the title. There have, however, in the same period, been thousands of research papers about burnout, and hundreds about secondary trauma and compassion fatigue (See Appendix 1). This literature review focusses upon vicarious trauma as a distinct and important impact of trauma work, hoping to move the discourse away from the slightly blaming overtones in the terminology of burnout and compassion fatigue.

Vicarious trauma is described as the impact upon a person from exposure to traumatic material.

The types of individuals who may be impacted by vicarious trauma include anyone who creates an empathic connection or bond with someone who is sharing the story of a traumatic event, or anyone who is repeatedly exposed to graphically disturbing or trauma content (Fohring, 2020). Individuals with higher empathy ratings have been shown to demonstrate a more greatly affected world view when impacted

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by vicarious trauma (Feldman & Kaal, 2007). Vicarious trauma can be seen within families where one member has experienced trauma (Boulanger, 2018) or after witnessing or hearing about the trauma event of a friend (Howard, 2021). Vicarious trauma is particularly prevalent in those professions which require an individual to be exposed to traumatic material repeatedly over time, particularly inter-personal trauma, such as trauma therapists and mental health professionals.

Vicarious trauma impact definitions

The definitions of vicarious trauma impacts have evolved over the past few decades, with the current agreed definition including an altered world view (Raunick et al, 2015), particularly an increasingly negative world view (Jordan, 2010) and a negative change in the perceptions of the safety of self and others (Holder, 2015), which creates further impacts on an individual's relationship with self, including self-esteem, intimacy, and relationships with others. It is important to note that vicarious trauma is separate and distinct from secondary traumatic stress or worker burnout, although they may have similar initial presentations (Canfield, 2005). Vicarious trauma refers to "pervasive and cumulative" changes in a person's view of the world, other people, and themselves because of repetitive exposure to traumatic material of any kind (Fohring, 2020).

Current Study

This study is a systematic literature review of research into vicarious trauma / vicarious traumatisation. The study has been formulated to look at emerging themes over the past thirty-one years and to explore potential future avenues for research. This systematic review looks at research literature on vicarious trauma from 1990, which is when vicarious trauma was named as such for the first time as opposed to the use of terms like "compassion fatigue" or "burnout".

The online library search engine of the Australian College of Applied Psychology was used to search a variety of online libraries for research literature regarding vicarious trauma. Thematic analysis was then applied to examine evolving themes over time, in five (5) year increments.

The potential audience for this review includes professionals exposed to trauma and organisations who have a duty of care to their workers exposed to traumatic material. This study hopes to add a cohesive assessment of the evolution of current research regarding vicarious trauma to help inform workplace policy and processes as per current best practice, and to explore where future research may be directed.

Method

Eligibility criteria

For inclusion in this systematic literature review, the literature fulfilled the following criteria:

- Vicarious trauma or vicarious traumatisation is included in the TITLE.

This criterion was established to ensure that the *idea* of vicarious trauma was considered important enough by the researchers that it be included in the title for ease of search by others. This narrower search thus hopefully focusses on research which considers vicarious trauma itself to be an important area of study. By highlighting the term in the title, rather than the phrase "Vicarious trauma/vicarious traumatisation" appearing in the description or subject, the search was narrowed to a reasonable volume. (See Table 1 and Table 2 for search results.)

Due the broad nature of this review only abstracts or descriptions were studied.

Search strategy

The online search engine of the Australian College of Applied Psychology was utilised for this search. The online libraries that returned items on search include:

- SAGE Journals
- ProQuest Psychology
- EBSCOhost
- Taylor & Francis
- APA PsycARTICLES
- SpringerLink Journals
- PubMed Central Open Access
- Directory of Open Access Journals
- Ebook Central

Further assessment for exclusion

All items returned on search, including books, journal articles, magazine articles (in professional publications, for example: Officer.com – an online Police force publication) were initially included.

There were very few exclusion criteria for this search, as it is a deliberately broad overview of research trends and theme evolutions.

Upon assessment of the returned research items, they were excluded from the review if:

- There was no abstract or description.
- If it was a duplicate.
- Vicarious Trauma as a *concept* was not included in the title. For example: Vicarious Resilience: A New Concept in Work With Those Who Survive Trauma. (Hernandez, Gangsei & Engstrom, 2007) was not included.

Search Results

As shown in Tables 1 and 2, the initial literature search yielded 132 (Title includes vicarious trauma) and 100 (Title includes vicarious traumatisation) papers from the online library search engine at ACAP. These results were segmented into five (5)-year blocks for ease of screening and examining trends over time. After any duplicates were removed, and items which did not include an abstract or description were removed, there were 188 eligible research items to be potentially included in the review. Where the return in a 5-year segment (excluding repeats or items without an abstract or description) was greater than 25 items, a 33% sample was chosen to ensure the scope of the project was within capacities. (This sampling was performed in a purposive manner which aimed at including a wide variety of professions and perspectives.) In total, the final number of research items to be thematically analysed stands at 130.

Table 1. Search returns for *TITLE contains vicarious trauma.*

Title contains: Vicarious trauma			
Year range segment	Search returns	Search returns (excluding repeats and items without an abstract or description)	Included in analysis
1990–1995	0	0	0
1996–2000	0	0	0
2001–2005	13	10	10
2006–2010	20	12	12
2011–2015	31	26	9*
2016–2020	62	59	18*
2021–2021	6	5	5
Total	132	112	54

**For the 5-year segments where the search returns (excluding repeats and items without an abstract or description) was greater than 25 items, 33% was purposively sampled from the total for inclusion in the thematic analysis. The purposive sampling aimed at including a wide variety of professions and perspectives.*

The research items included in the analysis (where the title contains "vicarious trauma") are summarised in Appendix 2.

Table 2. Search returns for *TITLE contains vicarious traumatisation/traumatization.*

Title contains: Vicarious trauma			
Year range segment	Search returns	Search returns (excluding repeats and items without an abstract or description)	Included in analysis
1990–1995	6	4	4
1996–2000	10	4	4
2001–2005	17	14	14
2006–2010	18	15	15
2011–2015	16	13	13
2016–2020	28	22	22
2021–2021	5	4	4
Total	100	76	76

The research items included in the analysis (where the title contains "vicarious traumatisation/traumatization") are summarised in Appendix 3.

Data analysis

As this research is studying emerging themes over time, all the included article descriptions/abstracts were grouped in five (5) year periods from 1990. Within each of these time periods the article description/abstracts were examined using thematic analysis (TA), where the selected text was colour coded for key ideas and word groupings to be used as building blocks for broader themes and patterns of meaning (Clarke & Braun, 2017). When coding for key ideas a semantic lens (word meaning) was used as opposed to an interpretive lens (Boyatsis, 1998). This helped ensure the inductive nature (letting themes develop via empirical observation) of the analysis rather than deductive (testing an existing theory).

The data was extracted manually and laid out in Word documents for manual processing. Software was considered for this process (MAXQDA), but ultimately not used.

In the manual analysis, a visual scan of the data sets was conducted to get a high-level view of the potential themes. These were separated out into:

- Vicarious trauma itself – definitions, impacts, potential risk factors, potential protective factors.
- Profession – type, professional factors (associated with vicarious trauma), organisational factors, the personal factors of an individual professional which may influence vicarious trauma, professional settings
- Situational factors such as natural disasters.
- Research development – trauma informed language, vicarious resilience and post-traumatic growth (as opposed to post traumatic stress disorder) and issues found in the research.

These themes were then colour coded by word or blocks of words to relate to a particular theme and to narrow the themes down to emerging primary themes. The first stage of this coding is described by Strauss and Corbin (1998) as open coding where the individual lines of text are examined to identify key concepts and ideas. The second phase of this process is axial coding where the broad concepts and ideas are refined by closer scrutiny, which did result in a slight shift in the themes to be analysed as discussed in the Results section.

Results

The overarching aim of this systematic literature review is to examine the predominant emerging themes in vicarious trauma research over the past 31 years (1990–2021). To this end, thematic analysis was employed to examine the abstracts of 130 pieces of literature using a semantic lens.

Theme Overview

On reviewing the abstracts and descriptions as laid out in 5-year segments, overarching primary themes started to emerge in the literature. The axial coding had some departures from the initial high-level scan. The primary themes (and sub-themes) that emerged after this refinement are:

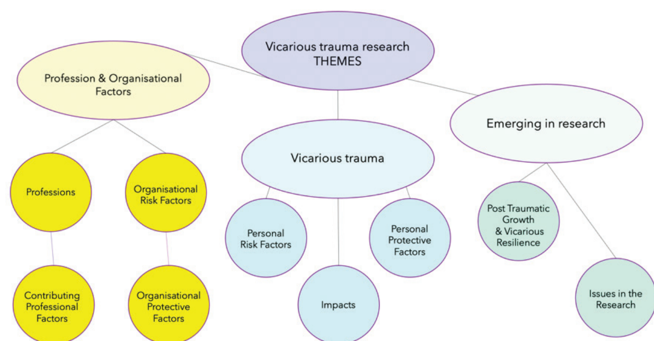
- Vicarious trauma:
    - o Vicarious trauma impacts,
    - o Personal risk factors influencing vicarious trauma impacts,
    - o Personal protective factors influencing vicarious trauma impacts.
- Profession and organisational factors:
    - o Professions exposed to vicarious trauma risk,
    - o Contributing professional factors (such as client groups),
    - o Organisation risk factors influencing vicarious trauma impacts,
    - o Organisation protective factors influencing vicarious trauma impacts.
- What has been recently emerging in the research:

- o Exploration of post traumatic growth and vicarious resilience,
- o Issues in the research.

Tangential themes and ideas (not explored closely in this paper):

- o Situational factors contributing towards vicarious trauma impacts (such as natural disasters, terrorist attacks and pandemic),
- o The growth of trauma-informed language.

Figure 1. Primary themes that emerged in the thematic analysis.



Themes emerging in each 5-year time period.

1990–1995 (4 search returns)

1990 was the first time the term vicarious trauma/ vicarious traumatisation was used in the title of a piece of literature (McCann & Pearlman, 1990).

The **impacts of vicarious trauma** were described as a negative effect related to the exposure to graphic material combined with the "therapist's own schemas, expectations and assumptions" (McCann & Pearlman, 1990). The negative effect was further elaborated as: "imagery associated with the patient's story and the same disruptions in relationships as the patient. … lack of attention, poor work performance, medication errors, sick calls, treatment errors, irreverence, hypervigilance, and somatic complaints" (Crothers, 1995) and impacts to other-esteem.

The **personal risk factor** explored was a personal trauma history which exacerbates the negative effects of the work. **Personal protective factors** were not explored in this period.

The **professions** covered by the research were therapists, trauma therapists and psychotherapists. The **contributing professional factors** described were client groups of survivors of childhood trauma and other victims, and "the empathic engagement with trauma survivors" (Neumann & Gamble, 1995).

Organisational risk factors explored were a lack of training in trauma therapy, supervision support and team support. Inversely, **organisational protective factors** were seen as adequate levels of training, supervision support and team support.

Post traumatic growth was not discussed in this period.

No **issues in research** were discussed in this period.

1996–2000 (4 search returns)

Vicarious trauma impacts were described as "the deleterious effects of trauma therapy on the therapist" (Pearlman & Mac Ian, 1990). Vicarious trauma was described as causing a disruption in the cognitive schemas of therapists, while counsellors working with trauma "experience greater emotional exhaustion and use more escape/avoidance coping strategies" (Johnson & Hunter, 1997). Further VT impacts on professionals were described as: "development of anxiety, depression, intrusive thoughts, alienation, dissociative episodes, feeling of helplessness, paranoia, hypervigilance, and disrupted personal relationships. (Blair & Ramones, 1996).

Personal risk or protective factors were not explored in this period.

The **professions** covered by the research were psychotherapists, counsellors, and therapists.

The **contributing professional factors** described were trauma survivor client groups, sexual abuse material, empathic engagement and victims of trauma and abuse.

No **organisational risk factors** or **organisational protective factors** were explored.

Post traumatic growth was not discussed in this period.

No **issues in research** were discussed in this period.

2001–2005 (24 search returns)

Vicarious trauma impacts were described as debilitating anxiety, distress, depressive symptoms, disruptions in self-intimacy and "profound changes in the way they experience self, others, and the world" (Crabtree, 2002). The posited cause of the **impact** was described as the process whereby "therapists go through an internal process as they try both to make sense out of the stories they hear from clients, and to integrate those stories into their own existing cognitive schemas" (Canfield, 2005).

Personal risk factors explored include gender, personal trauma history, therapist beliefs and psychosocial functioning. **Personal protective factors** described were education and knowledge about trauma, reflections on personal attitudes and reactions. "Self-care is described to ameliorate the emotional and cognitive effects of Vicarious Trauma." (Clemans, 2005).

The **professions** covered by the research were therapists, psychotherapists, counsellors, sexual assault and domestic violence counsellors, social workers, law enforcement, healthcare professionals, emergency service personnel, genocide instructors and researchers, grief counsellors, mental health workers, social work students and researchers.

The **contributing professional factors** described were client groups of victims of trauma such as sexual assault, domestic violence or child abuse, juvenile sex offenders, sex offenders and survivors of sexual victimization; as well as traumatic material in the context of academe (not in the frontline client context).

Organisational risk factors were described as violence in the workplace, career longevity and number of offenders in a case load. **Organisational protective factors** were described as clinical supervision, peer supervision and "participants who reported having a venue to address the personal impact of their work were found to be more likely to score lower on the measure of vicarious trauma than those who did not." (Kadambi and Truscott, 2003)

This is the first period in which **post-traumatic growth** was mentioned. It was described as "increased appreciation for the resilience and strength of survivors; a greater appreciation for one's life; a stronger Jewish identity; and a greater sense of justice." (Goldenberg, 2002).

This was also the first period in which **issues in the**

research were mentioned. Issues include a lack of baseline data, disparate results, meagre and inconsistent evidence, and includes a statement that “Vulnerable trauma therapists may too eagerly embrace the event countertransference and vicarious traumatization perspectives as a cover up for their own failures.” (Hafkenscheid, 2005).

2006–2010 (27 search returns)

Vicarious trauma impacts were described as disrupted cognitions about self-esteem and intimacy, post-traumatic stress, “disruption in cognitions about intimacy with others” (VanDeusen & Way, 2006), fatigue, emotional exhaustion, sleeplessness, decreased morale and increasingly cynical and negative feelings toward others.

Personal risk factors explored include gender, personal trauma history, childhood maltreatment and a non-productive coping style. **Personal protective factors** described were social support, resiliency, self-care, and leisure.

The **professions** covered by the research were therapists, mental health professionals, clinicians, teachers, therapist trainees, military therapists, psychiatrists, child welfare professionals, solicitors, counsellors, nurses who provide palliative and haematological cancer care, sexual violence counsellors, telephone counsellors, sexual abuse therapists, and psychotherapists.

The **contributing professional factors** described were client groups who are victims of family violence, combat veterans, adult survivors of sexual violence and child sexual abuse. Other areas of professional factors were nursing specialisations such as cancer, oncology, and AIDS nursing.

Organisational risk factors were described as work-related stressors, for example: “severity of combat trauma assigned/seen by the therapist” (Jordan 2010), and other professional trauma. **Organisational protective factors** were described as trauma sensitive supervision and therapist preparation with training in such coping strategies as “realistic goal setting and reframing” (Lucas, 2007), and theoretical frameworks deriving from “social justice principles, feminist, narrative theories and the ‘New Trauma Therapy’” (Pack, 2009).

Post-traumatic growth was described as the positive aspect of witnessing “human resilience and post-traumatic growth, personal growth, collegial support, increased sensitivity, compassion, insight, tolerance, spirituality and a sense of importance in providing a counselling service” (Todd, 2007).

Several **issues in the research** were discussed in this period including methodological limitations in terms of definitions and the literature, confusion about key terms and a “lack of conceptual clarity” (Boscarino et al, 2010), different scales using different concepts and researchers’ ability to clearly define vicarious trauma as a concept. A statement was also made that the research issues call into question “the existence of secondary trauma-related phenomena and enterprises aimed at treating the consultants.” (Devilly et al 2009).

2011–2015 (39 search returns; 22 search returns used)

Vicarious trauma impacts were described as negative effects in quality of life, sexual desire, levels of distress, personal, academic, and professional functioning, and staff turnover.

Personal risk factors explored include gender, personal trauma history, dysfunctional beliefs, and a negative coping style. **Personal protective factors** described were personal wellness, compassion satisfaction and the development of resilience; vicarious trauma itself was described as determined by individual variables.

The **professions** covered by the research were trauma workers, social workers, trauma therapists, sports coaches, medical staff, behavioural health clinicians, hospital personnel such as physicians, nurses and paramedics, volunteers, mental health professionals, medical students, psychiatric nurses, child welfare professionals, sexual abuse counsellors, telephone and online counsellors, law enforcement.

The **contributing professional factors** described were trauma work, cancer patients, torture survivors, traumatized individuals, survivors of intimate-partner violence, abused children and their families, experiences of violence while on student placement, exposure to patients’ violence, working in emergency situations, witnessing human cruelty, and witnessing a serious athletic injury.

Organisational risk factors were described as a heavy counsellor trauma case load, lack of clinical supervision, debriefing and training, as well as a lack of specific support to be able to recognise vicarious trauma. **Organisational protective factors** were described as a supervisory working alliance, management support; and embracing “effective recognition, non-stigmatised acceptance, and management of vicarious traumatisation” (Howlett & Collins, 2014).

Post-traumatic growth was implied as part of a non-binary view of trauma work in that therapists are changed in both positive and negative ways; and that to experience vicarious resilience therapists must be exposed to the resilience of clients.

No **issues in research** were discussed in this period.

2016–2020 (81 search returns; 40 search returns used)

Vicarious trauma impacts were described as serious individual consequences such as PTSD, suicide ideation, substance abuse, impacts to affective and cognitive aspects, an altered world view and feelings of powerlessness. Impacts to organisations were described as reduced job satisfaction and efficiency, burnout and higher staff turnover, and a poor workplace environment.

Personal risk factors explored include relatively young age, low emotional stability, personal trauma history, low level of wellness, “insecure attachment styles” (Merhav et al, 2018) and poor empathy skills. **Personal protective factors** described were high levels of personal wellness and emotional stability, being in therapy, strong empathy skills and a clear “differentiation of self” (Halevi & Idisis, 2018).

The **professions** covered by the research were first responder agencies (e.g., police, fire, ambulance), dental care practitioners, refugee trauma counsellors, lawyers, mental health professionals, psychiatrists, academe: professors and scholars teaching, researching and writing violence, child welfare workers, early childhood educators, child welfare attorneys, early childhood professionals, victim advocates, alcohol and other drug clinicians, emergency medical services (EMS) personnel, nurses, medical staff, interpreters, probation officers, trainee clinical psychologists and environmental researchers.

The **contributing professional factors** described were client groups such as survivors of interpersonal trauma such as child sexual abuse, sexual assault and domestic violence, suicide grief, traumatised asylum seekers, as well as client pain and discomfort, and exposure to traumatic material (including

environmental depredations).

Organisational risk factors were described as high weekly work hours, insufficient experience, poor quality in trauma training and a trauma-exposed client group. **Organisational protective factors** were described as a reflective practice, trauma-specific training and access to personal and professional support, in particular relational-oriented supervision, or supervision where therapists could process the stress caused by traumatic disclosures or a "supervision process to manage vicarious trauma and encourage vicarious post-traumatic growth" (Long, 2020).

Post-traumatic growth was proposed as a co-occurrence, or related phenomenon, to vicarious trauma, and vicarious trauma is seen as "essential in helping both clinicians and patients process the traumatic material" (Boulanger, 2018).

Several **issues in research** were discussed in this period including a failure to take socio-political factors into account, a confusion in terminology, and "conceptual, methodological, and analytical gaps in the empathy-based stress literature" (Rauvola et al., 2019). Lack of evidence is cited for an inability to support "belief changes in vicarious traumatization or a relationship between exposure to trauma work and general psychological distress" (Makadia et al., 2017).

2021 (9 search returns)

Vicarious trauma impacts were described as feelings of isolation and distress, impacts in both professional and personal lives, and the level of vicarious traumatisation experienced was higher in non-front-line staff than in front-line (Norhayati et al., 2021).

The **personal risk factor** explored was where the experience of the client was familiar to the worker. Personal protective factors described were self-care strategies and reflexivity.

The **professions** covered by the research were criminal lawyers, jurors, researchers, psychotherapists, forensic interviewers, healthcare provider, frontline healthcare workers.

The **contributing professional factors** described were stories of trauma and interpersonal trauma, stories of domestic violence, gruesome details, emotional evidence, and working with trauma survivors.

No **organisational risk or protective factors** have yet been described in this period.

Post-traumatic growth was not discussed in this period.

Issues in the research were not discussed in this period.

In conclusion, there were several interesting evolutions of theme over the years, and some overarching themes that emerged as potentially important, particularly around the research issues concerning confusion in terminology and general lack of clarity in definitions.

Discussion

The aims of this research were to examine the emerging trends in vicarious trauma research and any evolution within those themes, to understand implications for individuals and organisations regarding vicarious trauma, and to explore areas for possible future research. The data examined a range of themes which were collated into primary themes. This discussion is organised around these key themes.

Data Summary

In the area of **vicarious trauma impacts** the research shows a relatively steady set of definitions over the thirty years. The impacts are broadly defined as negative impacts on an individual's personal schemas and cognitions as they relate to self, others, and the world. These changes can then lead to displays of emotional dysregulation or development of mental wellbeing issues such as anxiety and depression. One theme that did evolve in vicarious trauma impact more recently (2016–2020) is that of the examination of the impacts on organisational health, such as high staff turnover, a reduction in efficiencies and a poor work environment.

In terms of the **personal risk and protective factors** that each individual brings to their role, the research evolved to become more nuanced and understanding of the intersectional nature of vicarious trauma at an individual level. The data evolved from broad strokes of "therapist's own schemas, expectations and assumptions" (McCann & Pearlman, 1990) to a more descriptive and nuanced view of personal attachment styles, productive and non-productive coping styles, personal resilience, and differentiation of self.

The data suggest an expansion in the **professions** being recognised as exposed to vicarious trauma risk; moving from a focus primarily on those professions in mental health support and expanding to include all professions which may be exposed to traumatic material in the course of their duties.

The data on **contributing professional factors** remain steady throughout the thirty years and describe an overarching theme of the exposure to traumatic material in its many and varied contexts as being a part of the professional's workday experience. The focus of this has been largely in the field of interpersonal trauma.

The results for **organisational protective and risk factors** are quite binary in that a lack of attention or investment in a domain will be a risk to staff, while attention or investment paid to that same domain will be a protection for them. For example: training in trauma, reasonable case load levels, clinical supervision and healthy peer support channels, and a general focus by the organisation on staff engagement in vicarious trauma awareness and bringing staff along a journey of affective connection with the organisation and its aims (and related job satisfaction). The evolution of theme in this area is related to the growing specificity and evolution of knowledge of inter-personal trauma therapy in general. For example, the data moves from recommending supervision in general, to recommending specific forms of supervision, such as reflective or relational-oriented supervision. There are also specific frameworks that are being recommended for use by therapists dealing with interpersonal trauma such as theoretical frameworks deriving from "social justice principles, feminist, narrative theories and the 'New Trauma Therapy'" (Pack, 2009).

The data for **post traumatic growth and vicarious resilience** emerged in the period 2001–2005; and as with personal risk and protective factors began with broad brushstrokes and became more nuanced and individualised over time. A key evolving theme of post-traumatic growth and vicarious resilience is that of its natural co-occurrence with the incidence of vicarious trauma, in that individuals will be both negatively and positively impacted by the trauma of others in the processing of trauma in

the context of the therapeutic alliance.

The data describe **issues in the research**, particularly centring around a lack of conceptual clarity regarding vicarious trauma itself, and a general lack of consistency and clarity in terminology. Some studies cite a paucity of data; other studies cite disparate and inconsistent results. In addition, one study states that therapists use the notion of vicarious trauma ideas to cover their own failings (Hafkenscheid, 2005), and another study states that the research issues call into question "the existence of secondary trauma-related phenomena" and the subsequent businesses created with the aim of treating the consultants. (Devilly et al 2009).

Implications

The evolutions of the research data explored in this review reflect evolutions in the field of interpersonal trauma treatment itself, in terms of understanding the impacts of trauma, the methodologies, and frameworks of treatment for trauma and the understanding of the role of the professional.

The expansion of research to explore vicarious trauma impact and risk in a broadening range of professionals demonstrates the importance of the recognition of vicarious trauma and an increasing cohort of professionals who should be protected from this risk. In the initial years of vicarious trauma research, the focus was on the professions who dealt directly in the emotional and mental health support of people impacted by trauma. During the past few decades of research, the types of professions examined have evolved from being primarily focused upon the professions of trauma therapy and support, to include professions like trauma researchers (Eades et al 2021; Fohring, 2020), legal and judicial professionals (Vrklevski & Franklin, 2008), and first responders such as police and other emergency responders (Brown et al, 1999).

A primary implication arising from this review is that, over time, researchers have recognised the importance of moving away from generalisations and towards individualised viewpoints of trauma in general and vicarious trauma. This was borne out by the move away from broad brush strokes of meaning in both personal risk and protective factors, and in post-traumatic growth and vicarious resilience factors. As part of the evolution of the research literature, there is also a general move towards examining the phenomenon of vicarious post-traumatic growth, vicarious resilience, and personal and professional growth through trauma work (Michalchuk & Martin, 2019).

The impacts of vicarious trauma, and the professional factors that contribute to vicarious trauma did not display many changes over time and seem to be relatively stable.

The biggest implication arising from the data is in the issues uncovered in research. It is posited that much of the research is flawed and lacking in conceptual clarity. It may be a rewarding avenue of future research to clearly define vicarious trauma in terms of nomenclature and concept, and to clearly outline and demonstrate a consistent and repeatable methodology of measurement and analysis.

The limitations of this current study are in the breadth and shallowness of the examination. In an examination of abstracts there is little contextual or granular information available. However, this type of broad data search does give a high-level scan across the decades of data that might not otherwise be apparent or available and provides signposts for future research.

Bio

Alison Howarth has worked as frontline counsellor, manager and service designer for trauma support services for over 25 years. During that time, she developed programmes to manage vicarious trauma for staff and organisations, which were adopted by government, not for profit and corporate organisations. Alison now leads a team to create evidence based, trauma informed training, protocols and processes to help organisations whose staff are at risk from unmanaged vicarious trauma.

Alison has just completed her Masters in Counselling and Psychotherapy through ACAP.

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References

Blair, D. T., & Ramones, V. A. (1996). Understanding vicarious traumatization. *Journal of Psychosocial Nursing and Mental Health Services,* 34(11), 24–.

Boscarino, J., Adams, R., & Figley, C. (2010). Secondary trauma issues for psychiatrists: identifying vicarious trauma and job burnout. *The Psychiatric Times*, 27(11), 24–26.

Boulanger, G. (2018). When is vicarious trauma a necessary therapeutic tool? *Psychoanalytic Psychology,* 35(1), 60–69. https://doi.org/10.1037/pap0000089

Boyatzis, R. (1998) *Transforming qualitative information: Thematic analysis and code development.* California, USA: Sage; 1998.

Brown, J., Fielding, J., & Grover, J. (1999). Distinguishing traumatic, vicarious and routine operational stressor exposure and attendant adverse consequences in a sample of police officers. *Work and Stress,* 13(4), 312–325. https://doi.org/10.1080/02678379950019770

Canfield, J. (2005). Secondary traumatization, burnout, and vicarious traumatization: a review of the literature as it relates to therapists who treat trauma. *Smith College Studies in Social Work,* 75(2), 81–101. https://doi.org/10.1300/J497v75n02_06

Clarke, V. & Braun, V. (2017) Thematic analysis, *The Journal of Positive Psychology,* 12(3), 297–298, DOI: 10.1080/17439760.2016.1262613

Clemans, S. E. (2005). Recognizing vicarious traumatization: a single session group model for trauma workers. *Social Work with Groups* (New York. 1978), 27(2, 3), 55–74. https://doi.org/10.1300/J009v27n02_05

Crabtree, D. A. (2002). *Vicarious traumatization in therapists who work with juvenile sex offenders.* ProQuest Dissertations Publishing.

Crothers, D. (1995). Vicarious traumatization in the work with survivors of childhood trauma. *Journal of Psychosocial Nursing and Mental Health Services,* 33(4), 9–13.

Devilly, G., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian and New Zealand Journal of Psychiatry,* 43(4), 373–385. https://doi.org/10.1080/00048670902721079

Eades, A.-M., Hackett-Williams, M., Raven, M., Liu, H., & Cass,

A. (2021). The impact of vicarious trauma on Aboriginal and/or Torres Strait Islander health researchers. *Public Health Research & Practice,* 31(1). https://doi.org/10.17061/phrp30012000

Feldman, D., & Kaal, K. (2007). Vicarious trauma and assumptive worldview: beliefs about the world in acquaintances of trauma victims. *Traumatology* (Tallahassee, Fla.), 13(3), 21–31. https://doi.org/10.1177/1534765607305437

Fohring, S. (2020). The risks and rewards of researching victims of crime. *Methodological Innovations,* 13(2), https://doi.org/10.1177/2059799120926339

Goldenberg, J. (2002). The Impact on the interviewer of holocaust survivor narratives: vicarious traumatization or transformation? *Traumatology* (Tallahassee, Fla.), 8(4), 215–231. https://doi.org/10.1177/153476560200800405

Hafkenscheid, A. (2005). Event countertransference and vicarious traumatization: theoretically valid and clinically useful concepts? *European Journal of Psychotherapy & Counselling,* 7(3), 159–168. https://doi.org/10.1080/13642530500183804

Halevi, E., & Idisis, Y. (2018). Who helps the helper? Differentiation of self as an indicator for resisting vicarious traumatization. *Psychological Trauma,* 10(6), 698–705. https://doi.org/10.1037/tra0000318

Hernández, P., Gangsei, D., & Engstrom, D. (2007). Vicarious Resilience: A New Concept in Work With Those Who Survive Trauma. Family Process, 46(2), 229–241. https://doi.org/10.1111/j.1545-5300.2007.00206.x

Holder, M. (2015) *Exploring the potential relationship between historical trauma and intimate partner violence among Indigenous women*. Ann Arbor, MI: University of Kansas; 2015

Howard, S. (2021) A causal model of children's vicarious traumatization. *Journal of Child & Adolescent Trauma.* https://doi.org/10.1007/s40653-020-00331-z

Howlett, S. L., & Collins, A. (2014). Vicarious traumatisation: risk and resilience among crisis support volunteers in a community organisation. *South African Journal of Psychology,* 44(2), 180–190. https://doi.org/10.1177/0081246314524387

Johnson, C. N. E., & Hunter, M. (1997). Vicarious traumatization in counsellors working in the New South Wales Sexual Assault Service: An exploratory study. *Work and Stress,* 11(4), 319–328. https://doi.org/10.1080/02678379708252995

Jordan, K. (2010) Vicarious trauma: proposed factors that impact clinicians. *Journal of Family Psychotherapy;* 21(4) 225-237. DOI: 10.1080/08975353.2010.529003

Kadambi, M. A., & Truscott, D. (2003). Vicarious traumatization and burnout among therapists working with sex offenders. *Traumatology* (Tallahassee, Fla.), 9(4), 216–230. https://doi.org/10.1177/153476560300900404

Long, S. (2020). Supervisors' perception of vicarious trauma and growth in Australian refugee trauma counsellors. *Australian Social Work,* 73(1), 105–117. https://doi.org/10.1080/0312407X.2018.1501587

Lucas, L. (2007). The pain of attachment – "you have to put a little wedge in there": how vicarious trauma affects child/teacher attachment. *Childhood Education,* 84(2), 85–91. https://doi.org/10.1080/00094056.2008.10522979

Makadia, R., Sabin-Farrell, R., & Turpin, G. (2017). Indirect exposure to client trauma and the impact on trainee clinical psychologists: Secondary traumatic stress or vicarious traumatization? *Clinical Psychology and Psychotherapy,* 24(5), 1059–1068. https://doi.org/10.1002/cpp.2068

McCann, I. L., & Pearlman, L. A. (1990). Vicarious trauma: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3,* 131–149. https://doi.org/10.1007/BF00975140

Merhav, I., Lawental, M., & Peled-Avram, M. (2018). Vicarious traumatisation: working with clients of probation services. *The British Journal of Social Work,* 48(8), 2215–2234. https://doi.org/10.1093/bjsw/bcx162

Michalchuk, S., & Martin, S. (2019). Vicarious resilience and growth in psychologists who work with trauma survivors: an interpretive phenomenological analysis. *Professional Psychology, Research and Practice,* 50(3), 145–154. https://doi.org/10.1037/pro0000212

Neumann, D., & Gamble, S. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy* (Chicago, Ill.), 32(2), 341–347. https://doi.org/10.1037/0033-3204.32.2.341

Norhayati, M. N., Che Yusof, R., & Azman, M. Y. (2021). Vicarious traumatization in healthcare providers in response to COVID-19 pandemic in Kelantan, Malaysia. *PloS One,* 16(6), e0252603–e0252603. https://doi.org/10.1371/journal.pone.0252603

Pack, M. (2009). Revisions to the therapeutic relationship: a qualitative inquiry into sexual abuse therapists' theories for practice as a mitigating factor in vicarious traumatisation. *Aotearoa New Zealand Social Work,* 21(4), 73–82. https://doi.org/10.11157/anzswj-vol21iss4id263

Pearlman, L., & Mac Ian, P. (1995). Vicarious traumatization: an empirical study of the effects of trauma work on trauma therapists. *Professional Psychology, Research and Practice,* 26(6), 558–565. https://doi.org/10.1037/0735-7028.26.6.558

Raunick, C., Lindell, D., Morris, D., & Backan, T.. (2015) Vicarious trauma among sexual assault nurse examiners. *Journal of Forensic Nursing.* 11(3):123–8.

Rauvola, R. S., Vega, D. M., & Lavigne, K. N. (2019). Compassion fatigue, secondary traumatic stress, and vicarious traumatization: a qualitative review and research agenda. *Occupational Health Science,* 3(3), 297–336. https://doi.org/10.1007/s41542-019-00045-1

Strauss, A., & Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (2nd ed.). Thousand Oaks, CA: Sage.

Todd, B. (2007). Assisting the traumatised: vicarious traumatisation and the preservation of meaning. *Psychotherapy in Australia,* 13(3), 44–49.

Van Deusen, K., & Way, I. (2006). Vicarious trauma: an exploratory study of the impact of providing sexual abuse treatment on clinicians' trust and intimacy. *Journal of Child Sexual Abuse,* 15(1), 69–85. https://doi.org/10.1300/J070v15n01_04

Vrklevski, L., & Franklin, J. (2008). Vicarious trauma: the impact on solicitors of exposure to traumatic material. *Traumatology* (Tallahassee, Fla.), 14(1), 106–118. https://doi.org/10.1177/1534765607309961

Appendix 1. A comparison of search returns (including repeats) where the TITLE contains "vicarious trauma/traumatisation", "compassion fatigue", "burnout" and "secondary trauma" (excluding physical trauma).

Year Range	Vicarious trauma/ traumatisation	Compassion Fatigue	Burnout	Secondary Trauma
1950–1995	6 (first appearing in search in 1990)	7 (first appearing in search in 1988)	415	12 (first appearing in search in 1986)
1996–2000	10	18	392	27
2001–2005	30	24	822	53
2006–2010	38	77	1,409	96
2011–2015	47	115	2,589	203
2016–2020	90	238	5,118	281
2021–2021	11	30	639	33
Total	132	112		54

Appendix 2. A summary of research items (where the title contains "vicarious trauma") included in the analysis.

Year range segment	Author/s	Title	Year
1990–1995	NIL returns		
1996–2000	NIL returns		
2001–2005	Adams, K., Matto, H., & Harrington, D.	The Traumatic Stress Institute Belief Scale as a Measure of Vicarious Trauma in a National Sample of Clinical Social Workers.	2001
2001–2005	Jenkins, S., & Baird, S.	Secondary traumatic stress and vicarious trauma: A validational study.	2002
2001–2005	Bell, H., Kulkarni, S., & Dalton, L.	Organizational Prevention of Vicarious Trauma.	2003
2001–2005	Trippany, R., Kress, V., & Wilcoxon, S.	Preventing Vicarious Trauma: What Counselors Should Know When Working With Trauma Survivors.	2004
2001–2005	Kadambi, M., & Ennis, L.	Reconsidering Vicarious Trauma: A Review of the Literature and Its' Limitations.	2004
2001–2005	Bischoping, K.	Timor mortis conturbat me: genocide pedagogy and vicarious trauma.	2004
2001–2005	Kadambi, M., & Truscott, D.	Vicarious Trauma among Therapists Working with Sexual Violence, Cancer and General Practice.	2004
2001–2005	Chamie, S.	Vicarious trauma: when the personal and professional collide	2004
2001–2005	Rasmussen, B.	An intersubjective perspective on vicarious trauma and its impact on the clinical process.	2005
2001–2005	Versola-Russo, J.	Vicarious Victims of Trauma: A Literature Review	2005
2006–2010	Rothschild, B., & Rand, M.	Help for the helper: the psychophysiology of compassion fatigue and vicarious trauma	2006
2006–2010	VanDeusen, K., & Way, I.	Vicarious Trauma: An Exploratory Study of the Impact of Providing Sexual Abuse Treatment on Clinicians' Trust and Intimacy.	2006
2006–2010	Versola-Russo, J.	Workplace Violence: Vicarious Trauma in the Psychiatric Setting.	2006
2006–2010	Way, I., VanDeusen, K., & Cottrell, T.	Vicarious Trauma: Predictors of Clinicians' Disrupted Cognitions About Self-Esteem and Self-Intimacy.	2007
2006–2010	Lucas, L.	The Pain of Attachment – "You Have to Put a Little Wedge in There": How Vicarious Trauma Affects Child/Teacher Attachment.	2007
2006–2010	Feldman, D., & Kaal, K.	Vicarious Trauma and Assumptive Worldview: Beliefs About the World in Acquaintances of Trauma Victims.	2007
2006–2010	Vrklevski, L., & Franklin, J.	Vicarious Trauma: The Impact on Solicitors of Exposure to Traumatic Material.	2008
2006–2010	Adams, S., & Riggs, S.	An Exploratory Study of Vicarious Trauma Among Therapist Trainees.	2008
2006–2010	Devilly, G., Wright, R., & Varker, T.	Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals.	2009
2006–2010	Jankoski, J.	Is vicarious trauma the culprit? A study of child welfare professionals.	2010
2006–2010	Boscarino, J., Adams, R., & Figley, C.	Secondary trauma issues for psychiatrists: identifying vicarious trauma and job burnout.	2010
2006–2010	Jordan, K.	Vicarious Trauma: Proposed Factors That Impact Clinicians.	2010
2011–2015	Brockhouse, R., Msetfi, R., Cohen, K., & Joseph, S.	Vicarious exposure to trauma and growth in therapists: The moderating effects of sense of coherence, organizational support, and empathy.	2011
2011–2015	Măirean, C., & Turliuc, M.	Predictors of Vicarious Trauma Beliefs Among Medical Staff.	2013
2011–2015	Day, M., Bond, K., & Smith, B.	Holding it together: Coping with vicarious trauma in sport	2013
2011–2015	Joubert, L., Hocking, A., & Hampson, R.	Social Work in Oncology-Managing Vicarious Trauma-The Positive Impact of Professional Supervision.	2013

2011–2015	Cohen, K., & Collens, P.	The Impact of Trauma Work on Trauma Workers: A Metasynthesis on Vicarious Trauma and Vicarious Posttraumatic Growth.	2013
2011–2015	Branson, D., Weigand, D., & Keller, J.	Vicarious Trauma and Decreased Sexual Desire: A Hidden Hazard of Helping Others.	2014
2011–2015	Măirean, C., Turliuc, M., & Cimpoeşu, D.	The associations between vicarious trauma dysfunctional beliefs and traumatic stress among hospital personnel.	2014
2011–2015	Hernandez-Wolfe, P., Killian, K., Engstrom, D., & Gangsei, D.	Vicarious Resilience, Vicarious Trauma, and Awareness of Equity in Trauma Work.	2015
2011–2015	Ayza Yazdani, Zainab F. Zadeh, & Khalida Shafi	Gender differences in adolescents experiencing vicarious trauma.	2015
2016–2020	Neswald-Potter, R., & Simmons, R.	Regenerative Supervision: A Restorative Approach for Counsellors Impacted by Vicarious Trauma/ Supervision regenerative : une approche retablissante pour les conseillers affectes par traumatisme vicariant.	2016
2016–2020	Ayza Yazdani, Zainab F Zadeh, & Khalida Shafi.	Potentially Traumatic Events as Predictors of Vicarious Trauma in Adolescents.	2016
2016–2020	Officer.com	Vicarious Trauma: Screening Police Officers for Risk.	2017
2016–2020	Maguire, G., & Byrne, M.	The Law Is Not as Blind as It Seems: Relative Rates of Vicarious Trauma among Lawyers and Mental Health Professionals.	2017
2016–2020	Kochi, C., Liu, H., Zaidi, S., Atrooz, F., Dantoin, P., & Salim, S.	Prior treadmill exercise promotes resilience to vicarious trauma in rats.	2017
2016–2020	Huggard, P., Law, J., & Newcombe, D.	A systematic review exploring the presence of vicarious trauma, compassion fatigue, and secondary traumatic stress in alcohol and other drug clinicians.	2017
2016–2020	Benuto, L., Singer, J., Cummings, C., & Ahrendt, A.	The Vicarious Trauma Scale: Confirmatory factor analysis and psychometric properties with a sample of victim advocates.	2018
2016–2020	Boulanger, G.	When Is Vicarious Trauma a Necessary Therapeutic Tool?	2018
2016–2020	Isobel, S., & Angus-Leppan, G.	Neuro-reciprocity and vicarious trauma in psychiatrists.	2018
2016–2020	Andaházy, A.	Tuning of the self: in-session somatic support for vicarious trauma-related countertransference.	2019
2016–2020	Nikischer, A.	Vicarious trauma inside the academe: understanding the impact of teaching, researching and writing violence.	2019
2016–2020	Uziel, N., Meyerson, J., Giryes, R., & Eli, I.	Empathy in dental care – the role of vicarious trauma.	2019
2016–2020	Hallinan, S., Shiyko, M., Volpe, R., & Molnar, B.	Reliability and Validity of the Vicarious Trauma Organizational Readiness Guide (VT-ORG).	2019
2016–2020	Wines, M.	Multifaceted Traumatic Exposure: Simultaneous Direct and Vicarious Trauma Among EMS Personnel.	2019
2016–2020	Branson, D.	Vicarious Trauma, Themes in Research, and Terminology: A Review of Literature.	2019
2016–2020	Long, S.	Supervisors' Perception of Vicarious Trauma and Growth in Australian Refugee Trauma Counsellors.	2020
2016–2020	Hazen, K., Carlson, M., Hatton-Bowers, H., Fessinger, M., Cole-Mossman, J., Bahm, J., Hauptman, K., Brank, E., & Gilkerson, L.	Evaluating the Facilitating Attuned Interactions (FAN) approach: Vicarious Trauma, professional burnout, and reflective practice.	2020
2021–2021	Burton, K., & Paton, A.	Vicarious trauma: Strategies for legal practice and law schools.	2021
2021–2021	McQuiston, D. E., Hooper, M. D., & Brasington, A. E.	Vicarious trauma in the courtroom: Judicial Perceptions of Juror Distress.	2021
2021–2021	Cullen, P., Dawson, M., Price, J., & Rowlands, J.	Intersectionality and Invisible Victims: Reflections on Data Challenges and Vicarious Trauma in Femicide, Family and Intimate Partner Homicide Research.	2021
2021–2021	Eades, A.-M., HackettWilliams, M., Raven, M., Liu, H., & Cass, A.	The impact of vicarious trauma on Aboriginal and/or Torres Strait Islander health researchers.	2021
2021–2021	Drapeau, C. E., Drouin, M.-S., & Plante, P.	Vicarious trauma and response art: A professional development workshop for psychotherapists working with survivors of trauma.	2021
2021–2021	Middleton, J., Harris, L. M., Matera Bassett, D., & Nicotera, N.	"Your soul feels a little bruised": Forensic interviewers' experiences of vicarious trauma.	2021

Appendix 3. A summary of research items (where the title contains "vicarious traumatisation/traumatization") included in the analysis.

Year range segment	Author/s	Title	Year

1990–1995	McCann, I. L., & Pearlman, L. A.	Vicarious traumatization: A framework for understanding the psychological effects of working with victims.	1990
1990–1995	Neumann, D., & Gamble, S.	Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist.	1995
1990–1995	Pearlman, L., & Mac Ian, P.	Vicarious Traumatization: An Empirical Study of the Effects of Trauma Work on Trauma Therapists.	1995
1990–1995	Crothers, D.	Vicarious traumatization in the work with survivors of childhood trauma.	1995
1996–2000	Blair, D. T., & Ramones, V. A.	Understanding vicarious traumatization.	1996
1996–2000	Johnson, C. N. E., & Hunter, M.	Vicarious traumatization in counsellors working in the New South Wales Sexual Assault Service: An exploratory study.	1997
1996–2000	Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F.	Vicarious Traumatization, Spirituality, and the Treatment of Sexual Abuse Survivors: A National Survey of Women Psychotherapists.	1998
1996–2000	Sexton, L.	Vicarious traumatisation of counsellors and effects on their workplaces.	1999
2001–2005	Crabtree, D.	Vicarious traumatization in therapists who work with juvenile sex offenders.	2002
2001–2005	Goldenberg, J.	The Impact on the Interviewer of Holocaust Survivor Narratives: Vicarious Traumatization or Transformation?	2002
2001–2005	Dane, B.	Duty to Inform: Preparing Social Work Students to Understand Vicarious Traumatization.	2002
2001–2005	Kadambi, M. A., & Truscott, D.	Vicarious Traumatization and Burnout Among Therapists Working with Sex Offenders	2003
2001–2005	McLean, S., Wade, T. D., & Encel, J. S.	The contribution of therapist beliefs to psychological distress in therapists: an investigation of vicarious traumatization, burnout and symptoms of avoidance and intrusion.	2003
2001–2005	Baird, S., & Jenkins, S. R.	Vicarious Traumatization, Secondary Traumatic Stress, and Burnout in Sexual Assault and Domestic Violence Agency Staff.	2003
2001–2005	Lerias, D., & Byrne, M. K.	Vicarious traumatization: symptoms and predictors.	2003
2001–2005	Sabin-Farrell, R., & Turpin, G.	Vicarious traumatization: implications for the mental health of health workers?	2003
2001–2005	Trippany, R., Wilcoxon, S., & Satcher, J.	Factors Influencing Vicarious Traumatization for Therapists of Survivors of Sexual Victimization	2003
2001–2005	Cunningham, M.	Teaching Social Workers about Trauma: Reducing the Risks of Vicarious Traumatization in the Classroom.	2004
2001–2005	Blanchard, E. B., Kuhn, E., Rowell, D. L., Hickling, E. J., Wittrock, D., Rogers, R. L., Johnson, M. R., & Steckler, D. C.	Studies of the vicarious traumatization of college students by the September 11th attacks: effects of proximity, exposure and connectedness.	2004
2001–2005	Canfield, J.	Secondary Traumatization, Burnout, and Vicarious Traumatization: A Review of the Literature as It Relates to Therapists Who Treat Trauma	2005
2001–2005	Clemans, S.	Recognizing Vicarious Traumatization: A Single Session Group Model for Trauma Workers.	2005
2001–2005	Hafkenscheid, A.	Event countertransference and vicarious traumatization: Theoretically valid and clinically useful concepts?	2005
2006–2010	Baird, K., & Kracen, A. C.	Vicarious traumatization and secondary traumatic stress: A research synthesis.	2006
2006–2010	Dunkley, J., & Whelan, T. A.	Vicarious traumatisation: current status and future directions.	2006
2006–2010	Sommer, C. A., & Cox, J. A.	Sexual violence counselors' reflections on supervision: Using stories to mitigate vicarious traumatization.	2006
2006–2010	Dunkley, J., & Whelan, T. A.	Vicarious traumatisation in telephone counsellors: internal and external influences.	2006
2006–2010	Byrne, M. K., Lerias, D., & Sullivan, N. L.	Predicting vicarious traumatization in those indirectly exposed to bushfires.	2006
2006–2010	Sinclair, H. A., & Hamill, C.	Does vicarious traumatisation affect oncology nurses?	2007
2006–2010	Palmer, S., Stalker, C. A., Harper, K., & Gadbois, S.	Balancing Positive Outcomes with Vicarious Traumatization: Participants' Experiences with Group Treatment for Long-Term Effects of Childhood Abuse.	2007
2006–2010	Pack, M.	The Concept of Hope in Gestalt Therapy: Its Usefulness for Ameliorating Vicarious Traumatisation.	2007
2006–2010	Todd, B.	Assisting the traumatised: vicarious traumatisation and the preservation of meaning.	2007

2006–2010	Sommer, C.	Vicarious Traumatization, Trauma-Sensitive Supervision, and Counselor Preparation.	2008
2006–2010	Sabo, B.	Adverse psychosocial consequences: Compassion fatigue, burnout and vicarious traumatization: Are nurses who provide palliative and hematological cancer care vulnerable?	2008
2006–2010	Harrison, R. L., & Westwood, M. J.	Preventing vicarious traumatization of mental health therapists: identifying protective practices.	2009
2006–2010	Ben-Porat, A., & Itzhaky, H.	Implications of Treating Family Violence for the Therapist: Secondary Traumatization, Vicarious Traumatization, and Growth.	2009
2006–2010	Chouliara, Z., Hutchison, C., & Karatzias, T.	Vicarious traumatisation in practitioners who work with adult survivors of sexual violence and child sexual abuse: Literature review and directions for future research.	2009
2006–2010	Pack, M.	Revisions to the therapeutic relationship: A qualitative inquiry into sexual abuse therapists' theories for practice as a mitigating factor in vicarious traumatisation.	2009
2011–2015	Tovar, L. A.	Vicarious traumatization and spirituality in law enforcement.	2011
2011–2015	Taylor, W., & Furlonger, B.	A Review of Vicarious Traumatisation and Supervision Among Australian Telephone and Online Counsellors.	2011
2011–2015	Bishop, S., & Schmidt, G.	Vicarious traumatization and transition house workers in remote, northern British Columbia communities.	2011
2011–2015	Culver, L. M., McKinney, B. L., & Paradise, L. V.	Mental Health Professionals' Experiences of Vicarious Traumatization in Post-Hurricane Katrina New Orleans.	2011
2011–2015	Hunter, S. V.	Walking in Sacred Spaces in the Therapeutic Bond: Therapists' Experiences of Compassion Satisfaction Coupled with the Potential for Vicarious Traumatization.	2012
2011–2015	Pack, M.	Vicarious traumatisation : an organisational perspective.	2012
2011–2015	Williams, A. M., Helm, H. M., & Clemens, E. V.	The Effect of Childhood Trauma, Personal Wellness, Supervisory Working Alliance, and Organizational Factors on Vicarious Traumatization.	2012
2011–2015	Pack, M.	Vicarious traumatisation and resilience: An ecological systems approach to sexual abuse counsellors' trauma and stress.	2013
2011–2015	Furlonger, B., & Taylor, W.	Supervision and the Management of Vicarious Traumatisation Among Australian Telephone and Online Counsellors.	2013
2011–2015	Howlett, S. L., & Collins, A.	Vicarious traumatisation: risk and resilience among crisis support volunteers in a community organisation.	2014
2011–2015	Al-Mateen, C. S., Linker, J. A., Damle, N., Hupe, J., Helfer, T., & Jessick, V.	Vicarious Traumatization and Coping in Medical Students: a Pilot Study.	2015
2011–2015	Zerach, G., & Shalev, T. B.-I.	The Relations between Violence Exposure, Posttraumatic Stress Symptoms, Secondary Traumatization, Vicarious Post Traumatic Growth and Illness Attribution among Psychiatric Nurses.	2015
2011–2015	Middleton, J. S., & Potter, C. C.	Relationship Between Vicarious Traumatization and Turnover Among Child Welfare Professionals.	2015
2016–2020	Darroch, E., & Dempsey, R.	Interpreters' experiences of transferential dynamics, vicarious traumatisaton, and their need for support and supervision: A systematic literature review.	2016
2016–2020	Setti, I., Lourel, M., & Argentero, P.	The Role of Affective Commitment and Perceived Social Support in Protecting Emergency Workers Against Burnout and Vicarious Traumatization.	2016
2016–2020	Makadia, R., Sabin-Farrell, R., & Turpin, G.	Indirect exposure to client trauma and the impact on trainee clinical psychologists: Secondary traumatic stress or vicarious traumatization?	2017
2016–2020	Peled-Avram, M.	The Role of Relational-Oriented Supervision and Personal and Work-Related Factors in the Development of Vicarious Traumatization.	2017
2016–2020	Gumani, M. A.	Vicarious traumatisation experiences among South African Police Service members in a rural setting: An exploratory study.	2017
2016–2020	Molnar, B. E., Sprang, G., Killian, K. D. et al	Advancing Science and Practice for Vicarious Traumatization/ Secondary Traumatic Stress: A Research Agenda.	2017

2016–2020	Halevi, E., & Idisis, Y.	Who Helps the Helper? Differentiation of Self as an Indicator for Resisting Vicarious Traumatization.	2018
2016–2020	Foreman, T.	Wellness, Exposure to Trauma, and Vicarious Traumatization: A Pilot Study.	2018
2016–2020	Merhav, I., Lawental, M., & Peled-Avram, M.	Vicarious Traumatisation: Working with Clients of Probation Services.	2018
2016–2020	Waegemakers Schiff, J., & Lane, A. M.	PTSD Symptoms, Vicarious Traumatization, and Burnout in Front Line Workers in the Homeless Sector.	2019
2016–2020	DelTosta, J. E., Ellis, M. V., & McNamara, M. L.	Trainee Vicarious Traumatization: Examining Supervisory Working Alliance and Trainee Empathy.	2019
2016–2020	Borjanić Bolić, E.	Secondary traumatic stress and vicarious traumatization in child welfare professionals in Serbia.	2019
2016–2020	Rauvola, R. S., Vega, D. M., & Lavigne, K. N.	Compassion Fatigue, Secondary Traumatic Stress, and Vicarious Traumatization: a Qualitative Review and Research Agenda.	2019
2016–2020	Njoku, E. T.	The ligaments of counter-terrorism regime: sexual violence and the vicarious traumatisation of female non-governmental organisation workers: evidence from Nigeria.	2019
2016–2020	Aafjes-van Doorn, K., Békés, V., Prout, T. A., & Hoffman, L.	Psychotherapists' Vicarious Traumatization During the COVID-19 Pandemic.	2020
2016–2020	Li, Z., Ge, J., Yang, M., et al	Vicarious traumatization in the general public, members, and non-members of medical teams aiding in COVID-19 control.	2020
2016–2020	Liu, C., & Liu, Y.	Media Exposure and Anxiety during COVID-19: The Mediation Effect of Media Vicarious Traumatization.	2020
2016–2020	Serafim, A. de P., Gonçalves, P. D., Rocca, C. C., & Lotufo Neto, F.	The impact of COVID-19 on Brazilian mental health through vicarious traumatization.	2020
2016–2020	Rønning, L., Blumberg, J., & Dammeyer, J.	Vicarious traumatisation in lawyers working with traumatised asylum seekers: a pilot study.	2020
2016–2020	Molnar, B. E., Meeker, S. A., Manners, K., et al	Vicarious traumatization among child welfare and child protection professionals: A systematic review.	2020
2016–2020	Nazia Mustafa, Fahad Haleem, Najm Us Saqib Khan, et al	Relationship of vicarious traumatization with family relations and coping strategies among healthcare professionals.	2020
2016–2020	Pihkala, P.	The Cost of Bearing Witness to the Environmental Crisis: Vicarious Traumatization and Dealing with Secondary Traumatic Stress among Environmental Researchers.	2020
2021–2021	Howard, S.	A Causal Model of Children's Vicarious Traumatization.	2021
2021–2021	Norhayati, M. N., Mofreh, S. A. M., & Azman, Y. M.	Vicarious Traumatization Questionnaire: Psychometric Properties Using Rasch Model and Structural Equation Modeling.	2021
2021–2021	Helpingstine, C., Kenny, M. C., & Malik, F.	Vicarious Traumatization and Burnout among Service Providers for Victims of Commercial Sexual Exploitation.	2021
2021–2021	Norhayati, M. N., Che Yusof, R., & Azman, M. Y.	Vicarious traumatization in healthcare providers in response to COVID-19 pandemic in Kelantan, Malaysia	2021

Aiming for Safety: Exploring Potential Dynamics within Line Managed Supervision

Carolyn Cousins

The safety to explore practice in open and transparent ways, where a practitioner can admit uncertainty and admit their potential biases is not always easy to achieve in supervision. Creating a safe space for genuinely reflective practice can be particularly challenging where the person providing clinical supervision is also responsible for the performance management of the practitioner and organisational oversight of cases. The tension and risk created in these dual roles can result in a range of pre-emptive and unconscious dynamics from both supervisee and supervisor. This paper considers some of the dynamics with a short description of each tactic, its aims and effects, before considering ways to manage dynamics and develop safety and trust. The context of exploration is individual supervision within workplaces where individuals are in a supervisory relationship by virtue of the posts they hold. The ideas raised may still be applicable to other supervisory contexts.

Keywords: *Supervision; dynamics; reflective practice*

Introduction

The act of supervision – time set aside between supervisee and supervisor to review and reflect on professional practice – is a corner stone of the profession and a key task relied upon for managing workload, regulating practitioner approaches and ensuring quality control in practice. Much has been written about the importance of supervision, and yet it is also clear a significant proportion of practitioners are not happy with the quality of the supervision they receive (see for example, Social Work Taskforce, 2009; Cortis, et al 2020). Adding to this, in many agencies in which counselling is practiced, supervisors and supervisees do not 'choose' each other, but rather enter this key professional relationship by virtue of the work posts they hold. This all makes for a complicated professional interaction, where complex dynamics can get in the way of a genuine, ethically mature (Carroll, 2012), reflective, and client focussed interaction. It is the intention of this paper to explore and outline some of the potential supervisory dynamics that can impact safety in this key relationship, identify the reasons and effects on practice, before considering ways to create greater genuine safety in these relationships.

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This paper will draw together ideas identified by key writers such as Berne (1964), Kadushin (1968), and Hawthorn (1975), before moving to more recent considerations and approaches to understanding the operation of power in supervisory relationships. The dynamics and tactics are not in themselves always problematic. They can sometimes develop in order to create one form of safety, protecting the practitioner from risk of criticism or even performance management. However, the dynamics can prevent appropriate practice examination and collective critical analysis of practice that is for the benefit of the client. By outlining some of these dynamics, this paper aims to provide a tool for practitioners to analyse and explore their own supervisory experiences in order to then create conditions to reach new levels of self-awareness and openness.

Definitions

Supervision - in this paper is taken to be the formal interaction between practitioner and team leader / manager encompassing (taken from Providing Effective Supervision, CWDC 2007):

- Line management: including accountability for practice and quality of service, workload management, and performance appraisal;
- Professional or case supervision: reviewing and reflecting on practice issues and looking at opportunities for learning;
- Continuing Professional Development: ensuring progression of skills, knowledge and understanding.

Organisationally oriented approaches (such as those proposed by Morrison and Wonnacott (2010), or Adamson (2012) add areas such as risk management, as well as practitioner resilience and sustainability.

Supervisory relationship – In this paper the focus is the relationship between the practitioner and their line manager. It is recognised that there are other contexts in which counsellors and practitioners choose or are provided alternative supervisors (such as peer, offline and external supervision), however this paper concentrates on the agency required supervisory relationship , with all its 'potentially conflicting roles, functions and purposes' and increasing shift toward 'mangerialism' (Adamson, 2012:186).

A background – 'game' playing

In his 1964 book, *Games People Play*, psychiatrist Dr. Eric Berne spoke of the dynamics underlying human relationships in theories that lead to the practice of transactional analysis. He described these games as a series of interactions (words, body language, facial expressions) between two or more people that follow a predictable pattern. These interactions ultimately progress to an outcome in which one individual obtains a payoff. Berne (1964:48) contended this is a form of unconscious behaviour, often with origins in past experiences and relationships which are being re-played in new contexts.

In his seminal work on the functions of social work supervision, Alfred Kadushin (1968) drew on Berne's ideas and noted that games in supervision are 'the kinds of recurrent interactional incidents between supervisor and supervisee that have a payoff for one of the parties in the transaction.' (1968:23) In 1975, Hawthorne notes that although usually initiated by one participant, these games require both parties need to engage, and that there can be a benefit for one, but usually both, participants.

Supervision's complicated relationship with power dynamics

The reality is that any supervisory relationship where the supervisor has line management responsibility is a relationship of unequal power. While the supervisor may attempt to hold this power lightly, being friendly, approachable, and supportive, the issue of whether the supervisee can actually trust the supervisor and how they will use their authority is crucial to a productive and honest relationship. For many practitioners, past negative experiences of line managers are powerful motivators for protective games (see for example Gibbs, 2001, Social Work Taskforce, 2009 Egan et.al. 2018). Where this is the case trust takes time to develop, if it can at all. Where the clinical supervisor has the dual responsibility of performance management and productivity of the team (which is the case in many situations), there will always be some tension in creating a safe and confidential supervisory space, where the supervisee can explore their doubts, fears and inadequacies, contrasted with the implications of the performance management requirements of the team leader / manager. A lack of safety to 'not know' can be further compounded by complexities arising from such intersectional differences of race, culture, age, gender, sexuality, and experience levels between supervisee and supervisor.

This is, by definition, a hierarchical relationship. For those managers who like to think they have developed a collegial "open door" relationship with staff, Kahn (1979:521) made some interesting observations, noting that old fears of inadequacy and criticism, as well as resistance to learning, come into play in all supervisory relationships. She cites research that while supervisors often see themselves as having relaxed, friendly attitudes, they were often seen by supervisees as admired teachers, but also feared and powerful judges. While Kadushin (1968:24) suggested the relationship is often unconsciously re-activating parent–child and teacher–student anxieties. He also proposes there is a heightened threat to the sense of self, for both the practitioner and supervisors, inherent in clinical supervision specifically because the work involves so much of the use of self as reflected in one's work. This can make it harder for either participant to take a stance of 'not knowing' and the vulnerability or exposure this involves. Cooper (2002) and Cortis et.al. (2020) note that pressures to meet managerial targets potentially reduce opportunities for reflection. O'Donoghue (2012) highlights how past supervisory experiences can result in future defensive tactics.

The dynamics and their intent

First, we will consider some of the supervisee initiated dynamics, which can be divided into two categories in terms of intent. Firstly, there are those aimed at trying to manage the level of demand on the practitioner and, secondly, there are those aimed at trying to reduce and or manage the power difference by the supervisee.

Tactics aimed at managing demand levels:

Two against the agency:

Kadushin identified this tactic which he also called 'seducing for subversion' (1968:25). He stated that this is generally implemented by supervisees who are frustrated by routine agency procedures and / or see themselves as agitators against the system. They will allude to a conflict between bureaucratic requirements and professional orientation. Essentially, they are asking the supervisor to allow them not to comply with bureaucratic requirements, such as recording or forms, as these tasks rob them of valuable time with clients.

Benefit for practitioner: If successful, this results in a reduction of administrative work. At its most extreme, this may actually see the supervisor completing some of these requirements on behalf of the practitioner.

Attraction for supervisor: The supervisor may identify with the practitioner's concern, and may also be frustrated with bureaucratic demands. If they are reluctant to assert their authority or struggle with having 'sold out' to the bureaucracy, they may be induced to allow the practitioner concessions. However, this exposes them both to the risks that are inherent in operating outside of agency policy, rather than challenging inappropriate practices openly and actively.

Treat me don't beat me

Identified by Kadushin (1968:26) and expanded by Cousins (2010) this self protective dynamic is where a practitioner finds it safer to focus on personal problems in supervision rather than their work, and invites the supervisor to assist them with their problems as a diversion. Kadushin states that, in more skilled versions, the practitioner relates these problems to difficulties related to the job. This dynamic should be separated from where the practitioner has a genuine one-off personal problem, where a short term adjustment to work is appropriate. Rather it is where

this is a distraction from examination of the work and has become a protective pattern of interaction.

Benefit for practitioner: This tactic invites the supervisor into the role of therapist and provider of support to the practitioner, which both deflects from examination of their cases and also makes it hard for the supervisor to then hold the worker accountable. The outcome can also be a reduction in work demand to allow the practitioner space to accommodate their personal challenges. This can have a side effect of significant resentment from other staff, who may be required to carry the additional workload.

Attraction for supervisor: Due to the use of 'self' in clinical work, any practitioner, when they are going through personal difficulties, is likely to need extra support, understanding, and often a temporary adjustment in workload. This is legitimate and it can be difficult for the supervisor to know when this adjustment should stop. They will not wish to be perceived as harsh or unfair, which can lead to this dynamic staying in place. This particular tactic also appeals to the therapeutic side of the team leader / manager, as they are invited into private world of the worker and sometimes back to a therapeutic or clinical role, which may be more familiar than a supervisory one. Kadushin (1968:26) feels that there is a perceived flattery of the supervisor in being chosen for the disclosure of personal information.

The perpetual 'new worker'

There is a time period, post qualifying, or when a practitioner is adjusting to a new role or work area, where the practitioner assumes the role of learner. This is to be expected and appropriate, however fear of judgement or inadequacy can lead this to go on too long. It can feel safer to 'stay new', and even after some years in a role, the practitioner may say things like, 'I am not sure I should take on that (routine) task, as I'm only fairly new'.

Benefit for the practitioner: If accepted, there is likely to be a reduction in workload or expectations, along with extra assistance or advice from others. While there may be genuine fears and anxieties the practitioner has, they need to be explored, and progress towards full case load and responsibility made.

Attraction for supervisor: Supervisors can be flattered through ongoing deference and remaining in the educator mode of supervision provision can feel comfortable and reassuring. Giving advice can come easily, however this allows the practitioner to continue to defer what may be appropriate responsibilities, whilst also avoiding areas that need vulnerability for growth.

Flattery - you are so wise…

Another related tactic Kadushin (1968:25) identified was simple flattery. The supervisee is full of praise: 'you're the best supervisor I have ever had', 'you're so perceptive', 'I always feel better after talking to you'. While this may be true, this form of flattery can be a way to avoid exploration of practice – by deferring to the expertise and wisdom of the supervisory. Some managerial roles are also under- appreciated and this tactic sometimes results in the supervisor providing additional support, guidance or preferential treatment to the sueprvisee who makes them feel good.

Benefit for practitioner: This approach effectively ensures the practitioner remains in the role of 'learner' for longer than is necessary, usually again with an accompanying reduction in expectations and workload, as the supervisor can find it hard to hold the worker to legitimate work demands.

Attraction for supervisor: This can be difficult for the supervisor to resist as 'it is gratifying to be regarded as an omniscient source of wisdom' (Kadushin,1968:25), or to be selected for emulation. Reassurance that the supervisee is learning and growing from the interaction is the kind of reassurance supervisors often need. It can take a while for the supervisor to recognise the potential effects of not focussing on building the competence of the worker or closely examining their own decision making.

Heading them off at the pass

This is where a practitioner is aware that they have made a mistake or let the client down in some way, and, anticipating that this will be raised by the supervisor, they 'get in first'. That is, they freely admit mistakes, confessing in advance and 'flagellating themselves to excess' (Kadushin, 1968:29). The supervisor, faced with the self-denigration , has little option than to reassure the supervisee sympathetically that all is well. Not only that - this dynamic can lead to overcompensation through praise of any (however limited) strengths the practitioner has.

Benefit for Practitioner: It is understandable a practitioner may have this pre-emptive reaction, however good reflective practice requires the courage to sit with and explore our errors and cautions in order for learning and redress. Where this becomes a problem is if it gets in the way of exploration of poor performance or practice. The benefit is obvious since the practitioner avoids a 'dressing down' or hearing the supervisor's concerns about their practice. They also will often avoid, though this technique, the consequences of performance standards or changes to practice the supervisor may have been planning to outline to them.

Attraction for supervisor: For the supervisor, this tactic relieves them of the uncomfortable task of raising a performance issue, a task few supervisors enjoy. It can allow the supervisor to (falsely) feel they have addressed the issue, when this may actually be far from the case. The test will be whether there is a change in practitioner behaviour in future or a repeat of the pattern.

Selective sharing

All supervisees have to make choices about which issues, which cases, and in what level of detail, they bring to a session for examination. However some supervisees, in order to avoid scrutiny of their work or a sense of exposure, may either choose to share inconsequential and peripheral information or can distort a matter to present a more favourable picture of their work. It is often very difficult for the supervisor to know that this is occurring.

Benefit for practitioner: This technique reduces the threat of criticism and can also result in a slower allocation of new work. It does however leave the practitioner isolated in much of their decision-making. At its worst, this tactic can be masking situations where a worker is not fulfilling even some of their most basic responsibilities, such as failing to visit clients or complete tasks.

Attraction for the supervisor: Supervisors can be unsure of the degree to which it is acceptable for them to 'intrude' into the privacy of the client-worker relationship, and unless there is some form of live observation of the practitioner with clients, either directly, or via third party colleagues, it can be difficult to know if appropriate issues are not being raised when they should in supervision. However, there are considerable risks for the supervisor in not knowing the practices of the practitioners they supervise, as the line supervisor can be held responsible for casework decisions. With this selective sharing, the supervisor can be completely unaware of vital pieces of information about

cases and the worker's practice that the 'system' would expect them to know.

Tactics aimed at reducing the power difference and avoiding exposure

Examining clinical practice in supervision, opening it up to the scrutiny of another, more powerful practitioner can be very exposing, and it is to be expected that sometimes tactics are employed to try to reduce the power differential in the supervisory relationship. This can be deliberate, based on fears and past experiences, and it can also be unconscious. Some identified ways this can occur include:

If you knew Dostoyevsky like I know Dostoyevsky ….

This is a situation in which during supervision, usually early on in the relationship, the supervisee makes reference to a theory or case that is raised in order to demonstrate the supervisee's superior clinical knowledge, and expose the supervisor's lack of it. Kadushin (1968:27) provides the following example script:

'the client's behaviour is reminiscent of Raskolnikov, which is, after all, somewhat different in etiology from the pathology that plagued Prince Myshkin in 'The Idiot'. You remember, don't you?'

It is equally clear to both the supervisee and supervisor, that the latter does not have knowledge of this, and the role of teacher–learner becomes reversed. This can be done with any number of theorists, political figures, literary figures to the same effect.

A more subtle version of this, is where the experienced practitioner and less experienced supervisee fall into more of a democratic peer – peer relationship where joint sharing of the agenda can easily become led by the supervisee. This 'democratic' approach can be hard for the inexperienced supervisor to resist as they do not want to seem controlling, and yet, they do have administrative authority. It is not an equal relationship, and this will need to be made clear at some point.

Benefit for practitioner: Apart from the obvious readjustment of power, this usually results in a supervisor too fearful of 'exposure' to question the practitioner's clinical practice, decision making or casework and the practitioner is left to 'get on with it' with little supervision, oversight or accountability.

Attraction for supervisor: The supervisor is invited to take part because a refusal would require an admission of ignorance, while further power is often gained by the supervisee who 'co-operates in a conspiracy with the supervisor not to expose his ignorance openly' (Kadushin, 1968:27). Thus discussion continues under the 'mutually accepted fiction' that they both know what they are talking about, with the supervisor feeling on the back foot. This dynamic is built on an assumption that the supervisor should always know more, which is a risky proposition and stifles cooperative exploration.

I'll just run this past you in the corridor

This could also be called 'we both know I don't really need supervision'. This is where the practitioner implies they do not really need formal sit down supervision or support, as "we are both far too busy", and that the practitioner states they already know what they are doing. Significant periods of time can pass without formal supervision, whether due to cancellation or 'forgetting' to re book.

Benefit for practitioner: This dynamic results in little accountability or intrusion as the practitioner is left to their own devices and does not risk the exposure of their practice.

Attraction for supervisor: The supervisor often is busy and relieved to have one less person to schedule time with. However, resistance builds and the foundations of a supervisory relationship are not established, making it difficult to begin to hold the practitioner accountable when oversight of work is needed.

I have a little list…

This supervisee arrives with a range of topics and questions about the work that are carefully designed to be relevant enough, but at the same time deflective from key issues the supervisor may wish to raise. The clever implementation of this tactic ensures the list is full of topics of interest to the supervisor. When the supervisor appears to be 'running out of steam', the supervisee introduces a new question and the cycle is repeated.

Benefit for practitioner: By ensuring the supervisor does most of the talking and stays 'busy' in the session, not only does the practitioner reduce their own level of participation, they can also control both the content and direction of the interaction, away from scrutiny. The author is conscious of having used this tactic with a supervisor who was unable to keep discussions in supervision confidential, hence this became the 'safest way' to manage up in the supervisory dynamic.

Attraction for supervisor: It is gratifying for the supervisor to be helpful and to display knowledge, and meeting the needs of the dependent person asking the questions. It can be easy to miss this form of 'managing up' and realise that the practitioner has avoided their practice being critically analysed.

Evaluation is not for friends

Identified initially by Kadushin (1968:26), this tactic sees the supervisory relationship redefined as a social one where the supervisee makes an effort to take coffee breaks, lunch or socialise with the supervisor. They make an effort to discuss common interests to build a bond that is beyond general office friendliness.

Benefit for practitioner: It is more difficult for a supervisor to hold a 'friend' to the required performance levels and tasks, or to question practice. The shift, if successful, to peer-peer relationship can result in preferential treatment or a failure to address concerns.

Attraction for supervisor: Management roles can be isolating and it can be nice to have a friendly colleague to discuss things with. The manager or team leader may also want to show they are still 'one of the gang" and it can be easy to be drawn in to this tactic.

There are further complications arising from this dynamic, where the practitioner and supervisor actually are friends either prior to, or as a result of, the working relationship, or where the supervisor has stepped up within team. Needless to say, it is a potential ethical dynamics minefield.

Email bombardment

This newer tactic, experienced by the author is where email allows the practitioner to copy their supervisor into everything. This can be legitimate at times, but also risks the supervisor being complicit in decisions to which they may not have enough background or context. If things go wrong, the practitioner can say, 'but you knew'. This is a more modern version of always asking for advice and then if it goes wrong, saying 'I only did what you told me.'

Benefit for practitioner: There is a reduction of responsibility and a perceived sense of additional safety through constant management oversight.

Attraction for supervisor: Although it can 'clog up the in box', this can appeal to the part of the supervisor that wishes to know more about what their practitioner is doing, hence this practice can be difficult to resist.

Supervisor Tactics

The role of a supervisor is not easy and many of those who find themselves responsible for others have never received specific supervision training, often being promoted for being good frontline workers, with little additional training for management responsibilities. Morrison and Wonnacott (2010) say the supervisors practical and emotional intelligence are crucial for detecting performance issues in their supervisees, yet many supervisors are anxious, unconfident and conflicted about their role and the power it brings. This complex and intense supervisory relationship occurs in an organisational environment where there are often cross-purposes (Adamson, 2012:186). Professions like social work and welfare can have complicated relationships with power, not wanting to use it 'over' others, whilst also recognising the need for legitimate oversight of work. Supervisor tactics can also be divided into two broad categories, based on purpose. There are dynamics that can develop that are aimed at supervisor avoidance or abdication of work responsibility and those that are broadly about power.

Dynamics around Abdication / avoidance

'They won't let me' or 'I wish I could, but I can't do anything'

Hawthorne identified this tactic (1975:180) in which the supervisor sympathetically expresses the desire to take or permit some action, but then advises it is not possible and does not explore the possibility further as their supervisors 'will not allow it.' This may be true or it can also be avoidance of tackling an issue or policy that needs changing or challenging. This technique allows the supervisor to preserve their image by expressing a willingness to take action, but then avoids any risk by surrendering their authority to higher powers (1975:79).

Benefit for supervisor / Effect on supervisee

The supervisor is protected from taking a risk or making a decision, whilst preserving their image of being helpful and willing to do something. They make others responsible for their indecision or unwillingness to challenge a policy or practice. For the practitioner, there are no further options for taking an issue forward, unless they decide to go above or directly challenge their supervisor, both of which bring risk.

'I wonder why you really said that?'

Identified by Kadushin (1968:30) this somewhat passive aggressive approach involves redefining an honest difference of opinion as hostility on the part of the supervisee. Rather than defend their stance, and present the evidence, research or policy for their position, the supervisor chooses to redefine the difference as resistance on the part of the supervisee. The supervisor therefore no longer has to justify their approach, but rather, begins to pathologise the resistance of the supervisee.

Benefit for supervisor / Effect on supervisee

The supervisor can avoid a topic, question or issue by taking the spotlight off the subject raised and turning it onto the supervisee. This dynamic not only buys the supervisor time to think, but also can result, if used often, in a practitioner who will stop bringing challenging or complex issues to supervision for fear of being deemed the problem.

One good question deserves another

Another supervisor tactic identified by Kadushin (1968:30) is where a supervisor, concerned that they don't know the answers to potential questions, replies, acting curious with, 'what do you think?. While the worker is trying to figure out the answer to their own question, this buys the supervisor time to think of a response, whilst looking like they knew all along. If neither come up with any useful suggestion, Kadushin says this allows the supervisor to look wise and suggest the supervisee continues to think about it and they can discuss it further next time, thus buying the supervisor time to research. While curiosity is sometimes an appropriate response, overuse of this tactic reinforces power differences, rather than taking an opportunity to learn together.

Benefit for supervisor / Effect for practitioner

The supervisor is able to avoid exposing their own uncertainties, whilst at the same time maintaining an air of wise and benevolent assistance to the practitioner. Despite being common, it can be very frustrating for the practitioner, and is likely to result in them eventually seeking the support and advice they need elsewhere. The brave practitioner can respond and say, 'no, I need to know what you think', thus refusing to engage in this approach.

I am so busy and stressed

This approach, witnessed by the author at its extreme, is where the supervisor regularly states they are too busy with administrative or senior management requirements for other supervisory tasks. This results in a role reversal, where the worker is asked to sympathise with the very busy supervisor and not make demands of them; a kind of 'poor me' approach. Hawthorne (1975:79) identifies a similar issue with quotes such as 'I wish I had time to discuss the case with you, but I have to get this report done for the director' and states that some will use this excuse to avoid providing supervision altogether. The author came across a situation where the supervisees were so genuinely concerned for the emotional and mental health of their supervisor that they had stopped taking all key decisions to him, and were glossing over problems in the unit, in an attempt to reduce his stress levels.

Benefit for supervisor / Effect for practitioner

This results in role reversal where the supervisor is inviting the supervisee to feel sorry for them and not impose any additional demands. Yet, the supervisor gets to still present a sympathetic, hardworking role model. This leaves the practitioner alone with their decision-making. At its extreme, this tactic invites the practitioner to start treating their supervisor like a client.

Tactics of Power

The lack of preparation for management roles can also result in supervisors who use their power over others in punitive or problematic ways, often with a belief this is required to ensure good practice and that mistrust of staff is now their responsibility. They may have had this modelled by their own supervisors, or just be anxious about their level of responsibility now.

Remember who is the boss

In this working relationship the supervisor defines themselves as having absolute power. Hawthorne (1975:181) says this is an environment in which no contradictions, disagreements or negotiations are acceptable. She identifies two ways this is imposed. One is regular reminders of control, for example 'My workers all know that I expect them to be at their desks on time' or 'we have always done things this way'. Second,

through an implicit possessive relationship 'my workers' and 'my unit'. This is usually an approach of a veteran in the agency who has a reputation for meeting all bureaucratic requirements.

Benefit for supervisor / Effect for practitioner

The supervisor puts themselves beyond reach and never has to defend their position. Their omnipotence is almost unquestioned (Hawthorne, 1975:181). At times, to maintain this, the supervisor may have to actually go higher and 'tell on' a difficult and challenging supervisee to reinforce their position. This is a very difficult situation for the practitioner to challenge and most will get their supervisory supportive needs met elsewhere if they are to survive. This style does, however, suit some workers who want certainty and a sense of benevolent protection.

'I'm only telling you this for your own good'.

Hawthorne described this approach as 'Mother / Father knows best' (1975:181) and occurs where the supervisor uses not their professional competence or knowledge to validate their authority, but their external position – their status, seniority, and past experience. They assume the role of wise and guiding parent, and the subordinate nature of the supervisee is made clear.

Benefit for supervisor / Effect for practitioner

As a feared and powerful, yet benevolent judge, this supervisor is rarely questioned or challenged. This results in lower expectations of the practitioner who is allowed, or even encouraged, to be dependent, and complicit in maintaining the supervisor's need to be indispensible. The approach fosters and encourages helplessness or submission on the part of the supervisee and ensures they never become a threat to the supervisor's authority or role.

Let's be friends

In a reversal of the supervisee tactic of friends, the author has come across some supervisors who try to redefine the power dynamics with their team by taking the approach that they can all 'be friends'. This usually involves social events (where the expectation is clearly attendance), over sharing of the supervisor's life and issues, as well as a lack of boundaries around information sharing that a supervisor would usually withhold.

This approach denies the reality of the power a supervisor holds and, almost inevitably, there will come a point of conflict when a supervisor needs to exercise their authority for some reason. It is deceptively appealing to the practitioner, at first, as there is less threat of judgement or criticism, and they can also access information they would not otherwise receive. Over time, however, this situation can become increasingly unsafe.

Donovan and Jackson (1991:342) suggest that to be a good manager, a supervisor needs to 'be secure and without the need to be universally loved.' This may sound obvious, but it can be quite difficult for a supervisor to realise they are no longer 'one of the team, and that people sometimes regard them with cynicism or mistrust. Hence, there is the temptation to show that they are still a friend.

As Durrant acknowledges (2001:4) staff can have a high level of expectation that they will participate in management decisions and call the supervisor to account for their use of power. This is positive and keeps the supervisor accountable. However, it can also be disconcerting to the new supervisor, as they try to work out when a democratic approach is required and when to display leadership. A supervisor who is the line manager will have to make tough decisions sometimes and this means there will be times when they will not be popular. This requires an awareness of appropriate boundaries.

Addressing tactics and dynamics

The difficulty with many of these dynamics is that even the most emotionally intelligent and self-aware practitioner will engage in aspects of some of these tactics at times. There is what Hawthorne calls an, 'essential validity' in most of these approaches, which is what makes them so difficult to call out and address. One of the key indicators that an approach is becoming a problem, is when it is affecting either the job satisfaction or productivity of the practitioner or risks the outcomes for clients. Dill and Bogo (2009:142), remind the supervisor that central to their performance is to ensure organisational accountabilities are met. The goal of both the practitioner and supervisor, is ultimately as, Kadushin (1976:21) states, 'to deliver to agency clients the best possible service, both quantitatively and qualitatively, in accordance with the agency policies and procedures.'

There are, however, some risks in exposing tactics. One option is to name the dynamic and explore the effects. However, this needs to be handled with care and in a way that allows both parties to maintain dignity. It is a bit like naming defensive mechanisms clinically – some weighing up of the consequences is required. Deciding to address and confront tactics, if you are to be successful, requires some understanding of the 'defensive significance' of the approach (Kadushin,1968:32). It requires empathy, compassion and caution, with a sense of timing and the ability to 'expose' the dynamics in a way that also offers some options for change. It is important to remember that both parties have usually engaged in the dynamic to a degree, and 'refusing to play' as Kadushin (1968:31) puts it, can mean forfeiting certain advantages. For example, the supervisor must be willing to deal with potential supervisee rejection and hostility; willing to accept criticism, deny flattery, or reject the voyeurism of acting as therapist; they may also need to be willing to openly admit ignorance of a subject or area.

With supervisor tactics, the supervisee may be in too vulnerable a position to manage the dynamic through open confrontation (Hawthorne, 1975:182). One option is to regularly point out the approach in a light-hearted way, if the supervisory relationship will tolerate this.

With the abdicating supervisor, Hawthorne (1975:182) suggests the practitioner present their needs persistently, professionally and in a non-threatening way. However, redress is more difficult with the authoritarian supervisor who likes to use their power, where the supervisee has to be careful to always operate within agency policies and procedures, which the supervisor will know well.

In some instances, the person seeking to address the tactics may wish to seek external advice and support before doing so. This may include seeking advice from Human Resources and respected peers. Where patterns are entrenched, or the defences too strong, it will not always be possible to address the tactics, and finding ways to 'stay safe' within them can be required. In these cases, it is the author's experience that it is useful to make alternative arrangements for external supervision to ensure your own professional needs are meet.

Creating Safety and Trust

The dynamics outlined in this paper are, on some

level, about trying to create safety in a complex professional relationship. For deep reflective supervision of clinical practice to occur, supervisees need to feel safe to explore uncertainty in their practice. The supervisee needs to be able to trust their supervisor to challenge them in ways that can grow their practice, yet not devastate them. There is an art to this form of challenge – to be able to assess how much true feedback and challenge a supervisee can tolerate before defensiveness arises. The author suggests Line Manager / Team Leader supervisors have two tasks in this area. They need to understand and ideally be able to define their approach to leadership – to be clear when they are acting within their line management responsibilities and in what ways. Alongside this, they need to skill themselves up in the provision of clinical supervision, and the creation of a safe clinically reflective space separate too but, while maintaining, their role as manager.

Neither of these are straightforward tasks, and rarely do organisations prioritise a team leaders professional growth amongst the busyness of tasks to be completed. Many practitioners feel unprepared when transitioning into a supervisory role (Hafford-Letchfield & Engelbrecht 2018).

Relational approaches to leadership and management (Uhl-Bien, 2006 and subsequent work) are often a good fit with counselling and welfare approaches. Goleman's leadership styles (Figure 1), based on his work around emotional intelligence, can provide a quick reference check for the various managerial hats that team leaders and managers need to get comfortable with. (appendix 1). Feminist Intersectional models of supervision would suggest self-disclosure to explore difference to work towards an egalitarian supervision relationship (Brown, 2016), however this may be difficult to achieve where there are inherent organisationally sanctioned power differences.

There is not an agreed industry standard of training to provide supervision, and many practitioners simply offer what they have experienced or would like to have experienced. Undertaking both training and supervision focused on the provision of clinical supervision can be valuable, as well as becoming aware of your own learning and conflict styles, in order to be able to examine how these play out in your supervisory provision. Supervision can be a form of clinical alignment between the supervisor and supervisee. The supervisor comes alongside and helps the supervisee examine their own practice to help that person uncover various alignments, biases and lenses they may have developed. To do this, the supervisor has to come alongside, build trust and then assess how much gentle challenge and critique a supervisee can cope with.

For both supervisees and supervisors, it is hoped this article will prompt practitioners to think about the impact and ramifications of past supervisory experiences on their sense of safety and where it may be that they can explore the down sides of engaging in pre-emptive dynamics. Supervisees are encouraged to understand and articulate their supervisory needs (See Cousins, 2020). It is also recognised that sometimes, supervisory safety will not be obtained, and the practitioner will need to look for other places to explore the more vulnerable aspects of their practice.

Conclusion

Whilst not a comprehensive list, it is hoped that by drawing together these examples of dynamics that can occur within a supervisory relationship, this article can become a useful reflection and discussion piece for practitioners and supervisors alike to examine this complex aspect of practice, their interactions and intentions within it. As mentioned, while many of the approaches outlined have legitimate aspects, they can also hinder safe, productive and effective supervision. The author would encourage practitioners and their supervisors to examine their motives, and their processes of accountability in regard to their supervisory relationships. It takes bravery to questions one's own practice, seek feedback and go after growth. However, to pursue transparency about these dynamics can be a catalyst for real professional development and ultimately result in more insightful responses to clients and professional challenges.

Bio

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References

Adamson, C. (2012) Supervision is not Politically Innocent, *Australian Social Work*, Vol. 65 (2), pp. 185 – 196.

Berne, E. 1964. *Games People Play: The Psychology of Human Relationships*, Mass Market Publishing, Penguin, London.

Brown, L. (2016) Supervision Essentials for the Feminist Psychotherapy Model of Supervision, Washington DC: American Psychological Association.

Carroll, M. & Shaw, E. Ethical Maturity in the Helping Professions, PsychOz Publications, Victoria.

Children's Workforce Development Council (CWDC) and Skills for Care 2007 *Providing Effective Supervision: A workforce development tool* (accessed 2nd April 2010) available at http://www.skillsforcare.org.uk

Cooper, L. (2002) Social Work Supervision: A Social Justice Perspective, In McMahon M. & Patton, W. (Eds) Supervision in the helping professions: A practical approach, NSW, Pearson Education.

Cortis, N., Seymour, K., Natalier, K. & Wendt, S. 2020 'Which Models of Supervision Help Retain Staff? Findings From Australia's Domestic and Family Violence and Sexual Assault Workforces', *Australian Social Work,* 74:1, 68-82

Cousins, C. (2010) 'Treat Me Don't Beat Me' … Exploring Supervisory Games and Their Effect on Poor Performance Management, *Practice: Social Work in Action,* Vol. 22, Issue 5, 281 – 292.

Cousins, C. (2020) Are you getting what you need from Supervision?, *Australian Counselling Research Journal,* Vol.14 (1), 10-15.

Dill, K. & Bogo, M. 2009. Moving beyond the administrative: Supervisors' perspectives on clinical supervision in child welfare.

Journal of Public Child Welfare , Vol. 3, Issue 1, 87-105.
Donovan, F. and Jackson, A. (1991) 'Human resource (personnel) management', Managing Human Service Organisations, Prentice Hall, New York, pp.305 - 319, 322 - 345.
Durrant, M. (2001) 'Solution focussed and strength based approaches to Supervision', unpublished paper, Brief Therapy Institute of Sydney.
Egan, R., Maidment, J., & Connolly, M. (2018), 'Supporting quality supervision: Insights for organisational practice', in *International Social Work*, vol. 61 no.3, pp. 353–367
Gibbs, J. (2001) Maintaining frontline workers in child protection: a case for refocusing supervision, *Child Abuse Review,***10**,5, 323 – 335.
Goleman, Daniel. "LEADERSHIP THAT GETS RESULTS." *Harvard Business Review,* vol. 78, no. 2, 2000, p. 78.
Hafford-Letchfield, T & Engelbrecht, L 2018, 'Contemporary practices in social work supervision: time for new paradigms?', in *European Journal of Social Work,* vol. 21, no. 3, pp. 329-332
Hawthorn, C. (1975), Games Supervisees Play, *Social Work,* May, pp.179 - 183.
Kadushin, A. (1968) Games People Play in Supervision, *Social Work,* July.
Kahn, E. (1979) 'The Parallel Process in Social Work Treatment and Supervision', *Social Casework: The Journal of Contemporary Social Work,* Family Service Association of America, pp. 520 - 528.
Morrison, T. & Wonnacott, J. (2010) Supervision: Now or Never. Reclaiming reflective supervision in social work, http://www.local.gov.uk/c/document_library/get_file?uuid=d4830a8e-5e1d-466b-a48b-572b210b5ff8&groupId=10171
O'Donoghue, K. (2012) Windows on the Supervisee experience: An exploration of supervisee's supervision histories, Australian Social Work, 65 (2), pp.214 – 231.
Social Work Taskforce, 2009, *Building a safe, confident future,* http://publications.dcsf.gov.uk/eOrderingDownload/01114-2009DOM-EN.pdf
Uhl-Bien, M. "Relational Leadership Theory: Exploring the social processes of leadership and organizing" (2006). Leadership Institute Faculty Publications. 19.

Appendix 1 – Adapted from (Goleman, 2000)

According to Daniel Goleman there are six basic styles of leadership, each making use of key components of emotional intelligence. The best leaders will be skilled at several styles and have the flexibility to switch based on situational need. Most roles will require a leader to be able to shift between all of these styles at some point.

The affiliative leader: creating emotional bonds and harmony: The hallmark of the affiliative leader is a "People come first" attitude. This style is particularly useful for building team harmony or increasing morale. But its exclusive focus on praise and motivation can allow poor performance to go uncorrected. Also, affiliative leaders rarely offer advice, which often leaves employees in a quandary.

The democratic leader: builds consensus through participation: By giving workers a voice in decisions, democratic leaders build organisational flexibility and responsibility and help generate fresh ideas. But sometimes the price is endless meetings and confused employees who feel leaderless.

The commanding leader: demands immediate compliance: This "Do what I say" approach can be very effective in a turnaround situation, a natural disaster, or when working with problem employees. But in most situations, coercive leadership inhibits the organization's flexibility and dampens employees' motivation.

The pacesetting leader: Expects excellence and self-direction: A leader who sets high performance standards and exemplifies them herself has a very positive impact on employees who are self-motivated and highly competent. But other employees tend to feel overwhelmed by such a leader's demands for excellence and to resent his tendency to take over a situation. This can create a negative climate.

The visionary leader: Mobilises people towards a vision: Continually concerned with positively energizing the team to reach objectives that contribute to achieving organisational goals. This leadership style is very effective for motivating team members. Works best when a clear direction or change is needed. The trade may be that this style of leadership lives too much in the future/clouds and is not concerned enough with the day-to-day.

The coaching leader: Develops people for the future: Concerned with the development of team members. The coaching leader attempts to identify the strengths and weaknesses of employees and encourage them to improve their skills and capabilities. The focus is on building long-term strengths.

Identifying the main components of a counselling modality that is culturally appropriate for an Australian Indigenous community.

Katarina Linder

The literature about culturally appropriate clinical practice when working with Aboriginal Australians focuses predominately on being culturally respectful and aware, particularly during assessments. What appears to happen after that, regardless of culturally appropriate methods, counselling therapies are still based on western individualistic models. In contrast, Aboriginal culture is based on a collective society that prioritises interdependence and a person's role within the larger group or community. Little research has been conducted within Australia that demonstrates the efficacy of current treatment models, other than highlighting the gap in the engagement of mental health services with Indigenous Australians. A counselling model of therapy for a collective society needs to be developed, which embeds Australian Indigenous views and perspectives.

Introduction

"Little recognition is given to Aboriginal and Torres Strait Islander worldviews, wisdom, knowledge and methods, which span more than 60,000 years and represent the resilience of the oldest living culture" (Dudgeon and Burgess, 2021).

The literature about counselling practice when working with Aboriginal Australians focuses predominately on being culturally competent and respectful, particularly during assessments (Purdie, Dudgeon and Walker, 2014). There is little literature available that describes what happens after the assessment phase and therapy has commenced. Regardless of culturally appropriate methods, the mental health system and counselling modalities are still based on western individualistic models (Dudgeon and Burgess, 2021). Overall, mainstream mental health services have poor engagement rates with the Aboriginal community (Dudgeon and Kelly, 2014). In contrast, Aboriginal culture is based on a collective society that prioritises interdependence and a person's role within the larger group or community. Little research has been conducted within Australia, demonstrating the efficacy of current treatment models, so a broader literature search on other collective societies will be included. Nagel et al. (2011) note the challenge of the unmet mental health needs in Indigenous communities and the need to change practice. Even so, they can also note that "evidence for effective treatment for depression or other mental illness in Indigenous peoples is difficult to find" (Nagel et al, 2011, p. 18).

It appears that a counselling model of therapy for a collective society that begins with and embeds Aboriginal views and perspectives is lacking and needs to be developed. The author's aim is to identify the main components of a counselling modality that does not superimpose western models of therapy and is culturally appropriate for an Australian Indigenous community.

Method

This review assesses the available literature regarding the historical and current barriers to a culturally appropriate model of therapy for Australian Indigenous people. The search strategy for research articles on this topic was conducted via the UNE Library website and Google Scholar. The primary phrases used in the searches were "counselling for Australian Aboriginal people"; "individualistic versus collective counselling therapy" and "mental health in Australian Indigenous communities". Due to the low number of articles directly relating to Australian Aboriginal collective society, searches were extended to include New Zealand Maori, American Indian and Indian societies as they are also collective communities. Further articles were located using the recommended list of articles to the right of the screen (in UNE library searches) and using the reference list of relevant articles. The selected research studies selected were published from 2010 until the present. Reports written on behalf of government

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agencies were also used as well as a recent newspaper article.

Results

Australian Indigenous people as a collective society

The primary feature of a collective society, including the Australian Indigenous people, are that the collective values of the community and family take priority over the individual; they also have a strong connection to land (McKivett, Paul and Hudson, 2019, p. 599). The kinship system within Indigenous communities are complex; they arrange their relationships so that each person knows their place within the community, their role and cultural responsibilities (Purdie, Dudgeon and Walker, 2014). The relationship also extends to the land of which Indigenous people have a strong spiritual connection; creation is told within Dreamtime stories and expresses a oneness with the land (Purdie, Dudgeon and Walker, 2014). An important aspect of being in a collective society is that they do not necessarily like to be alone but like to be left alone when they want privacy (Hagan, 2008, p. 32). There are also generalised differences in interaction in Australian Indigenous culture, for example - not asking direct questions (as in western cultures and, therefore mainstream services), and this may cause misunderstandings between cultures (Hagan, 2008).

International commonality between Indigenous communities

Chadda and Deb (2013, p S299) refer to Indian society as collective and define it as "the philosophic, economic, or social outlook that emphasizes the interdependence amongst human beings. It is the basic cultural element for cohesion within social groups, which stresses on the priority of group". Within the context of a collective community, Indian families can meet the physical, spiritual and emotional needs within the group including providing support and encouragement (Chadda and Deb, 2013).

Crozier and Pizzini (2019) refer to the Maori as a collective society where their identity is based on relationships within family and community but also extends to a connection and belonging that reaches into the past. Connor, Gremillion and Meima (2016, p. 242) highlight Māori concepts of "connectedness, interrelatedness, and relationality" as they do not view themselves as separate from spirituality or the environment. The Maori way of understanding the world around them, their beliefs and their cultural practices is often misinterpreted in a western-based psychiatric service (Crozier and Pizzini, 2019).

The colonisation of Canada and America has had a long-lasting negative impact of the North American Indigenous people as their culture is primarily grounded to a specific place and connection to the environment (Kirmayer et al., 2011, p. 84). The North American Indigenous people were historically displaced from their land and, still today, continue to experience oppression, western based control and a loss of community led governance (Kirmayer et al, 2011, p. 84). France (2020) is an Indigenous American and notes that there are strong similarities in spiritual concepts with Australian Indigenous people. Creative arts and traditional healing practices are important within the Indigenous American community (France, 2020).

Impact of colonisation resulting in poor mental health

In Australia, the term Social and Emotional Wellbeing is frequently used to broaden understanding of mental health in Indigenous communities. It is regarded as a holistic term that is culturally appropriate, as it reflects the holistic view that many Indigenous people have towards health and how traumatic experiences adversely affects an individual's wellbeing. (Day and Francisco, 2013). It is widely recognised that the poor mental health and associated issues within Aboriginal communities is a direct result of colonisation (Purdie, Dudgeon and Walker, 2014). This history includes the forced removal of Indigenous children and massacres of Indigenous communities, which has led to intergenerational trauma and entrenched disadvantage in health, education, work, financial and social areas (Dudgeon and Kelly, 2014). Trauma has been defined as "what happens to a person when there is either too much too soon, too much for too long, or not enough for too long (neglect)." (Duros and Crowley, 2014, p. 238). The overall trauma and disadvantage for Indigenous Australians includes structural oppression and discrimination, resulting in negative physical, social, and emotional outcomes for individuals, families, and communities (Redmond, Pedersen and Paradies, 2014). Many Indigenous Australians often find themselves feeling caught between two worlds — their Indigenous heritage and the white world; this confusion can lead to a sense of not belonging in either world, along with a feeling of isolation (Wallace, 2014). There is also a pervasive negative pattern of thinking regarding Australian Indigenous people that ignore the strengths of their familial, holistic and spiritual aspects in culture (Bourke, Humphreys, Wakerman and Taylor, 2010).

Impact of intergenerational and collective trauma

'Footprints in Time' was a study conducted with Aboriginal families over a ten-year period beginning in 2008 (Department of Social Services, 2020). The results showed for the parents that had experienced racism had poorer health and their children often had difficulties with social and emotional wellbeing (Calma, 2016). The Footprints in Time study also showed that child and their carers experience of racism were directly linked to increased rates of asthma, obesity, sleep disturbances and mental health issues (Shepherd et al., 2016). Adverse Childhood Events (ACEs) are known to increase the risk of poor health outcomes, including asthma, emotional, development and behavioural problems (Thompson et al., 2020). Bartley, Kelly and Sacker (2012) found in their prospective study of the National Child Development Study (NCDS) (1958–2004) a direct link between childhood financial adversity between birth and 11 years of age to lung function issues in midlife (ages 44–46 years) in men and women. The social conditions of early housing instability, social disadvantage and smoking were compared, and the results showed that the primary link (over two-thirds) to reduced lung function in adults was poor housing (Bartley, Kelly and Sacker, 2012). The poor housingthat related directly to poor educational outcomes, often leading to a lower social class and financial instability (Bartley, Kelly and Sacker, 2012).

Cultural awareness superimposed on existing therapies

Dudgeon and Kelly (2014, p. 9) warn against using "Western psychological concepts" as they may have the

unintended result of undermining the social and emotional well-being of Indigenous people as these models are not "culturally responsive" (Dudgeon and Kelly, 2014, p. 8). Bennett and Babbage (2014, p.19) attempted a study superimposing Indigenous cultural aspects into a CBT mode of therapy. They note that its effectiveness with ethnic minority groups is "less compelling" and incorporated Indigenous people in this category. It is interesting although they reference Dudgeon and Kelly's (2014) warning, their study went ahead with a Western model of therapy into an Indigenous cultural setting. Yeh, Hunter, Madan-Bahel, Chiang and Arora (2004) suggest that the mainstream primary method of counselling being based on talking theories may be inadequate but may also exclude Indigenous people as their values prioritise social connectedness and spiritual worldviews.

Western modalities that may be adapted to Indigenous needs

- **Polyvagal theory** provides a way of understanding the role and function of the autonomic nervous system in the human body's ability to connect with others and protect itself from danger (Dana, 2020, p. 26). The autonomic nervous system can self-regulate emotions and to socially engage with others; it is also capable of sensing threats whether that be within themselves or externally through social cues (Porges, 2021). Sociality, according to Polyvagal Theory, is the primary function which reduces possible danger reactions and supports mental and physical health (Portes, 2021).
  Dana (2020, p.26) outlines the three principles of Polyvagal Theory based on evolutionary neurological development –

1. Autonomic hierarchy – dorsal vagal system was developed first, and when activated, the body will become immobilised.
   - The sympathetic nervous system is used for the fight or flight response.
   - The latest part of the nervous system to develop is the ventral vagus system which gives the ability for safety through social connection.

   When a person perceives danger whether it be physically, psychologically, or emotionally, it is possible to ascertain whether the person is operating from a dorsal vagal dysregulation or a sympathetic state which a both different levels of survival states. When safety is established and the person is functioning for a ventral vagal state then the body and brain can work together again (Dana, 2020).
2. Neuroception – the body's nervous system operates without conscious awareness and is constantly assessing safety and danger within the body, in the environment and in relationship with others.
3. Co-regulation – is essential for survival as it is the way people connect with others and seek safety in relationship with others.
   As a result of trauma, people will often display "unpredictable, rapid, intense, and prolonged states of dysregulation. This autonomic imbalance and lack of flexibility leads to health problems" (Dana, 2020, p.34). When counselling people who have suffered trauma and their nervous system is dysregulated as a result, creating safety in the relationship is vitally important; "Without safety, there can be no progress." (Duros and Crowley, 2014, p. 240). A relationship between the Counsellor and client is an emotional and relational one where the Counsellor showing respect and unconditional positive regard can assist the client to feel safe (Duros and Crowley, 2014, p. 240).

- **Compassion-focused therapy** begins with creating safety and recognises the neurobiological impact trauma has on the nervous system. As the ventral vagus system is functioning, people can have an increased awareness of themselves and others; understand themselves and others holistically reaching a point of shared humanity that includes suffering (Steindl, 2020). Steindl (2020, p. 29) defines compassion as 'to suffer with' as the word is derived from Latin with 'com' meaning 'with, together' and pati 'to suffer'. Steindl highlights the importance of compassion flowing in three directions – compassion for others, compassion from others and self-compassion (Steidl, 2020, p. 30). Shame is a negative emotion that comes from how we view ourselves or are seen by others in a social context (Steidl, 2020, p. 113). Indigenous Australians have experienced and often continue to feel shame because of colonisation practices which may stop them from seeking assistance in times of need (Fiolet et al., 2019). Compassion-focused therapy can be used with clients experiencing shame as it may bring an understanding of the purpose of shame and have empathy with the hurt being felt as a result (Steidl, 2020).
  "Compassion is a sensitivity to suffering in self and others, and a motivation and commitment to try to alleviate and prevent it" (Steidl, 2020, p. 161).
- **Narrative Therapy** is primarily based in allowing the client to tell their story in their own constructed way but historically has not followed a strict theoretical approach (Meehan and Guilfoyle, 2015). As Solnit (2017, p. 19) states -
  "Liberation is always in part a storytelling process: breaking stories, breaking silences, making new stories. A free person tells her own story. A valued person lives in a society in which her story has a place."
  Narrative Therapy may be suitable to adapt for use with Indigenous Australians given their culture of yarning and storytelling with others with whom they have an established relationship rather than on a western model of question and answer (Lin, Green and Bessarab, 2016). Lin et al (2014) note that a significant barrier for Indigenous people to access healthcare that is responsive to their needs is communication. Lin, Green and Bessarab (2016) discuss clinical "yarning" that should be an important feature in medical and allied health sessions with Indigenous clients. They outline 3 features within clinical yarning – social, clinical and management. Lin et al (2014) also describe yarning as a two-way conversation, based on storytelling and is not confrontational. McKivett, Paul and Hudson (2019, p. 599) provide a framework for effective cultural communication in a medical sphere including five key steps to promote culturally effective communication; the five steps include "Initiating the session, gathering information, providing structure, building the relationship and explanation and planning". However, these concepts provide a good foundation for the introduction and foundation for therapy but do not address the actual dynamic within counselling therapy itself that may meet the needs of an Indigenous Australian person.
- **Emotion Focussed Therapy (EFT)** is based on four main principles – 1/ the empathetic and genuine relationship between client and Counsellor facilitates change; 2/ the identification and experiencing past events sustains change; 3/ therapy facilitates work on sources of trauma that have led to the current issues; and 4/ EFT can bring about self-agency and self-empathy (Murphy, Elliott, and

Carrick, 2019, p. 497; Harte, 2019, p. 43-44). Emotions are viewed as central to the understanding and experience of self and overall human functioning (Harte, 2019, p. 45) and if a client has had a traumatic experience resulting in painful emotions and unmet needs, EFT may assist in forming adaptive emotions (Timulak and Pascual-Leone, 2014, p. 619). "It is based on therapeutic methods designed to help people accept, express, regulate, make sense of; and, ultimately, transform difficult emotions" (Harte, 2019, p. 46). The Counsellor is supporting the client towards improving their emotional processing as well as more positive ways of relating to their experiences (Watson, Chekan, and McMullen, 2017, p. 122) with the aim of increasing emotional maturity and resilience (Timulak and Pascual-Leone, 2014, p. 627). When working with Indigenous Australians, EFT may be useful in the context of yarning which allows the client to tell their own story.

- **Problem solving therapy** aims to increase a client's resilience when working through how to approach problems as well as finding solutions to problems (Eskin, p. 1). It assumes that clients have lack the skill or knowledge to solve their problems on their own and this may lead to mental health issues (Eskin, p. 95). Hatcher, Coupe, Wikiriwhi, Durie and Pillai, (2016) conducted a study with Maori clients who had been admitted to hospital after self-harming. 95 people consented to the intervention group and 72 people consented to the control group. The intervention included four to six sessions of Problem Solving Therapy in the first four weeks after hospital admission. The Beck Hopelessness Scale was also used as a baseline then repeated after three months and twelve months. The results showed a significant improvement in the Hopelessness scale at three months with the intervention group compared to the control group, but this improvement was not evident at twelve months. The intervention group were less likely to represent at hospital for self-harm at three months but again this improvement was not evident at twelve months. Over the twelve months, the intervention group presented less often to hospital for non-self harm issues. The study shows that the Problem Solving Therapy was beneficial but as it was only offered in the first four weeks, the sustained benefit was not evident after twelve months. When considering Problem Solving Therapy with Indigenous Australians, a longer period using the modality may bring longer lasting results for the client.
- **Bowen Family Therapy** was developed from observations on the dynamics and emotional processes within families including the extended family (Chadda and Deb, 2013, p S299). It is in recognition that the family's culture, perspectives, beliefs including spiritual and religious are imprinted on everyone's life, which may be passed on to the following generation, and therefore must be taken into consideration in therapy (Bulut, 2020). The basic principles as outlined by Bulut, (2020, p. 67) are –
  - "The family is a whole that consists of systems that are interconnected or dependent on one another.
  - The path to understanding the individual is by understanding the family system within which the individual is found.
  - Each individual, being part of a system, is connected with the others.
  - The individuals in the system affect one another."

  Bowen Family Therapy may give a basis for understanding the family as a whole and the individual's ability function within the unit or differentiate from it, it does not consider the power and gender issues that may result in abuse and trauma (MacKay, 2012). Bowen did observe, however, the forces of individuality versus togetherness in relationships and to adapt there needs to a some accommodating or sensitivity to maintain balance (MacKay, 2012). This may result in situations such as emotional or physical distancing and over functioning or over responsibility for another (MacKay, 2012). In a therapeutic context, the client may come to greater awareness of the patterns of conflict including avoidance strategies that impede the overall functioning of the family and therefore the individual; dissociation or self-harm may be the result if not addressed appropriately (MacKay 2012). As noted previously, the Australian Indigenous people have suffered trauma as individuals and as a community. The Bowen Family Therapy may support a client in a greater awareness of these impacts on their community as a collective not only as individuals. Westermann (2010) recommends that a discussion regarding genealogy is paramount to increase the personal connection with the client. She also warns of misdiagnosis when clients are assessed outside or aside of the family and community (Westerman, 2010).

Traditional healing practice / spirituality

The incorporation of traditional cultural practices in therapy may have positive benefits in supporting Australian Indigenous mental health. Munro, Allan, Shakeshaft and Breen (2017) conducted a study in a Drug and Alcohol residential rehabilitation setting interviewing twelve clients (91% Aboriginal) and nine staff (67% Aboriginal). The results show that it was not only the length of time in the program but also the culture, activities and relationships that also increased the likelihood of success. In many Aboriginal communities there are recognised 'Healers' believed to have special skills and timeless wisdom who may support mental health (Yeh, Hunter, Madan-Bahel, Chiang and Arora, 2004). The use of art in a therapeutic environment may also calm the ventral vagal response and shift the way clients think and feel (Dana, 2020, p. 112). The use of storytelling that is based in local Indigenous culture can support the regulation of emotions, increase the person's sense of cultural identity and agency; overall it may promote a person's resilience in social and emotional wellbeing (Kirmayer et al, 2011, p. 84).

Application to author's own counselling practice

The author has recently taken up a position as a Child and Family Counsellor in a remote Aboriginal community in Northern Territory. The barriers for Aboriginal people accessing appropriate care are well documented and there is now increased awareness in state and national government to fund the provision of mental health counselling. The author's aim is to identify components important when counselling Australian Indigenous people so that western models of therapy are not superimposed during therapy but instead a model of therapy is developed that meets the cultural needs for an Australian Indigenous community. As the literature shows Aboriginal communities do not engage well with western models of mental health care, it is

important that the author reflects on her own counselling practice as a Caucasian person with different values, philosophy and belief systems. As a Counsellor within an Indigenous community, the author seeks to develop connections with the leaders and healers in the community and be open to their practices and beliefs and, if possible, incorporate these into therapy. The author has already incorporated conducting therapy with clients 'on country' meaning for example, sitting near the river or a location not in the office. One area of challenge is spirituality as the author does not consider herself to spiritual; incorporating this area into practice will take deep reflection on how the client's view their own spirituality and the significance in their life and community. Another area of challenge for the author is that healing for Indigenous people may not necessarily be measurable or goal oriented (Yeh, Hunter, Madan-Bahel, Chiang and Arora, 2004). Funding from government sources requires regular reporting and key performance indicators are used to support future funding so this is an area that has not yet been explored as the role in the author's community and any other community is in its infancy. The author is fortunate, however, to work in a community that has a strong governance structure and has an Aboriginal Corporation Board that comprises of local leaders from seven tribes. The community has a local decision making agreement with the state government and support their community in many areas as they now have a forum where their voice is heard.

Elements that [in the Author's view] are required in a collective therapy model for Australian Indigenous people

The foundation for a collective therapy model is the understanding, recognition, and acceptance of the nine principles as outlined in the document – Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (Department of the Prime Minister and Cabinet, 2017-2023). The principles highlight the impact that colonisation has had on the Australian Indigenous people individually and as a collective. Not only is therapy important for individuals or families, but there is also the recognition that due to the disempowering of Aboriginal communities that continues to this day, there is healing that also needs to happen on a community basis as well. The empowerment and support for self-determination can be a protective factor against psychological distress (Dudgeon and Burgess, 2021). Strong Indigenous governance combined with a healthy partnership with government and agencies also support social and emotional and wellbeing (Dudgeon and Burgess, 2021).

A counselling modality in a minority culture needs to ensure that it does not become another form of colonisation assuming that human experiences are universal (Crozier and Pizzini, 2019). Instead, a modality that is centred on a biopsychosocial and compassionate basis that incorporates empathy and distress tolerance is best placed to work within another culture (Steidl, 2020). An important feature of working in a minority culture is that often, English is not the primary language for many community members. The Footprints in time study found that children who were supported to speak their primary language (other than English) were more likely to have reduced social and emotional issues (As cited in Department of Social Services, 2020, Page 44). All attempts, therefore, should be made to learn the community's primary language and conduct therapy in that language to allow for freedom of expression of feelings.

Combining counselling modalities may also be of benefit such as art and narrative therapy (Davis, 2017). Art provides a non-threatening but culturally appropriate engagement and therapy tool that may allow clients to talk about their lives in positive and negative aspects (Davis, 2017). Meeting on country that is special to the client is an important factor in developing a safe trusting relationship where respecting their culture is paramount (Davis, 2017). Recognising that Indigenous Australians are part of a collective society and have complex familial relationships, it is important to see them as a part of the whole extended family which is often beyond the usual scope of a western family. Often, due to the extent of the trauma experience individually and collectively, counselling may be a difficult process for Australian Indigenous clients. A problem-solving modality may be of short-term benefit if there is concern that the client will find it difficult to attend therapy on a regular basis due to their difficulty in emotional self-regulation. If the client feels that the relationship provides safety, EFT may then be a modality to try with the aim of increasing emotional regulation and positive expression of feelings.

Conclusion

Counselling therapy is based on westernised modalities that emphasise direct question and answer style talking therapy. This may be the reason that Australian Indigenous people have been reluctant to use mainstream mental health services. The Australian Indigenous culture offers a rich but different way of understanding the world around us and should be incorporated and set as the foundation for counselling. A clear understanding and recognition of the trauma inflicted by historical and current colonisation practices needs to be part of the foundation of treatment. Therapy should include cultural practices such as art, storytelling, spiritual beliefs and belonging to country as well as provide as a holistic social and emotional wellbeing approach.

References

Bartley, M., Kelly, Y., & Sacker, A. (2012). Early Life Financial Adversity and Respiratory Function in Midlife: A Prospective Birth Cohort Study. *American Journal of Epidemiology.* 175(1). Pp 33–42. Retrieved from https://doi.org/10.1093/aje/kwr284

Bennett, S. T., & Babbage, D. R. (2014) Cultural Adaptation of CBT for Aboriginal Australians. *Australian Psychologist.* 49(1). Pp 19-21. Retrieved from https://www-tandfonline-com.ezproxy.une.edu.au/doi/full/10.1111/ap.12029?src=recsys

Bourke, L., Humphreys, J.S., Wakerman, J., & Taylor, J. (2010). From "problem-describing" to "problem-solving": Challenging the "deficit" view of remote and rural health. *Australian Journal of Rural Health.* 18(5). Pp 205–209. Retrieved from https://doi-org.ezproxy.une.edu.au/10.1111/j.1440-1584.2010.01155.x

Bulut, O. A. (2020). The Religious and Spiritual Dimensions of Bowen Family Therapy. *Spiritual Psychology and Counselling.* 5(1). Pp 65-85. Retrieved from https://dx.doi.org/10.37898/spc.2020.5.1.098

Calma, T. (2016). How discrimination and stressful events affect the health of our Indigenous kids, The Conversation. Retrieved from https://theconversation.com/how[1]discrimination-and-

stressful-events-affect-the-health-of-our[1]indigenous-kids-67

Chadda, R. K., & Deb, K. S. (2013). Indian family systems, collectivistic society and psychotherapy. *Indian J Psychiatry.* 55(2). Pp S299-S309. Retrieved from doi:10.4103/0019-5545.105555

Connor, H., Gremillion, H., & Meima, Y. (2016). Couples Work in Cultural Context: Te Ao Māori and Poststucturalist Practices Informing Counselor Training in Aotearoa New Zealand. *Family Process.* 55(2). 238–252. Retrieved from https://doi-org.ezproxy.une.edu.au/10.1111/famp.12210

Crozier, S. & Pizzini, N. (2019). Engaging with indigenous knowledge to shape a bicultural counselling programme in Aotearoa New Zealand. *Psychotherapy and Politics International.* 18(1). Ppi 1515. Retrieved from https://onlinelibrary-wiley-com.ezproxy.une.edu.au/doi/full/10.1002/ppi.1515

Dana, D. (2020). Polyvagal exercises for safety and connection. New York, USA: W. W. Norton & Company.

Davis, V. (2017). My meeting place: Rearming ourselves with cultural knowledge, spirituality and community connectedness. *The International Journal of Narrative Therapy and Community Work,* (3), 5-15. Retrieved from http://search.proquest.com.ezproxy.une.edu.au/scholarly-journals/my-meeting-place-rearming-ourselves-with-cultural/docview/2100822018/se-2?accountid=17227

Day, A. & Francisco, A. (2013). Social and emotional wellbeing in Indigenous Australians: identifying promising interventions. *Australian and New Zealand Journal of Public Health.* 37(4). Pp 350-355. Retrieved from https://doi.org/10.1111/1753-6405.12083

Department of Social Services (2020). *A Decade of Data: Findings from the first 10 years of Footprints in Time,* Canberra ACT.

Department of the Prime Minister and Cabinet. (2017-2023). *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing.* Retrieved from https://www.niaa.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf

Dudgeon, P., & Burgess, Z. (2021) Healing among Indigenous people is more crucial now than ever. Here's a way forward. *The Guardian.* Retrieved from https://apac01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.theguardian.com%2Fcommentisfree%2F2021%2Fjul%2F06%2Fhealing-among-indigenous-people-is-more-crucial-now-than-ever-heres-a-way-forward%3FCMP%3DShare_iOSApp_

Duros, P., & Crowley, D. (2014). The Body Comes to Therapy Too. *Clinical Social Work Journal.* 42(3). Pp 237-246. Retrieved from DOI:10.1007/s10615-014-0486-1

Eskin, M. (2012). *Problem Solving Therapy in the Clinical Practice*. Retrieved from https://ebookcentral-proquest-com.ezproxy.une.edu.au/lib/une/detail.action?docID=1048859

Fiolet, R., Tarzia, L., Owen, R., Eccles, C., Nicholson, K., Owen, M., Fry, S., Knox, J., & Hegarty, K. (2019). Indigenous Perspectives on Help-Seeking for Family Violence: Voices From an Australian Community. *Journal of Interpersonal Violence.* Retrieved from https://doi.org/10.1177/0886260519883861

France, H. (2020). Creative arts and the indigenous healing circle within an indigenous context. *Canadian Journal of Counselling and Psychotherapy (Online),* 54(3), 413-429. Retrieved from http://search.proquest.com.ezproxy.une.edu.au/scholarly-journals/creative-arts-indigenous-healing-circle-within/docview/2448943283/se-2?accountid=17227

Hagan, S. (2008). *Whitefella Culture.* Australian Society for Indigenous Languages. Casaurina, Northern Territory.

Hart, M. (2019). Processing Emotional Pain using Emotion Focused Therapy. Queensland, Australia: Australian Academic Press Group.

Hatcher, S., Coupe, N., Wikiriwhi, K., Durie, S. M., & Pillai, A. (2016). Te ira tangata: A zelen randomised controlled trial of a culturally informed treatment compared to treatment as usual in maori who present to hospital after self-harm. *Social Psychiatry and Psychiatric Epidemiology,* 51(6), 885-894. doi:http://dx.doi.org.ezproxy.une.edu.au/10.1007/s00127-016-1194-7

Kirmayer, L.J., Dandeneau, S., Marshall, E., Phillips, M. K., & Williamson, K. J. (2011). Rethinking Resilience from Indigenous Perspectives. *The Canadian Journal of Psychiatry.* 56(2). Pp 84-91. Retrieved from https://doi.org/10.1177/070674371105600203

Lin, I., Green, C., & Bessarab, D. (2016). 'Yarn with me': Applying clinical yarning to improve clinician-patient communication in aboriginal health care. *Australian Journal of Primary Health. 22*(5). Pp 377-382. Retrieved from doi:http://dx.doi.org.ezproxy.une.edu.au/10.1071/PY16051

Lin, I., O'Sullivan, P., Coffin, J., Mak, D., Toussaint, S., & Straker, L. (2014). 'I can sit and talk to her': Aboriginal people, chronic low back pain and heathcare practitioner communication. *Australian Family Physician.* 43(5), Pp 320-4. Retrieved from http://search.proquest.com.ezproxy.une.edu.au/scholarly-journals/i-can-sit-talk-her-aboriginal-people-chronic-low/docview/1528598250/se-2?accountid=17227

MacKay, L. (2012). Trauma and Bowen Family Systems Theory: Working with Adults Who were Abused as Children. *The Australian and New Zealand Journal of Family Therapy.* 33((3). Pp. 232-241. Retrieved from doi 10.1017/aft.2012.28

McKivett, A., Paul, D., & Hudson, N. (2019). Healing conversations: Developing a practical framework for clinical communication between aboriginal communities and healthcare practitioners. *Journal of Immigrant and Minority Health.* 21(3). Pp 596-605. Retrieved from doi:http://dx.doi.org.ezproxy.une.edu.au/10.1007/s10903-018-0793-7

Meehan, T., & Guilfoyle, M. (2015) Case Formulation in Poststructural Narrative Therapy. *Journal of Constructivist Psychology.* 28(1). Pp 24-39. Retrieved from DOI: 10.1080/10720537.2014.938848

Munro, A., Allan, J., Shakeshaft, A., & Breen, C. (2017). "I just feel comfortable out here, there's something about the place": Staff and client perceptions of a remote australian aboriginal drug and alcohol rehabilitation service. Substance Abuse Treatment, Prevention, and Policy, 12(1), 49. doi:http://dx.doi.org.ezproxy.une.edu.au/10.1186/s13011-017-0135-0

Murphy, D., Elliott, R., & Carrick, L. (2019) Identifying and developing therapeutic principles for trauma-focused work in person-centred and emotion-focused therapies. *Counselling and Psychotherapy Research.* 19, pp 497– 507. Retrieved from https://doi-org.ezproxy.une.edu.au/10.1002/capr.12235

Nagel, T., Kavanagh, D., Barclay, L., Trauer, T., Chenhall, R.,

Frendin, J., & Griffin, C. (2011). Integrating treatment for mental and physical disorders and substance misuse in Indigenous primary care settings. *Australian Psychiatry.* 19(1). Pp 17-19. Retrieved from https://journals-sagepub-com.ezproxy.une.edu.au/doi/pdf/10.3109/10398562.2011.583070

Our Watch (2018) *Changing the picture: A national resource to support the prevention of violence against Aboriginal and Torres Strait Islander women and their children.* Our Watch. Melbourne. Retrieved from https://www.ourwatch. org.au/resource/changing-the-picture/

Porges, S. W. (2021). Polyvagal Theory : A biobehavioral journey to sociality. *Comprehensive Psychoneuroendocrinology.* 7. Pp 1-7. Retrieved from https://doi.org/10.1016/j.cpnec.2021.100069

Purdie, N., Dudgeon, P., & Walker, R. (2014). *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (Second Edition).* Australian Government Department of Health and Ageing. Barton, ACT.

Redmond, J. D., Pedersen, A., & Paradies, Y. (2014). Psychosocial predictors of antiracist bystander action toward indigenous australians. *Peace and Conflict: Journal of Peace Psychology, 20*(4), 474-490. Retrieved from http://dx.doi.org.ezproxy.une.edu.au/10.1037/pac0000062

Shepherd, C.C.J., Li, J., Farrant, B., Hopkins, K. & Priest, N. (2016).

Racism and its impact on the health of Aboriginal children: Insights from the Footprints in Time Study, paper presented at the 2016 Lowitja Institute International Indigenous Health and Wellbeing Conference, November, Melbourne, Australia

Solnit, R. (2017). *The Mother of All Questions.* Chicago, Illinois: Haymarket Books.

Steindl, S. (2020). The Gifts of Compassion. Samford Valley, Queensland. Australian Academic Press Group Pty Ltd.

Timulak, L., & Pascual-Leone, A. (2014). New Developments for Case Conceptualization in Emotion-Focused Therapy. *Clinical Psychology and Psychotherapy.* 22(6). Pp 619-636. Retrieved from https://onlinelibrary-wiley-com.ezproxy.une.edu.au/doi/full/10.1002/cpp.1922

Thompson, L. A., Filipp, S. L., Mack, J. A., Mercado, R. E., Barnes, A., Bright, M., . . . Gurka, M. J. (2020). Specific adverse childhood experiences and their association with other adverse childhood experiences, asthma and emotional, developmental and behavioral problems in childhood. *Pediatric Research, 88*(1), 100-109. Retrieved from doi:http://dx.doi.org.ezproxy.une.edu.au/10.1038/s41390-020-0784-y

Wallace, G. P. (2014). What can circle sentencing courts tell us about drug and alcohol problems affecting Aboriginal communities? *Medical Journal of Australia.* 11. Pp 675-677. Retrieved from https://onlinelibrary-wiley-com.ezproxy.une.edu.au/doi/full/10.5694/mja14.00267

Watson, J. C., Chekan, S. S., & McMullen, E. (2017). Emotion-focused psychotherapy for GAD: Individual case comparison of a good and poor outcome case. *Person-Centered and Experiential Psychotherapies,* 16(2), pp.118– 139. Retrieved from https://doi-org.ezproxy.une.edu.au/10.1080/14779757.2017.1330707

Westermann, T. (2010). Engaging Australian Aboriginal Youth in mental health services. *Australian Psychologist.* 45(3). Pp 212-222. Retrieved from http://web.b.ebscohost.com.ezproxy.une.edu.au/ehost/detail/detail?vid=0&sid=2d522145-a69e-42b5-b0a8-68c8f62209c2%40pdc-v-sessmgr01&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db=a9h&AN=53467390

Yeh, C. J., Hunter, C. D., Madan-Bahel, A., Chiang, L., & Arora, A. K. (2004). Indigenous and interdependent perspectives of healing: Implications for counseling and research. *Journal of Counseling and Development.* 82(4). Pp 410-419. Retrieved from doi:http://dx.doi.org.ezproxy.une.edu.au/10.1002/j.1556-6678.2004.tb00328.x

Significance of ancient Indian wisdom and its relation to professional supervision

Sayee Bhuvaneswari, Dr. Vasuki Mathivanan

Tat Tvam Asi – "Thou art that "– "You are That" It is the Reality in me, in thee, and everything—therefore, "Tat Tvam Asi "– Indian Sacred text - Upanishad

Introduction

The human race evolved across countries over centuries, across cultures over boundaries. The best of brains led to many inventions and progression in our lifestyle. However, the mind has always remained a mystery and an object of study since the sixth sense came into existence. Every culture carries a vast level of literature from the time of its creation, written and/ or narrated by enlightened human minds. These are treasures of ancient wisdom explaining principles and practices not just for religious purposes but for varied subjects like philosophy, science, psychology, etc. The sacred Indian scriptures played a major role in creating a repository of writings and interpretations of Vedas, Upanishads, Bhagavad Gita, etc. These are like modern paintings by great saints who gave us hidden messages that there is more to life than what we just see with our senses. The Perception of those drawings was up to one's level of consciousness and their level of (in)ability to convey what they saw inwards and outwards.

When it comes to mental health, ancient Indian scriptures encompass deep, empirically derived psychological theories and concepts interlaced with religious principles. There are numerous researches done by wisdom seekers about counselling theories, drawing parallels with mental health practices from Indian Vedic literature and their relevance to modern practices. With the increasing demand for Counselling, not only has the counselling profession progressed, the risk of maintaining standards and effective practice increased too. So, supervision became the key to ensuring the effectiveness of the process. The necessity for supervisory practices has gained momentum over the years and the significance of supervision is being emphasized by every experienced mental health professional. The sacred texts still have untapped areas of wisdom relating to the mind and its wellbeing which is the subject of study for researchers worldwide. This article attempts to take a minuscule drop of wisdom to draw insights into one of those ancient texts called "Bhagavad Gita "to find the relevance of professional supervision practices. Gita has been studied extensively by scholars across the world for research across diverse areas like psychology, philosophy, business, Management, health, etc. It also combines key concepts written in Vedas and Upanishads and presented in a single complete version.

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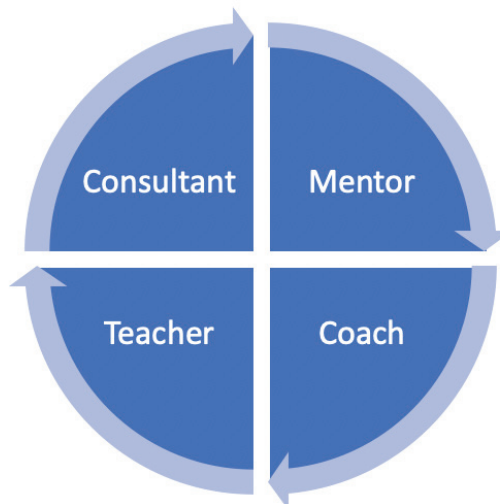
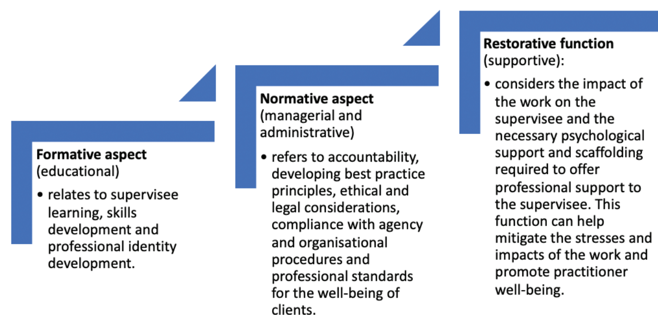
Supervision and its relevance to mental health

Supervision, as quoted by Inskipp and Proctor (1995 is a working alliance between a supervisor and a counsellor in which the counsellor can offer an account or recording of her work; reflect on it; receive feedback and, where appropriate, guidance. This alliance aims to enable the counsellor to gain ethical competence, confidence, and creativity to give her best possible service to her clients. Supervision is a discipline by itself that focuses primarily on teaching, coaching, mentoring, consulting capabilities, and supervisors' knowledge. The point to be noted here is that the supervision is to consult for enhancing and supporting the professional competency of the supervisee, not for counselling their personal issues. The personal issues are explored to an extent to see how it is becoming the barrier to their profession, rather than how it affects them personally. The supervisor dons' multiple hats during the process and it is the supervisor's competence that determines when to switch between those roles. The roles are.



- **Supervisor as a teacher** identifies effective interventions demonstrates models and multicultural issues.
- **Supervisor as a Coach** works with the supervisee to explore their feelings, helps them to define their growth areas, to identify their strengths and weaknesses, and work on them
- **Supervisor as a Consultant** provides and receives systematic feedback and does professional gatekeeping of their competency and discipline.
- **Supervisor as a mentor** teaches supervisees various alternative approaches, facilitates overall development, and helps to establish/emphasize the sense of identity.

This can also be viewed in a different aspect of their supervisory functions.



More than being a mandatory requirement in many countries, counsellors themselves, irrespective of their level of experience, look for supervision for the betterment of their practice and see this as an opportunity for self-development. The key here is about who they chose as a supervisor, as the choice we take in life always make or break us.

Background

The Bhagavad Gita is India's best-known scripture – sometimes called "song of the Lord" is magnificent poetry couched as a dialogue between a warrior prince named Arjuna and his charioteer and teacher, Sri Krishna, an avatar of God – that is, God in human form. This is part of an Indian epic called "Mahabharata".

This dialogue happens in a war field called" Kurukshetra" and it happens in the setting of war between two tribes of the royal family dispute over the power to put in simple words. One side was kurus led by Duryodhana, and another side was Pandavas, led by five princes, which had Arjuna, who was the best warrior prince at that time. It is a deep ingenious metaphor illustrated on every human mind – the fight between evil and good, between darkness and light. While Kurus are supported by renowned war-chiefs in their families, Pandavas are supported by the supreme Lord himself Krishna, who is a relative, friend, Mentor of Arjun. Though Arjun was the chief strategist of the war, on the day of the war, when he sees his own family on both sides wanting to kill each other, he loses his mind and starts to give in to the thought of losing his kinsmen. Krishna then helps Arjun to see the absolute point of view, the fairness of war, the Duties of a warrior, the need for attached detachment, and the ultimate realization of the connection between mind and soul. This was done in 700 verses of poetry called "Bhagavad Gita" which gave Arjun choices and reasons for those choices than commands.

Supervisee Background:

Arjuna is a warrior prince who was a master Archer, fought, and won many battles. He is a master in his field with so many victories to his credit and a well-experienced warrior. He was always clear about his strategies and hardly lost any battles. He was the key person who planned all strategies and done preparation for the Kurukshetra war. As a prince, he had so many struggles in the war field and personal life, but he never gave in to any pressure. Arjuna was the person any mother, wife, friend, the brother would cherish and be proud of. He had a great acumen in his profession, he was so dutiful, ethical, and loyal. In psychological terms, he was a great practitioner and never showed any psychosomatic symptoms due to his profession.

Supervisor Background:

Sri Krishna born as a cowherd was the world's renounced master of consciousness. He was one of the incarnations of Hindu God Lord Vishnu. He has played many roles throughout his life: warrior, Coach, Mentor, Strategist, go-getter, Charioteer. He celebrated life, always lived in the present, and treated darkness and light equally. He was respected by everyone equally. He was a scholar and a skilful master of many fields but a remarkable learner.

Arjuna's as a Supervisee and his view of Krishna as a Supervisor

Counsellors are exposed to situations that impose a great amount of stress. It's not possible to be objective about their agenda, practice, or ability during such times. Arjuna was in that kind of situation many times before, however, the battlefield now was completely different where he had confusion about the choice of duty vs values, and it was also about his inner conflict. E.g.,

Conflict 1: if he goes fighting in the war, he will be killing his kith and kin.

Reference: Bhagavad Gita Verse: 1:34 – 35:

"Teachers, fathers, sons, grandfathers, maternal uncles, grandsons, fathers-in-law, grand-nephews, brothers-in-law, and other kinsmen are present here, staking their lives and riches. O Madhusudan, I do not wish to slay them, even if they attack me. If we kill the sons of Dhritarashtra, what satisfaction will we derive from the dominion over the three worlds, what to speak of this Earth?"

Conflict 2: If he withdraws from the war, he is going to fail his duty and bring dishonour not only to his profession but to his lineage

Though he was so experienced, he couldn't be firm on which side to pick, and he goes to Krishna for guidance (Supervision). Krishna as a supervisor decided not only to counsel but to play all roles of a supervisor for the wholesome development of Arjuna than solving one of the issues. He spends 18 sessions (18 Chapters of Gita) to observe, mentor, coach, evaluate, inspire, Arjuna and though the environment (War) Wasn't very conducive, he gives such comfort to his supervisee that promotes self-motivation, learning, and professional development in a short span of time as time is of the essence here.

It is the supervisor who can be objective in such situations to help supervisees to learn and grow. In The battlefield of Kurukshetra, Arjuna was the victim of the situation whereas Krishna was the master of the situation. He was able to guide

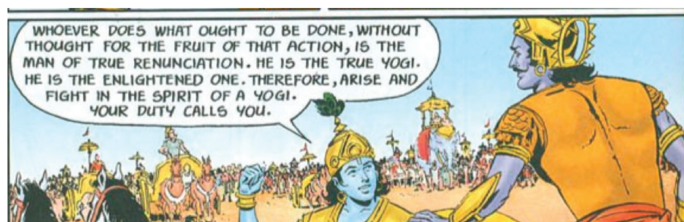
Arjuna to identify and handle his countertransference.

Let us now see how Krishna played all roles of a supervisor in such a situation. When Arjuna (Supervisee) came to him with a confusing thought and with the physical symptoms reported such as Body Shivers, Weakness of limbs, Goosebumps, Dry Mouth, Dropping the bow, Skin Burning Sensation, Krishna quietly listened to all his rantings, and he becomes quite objective in his approach as Krishna knows Arjuna's skills and immediately understands that it is not a question of competency but conflict. He immediately can see that Arjuna is in the level 2 stage of Supervisee one who is more focussed on process, Confused, lacks integration into the practical approach however highly ethical. Hence Krishna knows as a highly-skilled supervisor that his supervisee needed more suggestions for introspection, Alternative views/ approaches, deeper understanding of dynamics

Supervisor as a Coach

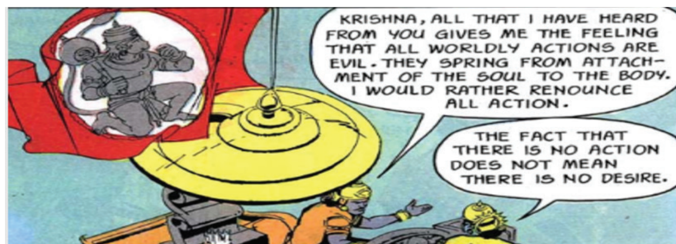
Knowing well of the background and skilled at war field, Krishna starts to coach by asking him a question "My dear Arjun, how has this delusion overcome you in this hour of peril? ". This makes Arjuna more objective about his problem; hetalks about his confusion about duty and the perceived consequences of his action. Krishna then starts to observe and explore Arjuna's total behavior of his thoughts, feelings/emotions, and actions. This helps Krishna to understand Supervisee's problem to plan for development, interventions, and corrections.

Supervisor as a teacher



After understanding the presenting problem in detail, Krishna decides his approach to supervision, and he picked up a treatment-based approach primarily relying on psychotherapy-based models modelling the behaviour of the supervisee. He starts to educate Arjuna about Karma Yoga, which he says to him that never consider yourself to be the cause of the results of your activities, nor be attached to inaction. He clearly teaches that "you are your choices." "He uses intervention client-focused techniques like Reality therapy where he asks a lot of questions which leads to greater introspection thus leading to realization. He uses metaphors effectively to tell him that like the ocean undisturbed by the streams coming in, one should know how to treat all life experiences equally. He also gets philosophical explaining the fight is the duty of a warrior and killing only harms the body of his family not the soul as the soul is immortal. He goes deeper educating him on soul and lifecycle, thus imparting knowledge on deeper theories.

Supervisor as a Consultant



Krishna now moves to a stage of giving feedback about Arjuna, which is given for him to review the process, improvise the supervisee's competency, and impart clarity of thoughts. He carries this process by allowing Arjuna to evaluate his actions and will enable him to question. The point to note here is that Supervisor is not an authoritative figure but a support system/ enabler for the supervisee and the dialogue should be healthy, two-way, and should be given freedom of confrontation and disagreement.

He also does the professional gatekeeping by explaining the qualities (Virtues) needed to develop competency with 360-degree development.

Bhagavad Gita: Chapter – 13 Verse 7-11

Humility, sincerity, violence, patience, simplicity, reverence for one's teacher, purity, firmness or stability, self-control; renunciation of the objects of sense gratification, absence of ego, perception of the evil of birth, death, old age and disease, non-attachment to children, wife, home, evenness of the mind in fulfillment and frustration of the mind; devotion to the service of the Lord, is called knowledge, and whatever remains is ignorance.

Supervisor as a Mentor

Though Arjuna now is clear about his duties and understands that he should go ahead fighting as it is his karma

yog, he still clarifies that you have talked not only about Karma yog, but you also educated me on Bhakti Yog, divine principles which teach that leading life with detachment through devotion as attachment leads to desire, and from desire arises anger. And you also talked about jnana Yog (knowledge) which is about the path of knowledge that leads to the absolute truth and the purest way of attaining absolute consciousness. So, if you consider knowledge superior to action, why do you ask me to indulge in this terrible war? This is where Krishna decides to coach his supervisee to enable him to see right through wrong, choose wisely, and give him more alternative ways to approach for success. He informs Arjun that you must understand the nature of all three—recommended action, wrong action, and inaction. Therefore, with the sword of knowledge, cut asunder the doubts that have arisen in your heart, Establish yourself in karm yog. Arise, stand up, and act. It is important to understand that action doesn't mean any activity, it means the righteous activity according to one's skill, position, and stature in society.

Throughout the sessions, Krishna uses stories, metaphors, shared self, humor given that the environment is not so conducive, and he ensures that his supervisee is not affected by physical setup but at the same time understands complex theories in a much simpler way. As a supervisor, it is your duty also to ensure that you don't intimidate the supervisee but be a friendly Coach with whom the supervisee can be himself without the fear of acceptance or being inferior. Krishna even goes to the threadbare detail of teaching techniques to keep the focus and the ways to reach absolute consciousness through meditation and mindfulness practices.

Conclusion

With the growing need for counselling and people are suffering from problems of different magnitude, it become mandatory to have a monitoring mechanism as counsellors are dealing with people who come to us during their vulnerable times. Because the field of counselling itself is a very slippery slope irrespective of age and experience of the counsellor, doing supervised practice or having a supervisor is one of the ways to mitigate the potential risks in the practice. This article is an attempt to show the practice of supervision is fruitful anytime even on the battlefield where a person like Arjuna who is been considered one of the best warriors in Indian culture, known for his Archery skills to become illusioned and directionless and needed guidance and clarity from Krishna, who used his wisdom to teach Arjuna to discover and gain Self-knowledge about the whole situation. Further, it is an acceptable practice in many cultures to be guided and mentored by a person with rich life experiences and uses his wisdom to guide the other person during such trying times and be a great example and a role model for them to follow and learn.

In Gita, Krishna also shares the same thought about how a supervisor should be in

Chapter 3 verse 20-21: perform your work to set an example for the good of the world. Whatever actions great persons perform, common people follow. Whatever standards they set; all the world pursues.

References

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2738332/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4791389/
- https://www.ncbi.nlm.nih.gov/books/NBK64848/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3361835/
- https://escipub.com/Articles/AJCRR/AJCRR-2017-09-0101
- https://www.researchgate.net/publication/259150579_Supervision_of_counsellors
- https://aspirace.com/wp-content/uploads/2015/11/Clinical-Supervision-and-Professional-Development-CE-Course-1.pdf
- https://www.jstor.org/stable/40017693
- Adhikari, N. (2071).What I understand Gita (Nepali). Lamjung, Nepal: Ramakanta Adhikari
- Agarwal, S.P. (1995). The social message of the Gita symbolized as Lokasamgraha. Maryland USA: Urmila Agrawal.
- Sen, A. (2000). Consequential evaluation and practical reason. The Journal of Philosophy, 92, 477–502.
- Bhagavad Gita As it is , By A.C. Bhaktivedanta Swami Prabhupada
- Perennial Psychology of the Bhagavad Gita, by Swami Rama
- Paramhansa, Yogananda. God Talks With Arjuna, Yogada Society of India, Kolkota, 2002.
- Radhakrishnan S. „The Bhāgvad-Gitā" (1973), Harper and Raw, New York
- Bhagavad Gita by Eknath Eswaran
- Picture references – Amar Chitra Kadha Book

Depression: A comparison of Australian and Indian University Students

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Ethical Standards: The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

Depression: A comparison of Australian and Indian university students

The present study compared Australian and Indian university students to examine their depressive experiences and the factors associated with their depressive symptoms. Australian (n = 417) and Indian university students (n = 397) completed a battery of questionnaires at their respective universities. Hierarchical regression analyses, after taking into account demographic factors, indicated that psychosocial factors in varying order were associated with depressive symptoms in both samples. In the Australian sample, a perceived lack of connectedness with the university appeared as the strongest factor followed by perceived stress, maladaptive perfectionism, and a decrease in coping, personal standards, organisation, and university support. In the Indian sample, maladaptive perfectionism emerged as the strongest factor, followed by university connectedness, perceived stress, and a low level of problem-focused coping. Implications for allied and health professionals in the two countries are discussed. More specialised and tailored support is recommended in the two countries.

Keywords: *Academic stress, connectedness, coping, depression, perceived stress, perfectionism, student, support, university.*

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Introduction

Depressive symptoms among university students are a major concern for university authorities and mental and allied health professionals (Acharya et al., 2018; Peltzer & Pengpid, 2015). There is considerable evidence that depressive symptoms are associated with university students' impaired psychosocial and academic functioning (Acharya et. al., 2018). Depressive symptoms increase the students' risk of other major mental health issues (Peltzer & Pengpid, 2015). In the West, extensive research on university students has focussed on prevalence and a range of demographic and psychosocial factors associated with university students' depressive symptoms. While information about the prevalence of depressive symptoms is emerging in non-Western countries, there is still limited information about depressive symptoms among students in these countries.

More specifically, it is unclear whether the levels of depression or demographic and psychosocial factors observed in Western countries are also comparable to students from different cultures. Cross-cultural investigations are vital to fully understand and manage students' depressive symptoms globally. Further, it is important to use appropriate scales developed to measure symptoms of depression among university students (Romaniuk & Khawaja, 2013).

Most studies with university students have used self–report measures to examine the depressive symptoms. A systematic review of depression in university students, which incorporated studies using a wider range of valid self-report measures, found that on average prevalence of depressive disorders was 30.6% across 24 studies (Ibrahim et al., 2013). However, as the majority of these investigations were carried out in Western countries (Ibrahim et al., 2013), to address this disparity, other research has examined depressive symptoms experienced by students in non-Western countries (Ben-Ezra & Essar, 2004; Peltzer & Pengpid, 2015).

University students from non-Western countries in Asia (Bayram & Bilgel, 2008; Gunay et al., 2011; Lei et al., 2016; Shamsuddin, et al., 2013; Takayama et al., 2011), the Middle East (Ibrahim et al., 2013; Dinkha & Mobasher, 2012; Hamdan-Mansour et al., 2009) and Africa (Othieno et al., 2014) have reported high levels of depressive symptoms. A systematic review by Akhtar et al. (2020), indicated that 24 % of university students from low- and middle-income countries experienced depression. According to some studies, the levels of depressive experiences were considerably higher than that of students in the West (Bayram & Bilgel, 2008). Studies in India, which examined depression among tertiary students, found a mean prevalence around 50 percent (Joseph, 2011; Nagendra et al., 2012; Singh et al., 2011).

There is substantial evidence that demographic factors are associated with university students' depressive symptoms (Farrer et al., 2016). Studies conducted in the Western countries have highlighted that financial burden, in the form of tuition and living expenses of university education tends to increase students' depression (Adams et al., 2016). Further, students have to enter paid work to manage their financial expenses. However, employment can increase students' overall workload and their susceptibility to depressive symptoms (Khawaja & Duncanson, 2008; World Health Organisation, 2012). The studies conducted in non-Western countries indicate depressive symptoms to be related to low socio-economic factors (Ibrahim et al., 2013; Othieno et al., 2014). A large cross-cultural comparison of university students from 23 countries with varying economical levels found students from developing countries with financial inequality experience more depressive symptoms than those from high-income individualistic countries (Steptoe et al., 2007). Nevertheless, another cross-cultural comparison (Khawaja et al., 2013) found students in Australia, compared to those from Iran and Portugal, reported a higher level of depression. According to the authors, despite the high quality of life in Australia, individualism and a competitive nature of the society contributed to the students' depression.

Considerable data collected from the Western countries indicates that depressive symptoms are higher in female university students, compared to their male counterparts (Acharya et al., 2018; Khawaja & Duncanson, 2008). Studies conducted in the non-West countries have revealed mixed findings for gender. Although, Singh et al. (2011) identified female students to be more depressed in India, others reported Indian males to be more depressed than females (Nagendra et al., 2012). Khawaja et al. (2013) compared university students in Australia, Iran, and Portugal and found depressive symptoms to be higher among male students in Iran. Other studies conducted in India, China and Turkey found no gender- based difference in depressive symptoms (Gunay et al., 2011; Joseph, 2011; Lei et al., 2016).

In the Western countries, other factors, such as living away from home, and the stress associated with this transition can increase the students' vulnerability (Robotham, 2008; Tosevski, Milovancevic, & Gajic, 2010). Further, younger students compared to the mature aged students (Cameron, 2010) and being in the first year of undergraduate education (Farrer et al., 2016) are also associated with depressive symptoms. Similarly, reserch conducted on students in non-Western countries have identified similar triggers for depression. Singh et al. (2011) identified higher rates of depression in those who were in their first or second year of their education, abused substances, or lacked support. Older compared to younger students, and single students compared to married ones, were similarly identified as more depressed in Turkish and Malaysian studies (Bayram & Bilgel, 2008; Shamsuddin et al., 2013).

In general, a range of psychosocial factors are found to be associated with depressive symptoms (Christensson et al., 2011). A bulk of literature indicates that academic stress is common globally and is associated with such symptoms (Barker et al., 2018). University students from all over the world are often burdened by the academic workload (Mikolajczk et al., 2008). There is a strain associated with attending lectures, completing assessment and obtaining high grades (Zhang & Zheng, 2017). In the West, academic stress, which may be related to inadequate skills, is associated with depressive symptoms (Hysenbegasi et al., 2005). Similarly, fluctuating academic demands through the academic year or course have also been associated with depressive symptoms (Barker et al., 2018; Leahy et al., 2010). It appears that in the case of university students in non-Western countries, academic stress in the form of high expectations to achieve is associated with depressive symptoms (Bilican et al., 2016). Further, low motivation and poor academic performance appeared to be related to depressive symptoms among students in Africa (Agolla & Ongori, 2009).

University education can be demanding and competitive, with students feeling pressure to obtain high grades to secure a place in professional degrees or in a work environment (Schofield et al., 2016). Therefore, many students in the West adhere to perfectionism to cope with the demands of academic achievement. Nevertheless, perfectionism can be either adaptive or maladaptive (Khawaja & Armstrong, 2005). Even though adaptive perfectionism in the form of being organised and having high standards may assist students, maladaptive perfectionism as manifested by unrelenting high standards and expectations to excel, along with a tendency to self-doubt and undermine one's abilities, is counterproductive and linked to depression (Mead & Hicks, 2010). Consistent with studies conducted in the West, maladaptive perfectionism was linked with depressive symptoms of students in China (Zhang et al., 2013). Further, in Iran perfectionism driven by social pressures and demands was associated with depression among tertiary students (Besharat et al., 2014).

Literature suggests that students' perception of their academic challenges and appraisal of their own capacity to cope is important for their wellbeing (Acharyta et al, 2018). Students

can perceive their university requirements and tasks as aversive and stressful (Adams et al., 2016). Further, their tendency to appraise their own coping skills and resilience as low can trigger depressive symptoms (Abdollahi et al., 2018). Findings based on studies conducted in the Western countries indicate that low self-efficacy, inadequate problem-solving skills, and a disengaged coping style can also increase the likelihood of depressive symptoms (Abdollahi et al., 2018; Julal, 2013). Further, studies conducted in non-Western countries show those university students' ruminations and thoughts about low self-esteem aggravate their symptoms (Martin & Atkinson, 2020). A low level of social support, lack of personal resources, limited resilience and coping are linked with depressive symptoms (Abdollahi et al., 2018; Martin & Atkinson, 2020).).

In general, universities are aware of the challenges students encounter and try to offer support (Barker et al., 2018). In the West, universities offer various academic and psychosocial supports to help students manage their academic and interpersonal difficulties (Julal, 2013). Many universities try to promote a sense of connectedness between students and the university, as it can act as a protective factor and help students manage their stresses (Levett-Jones et al., 2009). An absence of support and a lack of connectedness can contribute to depression symptoms (Cockshaw et al., 2013; Julal, 2013). Further, facilities vary in quality and may be absent in developing countries (Li et al., 2018; Soliman, 1991). Limited resources for students in low-income countries are related with depressive experiences (Agolla & Ongori, 2009).

In summary, the prevalence of depressive symptoms among university students appears to be a global problem (Ibrahim et al., 2013; Peltzer & Pengpid, 2015). Further, research conducted in both Western and non-Western countries has indicated that students perception of stress, negative thought processes) associated with maladaptive perfectionism and unrelenting high standards predict depressive symptoms (Dunkley et al., 2012; Mead & Hicks, 2010; Schofield et al., 2016). Further, low level of personal strengths and resilience, inadequate and poor coping and problem solving are associated with depression in university students (Abdollahi et al., 2018). Finally, an absence of social support and a sense of connectedness at university level predicted depressive symptoms (Cockshaw et al., 2013; Julal, 2013). Thus, these previous studies have highlighted the possibilities of some common features among the depressive experiences of students from both Western and non-Western countries. Nevertheless, some differences indicate the possibility of variation in the factors associated with the experiences of depressive symptoms of students in different parts of the world (Angolla & Ongori, 2009; Ibrahim et al., 2013; Khawaja et al., 2013; Nagendra et al., 2012;). Considering the adverse effect of depressive symptoms on students, it would be beneficial to examine the role a range of demographic and psychosocial factors play in the depressive symptoms of students (Khawaja et al., 2013; Steptoe et al., 2007). Subsequently, a cross-cultural investigation is important to understand the depressive features which may be common or unique to students from Western and non-Western countries.

The present study aimed to compare students from Australia and India. These two countries differ culturally, as Australia is part of the West and an individualistic and egalitarian society, while India is a collectivistic, authoritarian, and hierarchical society, and considered anon-Western countries (Basabe & Ros, 2005). The present study aimed to use the University Students Depression Inventory (USDI; Khawaja & Bryden, 2006) to explore differences in depressive symptoms between an Australian and Indian sample, and to understand any cultural differences in depression scores. The USDI was developed specifically for university students and has been evaluated using student populations from Western and non-Western countries (Khawaja et al., 2013). The stability of its factors and psychometric properties across cultures indicates its suitability for cross-cultural investigations (Habibi et al., 2014; Romaniuk & Khawaja, 2013). The study aimed to compare the students from the two countries to examine if there were differences in their level of depressive symptoms. As depressive experiences are common among students, it was hypothesised that there would be no significant difference between the two groups. The relationship of demographic and psychosocial factors, including coping, perfectionism, perceived stress, academic stress, and university connectedness and support, with depressive symptoms in the Indian and Australian students was also explored. It was also hypothesised that, due to the cultural contextual differences of these countries, psychosocial factors associated with depressive experiences of the two populations would differ. Taking into an account the exploratory nature of this investigation, no direction was specified.

Methods

Setting

The study was conducted at two universities: one in Australia and the other in India. The Australian university is a public institution established in a large metropolitan city. It falls in the category of younger universities (under 50 years). Its student population is approximately 45,000. The university has three campuses. The students are enrolled in undergraduate and postgraduate courses. The university has a strong emphasis on academic and research programs. The Indian institution is a central university, set in a smaller town. It is a young university (35 years old) with four campuses. The students (approximately 5000) at the university are enrolled in various postgraduate programs. However, nearly 45,000 students are enrolled in various undergraduate programs at 87 colleges linked with this university.

Participants

Participants fell into two samples. Sample 1 consisted of students from an Australian university (*n* = 417). The mean age was 24 years (*SD* = 8.49 years). Eighty percent were female and the others male. Almost all were Caucasian (85%) and domestic (96%) students. Forty-six percent of students were in first year, 25% in second year, and the remaining students (29%) were from third and fourth years, or from master or doctorate programs. The majority (83.3 %) were enrolled as full-time students, and 13.7% as part-time students. Forty-six percent of students worked casually, while 24% were unemployed, and the others were employed part-time (22 %) or full-time (8%). Eighty-three percent of participants were from the Faculty of Health and the remaining from other faculties. Just over half (52%) reported their financial situation as fair, while others considered it very satisfactory (30.5%) or poor (17.5%). Their sources of financial support varied. Nearly half (47%) supported themselves through employment, while other were supported by their parents (28%), spouses (6%), government allowance (14%), scholarships (4%),

or savings (1%). Half of them were very satisfied and the other half fairly satisfied with their living arrangement.

Sample 2 consisted of students from an Indian university (*n* = 396). The mean age was 23 years (*SD* = 1.96 years). Fifty-two percent were males, 47% were females, and the data were missing for two participants. Ethnically, they were all from India. Forty-seven percent of the students were enrolled in the master's program, 12% were doctoral students, and 36% were second year students, while the remaining students were from the other years. All students were enrolled full-time. A high number (78%) were not in any paid work, while 15% worked casually, and a very small number were in part-time or full-time paid work (7%). Nearly half of them were from Health and Law faculties and the others from the remaining faculties. They were either very satisfied (41%) or fairly satisfied (59%) with their financial situation. The majority of the participants were financially supported by their parents (80%), a small number (13%) were on scholarships, while a few (7%) supported themselves through employment. Most (80%) of them were fairly satisfied with their living arrangements, while some were very satisfied (13%), and a few (7%) claimed to be living poorly.

Procedure

Clearance was obtained from the ethical committees of the Australian and Indian universities. Participants were recruited from both universities, which had large student populations and offered a range of degrees and courses. In Australia, participants were used to participating in research projects through an online method, while in India participants were more used to hard copy collection in a face-to-face setting. Both samples received an exactly similar protocol, which consisted of information sheet, measures and a debrief note. All participants had the opportunity to ask questions before commencing their participation. They were also informed about confidentiality and their right to withdraw from the study. The Australian participants were informed that they would not be able to withdraw once the questionnaires were submitted. Submission of the hard or electronic copy was considered participants' consent. Though there was no known risk attached to the study, participants were informed about counselling and other mental health services that were available for participants on and off campus. They were asked to contact these services if, due to some reason, they experienced distress as a result of their participation in the project. Further, the participants were reminded about the facilities as a part of the debrief note. In Australia, the first author disseminated the information about the study through the official website for the School's research projects. Students were invited to participate in the study. Those who agreed to participate used an online link to complete the questionnaire. Participants completed the instrument in their own time. Only those enrolled in first-year psychology courses, received a credit for their participation. The second author collected the data from the Indian university. Information about the study was announced at lectures and students were invited to participate. Those who volunteered and expressed an interest in participating were asked to attend group data collection sessions organised on various days and times during the teaching period. Participants completed the hard copies of the questionnaires.

Measures

Demographic Questionnaire. Demographic details such as gender, age, marital status, ethnicity, course of enrolment, enrolment status, year level, occupation, and satisfaction with financial situation and accommodation were obtained.

University Student Depression Inventory (USDI; Khawaja & Bryden, 2006). The scale consists of 30 items, which fall in three factors and measure depressive symptoms among university students. The three factors were lethargy, cognitive-emotional and academic motivation. Depression is represented by cognitive, emotional, lethargy, and academic motivational symptoms. Respondents apply a 5-point Likert scale, ranging from 1 (not at all) to 5 (all the time), to each item in order to indicate how often they have experienced the depressive symptoms in the past two weeks. The Cronbach's alpha of the total scale and the factors ranged from .84 to .95. Test-retest for total scale and the factors range from .76 to .91. Convergent and discriminant validity is satisfactory (Khawaja & Bryden, 2006). Cut-off levels are provided to assess the level of severity (Romaniuk & Khawaja, 2013). Elevated scores indicate an increased level of student depressive symptoms.

The Coping and Self-Efficacy Scale (CSES; Chesney, Neilands, Chambers, Taylor, & Folkman, 2006). The scale consists of 26 items and measures the participant's belief about their capacity to cope with difficulties. The items fall into three factors: Problem-Focused Coping, Stopping Unpleasant Emotions and Thoughts, and Obtaining Support from Friends9 and Family. Respondents use a 10-point Likert scale, ranging from 0 (cannot do at all) to 10 (can always do it), to indicate how confident they feel utilizing a range of different coping strategies. Higher scores reveal an enhanced coping self-efficacy. The Cronbach's alpha for the three factors is reported as .91, .91, and .80 respectively (Chesney et al., 2006). Validity studies indicated that the three factors predicted a reduction in psychological distress over time (Chesney et al., 2006).

Frost Multidimensional Perfectionism Scale (FMPS; Khawaja & Armstrong, 2005). The scale is a revision of the original 35-item scale developed by Frost et al. (1990). Khawaja and Armstrong (2005) validated the scale on an Australian sample and identified four factors consisting of 24 items. The factors measure maladaptive and adaptive aspects of perfectionism and are used separately. Concern with Mistakes and Doubts about Actions, and Parental Expectation and Criticism, reflect the maladaptive perfectionism. Organization and Personal Standards reveal the adaptive perfectionism. The Cronbach's alpha for the total scale and its dimensions ranged from .70 to .90. Concurrent validity is supported by its high correlation with the original scale. The correlation for the total and the subscales ranged from .69 to .98 (Khawaja & Armstrong, 2005).

Perceived Stress Scale (PSS; Cohen & Williamson,1988). This 10-item scale measures the degree to which situations are appraised as stressful and uncontrollable during the previous one-month period. On a 5-point Likert scale ranging from 0 (never) to 4 (very often), respondents indicate how often they felt or thought a certain way over the past month. Robert et al., (2006) revealed a two-factor structure of Perceived Helplessness and Perceived Self-Efficacy. The Cronbach's alpha for the total scale is .89. The subscales Perceived Helplessness and Perceived Self-Efficacy had an internal consistency of .85 and .82 respectively. Convergent and divergent validity is supported. Higher scores indicate greater perceived stress.

Academic Stress Scale (ASS; Sam,2001). The scale consists of six items and measures academic stress. Items reflect problems related with concentration during lectures and

study, problems comprehending lectures and asking questions in class, and feeling overwhelmed and failing to manage studies. Respondents use a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree), to indicate how often he/she thought or felt in that way. The Cronbach's alpha for the total scale is .83 (Sam, 2001). Scores were reversed to make sure that the higher scores indicated an elevated academic stress.

University Connectedness and Support Scale (UCSS; Gloria & Kurpius,1996). The scale consists of 19 items and is an adapted version of the University Environment Scale (Gloria & Kurpius, 1996). The items were thematically grouped in two sub-scales: Connectedness and Support. Respondents use a 7-point Likert scale, ranging from 1 (not at all) to 7 (all the time), to indicate their perception of the support available from the university and a sense of belongingness and connectedness. The Cronbach's alpha for the original University Environment was .84 and its predictive validity was also supported (Gloria & Kurpius, 1996). Low scores on the two sub-scales indicate an absence of connectedness with the university and sense of not being supported by the university and the staff.

Results

Preliminary Analysis and Data Screening

Missing data were minimal. Most variables were missing less than 1% and the maximum amount of missing data for any variable was 3.9%. Replacement values were imputed with the estimation maximization method. Results of analyses with and without imputed data were compared with no notable differences in the strength and patterns noted, suggesting no systematic impact of missing data. Results reported herein are based on the data set incorporating imputed values to maximize power. All assumptions of the regression analyses conducted were met with no marked departures from normality and residuals related assumptions. Internal consistency for the measures used was evaluated using the two samples. Table 1 shows the Cronbach alphas for the scales and subscales used in the analyses. Overall, the internal consistency was satisfactory. The coefficients were higher for the Australian sample than the Indian sample. The internal consistency of 2 FMPS subscales (Parental Expectation and Organization) was low for the Indian sample. A decision was made to retain the 2 subscales in the analyses to maintain consistency across the 2 sample. Cut-off levels for USDI (Romaniuk & Khawaja, 2013) were used to identify the students' level of depressive symptoms (Table 2). Most of the students fell in the low category (43.0% Australians and 53.3% Indian (Table 2). Chi-square analysis revealed a significant difference in the distribution of proportions of students in each severity category between the Australian and Indian Samples ($\chi^2(3) = 18.91$, $p < .05$, $\Phi = .15$, 95% BCa CI = .079, .236). An examination of standardised residuals at the cell level showed that this significant result stemmed from the severe category, with significantly more Australian students than expected falling into this category and significantly less Indian students falling into this category than expected. Further, an examination of z-test for proportions results revealed a significantly higher proportion of Indian students falling into the low category (53.3%) than Australian students (43.0%, $p < .05$) though the standardized residuals for these cells within the chi-square analysis did not reach the significance threshold.

Table 1.

Cronbach's Alphas for the Measures used in the Analyses

Scale/ subscale	Australian Sample	Indian Sample
USDI	.95	.92
PSS	.88	.67
ASS	.71	.59
CSES-Problem Focused	.93	.84
CSES-Stopping Unpleasant Thoughts	.92	.77
CSES-Support	.82	.67
FMPS-Concerns with Mistakes and Doubts about Actions	.87	.71
FMPS-Parental Expectation and Criticism	.89	.54
FMPS-Organization	.86	.61
FMPS-Personal Standards	.76	.43
UCSS-Support	.86	.76
UCSS-Connectedness	.85	.65

Note. USDI: University Students Depression Inventory: CSES: Coping Self Efficacy Scale; FMPS: Frost Multidimensional Perfectionism Scale; UCSS: University Connectedness and Support Scale.

Table 2.

Proportions of Students within each severity category of the University Students Depression Inventory (USDI) with associated significance tests

USDI Category	Australian Sample (*n* = 414)	Indian Sample (*n* = 394)
Low *	43.0%	53.3%
Moderate	32.4%	33.5%
Severe * #	22.7%	11.7%
Extremely Severe	1.9%	1.5%

*Note. # = standardized residual for this cell within the cross-tabulation was larger than 1.96 and hence significant at p< .05. * p< .05 via z-test for proportions comparing column percentages for individual rows.*

Factors associated with Depressive Symptoms

Strong correlations are noted amongst the psychological variables used in the regressions. Two hierarchical regressions predicting USDI score were conducted with the two student samples with demographic variables entered in step one and psychological variables entered in step two. Additionally, Fisher's z transformation tests were used to test whether there were significant differences in the strength of predictors across the two sample groups. The results of these analyses can be found in Table 3.

The total model accounted for 69% within the Australian sample ($R^2 = .69$, $R^2_{Adj} = .67$, F(17, 399) = 51.24, p< .001) and 51% within the Indian sample ($R^2 = .51$, R^2_{Adj}j = .49, F(17, 375) = 23.17, p< .001). The demographic variables of age, gender, employment status, university year level, satisfaction with

financial support, and satisfaction with living arrangements accounted for 6% and 5% for the Australian and Indian samples respectively (Australia R^2 = .06, R^2_{Adj} = .05, F(6, 410) = 4.37, p< .001; India R^2 = .05, R^2_{Adj} = .04, F(6, 386) = 3.43, p = .003). Subsequently, these demographic variables were not significant in the depressive experiences of the students. The addition of the psychological variables added substantial predictive power to the two models with 63% added within the Australian sample (R^2_{change} = .63, F(11, 399) = 72.25, p< .001) and 46% added within the Indian sample (R^2_{change} = .46, F(11, 375) = 32.26, p< .001).

Table 3. Hierarchical Regression Analysis for Variables Predicting USDI Scores among Australian and Indian University Students

	Australian Students (N = 417)				Indian Students (N = 393)				
Variable	***B* (95% CLs)**	***SE B***	***β***	***sr 2***	***B* (95% CLs)**	***SE B***	***β***	***sr 2***	***Fisher's Z***
Step 1 – Demographics	R^2_{change} .06				R^2_{change} .05				
Age	-0.55 (-0.21, 0.10)	0.08	-.02	.00	-0.48 (-1.22, 0.25)	0.38	-.05	.00	0.40
Gender	-0.20 (-3.36, 2.95)	1.61	-.00	.00	-1.74 (-4.70, 1.22)	1.50	-.05	.00	0.54
Employment	0.42 (-2.46, 3.29)	1.46	.01	.00	-0.75 (-4.13, 2.64)	1.72	-.02	.00	0.34
University Year	-0.42 (-1.48, 0.64)	0.54	-.02	.00	-0.33 (-1.31, 0.65)	0.50	-.03	.00	0.03
Satisfaction with financial Support	1.57 (-0.39, 3.53)	1.00	.05	.00	1.67 (-0.45, 3.80)	1.08	.06	.00	0.17
Satisfaction with living arrangements	0.47 (-1.43, 2.37)	0.97	.02	.00	-0.30 (-2.07, 1.47)	0.90	-.01	.00	0.37
Step 2 – Psychological Variables	R^2_{change} .63 ***				R^2_{change} .46***				
PSS Total	0.91 (0.64, 1.17)	0.13	.27 ***	.04	0.74 (0.46, 1.02)	0.14	.23 ***	.04	0.01
ASS Total	-0.64 (-1.02, -0.27)	0.19	-.12 **	.01	-0.56 (-0.20, -0.92)	0.18	.12 **	.01	2.93 **
CSES Problem Focused	-0.04 (-0.15, 0.07)	0.05	-.04	.00	-0.16 (-0.28, -0.03)	0.06	-.15 *	.01	0.97
CSES Stop unpleasant	-0.12 (-0.25, -0.00)	0.06	-.11 *	.00	-0.80 (-0.22, 0.06)	0.07	-.06	.00	0.21
CSES Support	-0.11 (-0.30, 0.07)	0.09	-.06	.00	-0.29 (-0.49, -0.09)	0.10	-.14	.01	0.97
FMPS Concerns &Doubts	0.66 (0.44, 0.87)	0.11	.24 ***	.03	0.76 (0.52, 1.01)	0.13	.27 ***	.02	0.78
FMPS Parental Expectations & Criticism	0.10 (-0.16, 0.35)	0.13	.03	.00	-0.09 (-0.45, 0.27)	0.18	-.02	.00	0.55
FMPS Organization	-0.62 (-1.01, -0.23)	0.20	-.09 **	.01	0.23 (-0.32, 0.78)	0.28	.03	.00	1.68
FMPS Personal	-0.65 (-1.13, -0.18)	0.24	-.10 **	.01	-0.48 (-1.11, 0.15)	0.32	-.07	.00	0.30
UCSS Support	0.25 (0.10, 0.40)	0.08	.13**	.01	0.04 (-0.08, 0.17)	0.06	.03	.00	0.91
UCSS Connected-ness	-0.81 (-1.01, -0.61)	0.10	-.33 ***	.05	-0.61 (-0.80, -0.41)	0.10	-.25 ***	.05	0.03
Total Model R^2	R^2_{change} .69***				R^2_{change} .51***				

*Note. Gender coded as 1 = male, 2 = female, Employment coded as 1 = unemployed, 2 = some form of employment (part or full time). Fisher's z transformations were used to test the significance of the difference between semi-partial correlations for the Australian and Indian samples for individual predictor variables. All significance assessments withstand Bonferroni corrections and hence remain significant irrespective of adjustment apart from the two results significant at .05 as denoted by a single asterix. *p < .05. **p < .01.*

The three strongest predictors of USDI scores in both country groups were the same, though the ordering of importance differed slightly. Within the Australian student sample the UCSS-Connectedness was the strongest predictor and was negatively associated with USDI scores (β = -.33), followed by the Perceived Stress (β = .27) and the FMPS-Concern with Mistake and Doubts about Actions subscale (β = .24) both recording positive relationships as would be expected. For the Indian student sample it was the FMPS-Concern with Mistakes and Doubts about Actions subscale that was the strongest predictor (β = .27), followed by the UCSS-Connectedness (β = -.25), and then the Perceived Stress (β = .23). UCSS Support, Academic Stress, FMPS-Personal Standards, FMPS-Organisation, and CSES-Stopping Unpleasant Emotions and Thoughts emerged as the weaker predictors for the Australian students. Academic stress and CSES-Problem Focused seemed to be the weaker predictors for the Indian students.

Fisher's z transformation tests were conducted on the semi-partial correlations obtained in the regressions to test whether any predictors differed significantly in their predictive strength between the two sample groups. Among all the predictor variables entered into the regressions, only the Academic Stress yielded a significant result (z = 2.93, p = .003). Academic stress emerged as a relatively weak negative predictor of USDI scores within the Australian sample (β = -.12), while being related in equal strength but positively within the Indian sample (β = .12). This is not as a result of scoring occurring in opposite directions in the two surveys.

Discussion

The present cross-cultural study compared Australian and Indian university students' depressive experiences and factors associated with this emotional condition. The hypotheses were partially supported. Overall, the majority of students reported low levels of depressive symptoms. More Australian students than Indian students were categorised as experiencing severe levels of depressive symptoms. Contrary to the expectation, a similar combination of psychological factors predicted depression was found in the two samples. However, the importance of these variables varied for the students in the two countries.

In general, when compared with the standardisation sample used to interpret the USDI scores, the level of depressive symptoms was not high in the two groups (Romaniuk & Khawaja, 2013). Nearly half of the participants reported experiencing low level of depressive symptoms. The proportion of students falling in the moderate and severe categories was similar to previous findings (Ibrahim et al., 2013; Peltzer & Pengpid, 2015). It seems that participants manifested depression in the form of negative thinking, emotional distress, difficulty in engaging in academic tasks, and physical exhaustion (Bitsika et al., 2009; Mikolajczket al., 2008; Schofield, et al., 2016). Compared to the

Indian students, a higher proportion of Australian students was categorised as severely depressed. The result is consistent with a previous study, in which the Australian students in Brisbane emerged as more depressed than other nationalities (Khawaja et al., 2013). Nevertheless, this finding was not consistent with studies conducted on non-Western students, which reported their depression higher than students in the West (Gunay et al., 2011; Othieno et al., 2014; Shamsuddin et al., 2013). Depressive symptoms among Indian students were lower than the levels reported by recent studies in India (Nagendra et al., 2012; Sing et al., 2011). This difference may be due to differences in the measures used or the institutions targeted by the present or past studies. The Indian university from which the current study's sample was obtained is in a smaller city, while the other studies recruited students from larger Indian cities. Australian students were recruited from a large metropolitan city. It is possible that the stressors may be more severe for the Australian students or they may be lacking the protective factors, such as financial, familial and community support, available to the Indian students.

Hierarchical analyses highlight interesting links among a number of variables. Contrary to expectations, demographic variables were not associated with depressive symptoms. Participants' characteristics indicate that except for a minority, students were reasonably comfortable with financial and living arrangements. It is possible that Australian students planned their education carefully and were prepared well, while in India, it appears that due to the collectivistic culture students were supported by their parents. Inconsistent with previous findings (Cameron, 2010; Farrer et al., 2016), the younger age of students and year of study were not associated with depressive symptoms. Psychosocial factors such as coping, academic stress and perceived stress were correlated with each other and with depressive symptoms. Symptoms as measured by the USDI scale were correlated with perceived stress, academic stress, coping and self-efficacy, perfectionism, and university connectedness. Students in both countries experienced academic stress, interpreted their stressors negatively, criticised their own performance, engaged in maladaptive coping, and felt disconnected and unsupported by their universities. Overall, the student and university related factors were linked with their depressive symptoms. The outcome is consistent with previous studies, which indicated that university education was demanding, and students tend to cope poorly by setting unrelentingly high standards for themselves and perceiving their situation as averse (Abdollahi et al., 2018; Dunkley et al., 2012).

However, it is important to note that despite this commonality, subtle differences emerged. Within the Australian sample, academic stress, which measured the students' ability to comprehend lectures and to manage studies, was negatively correlated with depressive symptoms. It seemed that the scale measured a very narrow aspect of academic stress, such as poor concentration in lectures and inability to ask questions. It is possible that new pedagogical strategies of watching the recorded lectures or attending lectures in large auditoriums made these experiences irrelevant to the Australian students. In addition, various other aspects of academic stress, such as difficulty in achieving or maintaining high grades or getting into professional courses, were not measured by the scale. Further, in the case of Australian students, a perceived lack of connectedness with the university was the strongest contributor to depressive symptoms. Aligned with previous studies, a sense of not being valued on the campus and a feeling of not belonging to the university environment had the strongest link with depressive experiences of the Australian students (Cockshaw et al., 2013). Limited support at the university was also associated with depression in the Australian students (Levett-Jones et al., 2009). Further, inadequate adaptive perfectionism in the form of low personal standards and organisational skills, and a decrease in self-efficacy and coping through an inability to stop unpleasant thoughts, also contributed to their experiences of depression (Khawaja & Armstrong, 2005). Problem-focused coping and support-seeking tendencies were not contributing to depressive symptoms at all, as they are positive resources (Abdollahi et al., 2018; Besharat et al., 2014). Further, pressures and expectations of the parents were not important for the Australian students.

On the contrary, in the Indian students' sample, tendencies to engage in self-criticism and doubt emerged as the most important factors associated with their depressive symptoms (Julan, 2013; Zhang & Zhu, 2013). This appeared to be a maladaptive element of perfectionism, where the students expected high standards from themselves and then undermined their ability when these unrealistic expectations were not achieved (Mead & Hicks, 2010). A lack of connectedness with the university was seen to be associated with low mood (Cockshaw et al., 2013). Moreover, consistent with past findings (Abdollahi et al., 2018; Julal, 2013; Martin & Atkinson, 2020) low self-efficacy and coping in the form of limited problem focused coping were related to their depressive symptoms. Coping strategies such as the personal resources to stop negative thoughts and emotions, and seeking support, were not linked with depression in this sample. For the Indian students, academic stress in the form of limited capacity to understand the lectures, unable to ask questions or to organise one's study were associated with depressive symptoms (Agolla & Ongori, 2009; Barker et al., 2018;).

Implications

The findings support the notion that students across the world appear to have similar academic challenges and experiences of depressive symptoms. In line with the previous literature, they share the tendencies of maladaptive perfectionism, self-defeating and negative thinking, and poor self-efficacy and coping. Nevertheless, subtle differences also emerged, probably due to cultural differences (Khawaja et al., 2013). Thus, there is a need to assist students to cope with various challenges. Universities offer a range of academic and psycho-social supportive services (Julal, 2013), which aim to promote a sense of connectedness and also act as a protective factor for students to manage their stressors (Levett-Jones et al., 2009). However, the present findings indicate that students perceived themselves as disconnected from their institutions. This was a prominent issue for the Australian students, in spite of the support services available to them. It is possible that technological advances and the sheer size of universities are generating a perception among students that they are unfriendly and aloof places. However, in the case of Indian students, the lack of a sense of belongingness was probably due to an absence of counselling and support services in the university (Soliman, 1991). As a result of limited support service facilities, such as psychological care, academic support, and part-time work opportunities, it is easy for students to experience frustration, loneliness, stress, and depressive symptoms. The present findings emphasise the need for the institutions to promote realistic expectations, adaptive coping, self-efficacy and a sense of belonging among the students. Counselling and support services need to be introduced in India

and expanded in Australia. Workshops that enhance coping skills, self-efficacy, and positive perfectionism in the form of organisation and personal standards and assist students to manage maladaptive perfectionism associated with self-doubt and criticism would be helpful, along with other individual and group counselling programs.

Limitations & Future Directions

The present study is not free from limitations and the results should be interpreted with caution. First, the samples were limited to two universities and the outcome may not be generalisable to all Australian or Indian universities. Data should be collected from multiple universities in each country. Second, the participants were from a limited number of faculties and future investigations should recruit participants from a number of faculties, disciplines, year levels, and degrees. Third, responses were based on self-report measure and were subject to retrospective biases. Internal consistency of some scales was moderate for the Indian sample, which raises the question of their relevance to this population. Further, rigorous psychometric tests of these scales are warranted to determine their cross-cultural use. The items of the academic stress scale are limited to a few issues. A revision that involves adding items to encompass other academic challenges of the current times is required. Fourth, the data collection methods, which varied from on-line to completion of hard copies, may have introduced errors. Such variations should be avoided in future. The differences in coping styles and the link of culture with perfectionist thinking and perception of stress require further investigation in the students from different countries.

Conclusion

Finally, despite the limitations, the study is the first of its kind to directly compare Australian and Indian university students. Considering the globalisation of the world, many common challenges and depressive experiences were noted in the two countries. Interestingly, subtle differences also became apparent. The findings provide further directions to university authorities to foster the well-being of students in both countries.

References

Abdollahi, A., Hosseinian, S., & Asmundson, G. (2018). Coping styles mediate perfectionism associations with depression among undergraduate students. *The Journal of General Psychology, 145* (1), 93-105. doi: 10.1080/00221309.2017.1421137

Acharya, L., Jin, L., & Collins, W. (2018). College life is stressful today – Emerging stressors and depressive symptoms in college students. *Journal of American College Health, 66* (7), 655-664. doi: 10.1080/07448481.2018.1451869

Adams, D., Meyers, S., & Beidas, R. (2016). The relationship between financial strain, perceived stress, psychological symptoms, and academic and social integration in undergraduate students. *Journal of American College Health, 64* (5), 362-370. doi:0.1080/07448481.2016.1154559

Akhtar, P., Ma, L., Waqas, A., Naveed, S., Li, Y., Rahman, A., & Wang, Y. (2020). Prevalence of depression among university students in low and middle income countries (LMICs): A systematic review and meta-analysis. *Journal of Affective Disorders, 274,* 911–919. https://doi.org/10.1016/j.jad.2020.03.183

Angolla, J.E., Ongori, H. (2009). An assessment of academic stress among undergraduate students: The case of University of Botswana. *Educational Research and Review Vol. 4* (2),63-70.

Barker, E., Howard, A., Villemaire-Krajden, R., & Galambos, N. (2018). The rise and fall of Depressive symptoms and academic stress in two samples of university students. *Journal of Youth and Adolescence, 47* (6), 1252-1266. doi: 10.1007/s10964-018-0822-9

Basabe, N., & Ros, M. (2005). Cultural dimensions and social behaviour correlates: Individualism-collectivism and power distance. *Revue Internationale De Psychologie Sociale, 18* (1), 189-225.

Bayram, N., & Bilgel, N. (2008). The prevalence and socio-demographic correlations of depression, anxiety and stress among a group of university students. *Social Psychiatry and Psychiatric Epidemiology, 43*(8), 667-672. doi: 10.1007/s00127-008-0345-x

Ben-Ezra, M., & Essar, N. (2004). Depression and anxiety in developing countries. *The Lancet, 364* (9444), 1488. doi: 10.1016/s0140-6736(04)17269-3

Besharat, M., Issazadegan, A., Etemadinia, M., Golssanamlou, S., & Abdolmanafi, A. (2014). Risk factors associated with depressive symptoms among undergraduate students. *Asian Journal of Psychiatry, 10,* 21-26. doi: 10.1016/j.ajp.2014.02.002

Bilican, F., Yapici, A., & Kutlu, M. (2016). A value model for depressive symptoms and hopelessness among university students in Turkey. *Kuram ve Uygulamada Eğitim Bilimleri,* 16 (4), 1397-1418. doi:10.12738/estp.2016.4.0112

Bitsika, V., Sharpley, C., & Bell, R. (2009). The contribution of anxiety and depression to fatigue among a sample of Australian university students: suggestions for university counsellors. *Counselling Psychology Quarterly, 22* (2), 243-255. doi: 10.1080/09515070903216929

Cameron, T. A. (2010). *The relationship between obesity, depression, and age in a university sample.* Unpublished doctoral thesis, Argosy University, Dallas. Retrieved from: http://search.proquest.com/docview/305247312?accountid=13380

Chesney, M., Neilands, T., Chambers, D., Taylor, J., & Folkman, S. (2006). A validity and reliability study of the coping self-efficacy scale. *British Journal of Health Psychology, 11* (3), 421-437. doi: 10.1348/135910705x53155

Christensson, A., Vaez, M., Dickman, P. W., & Runeson, B. (2011). Self-reported depression in first-year nursing students in relation to socio-demographic and educational factors: A nationwide cross-sectional study in Sweden. *Social Psychiatry and Psychiatric Epidemiology, 46* (94), 299-310. doi 10.1007/s00127-010-0198-y

Cockshaw, W., Shochet, I., & Obst, P. (2013). General belongingness, workplace belongingness, and depressive symptoms. *Journal of Community and Applied Social Psychology, 23* (3), 240-251. doi: 10.1002/casp.2121

Cohen, S., & Williamson, G. (1988). Perceived stress in a probability sample of the United States. In S. Spacapan, &Oscamp, S (Ed.), *The social psychology of health: Claremont Symposium on Applied Social Psychology* (pp. 31-67). Newbury

Park, CA: Sage Publication.

Dinkha, J., & Mobasher, S. (2012). The risk of depression and suicide among University students of Kuwait: A cross-study of three Universities. *Psychology and Education Journal, 49* (2), 362-375. doi: 10.1111/j.2150-1092.2012.0004541

Dunkley, D., Berg, J., & Zuroff, D. (2012). The role of perfectionism in daily self-esteem, attachment, and negative affect. *Journal of Personality, 80* (3), 633-663. doi: 10.1111/j.1467-6494.2011.00741.x

Farrer, L., Gulliver, A., Bennett, K., Fassnacht, D., & Griffiths, K. (2016). Demographic and psychosocial predictors of major depression and generalised anxiety disorder in Australian university students. *BMC Psychiatry, 16* (1). doi: 10.1186/s12888-016-0961-z

Gloria, A., & Kurpius, S. (1996). The validation of the cultural congruity scale and the University Environment Scale with chicano/a students. *Hispanic Journal of Behavioral Sciences, 18* (4), 533-549. doi: 10.1177/07399863960184007

Gunay, O., Akpinar, F., Poyrazoglu, S., & Aslaner, H. (2011). Prevalence of depression among Turkish university students and related factors. *Turkish Journal of Public Health, 9* (3), 133-143. doi: 10.5421/10.5421%2F1304.1086

Habibi, M., Khawaja, N. G., Moradi, S., Dehghani, M., & Fadaei, Z. (2014). University student depression inventory: Measurement model and psychometric properties. *Australian Journal of Psychology, 66* (3), 149-157. doi: 10.1111/ajpy.12037

Hamdan-Mansour, A., Puskar, K., & Bandak, A. (2009). Effectiveness of cognitive-behavioral therapy on depressive symptomatology, stress and coping strategies among Jordanian university students. *Issues in Mental Health Nursing, 30* (3), 188-196. doi:0.1080/01612840802694577

Hysenbegasi, A., Hass, S. L., & Rowland, C. R. (2005). The impact of depression on the academic productivity of university students. *Journal of Mental Health Policy and Economics, 8* (3), 145-151.

Ibrahim, A., Kelly, S., Adams, C., & Glazebrook, C. (2013). A systematic review of studies of depression prevalence in university students. *Journal of Psychiatric Research, 47* (3), 391-400. doi: 10.1016/j.jpsychires.2012.11.015

Joseph, N. (2011). Prevalence of depression among pre-university college students in an urban area of South India. *International Journal of Current Research, 3* (11), 439-442.

Julal, F. S. (2013). Use of student support services among university students: Associations with problem-focused coping, experience of personal difficulty and psychological distress. *British Journal of Guidance & Counselling, 41*(4), 414-425. doi: 10.1080/03069885.2012.741680

Khawaja, N. G., & Armstrong, K. (2005). Factor structure and psychometric properties of the Frost Multidimensional Perfectionism Scale: Developing shorter versions using an Australian sample. *Australian Journal of Psychology, 57* (2), 129-138. doi: 10.1080/10519990500048611

Khawaja, N. G., & Bryden, K. (2006). The development and psychometric investigation of the university students' depression inventory. *Journal of Affective Disorders, 96,* 21-29. doi: 10.1016/j.jad.2006.05.007

Khawaja, N. G., & Duncanson, K. (2008) Using the University Student Depression Inventory to investigate the effect of demographic variables on students' depression. *Australian Journal of Guidance and Counselling, 18,* 1-15. doi:10.1375/ajgc.18.1.1

Khawaja, N. G., Santos, M. , Habibi, M., & Smith, R. (2013). University students' depression: A cross-cultural investigation. *Higher Education Research and Development, 32* (3), 392-406. doi:10.1080/07294360.2012.697129

Leahy, C., Peterson, R., Wilson, I., Newbury, J., Tonkin, A., & Turnbull, D. (2010). Distress levels and self-reported treatment rates for medicine, law, psychology and mechanical engineering tertiary students: Cross-sectional study. *Australian and New Zealand Journal of Psychiatry, 44* (7), 608-615. doi:10.3109/00048671003649052

Lei, X., Xiao, L., Liu, Y., & Li, Y. (2016). Prevalence of depression among Chinese university students: A meta-analysis. PLOS ONE, 11 (4), e0153454. doi: 10.1371/journal.pone.0153454

Li, W., Denson, L. A., & Dorstyn, D. S. (2018). Understanding Australian university students' mental health help-seeking: An empirical and theoretical investigation. *Australian Journal of Psychology, 70* (1), 30-40. 10.1111/ajpy.12157

Levett-Jones, T., Lathlean, J., Higgins, I., & McMillan, M. (2009). Staff-student relationships and their impact on nursing students' belongingness and learning. *Journal of Advanced Nursing, 65* (2), 316-324. doi10.1111/j.1365-2648.2008.04865

Martin, D., & Atkinson, C. (2020). University students' accounts of living with depression. *Research in Post-Compulsory Education, 25*(2), 127–148. https://doi.org/10.1080/13596748.2020.1742976

Mead, M. R., & Hicks, R. E. (2010). Are you a perfectionist and does it matter? Depression and perfectionism in Australian university students. In R. E. Hicks (Ed.), *Personality and individual differences: Current directions* (pp. 248-257). Bowen Hills: Australian Academic Press.

Mikolajczyk, R.T., Maxwell, A.E., Naydenova, V., Meier, S., & Ansari, W.E. (2008). Depressive symptoms and perceived burdens related to being a student: Survey in three European countries. *Clinical Practice and Epidemiology in Mental Health, 4,* 19–27, doi:10.1186/1745-0179-4-19

Nagendra, K., Sanjay, D., Gouli, C., Kalappanavar, N. K., & Vinodkumar, C. S. (2012). Prevalence and association of depression and suicidal tendency among adolescent students. *International Journal of Biomedical & Advance research, 3* (9), 714-719. doi: 10.7439/ijbar.v3i9.726

Othieno, C. J., Okoth, R. O., Peltzer, K., Pengpid, S., & Malla, L. O. (2014). Depression among university students in Kenya: Prevalence and sociodemographic correlates. *Journal of Affective Disorders, 165,* 120-125. doi:10.1016/j.jad.2014.04.070

Peltzer, K., & Pengpid, S. (2015). Depressive symptoms and social demographic, stress and health risk behaviour among university students in 26 low-, middle- and high-income countries. *International Journal of Psychiatry in Clinical Practice, 19* (4), 259–265. doi.org/10.3109/13651501.2015.1082598

Robert, P., Berr, C., Volteau, M., Bertogliati-Fileau, C., Benoit, M., Guerin, O., … Dubois, B. (2008). Importance of lack of interest in patients with mild cognitive impairment. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association*

for Geriatric Psychiatry, 16 (9), 770–776. doi.org/10.1097/JGP.0b013e31817e73db

Robotham, D. (2008). Stress among higher education students: Towards a research agenda. *Higher Education: The International Journal of Higher Education and Educational Planning, 56* (6), 735–746. https://doi.org/10.1007/s10734-008-9137-1

Romaniuk, M., & Khawaja, N. G. (2013). University student depression inventory (USDI): Confirmatory factor analysis and review of psychometric properties. *Journal of Affective Disorders, 150* (3), 766-775. doi: 10.1016/j.jad.2013.02.037.

Sam, D. L. (2001). Satisfaction with life among international students: An exploratory study. *Social Indicators Research, 53* (3), 315-337. doi: 10.1023/A:1007108614571

Schofield, M. J., O'Halloran, P., McLean, S. A., Forrester-Knauss, C., & Paxton, S. J. (2016). Depressive symptoms among Australian university students: Who is at risk? Depression among university students. *Australian Psychologist, 51*(2), 135-144. doi:10.1111/ap.12129

Shamsuddin, K., Fadzil, F., Ismail, W., Shah, S., Omar, K., Muhammad, N., … Mahadevan, R. (2013). Correlates of depression, anxiety and stress among Malaysian university students. *Asian Journal of Psychiatry, 6* (4), 318–323. doi.org/10.1016/j.ajp.2013.01.

Singh, A., Lal, A., & Shekhar. (2011). Prevalence of depression among medical students of a private medical college in India. *Online Journal of Health and Allied Sciences, 9* (4), 1-3. Retrieved from https://doaj.org/article/dde28693a5ec44fb983293c59fd2a54d

Soliman, A. (1991). The role of counselling in developing countries. *International Journal of the Advancement of Counselling, 14* (1), 3-14. doi: 10.1007/BF00116712

Steptoe, A., Tsuda, A., Tanaka, Y., & Wardle, J. (2007). Depressive symptoms, socio-economic background, sense of control, and cultural factors in university students from 23 countries. *International Journal of Behavioral Medicine, 14* (2), 97-107. doi.org/10.1007/BF03004175

Takayama, Y., Miura, E., Miura, K., Ono, S., & Ohkubo, C. (2011). Condition of depressive symptoms among Japanese dental students. *Odontology, 99* (2), 179-187. doi: 10.1007/s10266-011-0005-6

Tosevski, D. L., Milovancevic, M. P., & Gajic, S.D. (2010). Personality and psychopathology of university students. *Current Opinion in Psychiatry 23*(1), 48–52. doi: 10.1097/YCO.0b013e328333d625

World Health Organisation. (2012). Depression: A global crisis. Retrieved from https://www.who.int/mental_health/management/depression/wfmh_paper_depression_wmhd_2012.pdf

Zhang, B., Cai, T., Luo, X., & Zhu, H. (2013). Predictive value to depressive symptoms of perfectionism dimensions in college students. *Chinese Journal of Clinical Psychology, 21* (1), 101-105.

Zhang, J., & Zheng, Y. (2017). How do academic stress and leisure activities influence college students' emotional well-being? A daily diary investigation. *Journal of Adolescence, 60,* 114–118. doi.org/10.1016/j.adolescence.2017.08.003

Counselling and Hypnotherapy: Together for (almost) the first time

Karen Phillip

The purpose of this article is to explore how hypnotherapy can be utilised in counselling practice. The literature discusses the advantages of using hypnotherapy techniques for multiple issues often treated in counselling. This literature review will provide counsellors and other therapists with information on the various ways hypnotherapy can aid client issues when integrated into counselling and psychotherapy practices. The aim is to have counsellors and psychotherapists better informed on the uses of hypnotherapy and consider if learning and using hypnotherapy within their practice may further aid their therapy work. The article explores how the counselling therapist could consider integrating hypnotherapy within their therapy practice. Hypnotherapy boasts swiftness of change in the manner a person thinks, feels, and behaves. This paper will provide insight for counsellors and psychotherapists in relation to the use of hypnotherapy as a possible addition to their practice.

Keywords: *counselling, hypnotherapy, hypnosis*

Introduction

This paper will discuss how the counsellor and psychotherapist may consider using hypnotherapy in their therapeutic work for improved client outcomes. First of all, it will discuss how the integration of hypnotherapy in counselling can enhance the efficacy of client issues. Second, the paper defines the term and uses of hypnotherapy in a therapeutic context. Third, the commonalities counselling psychotherapy and hypnotherapy share is discussed. Fourth, the literature supports hypnotherapy to benefit the counselling process. Both counselling and hypnotherapy have been successfully used for a variety of client issues over many decades. These two modalities largely work independently of each other even though evidence indicates that integration in general psychotherapeutic practice is desirable (Zarbo et al., 2016). Counsellors and psychotherapists (both referred to as counsellors in the paper) have acknowledged the limitations of using one theoretical system within their practice and the potential value of additional theories and practices (Zarbo et al., 2016).

Professional counsellors strive to help their clients through complex trauma, childhood abuse, addictions, behavioural concerns, relationship difficulties, fear, and pain (Merriman & Joseph, 2018). These issues often result in the client presenting with depression, anxiety, and acquired phobias. In many cases, a counsellor is a person to whom the individual discloses issues of past abuse and trauma (Merriman & Joseph, 2018). Counsellors undertake substantial training in specific therapeutic techniques such as CBT, person-centred therapy, client-focused therapy, solution-focused therapy, and group work (AIPC, 2021).

This review will discuss how hypnotherapy could assist many of the issues counselling clients present as an integrated approach with counselling. Reviewing the specific problems hypnotherapy has been shown to benefit can add insight for counsellors on additional ways to aid clients. Gathering an understanding of how hypnotherapy can benefit clients is needed to discover how the modality may work congruently in conjunction with counselling. This paper seeks to bridge the work of counselling and hypnotherapy across both disciplines (Gilson & Goldberg, 2015). Using a link between both modalities is hoped to provide insight and broaden counsellors understanding of the use of hypnotherapy in their practice (Cropanzano, 2009).

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An integrative treatment approach to client recovery

The aim of counselling is to enhance the efficacy and relevance of client issues (Imel & Wampold, 2008), including those experienced by minority groups such as the Aboriginal and Torres Strait Islander (ATSI) community, and the lesbian, gay, bisexual, transgender, intersex, queer, and asexual (LGBTIQA+) community. No single approach is adequate for all clients and situations given the complexity of issues (Norcross et al., 2019). An integrative treatment approach utilising personalised treatments for each individual client enhances clinical outcome (Castonguay et al., 2015). Therapists in the professions of both counselling and hypnotherapy treat a variety of clients. Knowledge on diversity and inclusion of therapeutic modalities may aid clients who are seeking specific therapists for specialised presenting issues. Presenting issues include anxiety, depression, stress related issues, substance abuse, relationship concerns, but also gender affirmation processes, family acceptance, and potential harassment and discrimination issues that are often presented by the ATSI and LGBTIQA+ community (Jones et al., 2021; Kairuz, 2020; Meier & Labuski, 2013; Mizok & Lundquist, 2016).

Recovery is the fundamental focus for counsellors when working with clients (Bringer et al., 2016; Davidson, 2003). Recovery is not always about returning to full health but is seen as a journey, to aid clients to consider their abilities, possibilities and develop new meaning (Slade, 2010). Recovery relates to those with mental illness and those experiencing trauma, physical symptoms, gender identity issues, social and relationship issues. Client outcomes improve when the therapist works collaboratively with the client and chooses treatments (Goode et al., 2017).

There is an increasing trend within counselling toward an integrative and heterogeneous approach to enhance and expand client work. This eclectic approach opens new dimensions of training with a variety of developing modalities. An integrative approach includes working with marginalised and diverse communities while integrating modalities suitable for specific client issues. Evidence is mounting that individuals are favouring the introduction of hypnotherapy techniques in mainstream medicine and therapy (Flory et al., 2007). Hypnotherapy, often referred to as hypnosis, has evolved beyond direct suggestion to include suspending critical thinking of the conscious mind to allow the unconscious mind to make the internal alterations needed to achieve the client's desired behavioural and emotional changes (Ahlskog, 2018). Hypnotherapy in contemporary medicine has been shown to provide substantial benefits in many emotional and behavioural presenting issues (Stewart, 2005).

The heterogeneousness approach is guided basically by information on what has turned out best for others in the past with comparable issues and comparative qualities for whom intercession will work (Norcross, 2011). Assimilative integration involves establishing psychotherapy systems with an ability to join and absorb practices and perspectives from diverse frameworks and systems that can provide a more extensive scope of specialised intercessions (Messer, 1992; Norcross et al., 2019). Hypnotherapy is one framework that can easily integrate into counselling psychotherapy to provide extensive methods and techniques to aid client outcome (Alladin & Amundson, 2011).

Evidence indicates that integration of psychotherapeutic practices is beneficial to clients (Castonguay et al., 2015). Ramondo, Gignac and colleagues (2021) investigated the link between cognitive behavioural therapy (CBT) commonly used as part of the counselling process, combined with hypnotherapy, and named this cognitive behavioural therapy and hypnotherapy as CBTH. Their meta-analytic evidence demonstrated considerable benefit of using CBTH for clients struggling with depression, pain, and obesity, with better outcomes and enduring results. A study conducted by Bryant, Moulds, Guthrie and Nixon (2005), using CBT and hypnosis, reported that clinical gains through combining the full range of CBT techniques with hypnosis (CBTH) aided in alleviating posttraumatic stress (PTS) symptoms in patients.

It is accepted that the client is the expert in their personal experiences; therefore, each client can contribute to the direction of their treatment (Henkelman & Paulson, 2006). Client perspective in treatment improves the culture, quality, effectiveness, and responsiveness of mental health services. It has been suggested that it is the changing experience and behaviour of consumers that will dictate what therapies consumers will seek (Feltham, 2002; PACFA, 2012a). The issues hypnotherapy can aid include the many presenting matters culturally and gender diverse community members experience. ATSI and LGBTIQA+ community members may find they can obtain valuable support without the customary shaming, objectifying, or discrimination they report they receive from some medical and mental health providers (Poteat et al., 2013). The hypnotherapist works within the framework of clients' subconscious mind, not always needing to hear the intricate details unless the client wishes to share. This freedom allows for flexible and individualised therapeutic interventions for each client with more ease and less embarrassment (Norcross & Lambert, 2018).

Definition of hypnotherapy

Hypnotherapy has been defined as the experience of new awareness by using modified and concentrated attention to allow the individual to engage in improved ways of thinking, feeling, and behaving while experiencing new possibilities of self-control (Lankton, 2015). Therapeutically it aids the client to attain individual goals, accepting them as eminently possible and achievable (Araoz, 2005a). Psychologist Dr Michael Yapko (2012, p. 6) offers a definition of hypnotherapy that applies to counselling therapy: *"hypnosis is conceptualized and treated as a means of helping clients develop powerful personal resources that can be purposefully directed towards achieving their therapeutic goals."* The Yapko definition of hypnotherapy could also apply to counselling.

Hypnosis uses direct and indirect suggestion to induce a heightened state of suggestibility, where the critical faculty of the conscious mind is bypassed, and selective attention to suggestions given (McNeal, 2020). A hypnotic procedure is used to encourage responses to positive suggestions. Hypnosis is a multi-state phenomenon that features the use of the imagination, cognitive regression and altered subconscious (Entwistle, 2017). During a hypnotherapy session, one person (the client) is guided by another (the hypnotist) to respond to suggestions in guiding subjective experience, alterations of perception, emotion, thought, and or behaviour (Elias, 2009).

During hypnosis , the individual experiences a trance-like state that can be defined as an animated, altered, integrated state of focused consciousness with an attentive, receptive state of concentration that can be activated and measured (Spiegel

& Greenleaf, 2005). Evidence demonstrates that the hypnotic process produces a brain with differential effects of attention and relaxation, with evidence of cognitive and neurophysiological dissociation (Gruzelier, 2000; Jiang et al., 2017). Hypnotherapy is described as enhancing a different or unusual pattern of abilities involving selective inhibition and enhancement of cognitive processes (Gruzelier, 2000).

The professions of counselling and hypnotherapy

To maintain association membership, qualified counsellors engage in continuing professional development (CPD), thereby, expanding their knowledge and skills to keep up to date with developments in counselling theory and practice, and learning new skills to integrate into their treatments. Counselling associations encourage counsellors to expand their knowledge with professional development, in a variety of modalities. Recent literature discusses counsellors' utilising and integrating modalities such as mindfulness (Pearson, 2020), Gestalt therapy (Sapezinskiene et al., 2016), storytelling and sand play therapy (Mendoza, 2018), dance and music therapy (O'Donoghue et al., 2020), singing therapy (Daykin, 2018), working with family systems (Martin, 2017), developing phone rapport (Phillip et al., 2020), incorporating technology in counselling (Nagarajan & Yuvaraj, 2019), and working with ATSI and LGBTQIA+ communities (Kairuz, 2020; Mizok & Lundquist, 2016). However, to date there is no literature discussing the inclusion of hypnosis in counselling practice, only the use of hypnosis with CBT.

Both hypnotherapy and counselling cover similar methods such as active listening, somatic questioning, and rapport development. However, in counsellor training courses, counsellors undertake more training in specific therapeutic techniques such as CBT, person-centred therapy, client-focused therapy, solution focused therapy, and group work compared to what is taught in hypnotherapy training (ACA, 2021; AHA, 2021b; AIPC, 2021; PACFA, 2021a). Hypnotherapy training educates students in a variety of hypnotherapeutic topics including relaxation inductions, breathing techniques, hypnotic language, reframing, plus pacing and leading methods, all designed for beneficial client outcomes and not fully covered within counselling education (AHA, 2021b).

Literature failed to provide information on the number of registered counsellors who hold hypnotherapy qualifications in Australia's two largest counselling associations, the Australian Counselling Association (ACA) and the Psychotherapy and Counselling Federation of Australia (PACFA). Further, both associations advised they hold no records of this data. Further the Australian Hypnotherapy Association (AHA) and the Australian Society of Clinical Hypnotherapists (ASCH) advised they have no data on the number of registered hypnotherapists holding counselling qualifications. Added to this, after investigations were made, these four main counselling and hypnotherapy associations were unable to provide data to identify the ethnicity, cultural background, or gender of registered therapists holding membership with their associations. Therefore, no information is available to ascertain how many counsellors or hypnotherapists in the Australian associations who are culturally diverse, ATSI, or LGBTIQA+.

Commonalities counselling and hypnotherapy share

Research validates previous anecdotal claims of the benefits of hypnotherapy (Bryant et al., 2005; Yapko, 2006; Daitch, 2018). It demonstrates the efficacy of hypnotherapy as part of an integrative treatment for many conditions that traditional medicine, counselling, and psychology have found difficult to treat (Shedler et al., 2010). Evidence for the efficacy of hypnotherapy is gaining validity. Research conducted by Spiegel (2013) and Daitch (2018) found hypnotherapy has specific relevance in the assessment and treatment of anxiety disorders, including post-traumatic stress disorder (PTSD), due to its ability to enhance the mind-body control. These anxiety conditions are extensively treated through psychology and counselling. Hypnotherapy has been found to be as effective treatment but when used with CBT, client results are considered enhanced (Davis, 2016; Gunnison, 1990; Hammond, 2010; Valentine et al., 2019).

Clinical hypnotherapy curricula contain elements of counselling and psychotherapy training, and hypnotherapy associations require components of counselling and psychotherapy training within each hypnotherapy diploma course (AHA, 2021b).In a study conducted by Cowen (2015), almost 70 per cent of hypnotherapists responded with agreement they needed counselling skills within their hypnotherapy work and almost 98 per cent agreed counselling techniques should be practised within their hypnotherapy sessions. However, only 16 per cent believed they should work within the structured counselling process (Cowen, 2015). There remains no hypnotherapy training within any counselling educational training (ACA, 2021a; PACFA, 2021a).

The American Psychological Association (APA) acknowledged hypnotherapy as an effective additional treatment used with Cognitive Behavioural Therapy (CBT) when treating acute stress disorders (APA, 2021; Bryant et al., 2005). Hypnotherapy is often used as an adjunct treatment regime rather than as the primary modality (Heitkemper, 2009; Sierpina et al., 2007). Some studies support the effectiveness of hypnotherapy as a primary modality provided it contains elements of counselling techniques (Cowen, 2016). Research has demonstrated that hypnotherapy is effective for many conditions and the use of hypnotherapy within counselling therapy can be very beneficial for client outcomes (Gunnison, 1990; Heitkemper, 2009). The general public seem interested and open to the use of hypnotherapy (Krouwel et al., 2017).

Individuals are seeking alternative forms of therapeutic support, apart from those normally obtained under the medical model in mental health such as doctors, psychologists, psychiatrists, and pharmacology (Thompson et al., 2014). It is now recognised that our state of mind has a direct relationship to our mental, emotional, and physical health (Białkowska et al., 2020). Since the early 20th century there has been recognition of a link between the actions, cognitions, and body functioning of individuals. With the development of psychology, previously unknown connections to mental health issues and physical symptoms were revealed (Kraft, 2011). An interdisciplinary approach integrates knowledge and methods from different therapeutic disciplines using a synthesis of approaches for all type of clients (Okech & Geroski, 2015; Sperber et al., 2005; Zarbo, 2016). The interdisciplinary aspect of treatments aims to accelerate knowledge in the treatment and prevention of a wide range of health issues for a broad range of clients and community

members (Wilson, et al., 2019). Counselling and hypnotherapy are just two of these interdisciplinary methods.

Merging counselling and hypnotherapy structures

Therapists are often compelled to evolve their knowledge and specialty areas (Okech & Rubel, 2018). Therapists cultivate client's welfare and well-being by paying attention to what the client is expressing, without judgement (Elkins, 2018). All clinical therapy work involves planning, analysis, compassion, benevolence, and time management (Wong-Wylie, 2007). Hypnotherapy is regarded as an integral approach to counselling with uses in a range of issues (Kittle & Spiegel, 2021).

Counsellors use a variety of techniques to support clients with a range of mental health, physiological, emotional, and gender identity issues. Counsellors work with those suffering grief and loss, pain, eating disorders, anxiety, depression, illness, stress, acceptance, and relationship issues. There has been considerable research conducted regarding a variety of conditions and issues treated by counsellors that are also being treated by hypnotherapists, including chronic pain (Ahmadi et al., 2018; Taylor & Genkov, 2020), depression (Shih et al., 2009; Yapko, 2006), PTSD (Gold & Quinones, 2020; Wake & Leighton, 2014), anxiety (Hammond, 2010; Valentine et al., 2019; Spiegal, 2013), trauma (Gold & Quiñones, 2020), phobic issues (Bigley et al., 2010; Kraft, 2011), smoking cessation (Lancaster & Stead, 2017), weight loss (Bo et al., 2018), eating disorders (Milling et al., 2018), and irritable bowel syndrome (IBS) (Paulton et al., 2021)).

Counselling is also used for sleep issues and in the reduction of benzodiazepines, used for slowing down and calming the body to increase drowsiness (Salonoja et al., 2010). Counselling is based on the process of skills progression meaning counselling clients are taught to transition from unconscious incompetence to unconscious competence (Peel & Nolan, 2015). Hypnotherapy is regarded as an integral approach to counselling with uses in a range of issues to help the transition to unconscious competence (Duncan et al., 2007; Peel & Nolan, 2015). The purpose of hypnosis in therapy is to facilitate change through a focused state of attention (Capafons et al., 2008). Counsellors, like hypnotherapists, operate under the framework of providing clients with care, respect, empathy, and compassion, without judgment (PACFA, 2021b).

According to Singh and Kumar (2020), hypnosis is an effective clinical tool for incorporating the understanding of the daily mental health battle many individuals experience (ABS, 2018). The central theme of the practice of hypnotherapy includes the art of language presentation, part of which is connected to using neuro-linguistic programming language (NLP) (Hollander & Malinowski, 2016). NLP language is used as an integral part of the counselling principle in hypnotherapy training including the building of rapport, overcoming resistance, and positive alteration (Hollander & Malinowski, 2016). NLP is not taught within counselling training.

A counsellor trained in hypnotherapy may consider hypnosis an additional tool in their counselling therapy. Glaesmer, Geupel and Haak (2015) mentioned the study of hypnotherapy includes a person-centred procedure to achieve the alternative position of consciousness that is known as trance. The altered condition is featured by an increasing aspect of concentration and heightened awareness to help to achieve positive changes in the clients mental, emotional, and behavioural state. Within the therapy procedure, the counsellor using hypnotherapy, or the counselling hypnotherapist, can draw the client's attention toward new possibilities, creating alternative subconscious patterns of emotions and behaviour, with alternative understanding related to the conditioned responses (Facco et al., 2017). Hypnotic language is used in forming a suggestion to achieve the alteration within the mind-set that helps an individual to step into the future or adjust their past emotional attachment (Facco et al., 2017). Sheiner, Lifshitz and Raz (2016) discussed that hypnotic language is far more interactive than standard talk-therapy, such as counselling, as it focuses on the linguistic treatment to influence the procedure associated with neurology.

While literature seems to support the use of hypnotherapy within the counselling modality, Brugnoli (2016) criticised the procedure of hypnosis as inefficient to meet the potentiality of clinical intervention. One of the reasons mentioned was the lack of empirical proof to support the efficiency of the practices of hypnosis. However, Mizock and Lundquist (2016) countered the argument and found that over the past 30 years, many researchers have been published supporting the role of hypnosis in the field of medicine, especially psychological health. The authors further expanded on the use of hypnosis for the LBGTQIA+ community and the necessity of encouraging therapists to consider diversity and inclusion within their therapy practice. The American Psychiatric Association (APA) (2021) affirmed that hypnosis is also an effective tool in cognitive behavioural therapy. The collaboration of hypnotherapy with cognitive behavioural therapy (CBTH) is considered a therapeutic union in treating a variety of mental health issues when combined with relaxation and imagery (Białkowska et al., 2020; Alladin, 2016; Alladin & Amundson, 2016).

Literature supporting hypnotherapy to benefit counselling

Hypnotherapy has been shown as a positive, complimentary medicine used in a wide range of medical contexts and shown to improve clients' health. Hypnotherapy has been demonstrated to be effective for irritable bowel syndrome (Flik, et al., 2019), reducing headache pain (Ahmadi et al., 2018), and lowering the effects of chronic pain and anxiety (Davis, 2016). There are descriptions of positive results with hypnosis aiding to strengthen the immune system against disease (Schakel et al., 2019), reducing the effects of rheumatoid arthritis (Horton-hausknecht et al., 2000), and there is conclusive evidence on the positive effect of hypnotherapy used in the treatment of obesity (Kansagara et al., 2019). It is documented that using relaxation and guided imagery can help promote long-term health (Białkowska et al., 2020). This more holistic path of combining hypnotherapy with counselling may aid people to live a longer, healthier, happier life, and with less monetary strain on our health care system (Białkowska et al., 2020).

Conspicuous and consistent change in feelings of control is an essential element of hypnotic response (Woody & McConkey, 2003). Weitzenhoffer (1974, p. 259) named this phenomenon *"the classical suggestion effect"* and explained it as a transformation of communication into behaviour with a non-voluntary quality. Wark (2008) reviewed eighteen meta-analyses of hypnotherapy treatments and reported there were

multiple target disorders where hypnotherapy is possibly a better therapeutic modality compared to just counselling or psychological treatment.

Hammond (2010) reviewed the effectiveness of hypnotherapy in reducing anxiety in patients and found hypnotherapy was very effective in the treatment of anxiety associated with a wide range of medical issues. Further, it was concluded there was a reduction of anxiety related to surgical, medical, and dental procedures after using hypnotherapy with patients. The inclusion of hypnotherapy, along with other treatment modalities, such as those used in counselling, can improve the outcomes for patients suffering anxiety, compared to using a singular psychological therapeutic modality (Valentine et al., 2019).

Psychologist Michael Yapko has written extensively about the use of hypnotherapy as an effective intervention for the treatment of depression that is normally held predominantly by psychologists and counsellors (Yapko, 2006). Glaesmer, Geupel and Haak (2015) cited hypnosis is considered beneficial to treat depression and anxiety, an issue affecting so many in our society and communities (ABS, 2018). Andrick (2020) mentioned, that hypnosis contains a positive and greater impact in treating the mental health condition of depression. Empirical studies supporting the efficacy of hypnotherapy have been conducted including a meta-analysis by Kirsch, Montgomery and Sapirstein (1995) and by Alladin and Alibhai (2007). Both studies focused on the use of hypnotherapy as an effective treatment for clinical depression. Studies conducted by Shih, Yang and Koo (2009) identified hypnotherapy significantly improved depressive symptoms of patients, showing hypnotherapy as a viable intervention for depression when combined with counselling.

A review using meta-analysis of studies suggested that hypnotherapy as a feasible non-pharmacological intervention to treat the symptoms of depression, in conjunction with counselling (Shih et al., 2009). While the area of trauma and PTSD has been treated with psychological and counselling intervention, hypnotherapy has demonstrated positive results in treatment to benefit clients if used in combination with CBT (Pfitzer, 2008). A meta-analysis of 18 studies, comprising areas of obesity, pain, insomnia, anxiety, phobia, performance, and public speaking included hypnosis techniques such as relaxation, imagery, coping suggestions, self-reinforcement, desensitisation, stimulus control, and cognitive restructuring, found that hypnotherapy can strengthen the therapeutic outcome by influencing the client's beliefs and expectations (Kirsch, Montgomery, & Sapirstein, 1995; Lynn et al., 2000). A review of 31 articles by Krouwel, Jolly and Greenfield (2017), concluded that most people are positive toward the use of hypnotherapy. They advised individuals would consider using hypnotherapy for conditions such as psychological issues and to support medical interventions. Hypnotherapy can be considered a modality for people wanting to help themselves and those wanting to take charge of their symptoms (Kittle & Spiegel, 2021).

In a review of scientific research on obesity and eating disorders, conducted by Roslim et al., (2020), it was noted that hypnotherapy promoted weight reduction and improved the individual's eating behaviours and quality of life. Hypnotherapy has been found as an effective treatment for eating disorders, obesity and weight loss, either as a standalone treatment or when used in combination with other treatments, including counselling (Sapp et al., 2007). Weight issues are commonly treated with counselling support.

Hypnotherapy is also indicated as positive support for those in the LBGTIQA+ community and those struggling with gender issues, normally treated with psychology and counselling (Araoz, 2005b; IsHak & Fathy, 2010). Literature further indicates that ATSI communities use therapies that change the consciousness of their people's perceptions and cognitions, not unsimilar to techniques used in hypnotherapy (Krippner, 2009). While not referring this change to hypnosis, it seems indigenous practitioners provide basic components of psychotherapy which fosters the efficacy of hypnotic-like procedures to stimulate self-healing abilities (Krippner, 2009; Torryey, 1986). Therefore, if counsellors who worked with ATSI communities became more familiar with hypnotherapy techniques, they may be able to further aid these communities.

Conclusion

The ultimate aim of any therapy is to alleviate and reduce a disorder to help the client return to a normal life as best and as soon as possible. The different ways in which individuals may benefit from using alternative methods such as clinical hypnotherapy should be considered along with counselling methods. This article has demonstrated how hypnotherapy may benefit the counselling process in the treatment of a wide range of issues for the broad community. The increasing research on the benefits of hypnotherapy for issues currently treated with counselling, may provide an avenue for counsellors to consider further training to incorporate hypnotherapy within their counselling practice. Further, consideration could be made to investigate how hypnotherapy may assist culturally diverse, ATSIC, and LGBTIQA+ community members.

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References

Ahmadi, A. M., Jafari, M., Sabzevari, L., FallahTafti, A., & Bidaki, R. (2018). Evaluation of the effect of hypnotherapy on the headache. *Sleep Hypn, 20*(2), 114-19.

Ahlskog, G. (2018). Clinical hypnosis today. *The Psychoanalytic Review, 105*(4), 425-437.

Alladin, A. (2016). Cognitive hypnotherapy for accessing and healing emotional injuries for anxiety disorders. *American Journal*

of Clinical Hypnosis, 59(1), 24-46.

Alladin, A., & Alibhai, A. (2007). Cognitive hypnotherapy for depression: An empirical investigation. *Intl. Journal of Clinical and Experimental Hypnosis, 55*(2), 147-166.

Alladin, A., & Amundson, J. (2011). Cognitive hypnotherapy as an assimilative model of therapy. *Contemporary Hypnosis & Integrative Therapy,* 28, 17-45.

Alladin, A., & Amundson, J. (2016). Cognitive hypnotherapy as a transdiagnostic protocol for emotional disorders. *International Journal of Clinical and Experimental Hypnosis, 64*(2), 147-166.

American Psychiatric Association (APA), (2021). *Hypnosis*. Retrieved from https://www.apa.org/topics/hypnosis.

Andrick, J. M. (2020). Suggestive therapeutics, public psychologies, and new thought pluralism. *The "Chicago School of Psychology" and Hypnotic Magazine,* 1895–1910. *History of psychology, 23*(1), 1.

Araoz, D. (2005a). Defining Hypnosis. *American Society of Clinical Hypnosis,* 48(2/3), 1-6

Araoz, D. (2005b). Hypnosis in human sexuality problems. *American Journal of Clinical Hypnosis, 47*(4), 229-242.

Australian Bureau of Statistics, (ABS) (2018). Mental health. Contains key statistics and information about psychological distress, mental and behavioural conditions and its prevalence in Australia. Sourced https://www.abs.gov.au/statistics/health/health-conditions-and-risks/mental-health/latest-release

Australian Counselling Association (ACA), (2021). *Find an approved course.* Sourced from https://www.theaca.net.au/course_results.php.

Australian Hypnotherapy Association (AHA), (2021a). *AHA recognised hypnotherapy training courses.* Sourced https://www.ahahypnotherapy.org.au/hypnotherapy-training/aha-recognised-training/

Australian Hypnotherapy Association (AHA), (2021b). *Prospectus and information booklet.* Sourced https://www.ahahypnotherapy.org.au/public/21/files/Membership%20 documents/ AHA%20 NHRA%20Prospectus%20Information% 20Booklet%202018.pdf

Australian Institute Professional Counselling (AIPC), (2021). *Courses*. Sourced https://www.aipc.net.au

Białkowska, J., Juranek, J., & Wojtkiewicz, J. (2020). Behavioral Medicine Methods in Treatment of Somatic Conditions. *BioMed Research International,* 1–12. https://doi-org.libraryproxy.griffith.edu.au/10.1155/2020/5076516

Bigley, J., Griffiths, P. D. , Prydderch, A. , Romanowski, C. A. J. , Miles, L. , Lidiard, H. , & Hoggard, N. (2010). Neurolinguistic programming used to reduce the need for anaesthesia in claustrophobic patients undergoing MRI. *British Journal of Radiology, 83,* 113–117.

Bo, S., Rahimi, F., Goitre, I., Properzi, B., Ponzo, V., Regaldo, G., ... & Broglio, F. (2018). Effects of self-conditioning techniques (Self-hypnosis) in promoting weight loss in patients with severe obesity: A randomized controlled trial. *Obesity, 26*(9), 1422-1429.

Brugnoli, M. P. (2016). Clinical hypnosis for palliative care in severe chronic diseases: a review and the procedures for relieving physical, psychological and spiritual symptoms. *Ann Palliat Med, 5*(4), 280-297.

Bryant, R. A., Moulds, M. L, Guthrie, R. M., & Nixon, R. (2005). The Additive Benefit of Hypnosis and Cognitive-Behavioral Therapy in Treating Acute Stress Disorder. *Journal of Consulting and Clinical Psychology,* 73, 334-340. https://doi.org/10.1037/0022-006X.73.2.334

Capafons, A.; Espejo, B.; & Mendoza, E.M. (2008). Confirmatory factor analysis of the Valencia scale on attitudes and beliefs toward hypnosis: Therapist version. *International Journal of Clinical and Experimental Hypnosis,* 56, 281–294.

Castonguay, L. G., Eubanks, C. F., Goldfried, M. R., Muran, J. C., and Lutz, W. (2015). Research on psychotherapy integration: building on the past, looking to the future. *Psychothery. Res.* 25, 365–382. doi: 10.1080/10503307.2015.1014010

Cowen, L. W. (2015). *Developing clinical hypnotherapy educational guidelines through consensus.*

Cowen, L. W. (2016). Literature review into the effectiveness of hypnotherapy. *Australian Counselling Research Journal, 10,* 1-55.

Cropanzano, R. (2009). Writing nonempirical articles for Journal of Management: General thoughts and suggestions. Journal of Management, 35, 1304-1311

Daitch, C. (2018). Cognitive behavioral therapy, mindfulness, and hypnosis as treatment methods for generalized anxiety disorder. *American Journal of Clinical Hypnosis, 61*(1), 57-69.

Davidson, L. (2003). Living outside mental illness: *Qualitative studies of recovery in schizophrenia.* NYU Press.

Davis, E. (2016). Literature review of the evidence-base for the effectiveness of hypnotherapy, *PACFA Journal.*

Daykin, N., Mansfield, L., Meads, C., Julier, G., Tomlinson, A., Payne, A., Grigsby Duffy, L., Lane, J., D'Innocenzo, G., Burnett, A., Kay, T., Dolan, P., Testoni, S., & Victor, C. (2018). *What works for wellbeing? A systematic review of wellbeing outcomes for music and singing in adults.* SAGE Publications; 38: 39-46. https://doi.org/10.1177/ 1757913917740391

Duncan, B.L., Miller, S,D., & Sparks, J. A.(2007). Common factors and the uncommon heroism of youth. *Psychotherapy in Australia,* 13: 34–43.

Elias, J. (2009). What is hypnosis. *Journal of Experiential Trance, 1*(1), 66-73.

Elkins, G. R. (2018). *Mindful hypnotherapy: The basics for clinical practice.* Springer Publishing Company.

Entwistle, P.A., (2017). A pragmatic guide to the setting up of integrated hypnotherapy services in primary care and clinical settings. *International Journal of Clinical and Experimental Hypnosis, 65*(3), pp.257-295.

Facco, E., Testoni, I., Ronconi, L., Casiglia, E., Zanette, G., & Spiegel, D. (2017). Psychological features of hypnotizability: A first step towards its empirical definition. *International Journal of Clinical and Experimental Hypnosis, 65*(1), 98-119.

Feltham, C. (2002). Beyond denial, myth and superstition in the counselling profession. In *New directions in counselling* (pp. 309-320). Routledge.

Flik, C. E., Laan, W., Zuithoff, N. P., van Rood, Y. R., Smout, A. J., Weusten, B. L., Whorwell, P.J., & de Wit, N. J. (2019). Efficacy of individual and group hypnotherapy in irritable bowel syndrome (IMAGINE): a multicentre randomised controlled trial. *The lancet Gastroenterology & hepatology, 4*(1), 20-31.

Flory, N., Martinez-Salazar, G. M., Lang, E.V. (2007). Hypnosis for acute distress management during medical procedures.

International Journal of Clinical and Experimental Hypnosis, 55(3) 147-166.

Glaesmer, H., Geupel, H., & Haak, R. (2015). A controlled trial on the effect of hypnosis on dental anxiety in tooth removal patients. *Patient education and counseling, 98*(9), 1112-1115.

Gold, S. N., & Quiñones, M. (2020). Applicability of hypnosis to the treatment of Complex PTSD and dissociation. *American Journal of Clinical Hypnosis, 63*(2), 78-94.

Goode, J., Park, J., Parkin, S., Tompkins, K. A., & Swift, J. K. (2017). A collaborative approach to psychotherapy termination. *Psychotherapy, 54*(1), 10.

Gruzelier, J. (2000). Redefining Hypnosis: Theory, methods and integration. *Contemporary hypnosis (2000) Vol. 17, No. 2, pp. 51–70*

Gunnison, H. (1990). Hypnocounselling: Ericksonian Hypnosis for Counsellors. *Journal of counselling & development,* vol. 68

Hammond, D. C. (2010). Hypnosis in the treatment of anxiety- and stress-related disorders. *Expert Review of Neurotherapeutics,* 10(2), 263-273. doi: 10.1586/ern.09.140

Heitkemper, M. M. (2009). Evidence-based treatments for irritable bowel syndrome with constipation. *Journal of Family Practice, 58*(5), S13-S13.

Henkelman, J., & Paulson, B. (2006). The client as expert: Researching hindering experiences in counselling. *Counselling Psychology Quarterly, 19*(2), 139-150.

Hollander, J., & Malinowski, O. (2016). The effectiveness of NLP: Interrupted time series analysis of single subject data for one session of NLP coaching. *Journal of Experiential Psychotherapy/ Revista de PSIHOterapie Experientiala, 19*(4).

Horton-hausknecht, J. R., Mitzdorf, U., & Melchart, D. (2000). The effect of hypnosis therapy on the symptoms and disease activity in Rheumatoid Arthritis. *Psychology & health, 14*(6), 1089-1104.

Imel, Z. E., & Wampold, B. E. (2008). The importance of treatment and the science of common factors in psychotherapy. *Handbook of counseling psychology, 4,* 249-266. IsHak, W. W., & Fathy, H. (2010). Sexual and Gender Identity Disorders in *Clinical Psychiatry Essentials,* Roberts L., Hoop., & Heinrich T. Wolters Kluwer Health. P. 257.

Jiang, H., White, M. P., Greicius, M. D., Waelde, L. C., & Spiegel, D. (2017). Brain activity and functional connectivity associated with hypnosis. *Cerebral cortex, 27*(8), 4083-4093.

Jones, T. M., Jones, T. W., Power, J., Despott, N., & Pallotta-Chiarolli, M. (2021). Healing spiritual harms: supporting recovery from LGBTQA+ change and suppression practices

Kairuz, C. A., Casanelia, L. M., Bennett-Brook, K., Coombes, J., & Yadav, U. N. (2020). Impact of racism and discrimination on the physical and mental health among aboriginal and torres strait islander peoples living in australia: A protocol for a scoping review. *Systematic Reviews, 9*(1), 223-223. https://doi.org/10.1186/s13643-020-01480-w

Kansagara, D., Freeman, M., Ayers, C., Kondo, K., Noonan, K., O'Neil, M., & Morasco, B. (2019). *Guided Imagery, Biofeedback, and Hypnosis:* A Map of the Evidence.

Kirsch, I., Montgomery, G., & Sapirstein, G. (1995). Hypnosis as an adjunct to cognitive-behavioral psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology,* 63, 214-220.

Kittle, J., & Spiegel, D. (2021). Hypnosis: The Most Effective Treatment You Have yet to Prescribe. *The American Journal of Medicine, 134*(3), 304-305.

Kraft, D. (2011). The place of hypnosis in psychiatry, part 4: Its application to the treatment of agoraphobia and social phobia. *Australian Journal of Clinical & Experimental Hypnosis, 39*(1).

Krouwel, M., Jolly, K., & Greenfield, S. (2017). What the public think about hypnosis and hypnotherapy: A narrative review of literature covering opinions and attitudes of the general public 1996–2016. *Complementary therapies in medicine, 32,* 75-84.

Lancaster, T., & Stead, L. F. (2017). Individual behavioural counselling for smoking cessation. *Cochrane database of systematic reviews,* (3).

Lankton, S. (2015). A SoC Model of hypnosis and induction. *American Journal of Clinical Hypnosis,* 57:4, doi: 10.1080/00029157.2015.1011461

Lynn, S. J., Kirsch, I., Barabasz, A., Cárdena, E., & Patterson, D. (2000). Hypnosis as an empirically supported clinical intervention: The state of the evidence and a look to the future. *International Journal of Clinical and Experimental Hypnosis,* 48, 239-258.

McNeal, S. (2020). Hypnotic Ego-strengthening: Where We've Been and the Road Ahead. *American Journal of Clinical Hypnosis, 62*(4), 392-408.

Martin, D. M. (2017). School counselors' perceptions of family systems perspectives. *The Family Journal (Alexandria, Va.), 25*(3), 271-77. Sourced https://doi.org//10.1177/ 1066480717711109

Meier S. C., Labuski C. (2013). The demographics of the transgender population. In A. Baumle, *International handbook on the demography of sexuality* (pp. 289–327). New York, NY: Springer

Mendoza, K. A. (2018). *Counselors' perceptions of storytelling, fairytales, and sandplay in working with traumatically abused children* (Doctoral dissertation).

Merriman, O., & Joseph, S. (2018). Therapeutic implications of counselling psychologists' responses to client trauma: An interpretative phenomenological analysis. *Counselling Psychology Quarterly, 31*(1), 117-136.

Messer, S. B. (1992). *A critical examination of belief structures in integrative and eclectic psychotherapy.*

Milling, L. S., Gover, M. C., & Moriarty, C. L. (2018). The effectiveness of hypnosis as an intervention for obesity: A meta-analytic review. *Psychology of Consciousness: Theory, Research, and Practice, 5*(1), 29.

Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity, 3*(2), 148.

Nagarajan, M., & Yuvaraj, S. (2019). Mental health counsellors' perceptions on use of technology in counselling. *Current psychology,* 1-7.

Norcross, J. C. (ed.). (2011). *Psychotherapy Relationships that Work: Evidence-Based Responsiveness.* Oxford: Oxford University Press.

Norcross, J. C., Beutler, L. E., & Goldfried, M. R. (2019). Cognitive-behavioral therapy and psychotherapy integration. *Handbook of cognitive-behavioral therapies, 318.*

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy

relationships that work III. *Psychotherapy*, 55(4), 303. https://doi.org/10.1037/pst0000193

O'Donoghue, J., Moss, H., Clements-Cortes, A., & Freeley, C. (2020). Therapist and individual experiences and perceptions of music therapy for adolescents who stutter: A qualitative exploration. *Nordic Journal of Music Therapy, 29*(4), 353-370.

Okech, J. E. A., & Geroski, A. M. (2015). Interdisciplinary Training: Preparing Counselors for Collaborative Practice. *Professional Counselor, 5*(4), 458-472.

Okech, J. E., Rubel, D. J., (2018). *Counselor education in the 21st century: Issues and experiences.* American Counseling Association.

Paulton, J. P., Gill, A. K., & Prevost, J. (2021). Gut-directed selfhypnosis for inflammatory bowel disease protocol: complimentary psychotherapy for remission augmentation, IBS-like symptoms, and surgery recovery. *Am J Clin Hypn, 58*(1), 81-99.

Pearson, M. (2020). Counselling intern self-awareness and readiness for practice: reports from a mindfulness challenge. *Asia Pacific Journal of Counselling and Psychotherapy, 11*(1), 23-33.

Peel, J. L., & Nolan, R. J. (2015). You Can't Start a Central Line? Supervising Residents at Different Stages of the Learning Cycle. *J Grad Med Educ,* 7 (4): 536–538. doi: https://doi.org/10.4300/JGME-D-15-00025.1

Pfitzer, B. E. (2008). *A step towards a broader understanding of complex traumatization in victims of crime: psychological and physical health impacts and implications for psychological interventions and treatment evaluation* (Doctoral dissertation), p 7-9.

Phillip, K., Beel, N., & Machin, T. (2020). Understanding the cues and strategies counsellors use to develop rapport with clients through telephone counselling. *Psychotherapy and Counselling Journal of Australia, 8*(1), 1-9.

Poteat T., German D., Kerrigan D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care encounters. Social Science & Medicine, 84, 22–29

Psychotherapy and Counselling Federation of Australia (PACFA), (2021a). *PACFA course accreditation guidelines.* Sourced from https://www.pacfa.org.au/training-cpd/course-accreditation/accredited-courses/

Psychotherapy and Counselling Federation of Australia (PACFA), (2021b). *PACFA membership requirements.* Sourced https://pacfa.org.au/portal/Membership/ Membership-Requirements/ Portal/ /Membership/Join- PACFA/Eligibility.aspx?hkey=70624ce6-48be-47fb-ae19-8c7b9f49a72c

Ramondo, N., Gignac, G. E., Pestell, C. F., & Byrne, S. M. (2021). Clinical Hypnosis as an Adjunct to Cognitive Behavior Therapy: An Updated Meta-Analysis. *International Journal of Clinical and Experimental Hypnosis, 69*(2), 169-202

Roslim, N. A., Ahmad, A., Mansor, M., Aung, M. M. T., Hamzah, F., Hassan, H., & Lua, P. L. (2020). Hypnotherapy for overweight and obese patients: a narrative review. *Journal of Integrative Medicine.*

Salonoja, M., Salminen, M., Aarnio, P., Vahlberg, T., & Kivelä, S. L. (2010). One-time counselling decreases the use of benzodiazepines and related drugs among community-dwelling older persons. *Age and ageing, 39*(3), 313-319.

Sapezinskiene, L., Burkauskas, J., & Kretschmer, K. (2016). *Measurement of interpersonal power relations between the client and the therapist in Gestalt therapy session using metaphor.* In J. Roubal (Ed.), *The world of contemporary Gestalt therapy. Towards a research tradition in Gestalt therapy* (p. 244–270). *Cambridge Scholars Publishing.*

Sapp, E. D., Obiakor, F. E., Gregas, A. J., & Scholze, S. (2007). Mahalanobis distance: A multivariate measure of effect in hypnosis research. *Sleep and Hypnosis, 9*(2), 67.

Schakel, L., Veldhuijzen, D. S., Crompvoets, P. I., Bosch, J. A., Cohen, S., van Middendorp, H., Ottenhoff, T.H., Visser, L.G. & Evers, A. W. (2019). Effectiveness of stress-reducing interventions on the response to challenges to the immune system: a meta-analytic review. *Psychotherapy and psychosomatics, 88*(5), 274-286.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American psychologist, 65*(2), 98.

Sheiner, E. O., Lifshitz, M., & Raz, A. (2016). Placebo response correlates with hypnotic suggestibility. *Psychology of Consciousness: Theory, Research, and Practice, 3*(2), 146.

Shih, M., Yang, Y.-H., & Koo, M. (2009). A Meta-Analysis of Hypnosis in the Treatment of Depressive Symptoms: A Brief Communication. *International Journal of Clinical and Experimental Hypnosis,* 57(4), 431-442. doi: 10.1080/00207140903099039

Sierpina, V., Astin, J., & Giordano, J. (2007). Mind-body therapies for headache. American Family Physician, 76(10), 1518-1524.

Singh, H., & Kumar, P. (2020). Efficacy of hypnotism in the management of psychiatric disorders.

Sperber J., Landers S., Lawrence S. (2005). Access to health care for transgendered persons: Results of a needs assessment in Boston. International Journal of Transgenderism, 8, 75–91

Spiegel, D. (2013). Tranceformations: Hypnosis in brain and body. Depression and Anxiety, 30, 342–352.*Extramural*

Spiegel, H., & Greenleaf, M. (2005). Commentary: Defining Hypnosis. *American Society of Clinical Hypnosis,* 48(2/3), 1-8.

Stewart, J.H. (2005). Hypnosis in contemporary medicine. *Mayo Clinic Proceedings,* 80, 511–524.

Taylor, D. A., & Genkov, K. A. (2020). Hypnotherapy for the treatment of persistent pain: a literature review. *Journal of the American Psychiatric Nurses Association, 26*(2), 157-161.

Thompson, I., Amatea, E., & Thompson, E. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling, 36*(1), 58-77.

Valentine, K. E., Milling, L. S., Clark, L. J., & Moriarty, C. L. (2019). The efficacy of hypnosis as a treatment for anxiety: a meta-analysis. *International Journal of Clinical and Experimental Hypnosis, 67*(3), 336-363.

Wake, L. & Leighton, M, (2014). Pilot study using Neurolinguistic Programming (NLP) in postcombat PTSD. *Mental Health Review Journal,* 19(4), 251–264.

Wark, D. M. (2008). What we can do with hypnosis: A brief note. American Journal of Clinical Hypnosis, 51(1), 29-36. *ProQuest Psychology Journals.*

Weitzenhoffer, A. M. (1974). When is an "instruction" an "instruction"? *International Journal of Clinical and*

Experimental Hypnosis, 22(3), 258-269. https://doi.org/10.1080/00207147408413005

Wilson, D., Christensen, A., Jacobsen, P. B., & Kaplan, R. (2019). Standards for economic analyses of interventions for the field of health psychology and behavioral medicine, *Health Psychology,* vol. 38, no. 8, pp. 669–671.

Wong-Wylie, G. (2007). Barriers and facilitators of reflective practice in counsellor education: Critical incidents from doctoral graduates. *Canadian Journal of Counselling / Revue Canadienne De Counseling, 41*(2), 59-76.

Woody, E. Z., & McConkey, K. M. (2003). What we don't know about the brain and hypnosis, but need to: A view from the buckhorn inn. *International Journal of Clinical and Experimental Hypnosis, 51*(3), 309-338. https://doi.org/10.1076/iceh.51.3.309.15523

Yapko, M. (2012). *Trancework: An introduction to the practice of clinical hypnosis.* New York, NY: Routledge.

Yapko, M. D. (2006). Hypnosis in treating symptoms and risk factors of major depression. *Hypnosis and treating depression: Applications in clinical practice,* 3-24.

Zarbo, C., Tasca, G. A., Cattafi, F., & Compare, A. (2016). Integrative psychotherapy works. *Frontiers in psychology, 6,* 2021.

Anxiety – a rapidly worsening epidemic

Peter Smith

Are we looking in the right places for the source, or are we only treating the symptoms?
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"It is now affecting me in so many ways. I'm taking time off work and I'm worried about my job. I'm avoiding people and I just want to stay home. The only place I feel truly safe is wrapped up in bed…" Janet, a professional, aged 35.

For years now I've been listening to stories like Janet's. In recent times, they have increased in number and more often these days they come from younger people, even children.

This article needs to be written for those kids and for their kids yet to be born, as this rapidly increasing epidemic spreads. The generations that follow us, will have to deal with far greater global issues than we have. We must prepare them well and leave them a strong legacy, so that hopefully they can heal humanity in ways our generation hasn't been able to do. This means we have to find new and creative solutions to this epidemic of anxiety and set the generation that follows us…free.

For the past 12 years I've been working as a Clinical Hypnotherapist in Melbourne, Australia, working in the frontline with people's emotional disorders. I have studied anxiety and depression through the eyes of hundreds of clients, crafting individual solutions to what they encounter daily and I've come to some conclusions:

1. Our Mental Health System doesn't have a panacea for all those affected. Whilst the different resources/organisations etc. are helpful in offering education and support groups, they are often unable to find the source of the issue or if they do, have difficulty in remedying it. Anxiety needs to be "managed" my clients are often told. I firmly believe that it needs to be and can be healed, or more accurately "released".
2. Many are dependent on medications, which offer some form of temporary relief though I'm told by my clients constantly, that whilst they have lost the debilitating dips in their emotional state, this comes at the sacrifice of the joyful peaks. *"I'm feeling less anxious, but I've lost the zest for life that I still had occasionally."* (Robert - 61 year old retiree)
3. Cognitive Behavioural Therapy (CBT), whilst a somewhat proven scientific method remains limited in its battle against anxiety. Its understandable reliance on process, while robust, doesn't often get to the heart of the matter or bring the promised relief according to my clients. The source of the issue usually remains more deeply hidden. *"I've been having counselling for 6 months, but I'm still anxious"* (Wendy – 44 year old, Mother of three)

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You may be suffering from anxiety with the myriad of individual responses like hypervigilance, disrupted sleep patterns, Obsessive Compulsive Disorder, social phobia, procrastination, panic attacks or a deep and profound stress. I offer you something other than the suggestion you are "suffering a mental illness" and the stigma that this creates for you and those you are close to.

I completely acknowledge that you are suffering a debilitating condition and that your whole life is built around it. You have likely tried some forms of counselling, medication, support services and nothing has given you the deeper answers you seek. Can I offer to you that your "Fight or Flight" response is highly activated, as a way for your subconscious to keep you safe. A warning system has been put in place through subconscious programming that infiltrates your conscious thought processes, your physiology and permeates your behaviours. Whilst this warning system is powerful and effective, it has likely been put in place because of energy that has emerged in your life from your past, in ways you may not recognise or even know about. It is likely that the warning system is now obsolete, though this logic is beyond the timelessness of the subconscious.

The language of the conscious mind is time, the language of the subconscious is energy. It is the stored energy in the subconscious that is driving the system. Its source needs to be identified and released. Once this is done, the warning system structure can be collapsed and the conscious mind can relearn, without the highly charged energy that characterises anxiety.

Let me summarise in a more simple way; a part of you is trying to keep you safe, but it has gone off-beam and you can't reason with it, as you can't get to it. It is hidden behind the veil of the subconscious.

The traditional medical system has trouble dealing with this aspect as it doesn't readily recognise the incredible power of the subconscious, through the traditional CBT approaches. Thus the government supported infrastructure for mental health,

does not include dedicated subconscious work. Over the years, I have found in my clients that anxiety is often “unreasonable”, i.e. it can’t be reasoned with, analysed, talked out or made to see logic, all being aspects embraced through CBT.

Hypnotherapy as an alternate health modality, can be a hidden jewel in the battle against anxiety as it offers a powerful approach. In the same way that a master surgeon enters the body to expertly move past arteries and capillaries to find and remove a tiny tumour that debilitates an entire physiology, a well-trained intuitive Hypnotherapist can enter the subconscious to move beyond linear time to find the source of emotional debilitation and release the hold it has on a client.

Fascination with the subconscious is nothing new, having been the focus of indigenous shamans for thousands of years. In more recent times, it held the attention of Sigmund Freud (1856-1939) with his dream interpretation work and Carl Jung (1875-1961) with his theory of the Collective Unconscious. In fact, in a strange twist of fate, the original healing industries of humanity that was based on herbs, energy systems, body work and shamanic approaches is now seen as Alternative or Non-traditional Medicine even though it is many thousands of years old. Whereas Allopathic or modern Western Medicine is seen as Traditional Medicine even though it is still by comparison, in its infancy. There is an argument for scientific justification for medical approaches that are based on repetition and systemic reproduction under controlled environments, though I’d simply offer that every client I’ve seen over the years has their own unique story, circumstances and require an individual approach to healing. Whilst this may fail scientific scrutiny, people still get better - quickly. Subconscious healing is not a process, it is an experience of discovery and insight, that releases deep and profound issues, often beyond the line of sight of a client’s conscious awareness. Clients can heal in a moment of blinding insight, when they discover “consciously”, that a particular trauma anchored energetically in the subconscious is the source of their highly activated Fight or Flight state.

Where does the energy come from?

The following are some conceptual ideas about the original source of client’s anxieties that over the years, I’ve found form common trends. I’ll also share stories I’ve heard that may offer insight to readers who are suffering from anxiety. I share them in the hope that your search for healing, may embrace new territories you haven’t yet covered.

We all know that past trauma can bring anxiety, though I’ve found there to be various types of trauma. 1. There can be an elongated period of time under stress, like a difficult childhood, abusive relationship or period of workplace bullying. This can result in generalised anxiety. 2. Clients can also suffer from a single trauma or repeated series of them, leaving a client in a state of hypervigilance, ready to be triggered when something somehow echoes the original source of the energy. 3. The hardest one to discover, is when a small incident suddenly brings an overwhelming activation of previous incidents that have been dormant in the subconscious before that final incident becomes the straw that breaks the camel’s back. In its final analysis this is strong proof of the timelessness of the subconscious.

The most complex cases can involve an amalgamation of all three.

These basic sources of trauma and subsequent anxiety are well known to mental health professionals at all levels. I’ll simply offer that where some aspects of CBT do work well, there are a couple of simple things that for the main part go unacknowledged.

1. **Anxiety is a safety system not a mental illness.** Anxiety is a response to trauma and that energy of trauma is held subconsciously, not consciously. Logically, we can then understand why it doesn’t always shift with talk therapies. CBT is done in the conscious state (i.e. Beta brain wave patterns), the subconscious operates in Alpha or even Theta range. That is why CBT can’t always get to the trauma. To summarise, the trauma is subconscious, so the anxiety is subconscious too. It’s the specifically crafted solution by the client’s deeper self – it has to come from the same place, characterised by the same brain wave patterns.
2. There is a way in which the energy of trauma is held when it lodges in the subconscious. **Not only is anxiety held subconsciously, but it is held energetically entangled between an event, a feeling and a belief** in a triangular format. This self-sustaining energy framework starts to form solutions and programs that counteract the trauma energy. We are after all a remarkable survival species. Sometimes we just soldier on and do the best we can in life, carrying our experiences with us. Trauma doesn’t fully release unless we address the original energy in which it was stored, which means we have to search the energetic history of the client to locate the traumatic event(s) AND then address the feeling AND the belief.
Tim now aged 29, was traumatised repeatedly by an angry Father when he was small. His past was triggered when his new boss joined the firm, a man characterised by a short fuse and a booming voice, which he used often. Tim had a number of panic attacks at work before he sought help, as they had started to drift into his private life. In fact, one had emerged during the break-up with his girlfriend. In a deep trance state, Tim travelled back in time to again become the little boy facing his Father, as he held feelings of sheer terror and a belief that he was desperately unsafe. Little Tim was met by his 29 year old self, who held him and made him safe, changing his beliefs around personal safety. We released the feelings and beliefs across all similar events collapsing in minutes a safety system that had been carefully put in place over almost 3 decades. We matched the trauma held in Alpha brainwave patterns, with subconscious healing in the same brainwave state. Tim hasn’t had another panic attack since and he now lives a life without debilitating anxiety.

We know that similar wavelengths of opposite magnitude cancel each other out. Its common practice with technology like noise-cancelling earphones[1]. Again the logic of healing is evident. Trauma is held in an Alpha wavelength, so the healing interventions need to be offered in the same wavelength to match it.

Those all important childhood years

It is well known that our childhood shapes us for the rest of our lives. The so called “Formative Years” is the period of time when we form our values, beliefs and start to build our self-view. It is seen as something like the first 7 to 12 years of life, depending on your psychological model. During this period of

time, we are conditioned by our environment, by our role models who we copy both consciously and unconsciously and by our experiences, though brain wave patterns play an important role here once again. The subconscious mind is open through this period, as babies spend their time predominately in the Delta (Sleep) range of brainwave patterns. Between 2 and 6 years of age they are more often in the Theta range and then Alpha range from 6 years. After 12 years of age we are mostly in the conscious or Beta state and the "subconsciously open" years are completed. This is why children learn so well, though it is also a way in which trauma can be effectively stored. Bruce Lipton PhD articulates this phenomenon well in his book *The Biology of Belief* (2004) when he states; *"…the fundamental behaviours, beliefs, and attitudes we observe in our parents become "hard-wired" as synaptic pathways in our subconscious minds. Once programmed into the subconscious mind, they control our biology for the rest of our lives…or at least until we make the effort to reprogram them."* [2]

Bruce Lipton, even as a traditionally trained medical doctor, understands this critical aspect of how we respond to our environments and this has been fundamental to his own remarkable work.

The Womb – where consciousness is first active

Whilst our conscious memory may go back to when we are small children, our subconscious starts observing, recording and storing energy before we are even born. We are already assembling information and absorbing energy from whatever our mothers are experiencing. Again this makes perfect logical sense as we are completely connected by shared physiology, whether it be biologically, chemically or energetically and some would say psychically as well. So many times over the years, I have found anxiety originated in the womb and then gradually grew, event by event through the formative years.

Cheryl aged 38 was in a deep state of trance and travelled back in time to before she was born. When I asked how her Mother was feeling, Cheryl replied that her Mother was really anxious and worried about this, her first baby. When I asked how this affected her as the unborn child, Cheryl began to cry. She had been trying to help her Mother and took on her anxiety as a way to share the burden. She had been carrying it ever since. We released the energy and associated beliefs and feelings and Cheryl was set free from her anxiety.

Dr. Marcy Axeness, a professor of pre-natal development and expert in parenting offers this: *"If a mother is consistently filled with anxiety or stress during her pregnancy, the 'message' communicated to her baby (via stress hormones) is that they are in an unsafe environment — regardless of whether or not this is actually true. The baby's brain will actually adapt to prepare for the unsafe environment it perceives it is going to be born into!"* [3]

This opens a whole new avenue of exploration in the battle against the epidemic of anxiety. There are individual circumstances where it is literally true that he/she was "born anxious", though not everyone responds in this way. Again it is down to the individual and how they respond uniquely to the energy they receive.

Intergenerational Trauma – The Energenetic Lineage

The phenomenon of Intergenerational Trauma is starting to receive more attention. It is just possible that the trauma we hold in our being, transcends generations as a type of energetic legacy of safety. The new field of "Psychohistory" can be defined as: *group identity, the transmission of trauma across generations, processes of collective mourning and creativity.* [4]

Molly Castello PhD. Author of "The Me in We" (www.psychologytoday.com) tells us:

"What is overwhelming and unnameable is passed on to those we are closest to. Our loved ones carry what we cannot. And we do the same.

This is the subject of Lost in Transmission: Studies of Trauma Across Generations, edited by M. Gerard Fromm (2012). This collection of essays on traumatic transmission, builds on the idea that 'what human beings cannot contain of their experience—what has been traumatically overwhelming, unbearable, unthinkable—falls out of social discourse, but very often on to and into the next generation as an affective sensitivity or a chaotic urgency.' The child speaks what their parent could not. He or she recognizes how their own experience has been authored, how one has been authorized, if unconsciously, to carry their parents' injury into the future. In rising above the remnants of one's ancestors' trauma, one helps to heal future generations." [5]

Over the years I've seen my own examples of this remarkable phenomenon.

Dimitri, a 35 year old Business Analyst was off work for some time suffering workplace stress. Counselling and medication weren't helping. As we probed the source of his condition he told me a story about his Grandfather. In WWII, his Grandfather had been a tiny baby, living in a small village in Eastern Europe. Soldiers came through and took the entire population of the village to the large waiting room at the railway station. They were all then machine gunned to death, except for the baby who became his Grandfather. His Mother had shielded her baby from the hail of bullets with her own body. Many hours later, passers-by on the nearby road heard a baby crying and discovered this tragic scene. Dimitri's Grandfather was taken in by those kind people. Dimitri sobbed deeply as he told this story, releasing the profound pain of two generations before him, the trauma of this family tragedy deeply ingrained in his being. It was a critical turning point in his healing.

I've come to call this phenomenon the "Energenetic Lineage". Our parents come together to form us in more than just a mix of sperm, egg and shared DNA. Whilst that may underpin physical procreation, our energenetic lineage is a combination of quantum entanglement and morphic resonance.

Dr Rupert Sheldrake who first offered this hypothesis in his book "A New Science of Life" (1981), defines "Morphic Resonance" as *"a process whereby self-organising systems inherit a memory from previous similar systems…The hypothesis of morphic resonance also leads to a radically new interpretation of memory storage in the brain and of biological inheritance. Memory need not be stored in material traces inside brains, which are more like TV receivers than video recorders, tuning into influences from the past. And biological inheritance need not all be coded in the genes, or in epigenetic modifications of the genes; much of it depends on morphic resonance from previous*

members of the species. Thus each individual inherits a collective memory from past members of the species, and also contributes to the collective memory, affecting other members of the species in the future.” [6]

We know also from the laws of Quantum Physics that quantum entanglement means that which has been connected stays connected. Quantum particles form relationships that transcend time and space, in a phenomenon that Einstein once referred to as “spooky action at a distance”.

If we hold trauma from those who come before us, then surely we carry the energetic solution, the safety system trialled over generations in the entangled energy field of our family lineage where the morphic resonance would be even stronger, bolstered by quantum entanglement. In short, anxiety can be inherited as the unconscious solution to intergenerational trauma.

Louise was in her 60s and eager to explore some life-long blocks that stopped her making decisions and caused a “stuckness” in her life. She found any decision at any level, resulted in anxiety. As we moved back along her Energetic Lineage we discovered some powerful beliefs in her Paternal (male) line. Four generations of men had taken safe decisions as a way to protect their families and keep themselves safe. As we moved through a gestalt type process of sharing feelings and concerns, they came to realise that their beliefs were in fact holding their descendants back. When we released their anxiety and replaced it with courage, they then stood behind Louise to show loving support. When we turned to the Maternal (female) line, we found several generations, keeping themselves invisible as a way to stay small and be safe. This too was released, sending waves of healing back through the generations and setting Louise free from her blocks.

Quantum Echoes across time and space

The belief system of a therapist is critical to a client’s healing. If we place our own barriers and beliefs on a session we often won’t find the deeper layers that may be lying close by, in a multidimensional and metaphysical landscape. Simply put, we are multidimensional in our real state of being, as anyone who has had a Near Death Experience (NDE), witnessed paranormal phenomenon or had out of body experience will readily confirm.

In order to chase down the source of anxiety, I have witnessed clients talk about energy coming from alternate selves in other realities – a firm fit with many aspects of Quantum Physics and my own research into Quantum Consciousness in recent years.

I have heard clients share what appear to be Past Life imprints under the theory of reincarnation, a theory expertly researched and investigated by Dr. Ian Stevenson and his work at the University of Virginia[7]. His work is now continued by others, since his passing in 2007.

Sometimes we discover a pattern of trauma across multiple lives, which can be released in a deeper state of trance under the Life Between Lives® methodology, brought to the world by Dr. Michael Newton and his 7000 client cases.[8]

I acknowledge these layers are outside most people’s thinking, however we’ve reached a point in the battle against anxiety where we need to consider more creative solutions.

Ultimately, an energetic disorder like anxiety may have multiple layers that echo who we truly are. We simply must have the courage to follow where we need to go in order to find the source and in so doing so, we may uncover much more about ourselves and even where we fit into the landscape of an ever unfolding universe.

These are anxious times

One of the challenges for people suffering from anxiety, is how to start to feel safe in a world that we are continually told is not safe. Our main stream media is permeated with the threat of terrorism, potential widespread epidemics like ebola (and there were several before that), and a modern world torn apart by war and crime. Our news broadcasts, television programs, movies and even computer based game industry, echo these themes.

I’ll often ask clients who present with anxiety, how they build purpose and inspiration into their lives, to balance these other energies. When you feel unsafe, you are even more vulnerable to the fear mongers, though we don’t have to listen to them, we have a choice.

A message for people with anxiety

There’s a part of you that is trying to keep you safe. This part of you may have been there a long time or a short time, it may be simple or complex, though it has the pure intention to be of service to you.

Look deeper and further for the source of what you are experiencing and those answers lie within. You don’t have to live with the debilitating energy of this for the rest of your life.

When you find your personal and unique solution, tell your story and help others. That will transform your difficult journey into a source of inspiration for others, and you will have found purpose.

Bio

Peter Smith was president of The Michael Newton Institute from 2009 to 2019 and now serves as an advisor to the Board of Directors. He is the founder of the Institute for Quantum Consciousness and is based in regional NSW, Australia. Peter created the modality of *Hypnoenergetics* an approach to Hypnotherapy based on energy and consciousness. He has been interviewed on a variety of television and radio programs and has contributed to a number of documentaries. Peter’s latest book is *Quantum Consciousness - Journey through other realms* (Llewellyn Publishing 2018) He also writes for number of publications including *Nexus Magazine* and *Stories of the Afterlife* – The Newton Institute’s research journal.

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End Notes

1. How noise-cancelling headphones work: http://www.audio-technica.com/cms/features/b3ef06fca462fcad/
2. Lipton, Bruce Dr. *The Biology of Belief,* Hay House Publishing 2004, p133
3. Marcy Axness: http://marcyaxness.com/parenting-for-peace/mental-health-begins-in-the-womb/

4. Psychohistory: https://en.wikipedia.org/wiki/Psychohistory
5. Dr. Molly Castelloe: https://www.psychologytoday.com/blog/the-me-in-we/201205/how-trauma-is-carried-across-generations
6. Sheldrake, Rupert Dr.: http://www.sheldrake.org/research/morphic-resonance
7. Stevenson, Ian Dr. : https://en.wikipedia.org/wiki/Ian_Stevenson
8. Newton, Michael Dr. : More information at www.newtoninstitiute.org

What Makes Grief Complicated? A Review

Jarrod Clarke

Grief is a common and natural reaction to loss, involving a preoccupation with thoughts of the deceased, emotional 'hollowness', and physical manifestations. Whilst, in most cases these subside over time, a sizable proportion of grievers will experience a prolonged, maladaptive reaction, referred to as complicated grief. The onset of complicated grief is mediated by factors relating to death circumstances and coping styles, moderated by factors, such as individual's developmental period, the relationship with the deceased, and the presence of concurrent stressors. Historical theories of grief have been found outdated by the findings of contemporary theories, calling into question the efficacy of treatment methods derived from these theories. The COVID-19 pandemic presents a particularly daunting period, with diagnostic rates of complicated grief expected to rapidly rise. This highlights to need for the development of modern grief treatments and greater availability of death and grief education in a psychological context.

Keywords: *counselling, hypnotherapy, hypnosis*

What Makes Grief Complicated? A Review of Current Understandings

In 2019 there were an estimated 55.4 million deaths worldwide (World Health Organization, 2020), leaving behind an average of 5 grievers per individual (Anttonucci, et al., 2004), or about 277 million grievers (accounting for approximately 3.63% of the worldwide population). This number, whilst disregarding those grieving a non-death related loss, serves to highlight the widespread prevalence of the grief experience. Almost everyone will experience some form of loss in their lifetime, so that the experience of grief can almost be considered universal. Grief is a term used to describe the emotional, cognitive, and behavioural responses to the loss (typically to death) of a loved one. Grieving individuals often report a preoccupation with thoughts of the deceased, and physical manifestation such as weakness, a lack of energy, and a sensation of physical and emotional 'hollowness.' Manifestations of grief vary greatly between individuals, cultures, and situations; however, individuals suffering from grief typically present with feelings of sadness, guilt, numbness, and/or shock. Howie (2007), notes a list of the grieving styles commonly presented in clinical practice;

- Absent Grief- no outward displays of grief. This may be due to emotional inhibition, denial of feelings, or the absence of typical grief reactions.
- Delayed Grief- grief that takes place sometime after the loss. This delay may be caused by other emotions, or the well-being of others, taking precedence, or the consistent and purposeful distraction of self.
- Chronic Grief- grief that is maintained or fails to diminish over time. This chronic course may be a result of unresolved guilt, anger, and/or depressive preoccupations.
- Somatised Grief- grief which is accompanied by variety of psychosomatic symptoms, caused by the suppressing of grief emotions due to a lack of social support, leading to externalisation in the form of somatisation.
- Distorted Grief- a disproportionate grief reaction, involving extreme anger, anxiety, or guilt which hinders other elements of the grief experience, by overwhelming normative emotional reactions. Excessive anger may be displaced onto others, including the deceased, leading to a loss of social support. Disproportionate grief may also lead to excessive rationalisations, to pry meaning from the loss. The level of negative affect required for grief to be considered 'disproportionate' depends on the cultural norms of those experiencing it.

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- Unresolved grief- a delayed or prolonged grief reaction, associated with clinical symptomology such as depression and sleeplessness (Zisook, & DeVaul, 1983).
- Disenfranchised grief- grief that is unacknowledged or invalidated by social norms, and therefore cannot be openly acknowledged or socially supported (Doka, 1999).

Historical Models of Grief

Psychoanalytic

Freud describes grief as a state of melancholia, whereby the grieving individual is searching for an attachment that is no longer there. The purpose of grief, therefore, is to stimulate the detachment process of the griever from the deceased. Successful resolution of grief requires 'grief work,' the process of thinking about the deceased, events following and after death, and working towards detachment from the deceased. Grief work involves three elements: detachment from the deceased; readjustment to new life circumstances; and, building of new relationships. Freud (1961) describes grief work as an arduous process, whereby purposeful engagement by the griever is necessary to resolve grief. According to this theory, typical mourning periods are relatively short; however, refusal to complete grief work can complicate this process, leading to a prolonged or pathological reaction (Freud, 1961). This theory, however, is based on clinical work with depressed grieving populations, and may not be generalizable to other grieving populations (Buglass, 2010).

Phase Theory of Grief

The Phase Theory of Grief, proposed by Lindemann (1944) describes grief as experienced by; (1) somatic disturbance, (2) preoccupation with thoughts/memories of the deceased, (3) guilt, (4) anger and/or hostility, and (5) mild functional impairment. Lindemann also mentions a less common sixth phase, where the bereaved takes on traits of the deceased. Included in this theory are identifiable parameters of normal vs pathological grief, differentiated by duration, intensity, and level of functional impairment. Based on the Freudian perspective, recovery is said to come about through three fundamental phases; (1) accepting the loss as a definitive fact, (2) adjusting to life without the deceased, and (3) forming new relationships.

Attachment Theory

Attachment theory is based on the assumption that humans have an intrinsic, fundamental, and biologically driven, need to form strong bonds with others (Bowlby, 1973). The irreparable severing of these bonds, through death, is therefore associated with a biological disequilibrium brought about by a sudden change in environment. The theory emphasises this disequilibrium in terms separation anxiety and distress (Klass, 1988). This distress is presented through four interrelated, flexible phases: Shock, yearning and protest, despair, and recovery. This theory borrows from Freud and emphasises the need for grief work in order to relinquish bonds; however, unlike the psychoanalytic viewpoint, relinquishment is to change bonds, rearrange interpretations of the deceased, and consequently of the self (Bowlby, 1973). Bowlby's attachment styles have been related to bereavement reactions, whereby the attachment styles, in conjunction with specific attachment factors between the bereaved and the deceased, differently related to experiences of grief, depression, or somatization. For example, avoidant attachment style was associated with higher levels of somatization during grief, while anxious-ambivalent style of attachment was associated with experiencing greater depressive symptoms (Wayment & Vierthaler, 2011).

Kübler-Ross' Five Stages of Grief

One of the widest known models of grief is Kübler-Ross' five stages of grief. The stages were developed based on the experiences of the terminally ill coming to terms with their impending deaths. The five stages are as follows (Kübler-Ross, 1970):

1. denial: rejecting the reality of newly presented information (i.e., a patient diagnosed with a terminal illness may deny the diagnosis),
2. anger: often manifested as misguided outbursts of blame towards others out of frustration of perceived unfairness,
3. bargaining: verbal or internal negation often in a religious nature,
4. depression: immense sadness and fatigue, and
5. acceptance: recognising reality, preparing for death and reflecting on life.

Kübler-Ross' stages have since been adapted to describe grief reaction towards another's death, with the stages describing these emotions being experienced about others. Major criticisms of this theory are that the stages are rarely sequential, and the common misinterpretation of these stages to describe experiences of the bereaved may not be appropriate (Corr, 1993 as cited in Buglass, 2010).

Contemporary Models of Grief

Task-Based Model

Worden's (2008) Task-Based Model describes grieving as an active process requiring the griever to engage in four tasks: (1) accepting the reality of loss; (2) process grief-related pain; (3) adjust to the world without the deceased; and, (4) maintaining an enduring connection with the deceased. Included in this theory are a list of seven protective/risk factors to explain differentiation in individual reactions: (a) who the deceased was; (b) what relationship the griever had with the deceased; (c) how the person died; (d) historical antecedents; (e) griever personality traits; (f) social mediators; and, (g) concurrent stressors. Like grief work, Worden's tasks are to be purposefully engaged in, and failure to complete each task results in a worsened grief reaction.

Dual Process Model of Coping with Bereavement

An adaptive grief theory, proposed by Stroebe and Schut (1999), is The Dual Process Model of Coping with Bereavement. The model identifies two stressors related to bereavement: loss–oriented (related to the coping of the experience of the loss); and, restoration-oriented (coping with the lifestyle changes that come about due to the loss). The central theme of this theory is the oscillation between confrontation of the loss (by attending to feelings regarding loss), and purposeful avoidance of thoughts related to the loss. This allows for the griever to both process feelings while allowing for the capacity to deal with associated life changes, which come about as a result of the loss. In contrast to the psychoanalytic 'grief work approach', whereby avoidance is seen as inherently harmful to the grieving process, Stroebe and Schut (2010) argue the need for taking 'time off' when it gets

too painful, and restoration-oriented tasks must be attended to, provided the avoidance is not extreme or persistent.

Continuing Bonds

A current trend in the field of grief and psychology is the moving away from the belief that successful grieving requires 'letting go.' This movement, introduced by Klass, Silverman, and Nickman (1996), referred to as 'continuing bonds,' stipulates that, not only is the severing of bond unnecessary, but maintaining them after death is a healthy coping mechanism. At the core of the model is the idea of continuing bonds; bonds once held with the deceased are adjusted and redefined, with the bereaved carrying an internal representation of the deceased attachment figure. The theory was prompted by the observation that the establishment of ongoing bonds was normative and considered healthier across other, non-western, cultures (Klass et al., 1996). This theory is in major opposition to that of Freud (1961), who viewed the maintenance of bonds following death a maladaptive grief reaction, leading to a prolonged, chronic, course of grief. Provided that the theory is contradictory to historical models and treatment methods derived from them (aimed at reducing lingering bonds), a greater depth of research is required to support the notion. However, some research exists to suggest that continuing bonds may provide grievers with some measure of comfort (Foster, et al., 2011).

Grief Comorbidities

Due to the distressing nature of grief, grievers are at a higher risk of developing co-morbid mental illnesses, such as depression, anxiety, and Post Traumatic Stress Disorder (PTSD) (Friedman, 2012; Shear & Skritskaya, 2012; Zakarian et al., 2019). Manifestations of grief are often confused with these disorders, as they can share clinical presentation features. However, while they can be experienced alongside grief, they are not a part of a normative grief reaction. Prolonged periods of sadness are common during mourning and they typically resolve without the need for treatment within 2 to 6 months (Friedman, 2012). Normative grief was differentiated in the DSM-IV from Major Depressive Disorder (MDD) by requiring a greater period of active symptomology and more substantial functional impairment in current grievers, to reduce overdiagnosis (Maj, 2012). The bereavement exclusion was, however, removed in the DSM-5, meaning bereaved individuals could be diagnosed with MDD after only 2 weeks of mild depressive symptoms. This change has been criticised for its lack of empirical support and potentially inciting an influx of MDD diagnoses (Friedman, 2012; Wakefield & First, 2012). Others, however, have supported the change, citing the removal of the bereavement exclusion allows for greater diagnostic accuracy through bypassing arbitrary time-frames. Additionally, no significant increase in the diagnosis of MDD during bereavement has been found following the removal of the exclusion (Iglewicz, et al., 2013). The exclusion was replaced, in the DSM-5, by notes in the diagnostic criteria which precautions practitioners to differentiate normative grief from MDD by observing symptomatology. The APA advises that while grief and MDD share features they can be differentiated by important aspects such as; the perseverance of self-esteem during grieving, while in MDD a diminishment in self-worth is common. Additionally, grievers often experience waves of pain, often associated with experiencing positive memories of the deceased, while in MDD mood is often a persisting negative (American Psychiatric Association, 2013).

Another co-morbid condition of grief is anxiety, which, in cases of acute grief, typically subside after 6 to 8 months following bereavement (Shear & Skritskaya, 2012). The development of an anxiety disorder during bereavement is estimated between 10%-20% of bereaved people (Shear & Skritskaya, 2012), with the presence of anxiety disorders having the potential to distort and complicate grief reactions (Howie, 2007; Shear & Skriskaya, 2012). Grief reactions can also have similar characteristics to PTSD, most notably in the form of memory intrusions. Whilst easy to confuse, PTSD is defined by intrusive images of the traumatic incident, causing intensified arousal and anxiety but, in grief reactions, intrusive images of the deceased often trigger feelings of longing, sadness or depressive symptoms (Howie, 2007). PTSD can, of course, develop in conjunction with a grief reaction following a particularly traumatic (unexpected, or outside typical human experience) or violent loss, which may complicate the course of normal grief (Zakarian et al., 2019).

Complicated grief

Complicated grief (CG) (otherwise referred to as prolonged grief, persistent bereavement, and pathological grief) is a popular term used to describe a maladaptation of the normative grief reaction, including;

"Current experience (more than a year after a loss) of intense intrusive thoughts, pangs of severe emotion, distressing yearnings, feeling excessively alone and empty, excessively avoiding tasks reminiscent of the deceased, unusual sleep disturbances, and maladaptive levels of loss of interest in personal activities" (Horowitz et al., 1997, p. 904).

CG has an estimated worldwide lifetime prevalence of 2.4%–4.8% (Fujisawa et al., 2010; Kersting et al., 2011), and approximately 10-25% among grievers (Mancini et al., 2012; Robbins-Welty et al., 2018; Newson et al., 2011). This proportion is thought to increase following the death of a spouse, child, or someone with which a person had a particularly close relationship (Neimeyer et al., 2012; Nader & Salloum, 2011; Newson et al., 2011), and/or following a sudden and/or unexpected death of a loved one (Wilson et al., 2020). In a population-based sample, prevalence rates of 3.7% of the general sample and 6.7% following a major bereavement, have been found. The study also identified the highest risk factors as being female gender, low income, older age, having lost a child or spouse, and cancer as the cause of death (Kersting et al., 2011). CG is differentiated from normal/acute grief by intensity, duration and symptomology above and beyond clinically and culturally expected norms (Strobe et al., 2013). From a descriptivist perspective the primary differentiation between normal (acute) grief and CG is pathological functioning. Whilst normal grief involves experiencing negative emotions, the process involves no dysfunction, whereas a primary characteristic of CG is the social/occupational impairment that it causes. As a result,is considered maladaptive and a form of mental disorder (Strobe et al., 2013).

Freud is the first credited to differentiate between grief and pathological grief (Granek, 2010) in his book *On Mourning and Melancholia* (Freud, 1914-1916). This differentiation, however, is difficult to distinguish from Major Depressive Disorder as his writings were derived from working with a subset of depressed grievers. Horowitz et al., (1993) introduced pathological grief as a

diagnostic modification to PTSD to be included in the DSM-IV. The proposed diagnosis stipulated that pathological grief is a result of an individual failing to incorporate the death of a loved one into their representational schema due to a pathological tendency to stifle negative emotions. This failure results in prolonged and intensified grief symptoms. The proposed diagnostic criteria of pathological grief is be similar to the diagnosis of PTSD; however, the primary difference is that the triggering stressor is no longer be required to be 'outside the range of usual human experience', as grief is an experience almost every person will face (Horowitz et al., 1993). The incorporation of pathological grief (later referred to as complicated grief in a follow-up article) to the DSM-IV was debated by the American Psychiatric Association (APA), and the diagnosis was rejected due to the lack of empirical evidence (Horowitz et al., 1997).

The term, complicated grief, is now widely used, and much research has been dedicated to it (Shear & Shair, 2005; Boelen et al., 2006; Fujisawa et al., 2010; Kersting et al., 2011; Dodd et al., 2016; Nakajima, 2018; Iglewicz et al., 2019), with adaptations of this disorder added to the 11th Iteration of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11) and mentioned in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). Persistent Complex Bereavement Disorder is found in the chapter "Conditions for Further Study" of the DSM-5. The condition is marked by persistent yearning/longing for the deceased, intense sorrow, and preoccupation with thoughts of the deceased, resulting in clinically significant distress or impairment in psychological functioning, for at least 12 months (6 in children). This is distinguished from normal grief by the presence of severe grief reactions that interfere with the individual's capacity to function in social, occupational and other important domains [see DSM-5 for full diagnostic criteria] (American Psychiatric Association, 2013). Coded as 6B42, *'Prolonged Grief Disorder'* is classified as a stress-associated disorder in the ICD-11. The disorder is characterized by a persistent and pervasive grief response, including preoccupation with the deceased, intense negative affect and difficulty engaging in social or other activities, exceeding social, cultural or religious norms. The disturbance causing significant impairment in social, occupational or other important areas of functioning, for at least 6 months [see ICD-11 for full diagnostic criteria] (World Health Organization, 2020).

Complicated grief has been associated with neurological abnormalities in the reward system, and lower levels of serotonergic brain activity similar to depressive disorders (Neimeyer et al, 2012; Bui et al., 2012). This explains the high comorbidity rates between grief and depressive disorders, with similarities in diurnal cortisol profiles between the disorders, suggesting a shared pathophysiological underlying (Bui et al., 2012). The normal grieving process has been observed to activate brain regions such as the dorsal anterior cingulate cortex (ACC), insula, and periaqueductal gray (PAG), regions of which are commonly associated with experiences of pain. This reaction was not, however, noticeably different between 'normal' grievers and those with CG, suggesting that these areas may not play a role in the development of CG.

In a study of bereaved parents in China following the one-child policy, smaller left hippocampal volumes were identified in those grieving compared to the non-bereaved, a symptom that has been associated with those suffering from PTSD. Interestingly, when the group was subdivided from those with/without PTSD no differences were found in hippocampal volume, suggesting that bereavement specifically, rather than PTSD, is related to smaller left hippocampal volumes (Neimeyer et al., 2012). Hippocampal volume is directly related to declarative memory, the ability to recall facts and event suggesting prolonged grief can lead to declines in short-delay retention, long-delay retention and discriminability (Pohlack et al., 2012).

Additionally, those with CG have been found to have significantly less gray and white matter than those with acute grief, who showed no differences between the non-bereaved, suggesting the heightened grief severity, rather grief itself is associated with reduced brain volume. This is supported by the findings that greater cognitive difficulties, in the areas of processing speed and verbal fluency, have been observed to be in those with CG compared to acute grievers and the non-bereaved (O'Conner & McConnel, 2018; Bui, 2018).

Grief Complications in Children/Adolescence

It is estimated that 5-10% of children and adolescents who experience the loss of a loved one will experience some form of psychiatric difficulty (Spuij et al., 2013). In younger children, the inability to understand death may lead to grief reactions of general distress, regression, and separation anxiety, while adolescents, who have a clear perception of death may present with existential crises, anxiety, isolation, and risky behaviour (Revet et al., 2018). These findings suggest that during childhood, developmental periods may be a key mediator in how grief reactions are manifested. In a misconstrued effort to reduce the suffering of children, caregivers may explain the events of loss vaguely, or using unclear metaphors. This can lead to misunderstanding regarding a loss's permanence, causing a multitude of complications (Howie, 2007). Children may also inconsistently present grief, with a short period of sadness intermittent with regular behaviour. This presentation can often be misunderstood by caregivers as healthy coping, further undermining children receiving the required support (Howie, 2007).

Grief Complications of the Elderly

Research indicates that 20-30% of the elderly are likely to develop a mental health complication, such as depression, PTSD, or complicated grief disorder following the loss of a loved one (Robbins-Welty et al., 2018). This higher proportion of complications is likely due to the nature of the loss; as the elderly are more likely to experience the death of parents, siblings, and spouses, loss of which is considered to increase the risk of CG development (Robbins-Welty et al., 2018; Newson et al., 2011). Additionally, early signs of complicated grief, such as cognitive decline, social withdrawal, and negative affect, often go unnoticed, overlooked as age-related decline. Complicated grief in older adults has also been associated with higher mortality rates (Robbins-Welty et al., 2018). Older individuals presenting with complicated grief, may also have higher rates of developing comorbid disorders than the general population, with 17.2% developing an anxiety disorders and 17.2% for major depression (Newson et al., 2011).

Death of a child

The death of a child is considered a highly challenging

situation, accounting for the highest prevalence of complicated grief reactions (Neimeyer et al., 2012; Nader & Salloum, 2011; Newson et al., 2011). This is due to several factors. Firstly, the death of a child is almost always considered traumatic (i.e., not anticipated); with accidental injuries leading to over half of all childhood deaths. Secondly, the bond between child and parent is particularly strong, so that separation leads to an equivalently strong grief reaction. Finally, the bond between child and parent is also integral to both parties' core identity, leading to a large secondary loss (i.e., the loss of role as a parent/caregiver). This secondary loss also extends to the loss of a parent's aspirations and hopes regarding the child's future (Christ et al., 2003). These factors combined may increase the risk of grieving maladaptations, with sense-making (i.e., difficulty making sense and processing the child's death) as the largest moderating factor of grief intensity for grieving parents (Keesee et al., 2008).

Complicated Grief and COVID-19

Grief and mourning have been further complicated in recent times, as a direct result of the 2019 novel coronavirus (COVID-19) pandemic, since it is responsible for not only primary loss but a variety of secondary losses. Secondary losses include; loss of job, loss of economic stability, loss of certain individual freedoms, and loss of community (Diolaiuti et al., 2021). The pandemic has also lead to the loss of certain rituals, important in the mourning process. Mourning rituals such as attending a funeral and/or wake are important buffers in the defence of pathological grief (Nakajima, 2018; Diolaiuti et al., 2021; Wallace et al., 2020), and can lead to increased feelings of control and mitigate negative emotions (Norton & Gino, 2014). Due to social distancing restrictions, attending funerals has been prohibited, and visiting the dying in hospital or residential care has been made difficult or impossible, stripping some of their chance to say last goodbyes. This can complicate the integration of loss into representational schema (Diolaiuti et al., 2021), leading to experiences of disenfranchised grief (Wallace et al., 2020).

Disenfranchised grief, otherwise known as hidden sorrow, refers to grief that is unacknowledged or invalidated by social norms, and therefore cannot be openly acknowledged or socially supported (Doka, 1999). For example, if the deceased had not followed proscribed Covid-19 quarantine laws, the emotional impact of the death may be invalidated by the wider community due to intertwined anger and/or blame. This can also be caused by the large numbers of deaths, with the bereaved struggling to disconnect the individual from the statistics and receiving less individualised support (Wallace et al., 2020). Geriater and Shear (2020), predicts that diagnostic rates of PGD will increase during the COVID-19 pandemic, especially in older adults who are partially susceptible to the virus. Due to this susceptibility, elderly grievers face greater social isolation, due to imposed distancing practices to reduce chances of infection. Additionally, newly imposed social distancing laws have caused a postponement or loss of mourning rituals, and loss of religious rituals due to the closure of places of worship, impacting all grievers ability to appropriately outlet feelings associated with the loss.

An important consideration is the emotional consequences COVID-19 has had on front line carers. Throughout this pandemic, many providers have been exposed to death, on unprecedented levels. To deal with the emotional strain many providers may rely on coping strategies such as compartmentation, and avoidance through distraction, such as increased occupational/social engagement, and/or emotional numbing through the use of alcohol, tobacco products, or recreational narcotics (Wallace et al., 2020). These strategies have a high chance of leading to unresolved grief, a delayed or prolonged grief reaction, associated with clinical symptomologies such as depression and sleeplessness (Zisook, & DeVaul, 1983). Providers are also likely to experience disenfranchised grief, as professional and cultural norms indicated that health care providers' grieving or the loss of patient are viewed as unacceptable and unprofessional (Feldstein, 1995; Granek et al., 2012; Papadatou, & Bellali, 2002 as cited in Carton, & Hupcey, 2014).

Another important consideration is the effect that COVID-19 has on the grieving of adolescence. Due to the nature of the virus, the majority of deaths are those with pre-existing vulnerability or the elderly, with every COVID-19 death leaving behind an estimated average of 2 children and 4 grandchildren (Birkner & Soffer, 2020 as cited by Weinstock et al., 2021), meaning that a substantially disproportionate subset of grievers are adolescents. As previously mentioned, adolescents present grief through existential crises, anxiety, isolation, and risky behaviour (Revet et al., 2018). Unfortunately, the circumstances brought about because of COVID-19, such as a reduction in peer social support and breakdown of community, have a real possibility to exacerbate these maladaptive reactions (Weinstock et al., 2021). Weinstock et al. (2021) states that the current pandemic may be a catalyst for a decline in the mental health of the youth, calling professionals and community support services into action to prevent the development of secondary problems, such as anxiety, depression and substance abuse.

Models of Complicated Grief

Cognitive-Behavioural

Complicated grief from the cognitive-behavioural perspective is the result of three interrelated processes: (a) insignificant elaboration and integration of loss within autobiographical memory; (b) negative thinking; and, (c) anxious depressive avoidance behaviours (Boelen et al., 2013). 'Insignificant elaboration and integration' is described as the lack of integration regarding a loved one's death into autobiographic memory, resulting in memories being easily elicited and the loss being constantly viewed as new, shocking, and unbelievable. The process serves to prolong the grief process, increase instances of unwanted memory intrusion, and exacerbate negative affect. 'Negative thinking' is presented as rigid and negative global cognitions regarding the self and future, which may result in a sense of blighted future and reduced goal-seeking behaviour. Secondary to this process is the misinterpretation of normative grief reactions, such as vivid and unwanted memory intrusion, as signs of one'sown insanity. 'Anxious and depressive avoidance' includes both physical and cognitive avoidance, whereby the grieving attempt to alter the duration, frequency, and form of negative thoughts, feelings, and memories, and a withdrawal from social, occupational, and recreational activities is typically viewed (Boelen et al., 2006- 2013).

Following the aforementioned model of complicated grief, cognitive-behavioural therapy (CBT) of complicated grief involves: the integration of loss with existing autobiographic schemas; identifying and modifying negative cognitive schemas;

and, replacing avoidance strategies with more helpful ones. This is achieved through psychotherapy and the setting of homework tasks. To assist with the integration of loss into existing knowledge, tasks such as imaginal exposure, retelling of the event, journal keeping, writing a letter to the deceased, or exposure to memory triggering stimulation are used. To reduce negative thinking, cognitive restructuring (the processes of identifying maladaptive cognitions, examining their validity, and reformulating those cognitions) is used. In the reduction of anxious and depressive avoidance, behavioural activation and/or response prevention is implemented (Strobe et al., 2013).

CBT has been proven to be an effective treatment method for grief disorders (Mancini et al., 2012). In randomized clinical trial CBT when combined with exposure therapy (PG-CBT) show significantly greater reductions in depression, negative appraisals, and functional impairments than CBT alone. Additionally, at a six month follow-up fewer participants in the exposure group were diagnosable with prolonged grief disorder than CBT alone group (14.8% vs 37.9%) (Bryant et al., 2014). Rosner et al. (2014) found similar results with PG-CBT showing significant symptom reduction over the control, waiting list group.

Multidimensional Grief Theory

The Multidimensional Grief Theory was developed as a childhood grief theory. It postulates that complicated grief is a result of maladaptive reactions within three content domains: (1) separation distress; (2) existential/identity-related distress; and, (3) developmentally link manifestations of grief. The theory is based on the assumption that both positive and maladaptive adjustment can occur within each domain, mediated by a combination of causal risk factors (e.g., etiological risk factors, circumstances of death), causal consequences (e.g., functional impairment), key mediators and moderators (e.g., cultural background, developmental stage), and developmentally linked manifestations of grief (in younger children general distress, regression, and separation anxiety, in adolescents, existential crises, anxiety, isolation, and risky behaviour) (Kaplow et al., 2013). Within the domain of ‘separation distress,’ normative manifestations are seen as missing the deceased, heartache, and yearning/longing (within culturally accepted limits), whereas maladaptive manifestations include the aforementioned manifestations beyond culturally acceptable thresholds and include suicidal ideation and/or developmental slowing or regression. Normative manifestations in the domain of *‘existential/identity-related distress’* are the contention with disruption in sense of self, meaning, and purpose. Within this domain, maladaptive manifestations emerge as severe distress and loss of personal identity, the resignation of future aspirations, and a sense of ‘blighted’ future. In the final domain of *‘Circumstance-Related Distress’*, normative reactions include acute sadness, anger, disgust and horror, whilst maladaptive reactions include persistent rage, guilt, shame, or ‘psychic numbing’ through behavioural and cognitive avoidance (Kaplow et al., 2013).

Treatment based on multidimensional grief theory is based on four primary assumptions: (1) adaptive and maladaptive reactions to grief are inherent in the bereavement process and may arise within each content domain; (2) normative and maladaptive reactions can co-occur within each domain; (3) the different dimensions of grief and their related manifestations call for different intervention methods; and, (4) the intervention aims to encourage adaptive grieving and reduce the frequency, intensity and duration of maladaptive manifestations (Kaplow et al. 2019; Layne et al., 2017; Hill et al., 2019). Multidimensional grief theory has a heavy focus on socio-environmental contexts and assumes that grieving children rely heavily on their caretaking environment to facilitate the grieving process (Clark et al., 1994). Multidimensional grief therapy (MGT) is specially designed for bereaved children aged 6 to 17 (Kaplow et al., 2019). The treatment is divided into two phases. Phase 1 *‘Learning about Grief’* includes psychoeducation, skill-building, and identification/regulation strategies. Phase 2 *‘Telling My Story’* guides the children through telling their story through each content domain and encouraging adaptive grief responses (Hill et al., 2019). A pilot study of MGT revealed that completion of phase 1 resulted in significant reductions of maladaptive manifestations in all three content domains. Completion of phase 2 also presented significant reductions, apart from existential/identity distress, beyond phase 1; however, phase 2 resulted in a significant reduction of PTSD symptoms in those presenting (Hill et al., 2019).

Attachment Theory

Shear et al. (2007) proposes that the death of a loved one results in a decisive mismatch between the unrevised mental representation of that person and a dramatic change in the ongoing relationship with that person. This mismatch results in: (a) an unrevised working model producing a continuing sense of the deceased; (b) stress-related to bereavement activating proximity seeking and a sense of yearning and thoughts/memories of the deceased; (c) a disruption in the function of the working model resulting in a loss of emotional and attentional regulation; and, (d) inhibition of world interest and goal-seeking due to strong activation of attachment. In summary, grief triggers a preoccupation with thoughts of the deceased, accompanied by yearning and longing, which results in a detachment in the interest of others and life occupations. This experience typically resolves as the permanence of the loss is integrated into long-term memory and, as such, thought of the deceased become no longer preoccupying. Through this model complicated grief is seen as a stress response syndrome, in which the death of an attachment figure has failed to be incorporated into their schema, resulting in a cyclical grief reaction (Shear et al., 2007). According to Shear et al. (2007) assimilation of knowledge of a person’s death into the working model, schema requires significant time, with this time being reduced by the expectation of death, which suggests that sudden unexpected deaths take longer to incorporate and would be more likely to develop CG.

Complicated grief treatment (CGT) is heavily based on Strobe and Schut’s Dual-process Model, but incorporates aspects from attachment theory, interpersonal psychotherapy and CBT (Wetherell, 2012; Shear, 2010; Igelwicz et al., 2019; Neimeyer, 2014). The treatment is focused on two key areas: restoration and loss. Restoration focuses on the restoring of self-functioning by generating enthusiasm and creating plans for the future. The Loss focal area helps clients to think about death in a way that does not trigger excessive negative emotions (Neimeyer et al., 2012). The treatment has seven core themes: (1) Providing information to help participants understand and accept grief; (2) managing emotional pain and monitoring symptoms; (3) thinking about the future; (4) reconnecting with others; (5) telling the story of death; (6) learning to live with reminders; and, (7) connecting with memories (Igelwicz et al., 2019). These themes are addressed during a treatment period of typically 16 sessions over four months, using techniques such as psychoeducation,

in-vivo and imaginal exposure, and working on self-care (Shear, 2010). CGT has proven more efficacious than common depression treatments (Igelwicz et al., 2019), and is superior to interpersonal psychotherapy, showing higher response rates and faster response time (Shear et al., 2005). A promising treatment method of CG is the use of pharmacotherapy in conjunction with psychotherapy. The use of antidepressant medication has been found to increase the likelihood of completing a full course of Complicated Grief Therapy (CGT) (91% CGT with antidepressants vs. 58% CGT alone) (Simon, et al., 2008). Mancini et al. (2012) suggest that the use of antidepressants may serve a benefit in the completion of a course of grief therapy as it may help patients tolerate emotional pain that grief psychotherapy arouses.

Complicated grief in clinical practice

Gamino and Ritter (2009 as cited in Gamino & Ritter, 2012) identified four impediments of therapists working effectively with grief (1) unfinished business regarding the death of a loved one; (2) excessive death anxiety; (3) a lack of education leading to generalisations based on personal experience; and, (4) a lack of personal history of loss leading to unawareness of personal or individual grief reaction. Stephen (1981, as cited in Dodd et al., 2017) found that 90% of therapists report competency in providing grief counselling despite having received little, to no, specialist training in the area. Despite the commonality of grief in clinical practice, a study of US colleges found that only 20% offered courses in death education (Eckerd, 2009 as cited in Dodd et al., 2017). Rogalla-Hafley (2008) suggests that death education can serve to help manage personal death anxiety, increase empathy and provide a deeper understanding of the client's experience. Simply put, while many professionals report having the personal competency to work with grievers, many still lack the technical skills to adequately provide specialised grief therapy (Dodd et al., 2017). These findings and discoveries in the area of grief disorders, call to light the need for greater practitioner education, especially considering the removal of the bereavement exclusion from the DSM diagnosis of MDD.

Conclusion

The subject of grief, especially complicated grief, has been subject to a great deal of research in recent years. This research has provided a framework for understanding and diagnosing maladaptive grief reactions. This is especially important due to the difficulty in differentiating acute/normative grief reactions from their maladaptive counterparts and comorbid mental illnesses. Historical frameworks of grief are now outdated, considering new advancements in the field, because they can lead to potentially harmful assumptions by mental health practitioners, impacting their ability to adequately provide support. A prime example is the concept of Freud's grief work, which is in opposition to newer theories, especially regarding the notion of continuing bonds. This contention calls to attention the need for greater research regarding the nature of grief disorders and treatment approaches. As it currently stands, the majority of Mental Health practitioners are underequipped to treat grief disorders, lacking the technical skills required to work with grieving populations, potentially due to lack of mandated and/or available specialist education courses. Furthermore, with the removal of the bereavement exclusion from the diagnosis of Major Depressive Disorder, and the predicted influx of complicated grief due to COVID-19, education of mental health professionals in this area is of particular importance.

Suggestions for future research included investigating the current competency and level of training that mental health professionals possess in the diagnostic of grief disorders. Additionally, further research is required to effectively apply the continuing bonds theory to treatment methods, and subsequently, investigate its efficacy compared to historical approaches.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Antonucci, T., Akiyama, H., & Takahashi, K. (2004). Attachment and close relationships across the life span. *Attachment & Human Development, 6*(4), 353-370. https://doi.org/10.1080/1461673042000303136

Bertuccio, R., & Runion, M. (2020). Considering grief in mental health outcomes of COVID-19. *Psychological Trauma: Theory, Research, Practice, And Policy, 12*(S1), S87-S89. doi: 10.1037/tra0000723

Boelen, P., van den Hout, M., & van den Bout, J. (2006). A cognitive-behavioral conceptualization of complicated grief. *Clinical Psychology: Science and Practice, 13*(2), 109-128. doi: 10.1111/j.1468-2850.2006.00013.x

Boelen, P., van den Hout, M., van den Bout, J. (2013). Prolonged grief disorder: Cognitive-behavioural theory and therapy. In Stroebe, M., Schut, H. and Van den Bout, J. (eds.) *Complicated Grief; Scientific Foundations for Health Care Professionals*. Hoboken: Taylor and Francis.

Bowlby, J. (1973). Attachment and Loss: Separation, Anxiety and Anger. Volume II. Hogarth Press, London.

Bryant, R., Kenny, L., Joscelyne, A., Rawson, N., Maccallum, F., & Cahill, C. et al. (2014). Treating prolonged grief disorder. *JAMA Psychiatry, 71*(12), 1332. https://doi.org/10.1001/jamapsychiatry.2014.1600

Buglass, E. (2010). Grief and bereavement theories. *Nursing Standard, 24*(41), 44-47. https://doi.org/10.7748/ns2010.06.24.41.44.c7834

Bui, E., Nadal-Vicens, M., & Simon, N. (2012). Pharmacological approaches to the treatment of complicated grief: Rationale and a brief review of the literature. *Bereavement And Complicated Grief, 14*(2), 149-157. doi: 10.31887/dcns.2012.14.2/ebui

Carton, E., & Hupcey, J. (2014). The forgotten mourners. *Journal Of Hospice & Palliative Nursing, 16*(5), 291-303. doi: 10.1097/njh.0000000000000067

Christ, G., Bononno, G., Malkinson, R., & Rubin S. (2003). Bereavement experiences after the death of a child. In in Chambers, T. (Eds.), *When children die: Improving palliative and end-of-life care for children and their families. JRSM, 96*(8), 419-420. https://doi.org/10.1258/jrsm.96.8.419-a

Clarke, S., Koenen, K., Taft, C., Street, A., King, L., & King, D. (2007). Intimate partner psychological aggression and child behavior problems. *Journal Of Traumatic Stress, 20*(1), 97-101. doi: 10.1002/jts.20193

Diolaiuti, F., Marazziti, D., Beatino, M., Mucci, F., & Pozza, A.

(2021). Impact and consequences of COVID-19 pandemic on complicated grief and persistent complex bereavement disorder. *Psychiatry Research, 300,* 113916. doi: 10.1016/j.psychres.2021.113916

Dodd, A., Guerin, S., Delaney, S., & Dodd, P. (2017). Complicated grief: Knowledge, attitudes, skills and training of mental health professionals: A systematic review. *Patient Education And Counseling, 100*(8), 1447-1458. doi: 10.1016/j.pec.2017.03.010

Doka, K. (1999). Disenfranchised grief. *Bereavement Care, 18*(3), 37-39. https://doi.org/10.1080/02682629908657467

Foster, T., Gilmer, M., Davies, B., Dietrich, M., Barrera, M., & Fairclough, D. et al. (2011). Comparison of continuing bonds reported by parents and siblings after a child's death from cancer. *Death Studies, 35*(5), 420-440. https://doi.org/10.1080/07481187.2011.553308

Freud, S. (1917). Mourning and Melancholia. The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XIV (1914-1916): On the History of the Psycho-Analytic Movement, Papers on Metapsychology and Other Works, 237-258

Freud, S. (1961). Mourning and melancholia. In Strachy, J. (Ed). *The Complete Psychological Works. Standard edition.* Hogarth Press, London

Friedman, R. (2012). Grief, Depression, and the DSM-5. *New England Journal Of Medicine, 366*(20), 1855-1857. doi: 10.1056/nejmp1201794

Fujisawa, D., Miyashita, M., Nakajima, S., Ito, M., Kato, M., & Kim, Y. (2010). Prevalence and determinants of complicated grief in general population. *Journal Of Affective Disorders, 127*(1-3), 352-358. doi: 10.1016/j.jad.2010.06.008

Goveas, J., & Shear, M. (2020). Grief and the COVID-19 pandemic in older adults. *The American Journal af Geriatric Psychiatry, 28*(10), 1119-1125. doi: 10.1016/j.jagp.2020.06.021

Granek, L. (2010). Grief as pathology: The evolution of grief theory in psychology from Freud to the present. *History Of Psychology, 13*(1), 46-73. https://doi.org/10.1037/a0016991

Hill, R., Oosterhoff, B., Layne, C., Rooney, E., Yudovich, S., Pynoos, R., & Kaplow, J. (2019). Multidimensional grief therapy: Pilot open trial of a novel intervention for bereaved children and adolescents. *Journal Of Child and Family Studies, 28*(11), 3062-3074. doi: 10.1007/s10826-019-01481-x

Horowitz, M., Bonanno, G. and Holen, A., 1993. Pathological grief: Diagnosis and explanation. *Psychosomatic Medicine,* 55(3), pp.260-273.

Horowitz, M., Siegel, B., Holen, A., Bonanno, G., Milbrath, C. and Stinson, C., 1997. Diagnostic criteria for complicated grief disorder. *American Journal of Psychiatry, 154*(7), pp.904-910.

Howie, P. (2007). Counselling in loss and grief. In N. Pelling, J. Bowers & P. Armstrong, *The Practice of Counselling (*1st ed., pp. 269-351). Thomson.

Iglewicz, A., Seay, K., Vigeant, S., Jouhal, S., & Zisook, S. (2013). The bereavement exclusion: The truth between pathology and politics. *Psychiatric Annals, 43*(6), 261-266. doi: 10.3928/00485713-20130605-05

Iglewicz, A., Seay, K., Zetumer, S., & Zisook, S. (2013). The removal of the bereavement exclusion in the DSM-5: Exploring the evidence. *Current Psychiatry Reports, 15*(11). doi: 10.1007/s11920-013-0413-0

Iglewicz, A., Shear, M., Reynolds, C., Simon, N., Lebowitz, B., & Zisook, S. (2019). Complicated grief therapy for clinicians: An evidence-based protocol for mental health practice. *Depression And Anxiety, 37*(1), 90-98. doi: 10.1002/da.22965

Jacobs, Carolyn Mazure, Holly Prige, S. (2000). Diagnostic criteria for traumatic grief. *Death Studies, 24*(3), 185-199. https://doi.org/10.1080/074811800200531

Kaplow, J. B., Layne, C. M., Pynoos, R. S., & Saltzman, W. R., (2019). Multidimensional grief therapy: A flexible approach to assessing and supporting bereaved youth. New York: Cambridge University Press, in press.

Kaplow, J., Layne, C., Saltzman, W., Cozza, S., & Pynoos, R. (2013). Using multidimensional grief theory to explore the effects of deployment, reintegration, and death on military youth and families. *Clinical Child and Family Psychology Review, 16*(3), 322-340. doi: 10.1007/s10567-013-0143-1

Keesee, N., Currier, J., & Neimeyer, R. (2008). Predictors of grief following the death of one's child: The contribution of finding meaning. *Journal Of Clinical Psychology, 64*(10), 1145-1163. https://doi.org/10.1002/jclp.20502

Kersting, A., Brähler, E., Glaesmer, H., & Wagner, B. (2011). Prevalence of complicated grief in a representative population-based sample. *Journal of Affective Disorders, 131*(1-3), 339-343. doi: 10.1016/j.jad.2010.11.032

Klass, D. (1988). John Bowlby's model of grief and the problem of identification. OMEGA - Journal Of Death And Dying, 18(1), 13-32. doi: 10.2190/63pm-gef7-3p13-473d

Klass, D., Silverman, P.R., & Nickman, S. (Eds.). (1996). Continuing bonds: New understandings of grief (1st ed.). Taylor & Francis. https://doi.org/10.4324/9781315800790

Kübler-Ross, E. (1973). On death and dying. London: Routledge.

Layne, C. M., Kaplow, J. B., Oosterhoff, B., Hill, R., & Pynoos, R. S. (2017). The interplay between posttraumatic stress and grief reactions in traumatically bereaved adolescents: When trauma, bereavement, and adolescence converge. *Adolescent Psychiatry, 7*, 220–239.

Lindemann, E. (1944). Symptomatology and management of acute grief. *The American Journal of Psychiatry, 101,* 141–148. https://doi.org/10.1176/ajp.101.2.141

Louis A. Gamino & R. Hal Ritter Jr. (2012) Death competence: An ethical imperative. *Death Studies,* 36:1, 23-40, DOI: 10.1080/07481187.2011.553503

Maciejewski, P., Maercker, A., Boelen, P., & Prigerson, H. (2016). "Prolonged grief disorder" and "persistent complex bereavement disorder", but not "complicated grief", are one and the same diagnostic entity: an analysis of data from the Yale Bereavement Study. *World Psychiatry, 15*(3), 266-275. doi: 10.1002/wps.20348

Maj, M. (2012). Bereavement-related depression in the DSM-5 and ICD-11. *World Psychiatry, 11*(1), 1-2. doi: 10.1016/j.wpsyc.2012.01.001

Mancini, A., Griffin, P., & Bonanno, G. (2012). Recent trends in the treatment of prolonged grief. *Current Opinion in Psychiatry, 25*(1), 46-51. https://doi.org/10.1097/yco.0b013e32834de48a

Nader, K., & Salloum, A. (2011). Complicated grief reactions in children and adolescents. *Journal Of Child & Adolescent Trauma, 4*(3), 233-257. doi: 10.1080/19361521.2011.599358

Nakajima, S. (2018). Complicated grief: recent developments in diagnostic criteria and treatment. *Philosophical Transactions of The Royal Society B: Biological Sciences, 373*(1754), 20170273. doi: 10.1098/rstb.2017.0273

Neimeyer, R. (2014). The changing face of grief: Contemporary directions in theory, research, and practice. *Progress In Palliative Care, 22*(3), 125-130. doi: 10.1179/1743291x13y.0000000075

Neimeyer, R., Harris, D., Winokuer, H., & Thornton, G. (2012). Grief and Bereavement in Contemporary Society. Hoboken: Taylor and Francis

Newson, R., Boelen, P., Hek, K., Hofman, A., & Tiemeier, H. (2011). The prevalence and characteristics of complicated grief in older adults. *Journal of Affective Disorders, 132*(1-2), 231-238. doi: 10.1016/j.jad.2011.02.021

Norton, M., & Gino, F. (2014). Rituals alleviate grieving for loved ones, lovers, and lotteries. *Journal Of Experimental Psychology: General, 143*(1), 266-272. https://doi.org/10.1037/a0031772

Pohlack, S., Meyer, P., Cacciaglia, R., Liebscher, C., Ridder, S., & Flor, H. (2012). Bigger is better! Hippocampal volume and declarative memory performance in healthy young men. *Brain Structure And Function, 219*(1), 255-267. doi: 10.1007/s00429-012-0497-z

Revet, A., Laifer, L., & Raynaud, J. (2018). Grief reactions in children and adolescent. In Bui, E. (Eds.), *Clinical Handbook of Bereavement and Grief Reactions* (pp. 63-80). Current Clinical Psychology.

Robbins-Welty, G., Stahl, S., & Reynolds, C. (2018). Grief reactions in the elderly. In Bui, E. (Eds.), *Clinical Handbook of Bereavement and Grief Reactions* (pp. 63-80). Current Clinical Psychology.

Rogalla-Hafley, K. (2018). Exploring personal death anxiety: increasing counselor competence for grief and loss. *Journal of Global Engagement and Transformation 3*(1), https://www.proquest.com/scholarly-journals/exploring-personal-death-anxiety-increasing/docview/2386094712/se-2?accountid=14649

Rosner, R., Pfoh, G., Kotoučová, M., & Hagl, M. (2014). Efficacy of an outpatient treatment for prolonged grief disorder: A randomized controlled clinical trial. *Journal Of Affective Disorders, 167,* 56-63. doi: 10.1016/j.jad.2014.05.035

Shear, K., & Shair, H. (2005). Attachment, loss, and complicated grief. *Developmental Psychobiology, 47*(3), 253-267. doi: 10.1002/dev.20091

Shear, K., Frank, E., Houck, P., & Reynolds, C. (2005). Treatment of complicated grief. *JAMA, 293*(21), 2601. doi: 10.1001/jama.293.21.2601

Shear, K., Monk, T., Houck, P., Melhem, N., Frank, E., Reynolds, C., & Sillowash, R. (2007). An attachment-based model of complicated grief including the role of avoidance. *European Archives of Psychiatry And Clinical Neuroscience, 257*(8), 453-461. https://doi.org/10.1007/s00406-007-0745-z

Shear, M. (2010). Complicated grief treatment. *Bereavement Care, 29*(3), 10-14. https://doi.org/10.1080/02682621.2010.522373

Shear, M. (2015). Complicated Grief. *New England Journal Of Medicine, 372*(2), 153-160. doi: 10.1056/nejmcp1315618

Shear, M., & Skritskaya, N. (2012). Bereavement and anxiety. *Current Psychiatry Reports, 14*(3), 169-175. https://doi.org/10.1007/s11920-012-0270-2

Simon, N., Shear, M., Fagiolini, A., Frank, E., Zalta, A., & Thompson, E. et al. (2008). Impact of concurrent naturalistic pharmacotherapy on psychotherapy of complicated grief. *Psychiatry Research, 159*(1-2), 31-36. doi: 10.1016/j.psychres.2007.05.011

Spuij, M., Prinzie, P., Dekovic, M., van den Bout, J., & Boelen, P. (2013). The effectiveness of grief-help, a cognitive behavioural treatment for prolonged grief in children: study protocol for a randomised controlled trial. *Trials, 14*(1), 395. doi: 10.1186/1745-6215-14-395

Stroebe, M., & Schut, S. (1999). The dual process model of coping with bereavement: rationale and description, *Death Studies, 23*(3), 197-224. doi: 10.1080/074811899201046

Wakefield, J., & First, M. (2012). Validity of the bereavement exclusion to major depression: Does the empirical evidence support the proposal to eliminate the exclusion in DSM-5?. *World Psychiatry, 11*(1), 3-10. doi: 10.1016/j.wpsyc.2012.01.002

Wallace, C., Wladkowski, S., Gibson, A., & White, P. (2020). Grief during the COVID-19 pandemic: Considerations for palliative care providers. *Journal Of Pain and Symptom Management, 60*(1), 70-76. doi: https://doi.org/10.1016/j.jpainsymman.2020.04.012

Wayment, H., & Vierthaler, J. (2002). Attachment style and bereavement reactions. *Journal Of Loss and Trauma, 7*(2), 129-149. https://doi.org/10.1080/153250202753472291

Weinstock, L., Dunda, D., Harrington., H, Nelson, H. (2021) It's complicated—adolescent grief in the time of Covid-19. *Frontiers in Psychiatry 12* doi: 10.3389/fpsyt.2021.638940

Wetherell, J. (2012). Complicated grief therapy as a new treatment approach. *Bereavement And Complicated Grief, 14*(2), 159-166. doi: 10.31887/dcns.2012.14.2/jwetherell

Wilson, D., Darko, E., Kusi-Appiah, E., Roh, S., Ramic, A., & Errasti-Ibarrondo, B. (2020). What exactly is "complicated" grief? A scoping research literature review to understand its risk factors and prevalence. OMEGA - Journal of Death And Dying, 1-17. https://doi.org/10.1177/0030222820977305

Worden, J.W. (2008). Grief counseling and grief therapy: A handbook for the mental health practitioner (4th ed.). New York: Springer.

World Health Organization (2020). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

Zakarian, R., McDevitt-Murphy, M., Bellet, B., Neimeyer, R., & Burke, L. (2019). Relations among meaning making, PTSD, and complicated grief following homicide loss. *Journal Of Loss and Trauma, 24*(3), 279-291. https://doi.org/10.1080/15325024.2019.1565111

Zisook, S., & DeVaul, R. (1983). Grief, unresolved grief, and depression. *Psychosomatics, 24*(3), 247-256. https://doi.org/10.1016/s0033-3182(83)73227-5