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Editorial

Volume 14, Issue 1 - 2020. Dr Ann Moir-Bussy

The beginning of this year has provided many unexpected events from the raging and devastating bushfires over summer to the spread of CoVID19 around the globe. And we find we are in a liminal space – a space between life as it was and how it will be when the virus finally subsides. It certainly can't be the same. What we do within this space and time, especially if we are in lockdown, and how we respond is so important both for ourselves and for others. It is a challenge to each of us to awaken all that is within and to bring to light and awareness the love and beauty that can be shared.

This issue has some thoughtful reading and reflection beginning a powerful piece by Catherine Sun Tien-Lun from Hong Kong Shue Yan University. It is the closing address from the 6th Asia Pacific Rim International Counselling Conference held in Brisbane late last year. The topic is most fitting for the current situation in which we find ourselves as Catherine looks at the relationship between socio-political turmoil and mental health. There is turmoil everywhere in spite of the enormity of suffering, uncertainty and the huge death toll that the virus is taking. Even this does not deter the petty arguments and political grandstanding that is so rampant. Catherine's article is a powerful reminder of what we can do to ensure that we are there to support those around us who are not coping with the fluctuations and uncertainty around them.

Stallman, Hutchinson and Ohan also touch on trauma – bereavement after suicide and the stigma that is often added to complicate an already painful situation. Becoming aware of the narrative we or others have created around the suicide and changing or reframing this narrative to one of love and support can allow the bereaved to grieve and to cope and to begin a new way of living. This is another powerful article showing how we can bridge the transitions we find ourselves within in so many ways.

On a different note Carolyn Cousins addresses the needs of clinical supervision and in particular form the supervisees's experience – are you getting what you need from supervision? Cousins examines the different elements of supervision and challenges the supervisee to explore what their needs are to ensure they get supportive and educative supervision.

Joshua Kubler brings for us a small research which he completed as part of his Master of Counselling. Researching and important topic for counsellors – their perception of client outcomes and the therapeutic alliance in counselling, he used Interpretive Phenomenological analysis to examine the result from four counsellors he interviewed. He recognises it is a very small sample, however, it is an important start in the career of a counsellor to recognise the value of research for evidence in their work.

Editors

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The final research in this issue is from Zoe Tziannis which is a study on parental psychological control, childhood anxiety and self-perception in later adulthood. Zoe completed here studies at the Australian College of Applied Psychology (ACAP) and completed this topic' because she wanted to increase her understanding of her personal exposure to the later-life effects of psychological control within her own family, particularly within the context of self-perception in later adulthood'. It can point counsellors to the dilemmas and struggles an adult may encounter because of such control in childhood.

Wherever you are in the world, may you continue to stay safe and well in this time of turmoil and transition. May we all provide a leadership that will inspire and encourage all to be patient in times of isolation and to hold the space so that the new may emerge. Here in Australia we are well into autumn and moving to winter – the season when the leaves die off and new buds form – a time of rest and silence and allowing the new growth to emerge. Let us use this time to do the same. We look forward to some great research and reflection s for the next issue later this year.

Ann Moir-Bussy
Editor

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Mental Health, Socio-Political Turmoil, and the Place of the Counsellor

Catherine Sun Tien-Lun

Closing Address of Professor Catherine T.L. SUN, President of the Asia Pacific Rim Confederation of Counsellors at the 6th International Conference of the APRCC in Brisbane on 28 September, 2019 at the Brisbane Hilton Hotel.

Secretary-General of APRCC, Delegates, and Fellow Counsellors:
Good afternoon and thank you for staying with the conference till the end. For this closing address, I have chosen to talk about the relationship between socio-political turmoil and mental health, and how we as counsellors can provide some amelioration to the situation.

A Little Background

Socio-political turmoil seems to be everywhere these days. For instance, the Arab Spring, a series of anti-government protests, uprisings, and armed rebellions spreading across much of the Islamic world in the early 2010s against oppressive government regimes has evolved into the Arab Winter (Grinin, Korotayev & Tausch, 2018), threatening to topple the old Islamic world as evidenced by uprisings in Tunisia, Sudan and Algeria. Slightly more recently is the Yellow Shirts Movement in France which originated with French motorists from rural areas who had long commutes protesting against an increase in fuel taxes. It has quickly evolved into a demand for a change of government, and is now in its 11th month of protests. The most recent is the situation in Hong Kong where we are in the 4th months of marches, protests and riots, with a band of rioters vandalizing and destroying selected public and private properties, and underground railway stations every weekend. The movement started with a protest against a proposed amendment to an extradition law but have rapidly evolved into an anti-police rampage, and there seems to be no end in sight as of today. Among social movements of a longer duration are protestors demanding the independence of Catalonia and its establishment as a sovereign state under the slogan “Catalonia, New State in Europe”, which is now in its 7th year of struggle. Of course, even longer are the socio-political conflicts in Palestine which have been ongoing for decades. In short, these so-called colour-coded revolutions are running rampart in almost all corners of the world.

Political campaigns have also been known to contribute to stress. In America, PTSD has been flippantly termed President Trump Distress Disorder, referring to post-election anxieties in 2016 and beyond (Rayner, 2016). In Britain, anxiety surrounding Brexit is called “brexiety”, referring to a collective mental breakdown involving identity crisis, increased risky behaviour and the perceived schizophrenic stance of the political parties (Chakelian, 2018). Reportedly, up to 20% of clients in therapy spoke about the Brexit and its effect on them.

Psycho-social Effects of Socio-Political Turmoil

It is a well-established fact that prolonged socio-political conflict has a high correlation with the risk of post-traumatic stress disorder (PTSD) and major depression. For instance, Cannetti et all (2010) claimed that approximately one-fifth of Palestinian men and women were diagnosed with PTSD and major depression. The reason for this is uncomplicated: Most, if not all, socio-political conflicts tend to drag on interminably, creating a tremendous amount of uncertainly in one’s livelihood, future prospects and even sense of identity. These uncertainties pose immense challenges to traditional and core beliefs and values, further aggravating one’s sense of security. As Dr. Jay Watts, known psychotherapist and activist, so aptly put it, “Uncertainty is one of the most difficult states to inhabit”. Therefore, during socio-political turmoil, where there is extreme polarization of the society in question with high stakes such as freedom, democracy, economic development and so on at play, plus uncertain outcomes, there is a ready recipe for anxiety.

Socio-political turmoil is an aberration from previous phases of relative stability, and dynamic adjustment is often needed emotionally, psychologically, physically and financially. In the process of adjustment, interpersonal relationships are often challenged. A common issue appearing in family therapy is dealing with family members holding opposing views and unwilling to make concessions, often resulting in intergenerational discord and marital breakups. Friendships have also known to suffer.

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The Shape of Suffering

Being forced to live with a new reality and simultaneously feeling compelled to continuously reinvent oneself to cope with the changing reality takes toll on individuals in varied ways. Overall, common responses include:

- Catastrophizing, blowing every mishap out of proportion and embracing an end-of-the-world sentiment;
- Avoiding the demands for change by physically or psychologically distorting one's predicament or refusing to accept it;
- Increasing risk-taking behaviour by illogically maximizing gains and minimizing losses;
- Experiencing elevated levels of distress and despair with alternating periods of anger and rage;
- Feeling embroiled in situations over which one has little control, and consequently becoming easily frustrated and helpless;
- Harbouring ideations of doing harm to those seen as responsible for one's predicament or acting on these ideations;
- Harbouring ideations of doing harm to oneself out of a growing sense of helplessness and hopelessness; and
- In the case of those with pre-existing conditions, experiencing an exacerbation of these conditions.

Are We Talking About PTSD Here?

Cursorily, the responses outlined above have the appearance of PTSD but there are some variations, and this warrants a closer examination.

The DSM-5 lists eight criteria for PTSD and the table below attempts to establish a checklist for comparison.

PTSD	**Long-term Political Conflicts**	**Notes pertaining to clients suffering from political turmoil**
Criterion A Stressor (one required) Individual was exposed to: death/threatened death, actual/threatened serious injury, or actual/threatened sexual violence through: • Direct exposure • Witnessing the trauma • Learning that a relative or close friend was exposed to a trauma • Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g. first responders – police, medics)	✓	The stressor for political conflicts tend to be mostly long-term and indirect, and rarely a one-time event.
Criterion B Intrusion Symptoms (one required) The traumatic event is persistently re-experienced through: • Unwanted upsetting memories • Nightmares • Flashbacks • Emotional distress after exposure to traumatic reminders • Physical reactivity after exposure to traumatic reminders	✓	The intrusion also encompasses re-experiencing through almost unavoidable exposure to media and mass media accounts.
Criterion C Avoidance (one required) Avoidance of trauma-related stimuli after the trauma including: • Trauma-related thoughts or feelings • Trauma-related external reminders	✓	Individuals might find avoidance of external reminders difficult unless they resolutely obliterate their presence on social media.
Criterion D Negative alterations in cognitions and mood (two required) Negative thoughts or feelings that began or worsened after the trauma, including: • Inability to recall key features of the trauma • Exaggerated negative thoughts and assumptions about oneself or the world • Exaggerated blame of self or others for causing the trauma • Negative affect • Decreased interest in activities which were previously considered enjoyable • Feeling isolated • Difficulty experiencing positive affect	✓	This is reported by the majority of clients.
Criterion E Alterations in arousal and reactivity Trauma-related arousal and reactivity that began or worsened after the trauma, including: • Irritability or aggression • Risky or destructive behavior • Hypervigilance • Heightened startle reaction • Difficulty concentrating • Difficulty sleeping	✓	There is often observable escalation in aggressive, risky and destructive behaviour. Alterations in reactivity include increased tolerance of violence, and decreased tolerance of different socio-political views.

Criterion F Duration (required) • Symptoms last for more than 1 month.	✓	This is usually the case.
Criterion G Functional Significance (required) • Symptoms create distress or functional impairment (e.g., social, affective, occupational)	✓	In counselling sessions, there have been frequent reports on inability to focus on work/study, and a general sense of anhedonia which caused a reluctance to engage in social interaction.
Criterion H Exclusion • Symptoms are not due to medication, substance use, or other illness.	✓	During periods of socio-political turmoil, counsellors witness a worsening of symptoms in clients with pre-existing mental health issues, and an increase of reported symptoms in clients without pre-existing mental health issues.

From the table above, it can be seen that although there are similarities, yet the fit is by no means perfect due to three main reasons. First, since socio-political turmoil is usually prolonged, lasting from anything between a few weeks to a few years, individuals are traumatized repeatedly. This re-traumatization is almost unavoidable because of rampant reporting through paper and social media, on television, and between peers. Second, socio-political turmoil sometimes does not have an end in sight, and the looming uncertainty adds to the traumatization. Third, because everyone in the same community is exposed to the turmoil, people are inclined to gradually "normalize" it instead of identifying the symptoms as worthy of seeking professional help. Therefore, given the sprouting of colour-coded revolutions all over the world today, perhaps we should consider a distinct category of stress disorder, Socio- Political Turmoil Stress Disorder (SPTSD), and develop a unique system of identifying symptoms of SPTSD, and evolve possible protocols of intervention.

Symptoms of SPTSD

Physiological

Include palpitation, increased heart rate, constriction of visceral muscles, shortness of breath and general restlessness.

Psychological

Include inability to focus, difficulty in making simple decisions, loss of confidence, being easily angered and frustrated, being usually anxious, experiencing unreasonable fear, having flight of ideas, and harbouring strong feelings of being pressurized or even persecuted.

Behavioural

Include taking up smoking or increased smoking, increased medication, becoming jumpy, reporting a deterioration of short-term memory, being accident-prone, experiencing a notable increase or decrease in appetite, experiencing a notable increase in hours of sleep or becoming insomniac, increased intake of alcoholic beverages, increased intake of prescription and recreational drugs, careless driving, and a proneness to resort to violence in navigating interpersonal conflicts.

A Suggested Protocol for Counsellors Dealing with SPTSD

Assimilating the experience of counsellors with practice in regions with socio-political turmoil, a 7-step protocol has been developed for use.

Step 1

Increase awareness of the presence of SPTSD symptoms. Just because everyone has these symptoms does not make them normal, nor does it mean that professional intervention is unnecessary. For clients who are reluctant to be engaged in any formal intervention, suggest a trident-approach:

1. Exercising – Physical exercise is known to burn off stress hormones such as adrenaline and reduce excess energy and tension. Exercise also compel healthier breathing, and in the process release neuro-transmitters which are natural anti-depressants.
2. Breathing – By breathing more deeply and slowly, the heart rate is decreased and the amount of adrenaline produced by the body is reduced. In mindfulness training, one's breath is deemed to function as an anchor to still the mind.
3. Eating well – Anxiety is often further impaired by irregular meals, too much alcohol and caffeine. When symptoms of SPTSD are noted, a healthy diet becomes crucial.

Step 2

Differentiate between fear and anxiety. This is important especially for young clients whose limited verbal skills may cause the counsellors to misinterpret their state of mind. If the client is experiencing fear which is a response to immediate danger, he/she must be assisted to secure his/her safety. If the client is experiencing anxiety which is a response to the idea of a threat, then talking it through may be useful in alleviating the anxiety.

Step 3

Employ relaxation techniques. Often, in the counselling room, counsellors encounter clients who appeared to be wedged in the fight-flight mode which makes then unamenable to any counselling intervention. In this sort of situation, simple progressive relaxation techniques are extremely effective.

Step 4

Taking stock of client's well-being. Assist and guide the client to take an inventory of his/her well-being in all realms of his/her existence. Introduce a two-pronged intervention: On the one hand, help the client to focus on the here and now, and let him/her realize that groping in uncertainty and catastrophizing things prevent him/her from enjoying the present. On the other hand, assist the client to accept his/her predicament because avoiding his/her feelings would simply compound his/her suffering.

Step 5

Develop a safety plan. For the client's peace of mind and to lesson his/her anxiety, help him/her to develop a safety plan for himself/herself and his/her significant others. This safety plan should also be rehearsed to allow the client to develop a sense of control in an otherwise uncertain environment.

Step 6

Live normally. Counsel clients to live a normal life as far as is permissible, and that they should endeavour to continue doing things they enjoy as much as possible. If circumstances are restrictive, they should be advised to scale back but not to cancel altogether. Assist them to design a reasonable lifestyle. For instance, if crowds frighten them, they should frequent less crowded places; if watching the news distresses them, they should just skim the headlines to stay in touch; if certain friends or relatives are too negative, then contact with them should be minimized for the time being.

Step 7

Stay hopeful. Here, the counsellor can benefit from referring to Snyder's (1996, 2000) Hope Theory. Snyder proposed three types of thinking: goals thinking, pathways thinking and agency thinking. Goals could be anything an individual is desirous of experiencing, creating, getting, doing or becoming. It could be a significant long-term pursuit or a mundane and simple goal. Within the context of SPTSD counselling, the counsellor can inject a sense of optimism in the client by prompting him/her to think about his/her passions in life, the things that really excite them. Pathways refer to the perceived ability to generate possible routes to achieve one's goals. For SPTSD clients, counsellors would do well to guide them to be more selective and invest their resources in the passions that they are really adept at, and to construct sturdy people relationships around these passions so that they feel supported. Agency refers to the willpower to move toward one's goals. Being surrounded by sturdy people relationships is as important as developing a game plan to increase one's chances of spending more time and resources on pursuing one's passion.

Concluding Remarks

Monumental advances in information technology means that we are rapidly assimilating impetus for change, and change will no longer occur in measurable or predictable increments, but rather in "revolutionary" proportions. This is to say that the so-called "colour-coded revolutions" are going to occur more frequently and pugnaciously, and they will wreak havoc in the lives of many. Thus far, research on SPTSD has been scanty and relegated to the traditional PTSD genre. Hopefully, in the not too distance future, academics would recognize SPTSD as an independent and rather unique category of mental health issues, deserving of focused study. In the meantime, counsellors can do well to:

- Recognize that socio-political turmoil is no longer a rare societal feature;
- Develop better awareness of the symptoms of SPTSD;
- Realize that the turmoil affects people differently, and intervention must be individualized;
- Consider the 7-step protocol presented in this paper and to provide evidence either in support of or against it, so that hopefully a more solid evidence-based model may emerge;
- Contemplate how to keep hope alive for clients; and
- Be the psychological balm to sooth suffering, to make life at least bearable, and to breed in clients the courage, resilience and faith to seek a better tomorrow.

Thank you.

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Coping planning to reduce stigma and support coping after suicide

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Bereavement after a death by suicide can be complicated by stigma. Stigma can result from conceptualising suicide and the causes of suicide, as a personal and/or familial fault, flaw, or deficiency. This stigma can cause negative thoughts about the person who died, engender blame, and result in real or perceived judgment or ostracism. To effectively decrease the stigma surrounding suicide, we need to change the narrative surrounding it and its causes. A coping planning framework conceptualises suicide as the final strategy to reduce overwhelming distress, when a person has no other effective strategies. Within this paradigm, bereavement counselling following suicide involves supporting people to cope with the loss of a loved one rather than the cause of death. Reframing suicide using a coping paradigm has the potential to eliminate the stigma that can complicate bereavement. It also has the potential to contribute to better coping in people experiencing bereavement.

Keywords: *bereavement; coping; stigma; suicide; survivor*

Coping planning to reduce stigma and support coping after suicide

Bereavement is the combination of the physiological, psychological, behavioral, and social response patterns experienced following the loss of a significant person (Dunne et al., 1987). It is typically characterized by a period of mourning followed by eventual adaptation to life without the deceased person. Adaptation following the death of another varies substantially (Maercker et al., 2017). While many experience distress and grief in response to a significant loss, others experience more severe or protracted grief, which is associated with poorer adjustment and is sometimes described as complicated or prolonged grief (Cutcliffe, 1998). There are a number of risk factors for complicated grief, including low levels of social support, dissatisfaction with information provided regarding the death, attachment style, and being a parent or spouse of the deceased (Burke & Neimeyer, 2012; Maercker et al., 2017). Furthermore, there is evidence that traumatic or violent deaths are associated with more intensive or prolonged grieving (Kaltman & Bonanno, 2003; Nakajima et al., 2012).

Of the factors that complicate bereavement, poor social support, traumatic death, and a lack of information may be particularly relevant for those grieving a death by suicide. In particular, those who find it difficult to make sense of the loss are also more likely to experience complicated grief than those who find meaning in their experience (Burke & Neimeyer, 2012). It can be particularly difficult for friends and family to make sense of death by suicide. Their search for causes can lead to them to believe the stigma that often surrounds suicide, and experience blame and shame as a result. Along with other potentially relevant factors—such as lack of support, a violent or traumatic death— this may increase risk for complicated or traumatic grief responses and even suicidality during bereavement (Currier et al., 2006; Jordan, 2017; Pitman et al., 2014).

Stigma and suicide

Stigma is a mark of disapproval by most people in a society toward a particular circumstance, quality, or person (Link & Phelan, 2001). It is “manifested by bias, distrust, stereotyping, fear, embarrassment, and/or avoidance” of the stigmatized individual or group (U.S. Department of Health and Human Services, 1999, p.18). The stigma towards people who have attempted or died by suicide developed through both religion and then criminalization (Tadros & Jolley, 2001). However, despite decriminalization, stigma remains pervasive. People who experience suicidality may be subject to a sort of ‘double stigma’, one of incompetence and danger assumed due to mental illness,

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and another of being immoral for the attempt of ending one's own life (Sheehan et al., 2017). As a result, people who have attempted suicide are frequently stigmatized as being selfish, incompetent, crazy, untrustworthy, immoral, and hopeless (Sheehan et al., 2017). One study for example, found that almost a quarter of the general population would not purchase a house next door to someone who had attempted suicide (Lester & Walker, 2006).

Stigma extends beyond the person who attempted or died by suicide to include those who are close to the individual—parents, spouses/partners, children, and close friends—due to their close ties with the person (Sheehan et al., 2018). Named 'courtesy stigma' (Goffman, 1963), this extension of stigma results directly from the person's relationship with the stigmatized individual, such as through presumed responsibility for the suicide genetically and/or socially (e.g., not acting to prevent the death and being negligent). Those who grieve an individual who has died by suicide have noted the tremendous impact of stigma on them as a result of their loved one's cause of death, including the beliefs of others that they caused the suicide through abuse, lack of love, failure to act, or shared flawed genetic vulnerabilities (Sheehan et al., 2017). They also report the withdrawal of social support from their family and community (Feigelman et al., 2009) and describe feeling blamed and pitied, and being subject to discrimination, such as through shunning, shaming, and impatience (Feigelman et al., 2009; Sheehan et al., 2017).

Stigma is also prevalent amongst health professionals. From the perspective of suicide attempt survivors, interactions with health professionals are often seen as either over-reactive or, at the other end of the spectrum, dismissive, with health professionals assuming that those who attempt suicide are dangerous, hopeless, and/or perplexing (Sheehan et al., 2016). This treatment extends to the treatment of family members. One study found that despite international suicide prevention strategies recommending the provision of support to families bereaved by suicide, next-of-kin of patients who had comorbid unhealthy coping strategies or problematic psychosocial histories prior to their death by suicide (e.g. forensic history, unemployment, and primary diagnosis of alcohol or drug dependence or misuse) were significantly less likely to be contacted by psychiatric professionals following a death by suicide (Pitman et al., 2017).

As a member of a culture that stigmatizes death by suicide, the bereaved people also have their own beliefs about the deceased and suicide as a cause of death. This stigma can include feelings of rejection, isolation, shame and blame towards the person who died and they may subsequently conceal the cause of death (Sveen & Walby, 2008). This appears to be greater following an unexpected death by suicide, compared with those where both the deceased and/or family members had experienced significant difficulties and worry in the lead up to the death, which is more likely to result in relief for those bereaved (Sveen & Walby, 2008). Stigma experienced by those bereaved after a death by suicide is therefore a combination of their own negative self-talk (Jordan, 2001) and the perceived or actual stigma from others (Dunne et al., 1987).

The bereaved person may also experience 'self-stigma,' which is the term used to describe the individual accepting the stigma as legitimate, and thus seeing themselves in the same stigmatized way as others do (Corrigan & Watson, 2002). For people who are stigmatized due to mental illness, self-stigma is particularly harmful, resulting in diminished self-esteem, self-efficacy, and social connectedness (Corrigan & Rao, 2012; Corrigan et al., 2006; Watson et al., 2007; Yen et al., 2005). Although there is little research available on the topic, emerging research and self-reports on self-stigma experienced by those bereaving the loss of a loved one due to suicide indicate that this is an additional source of pain (Sheehan et al., 2017; Sudak et al., 2008). Qualitative research has recently noted the extreme feelings of contamination, self -blame and shame, followed by extreme social avoidance to avoid triggering the feelings (Sudak et al., 2008). One professional and author, for example, disclosed, "Eventually I went to a different bank, food store, gas station, etc., so I would not be recognized as the mother of a young man who took his life" (Sudak et al., 2008; p.140). These reports have resulted in calls for approaches to suicide that reduce stigma, and to support bereaved families in ways that are free of stigma (Maple et al., 2014; Sheehan et al., 2017; Sudak et al., 2008). Given that perceptions of stigma are affect seeking and receiving social support amongst those bereaved due to their loved one's suicide (de Groot et al., 2006), addressing this topic is an urgent matter.

Coping paradigm

The coping paradigm is part of a biopsychosocial approach to suicide prevention that is person- and strengths-focused (Stallman, 2018). This framework, illustrated in the Coping Continuum (Figure 1), is stigma-free because distress is conceptualized as a normal human experience (Stallman, 2017). Subsequent to distress, everyone will attempt to feel better by using conscious and unconscious strategies to cope. With the goal of survival, people will firstly draw on healthy coping strategies. These include self-soothing activities (e.g. deep breathing, coping self-talk, and mindfulness), distracting or relaxing activities, and gaining support from family and friends. Healthy coping also includes accessing professional support when personal strategies are not effective. When people do not have adequate healthy coping strategies, their mind will still try to find ways to reduce their distress. It does this by drawing on unhealthy coping strategies. These strategies may reduce distress momentarily, but they are unhealthy because they are likely to result in adverse consequences and can weaken the natural survival instinct. Unhealthy coping strategies can include negative self-talk, activities (e.g., emotional eating, aggression towards self or others, alcohol and drug use), social isolation, and suicidality. Suicidal ideation can become habitual and, in the absence of other strategies to reduce distress, can lead to the thought that the only option to stop the distress is suicide. From a coping perspective, suicide is the result of an absence of coping skills.

Language and stigma

The narrative around deaths by suicide perpetuates stigma (Stallman & Ohan, 2018) . Society does not stigmatize the death of people who die from physical illnesses, even those with significant lifestyle causal factors (e.g. heart disease and diabetes) by saying "s/he killed him/herself", "committed suicide", "were selfish not to consider the impact on their family", "they chose to die", or "some people just weren't meant to live". Yet, this stigma is prevalent in discussions about those who die by suicide. Similarly, terms such as 'suicide survivor' to refer to a bereaved person implies difference, as it would not be equally applicable to physical illnesses for example, 'heart failure

survivor' or 'pneumonia survivor'. Language that chains those experiencing bereavement to the cause of death, that is suicide, perpetuates the focus on the cause of death, rather than the grief process related to the loss of a significant person in their lives. The coping paradigm aligns language about psychological problems with that used for physical illnesses (Stallman, 2018). Suicide, almost without exception, occurs as a result of an absence of alternative coping strategies. Stigma disappears when the narrative about deaths by suicide are comparable with other causes of death. It destigmatizes the deaths of people who die as a result of suicide, by changing language to 'died by suicide' similar to 'died from heart failure', 'died from a stroke', or 'died from pneumonia'.

Coping after the death of a loved one by suicide

As with other distressing events, the initial task following the death of a loved one is coping. Events do not cause emotions. Emotions arise subsequent to individual thoughts about an event (see Beck & Haigh, 2014). Emotions, therefore, drive distress. Distress drives coping. Unhealthy coping strategies, including suicidal ideation and suicide, are more common in family, friends and colleagues following a death by suicide than other causes of death (Brent et al., 2009; de Groot & Kollen, 2013; Hedstrom et al., 2008). This suggests differences in the way suicide is thought about. As shown in Table 1, thoughts that use a coping paradigm explanation of death by suicide result in emotions that focus on the loss of a loved one, rather than the cause of death. Stroebe and Schut's (1999) dual process model of coping with bereavement purports that coping involves confronting grief through loss oriented processes as well as focusing on restorative processes that allows both distraction from grief and investment in new identities, tasks and relationships. Similarly, the coping paradigm presented here allows the bereaved people to focus on their loss and grief (loss-oriented coping) as opposed to the cause of death and to engage in healthy coping strategies such as connecting with others and engaging in distracting activities (restoration-oriented coping).

Professional support after the death of a loved one by suicide

The needs of family, friends, and colleagues after a death by suicide is like any death—to cope with their grief and loss. It is important that professionals who have contact with the bereaved have the knowledge and skills to counter the prevailing stigma. There are four steps to a strengths- and person-focused approach to supporting people during bereavement following the death of a loved one by suicide:

1. Cause of death. To be able to assist those bereaved from a death by suicide, health professionals and others who communicate causes of death (e.g. coroners, police officers) need to: a) understand the coping paradigm of suicide; and b) communicate it to the next of kin. This provides the loved ones with a stigma-free narrative to be able to confidently communicate the cause of death with family and friends. This aids connection with social support during their grieving and minimizes social isolation caused by stigma.
2. Access to professional support. Professional support is an important part of everyone's coping continuum, to assist when personal supports are no longer sufficient. Support services should also use non-stigmatizing language—that is, language that would be equally applicable to a person bereaved by a loved one dying from a physical illness or suicide.
3. Support that is strengths- and person-focused and uses a coping paradigm. The Care · Collaborate · Connect format of supporting people who are distressed involves attending to their distress (listening), exploring their coping strategies (asking how they are coping), and connecting them with more intensive professional support people, as needed (working with them to identify and support their needs) (Stallman, 2017, 2018).
4. Tailored interventions. Psychotherapy may be useful for people experiencing complicated grief. Within a strengths-focus, the key tasks are promoting healthy coping and challenging dysfunctional beliefs about suicide and the person who died. People with complicated grief may also have comorbid psychiatric illnesses that warrant assessment and evidence-based treatment—Major Depressive Disorder and Post-Traumatic Stress Disorder are particularly prevalent in this population (Robinaugh et al., 2012).

Conclusion

Suicide prevention involves many factors, including healthy environments, responsive parenting, healthy behaviors, belonging, coping, resilience, and treatment of mental illness (Stallman, 2018). In the absence of alternative coping skills, some people die by suicide. Coping can then be particularly challenging for those bereaved following the death by suicide because of the prevailing community and self-stigma associated with suicide. This may result in unhealthy coping strategies, including social isolation, suicidal ideation, and suicide. The coping paradigm provides a non-stigmatizing explanation for the cause of death, tasks for those who are bereaved and a strengths- and person-focused approach to supporting people during bereavement. This approach removes stigma and promotes healthy grieving. Changing the narrative around the cause of death and connecting people with complicated grief with appropriate professional support and treatment may contribute to a decrease in stigma and a reduction in suicide in those bereaved following the deaths by suicide of family, friends or colleagues.

Footnotes

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Situation	Thoughts	Emotion	Behaviour
Death of a loved one by suicide	Stigma framework Self-stigma Actual social stigma Perceived social stigma	Distress	Unhealthy coping strategies
Death of a loved one by suicide	Coping planning framework Suicide results from coping skill deficits	Grief	Healthy coping strategies

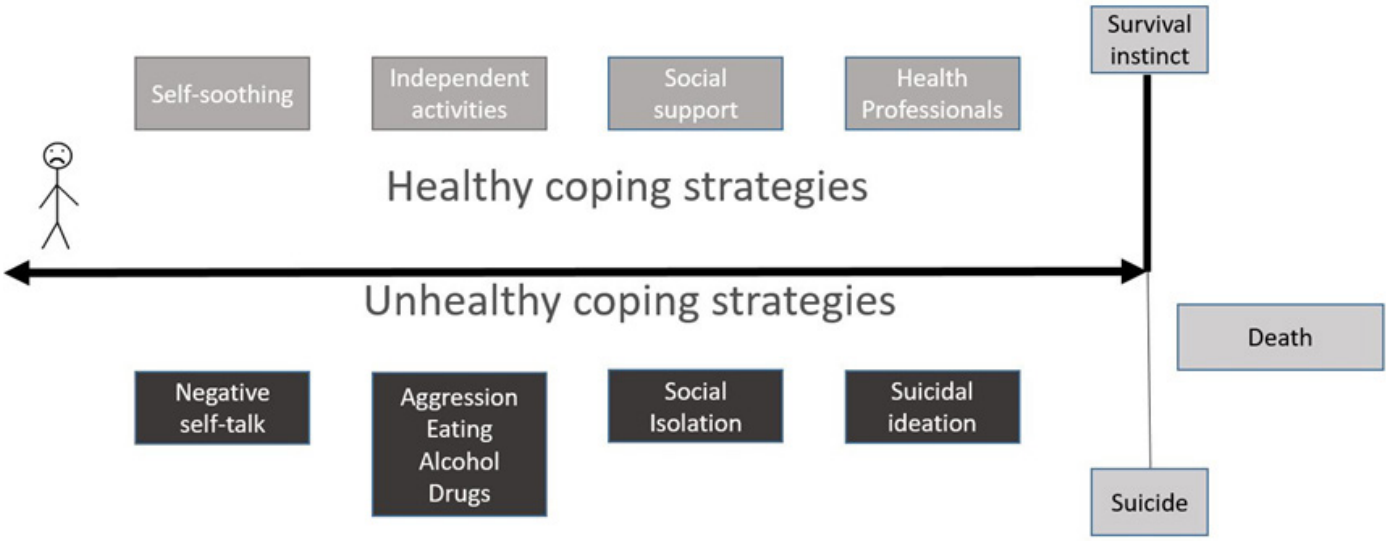

Figure 1
Coping Continuum (Stallman, 2017)

Are you getting what you need from supervision?

Carolyn Cousins

This article aims to provide practitioners with information to evaluate whether they are getting what they need from their current supervision and to think about how to adjust the focus of supervision where this is required. In part, this is achieved by considering the different elements, purposes and possibilities that can be fulfilled within the supervisory relationship, as well as outlining some of the requirements for a safe and reflective experience. It is proposed that a practitioner's needs will vary at different points in their career, and a tool is provided to assist in describing these needs to others. The article includes information about learning styles and how these can influence what 'good' supervision for each individual, as well as an assessment tool for those who do not know what their learning style is. The overall aim is to enhance the supervisory experience of practitioners and increase the value of time spent in supervision.

Keywords: *supervision*

Are you getting what you need from supervision? This is an important question. An increasing number of welfare and health-related professions are relying on forms of either management or clinical supervision to provide oversight of work and support to workers. And yet, research is telling us that many workers are not satisfied with the supervision they are being provided (Grant & Kilman, 2015; Gibbs, 2001). There is a need to assist workers in understanding better the benefits supervision can potentially offer, as well as to articulate better what their needs are to their supervisors.

While an increasing number of organisations are recognising there is a benefit to providing supervision (both to the organisation and the worker), very few ask questions about the quality of the supervision, instead of assuming its simple provision is enough (e.g. Davys and Beddoe, 2010). Supervision is held up variously as a protective mechanism for clients and agencies, a quality work check, and a prevention strategy for vicarious trauma (Hingley-Jones, 2016). Yet, there is little evidence of what needs actually to occur in supervision to achieve these outcomes.

Many of those providing supervision have also not been trained in its provision (Kettle 2015), or where they have, there is a reliance on simple attendance at a short course, rather than any rigorous or benchmarked assessment against a supervision skill set. Many management or team leader posts list the provision of supervision as one of the critical tasks of the role, and yet this is rarely a skill set that has been required at recruitment or tested for afterwards. The assumption seems to be that if you have received supervision in the past, you will somehow know how to provide it.

Similarly, the assumption often is made that workers themselves know how to utilise or make the most of supervision. It has been the author's experience that where workers have experienced proper quality supervision in the past, they tend to know what it can offer, are more aware of what they need, and are likely to both seek it out, and even demand it. However, other workers who have experienced supervision that has been unproductive, unsafe or even a waste of time, will either not seek it out, or will actively avoid it.

This article intends to outline the various options and functions that supervision can cover, to assist both supervisee and supervisor better discuss and negotiate what is needed, and what is on offer. Each party comes to the interaction with different skills, styles and requirements (personally and in their role).

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The more able the two parties are to have an open discussion about the elements and possibilities in supervision, the better the chance of negotiating a useful, positive and productive supervisory experience, rather than what can become a 'time in the diary' to be endured.

The different elements of supervision

There is a wide range of areas of potential focus in supervision as well as different needs at differing career stages. The relative emphasis and attention should consider the needs of the individual involved, as well as their work context. For example, a more newly qualified worker or someone who has changed fields to a new content area is likely to need a more substantial educative element to supervision for a time. In contrast, a worker in a clinical role long term is more likely to be looking to be challenged about their clinical practice, to better understand their bias and to continue to deepen their learning and reflection.

The nature of the relationship between supervisee and supervisor will also effect the emphasis. Line management or in house supervision is more likely to have a stronger focus on management requirements and the completion of tasks, while external supervision, particularly if paid for by the worker, is more likely to have a focus on the worker's self-determined professional needs and even longer-term career aspirations.

It is also a myth held by many that a "good supervisor" will be able to meet all of someone's professional needs. On the one hand, part of the success of supervision depends on the initiative, preparation, thoughtfulness, honesty and self-insight of the supervisee. However, on the other hand, it is also the case that different elements of supervision can be. It most likely will need to be, provided by various professionals in the worker's sphere. It is unlikely that at all times, a worker will find one supervisor who meets all of their needs. When this does occur, it should be considered a rare and precious find.

Kadushin (1992) argues that there are three main functions of supervision: educational, supportive and administrative. O'Donoghue et al. (2018) analysed 130 articles on social work supervision published from 1958 to 2015, finding supervision consists of organisational, educative, and support functions, and the ways these functions are enacted depends on the context. Over time others have added areas such as personal reflection and impact, clinical issues, work content exploration, systemic issues, career development, and the challenges that come from working with others. There is no one agreed on definitive list of what constitutes supervision, and some supervisors will include areas in their provision that others will not (see Wilkins & Antonopoulou, 2019).

Elements of Supervision

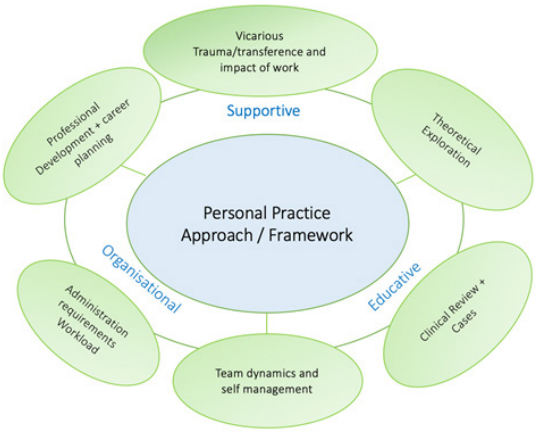

Diagram 1. Elements of Supervision

Articulating your Professional Practice Framework

The author has chosen to centre this article around a part of supervision that is often neglected as an area of explicit focus. That is assisting the worker in articulating their preferred practice framework and approaches. The reason for this is that it underpins and influences all other choices. Not all workers can articulate a coherent model for why they do the work they do and how they go about it. This Approach or Framework includes exploring the messages of their discipline and training, their world views and meta-theories, as well as the causational and treatment models they are drawn to. The author proposes that this is an essential area of exploration in supervision, not every session, but at regular intervals. Assisting a worker articulate their approach to their work, helping them ground their approach in theory and models, can not only make a worker more confident, but it can also open up areas of vulnerability and more significant, more in-depth reflection. This can include reflections on issues important to vicarious trauma such as the maintenance of hope and meaning in work, whether the worker's career trajectory and current role fit with their professional world view and intentions, as well as how their models affect the way they approach their tasks and cases. We all act from theory and belief, whether we can articulate it or not, and coming back to this as a regular review part of supervision can create deep and fruitful supervisory relationships. It is not always safe to start with these discussions, and however, once there is enough trust and safety established, they can be transformative. Paul Gibney's (2014) article can be a sound basis for these kinds of discussions.

Educative

At the early stages of career, or when we change roles/ areas of work, supervision can, for a time, take an educative tone. Sometimes we will also seek out a supervisor with a particular skill set or area of practice from whom we wish to learn. Much supervision will have educative elements to it, but sometimes this is a clear and contracted purpose. One option can include both parties researching, reading about, and discussing issues, reading articles or pursuing a specific area of learning. This could be around clinical topics and issues, policies and procedures,

theoretical approaches, or even new and emerging areas of practice.

This can sometimes be the safest area of supervision to focus on early in a supervisory relationship when both parties are still getting to know each other and are reluctant to explore areas that are deeper or more vulnerable.

Dynamics to watch for are where this role is enacted to avoid examination of work - that is, where the supervisee continues to take the one-down position to the supervisor, asking for teaching and 'input' at the expense of worker reflection, vulnerability or exploration of their work in supervision.

Administrative / Task-based supervision

This is a particular and often necessary focus in line management provided supervision and unfortunately, in busy modern workplaces, research is indicating that this form of supervision is focussed on, sometimes to the exclusion of other elements. Weld highlights how managers can struggle to create supervision as a learning environment, and supervision becomes too closely linked with compliance measures and performance (2012:24). This can result in both worker dissatisfaction, but also a genuine risk of complaint but non-reflective workplaces – not at all ideal in a field as complex as welfare. The author would argue a crucial element of supervision, if we are going to claim it is about keeping clients safe and the work accountable, is not just to monitor adherence to tasks and timeframes, policy and legislation, but to also ensure thoughtfully, considered, and accountable practice, which can only be achieved by leaving space for the other elements of supervision.

In many workplaces, there will, of course, need to be space for checking on leave requirements, planning of future work tasks, overview discussion of the case or task progress, monitoring adherence to policy and timeframes, as well as passing information from management to staff and vice versa. However, this should never be the whole sum of supervision. Where too much time is taken up with an administrative focus, consideration needs to be given to separating the functions. Some services now have clearly differing processes with, for example, a monthly administrative 'catch up's' and a separate, more reflective supervision meeting.

Clinical / Content Supervision

For those working with clients or patients, clinical supervision, including that which examines the decision making, case progression, client issues and worker actions, is a crucial area of focus. Clinical supervision can take many forms, and depending on the level of safety in the supervisory relationship. The skill of the supervisor, it can remain surface level, or go quite deep. The author has received supervision at both extremes and a range of places in between. Some clinical supervision is actually administrative supervision in disguise. In essence, it is about discussing the cases and clients, but really just to see if the worker is moving things along, keeping to policy, workload matters or getting close to closing. The author has also worked in a role in a very psychodynamically orientated organisation where supervision was provided three times a week, and there was an expectation of very deep and detailed exploration of clinical decision making and what was influencing this, at all levels. However, clinical supervision at this end of the spectrum appears to be relatively rare – many workers would like it, and state it is what they want, but creating an environment safe enough to get to that level of vulnerability in one's practice, especially if it is with the person who also does your performance appraisal, is very rare. Peach and Horner (2007) and Beddoe (2010) identify tensions between what they refer to as surveillance on the one hand and support or reflection on the other.

There are some specific clinical supervision models that a number of supervisors are trained in, and different sectors will value this clinical focus more highly than others. Supervisors can also link clinical supervision to a process of clearly articulating one's personal theoretical stance and examining its impact on clinical work.

At the very least, it is suggested that supervision where it is safe to admit and explore areas of doubt and 'imposter syndrome', as well as bias and issues of alignment and over-identification, is crucial for those working with vulnerable clients. If we are truly going to say that supervision is in part about ensuring accountability in the work and that clients are receiving the best service, then getting to discuss these issues, reflecting on challenging experiences and seeking to grown and learn from them, is vital.

For those working in non-clinical roles, supervision of day to day work content is very useful. The author has experience supervising a range of team leaders, managers well removed from clinical practice, and also those working in a range of prevention, project and policy roles. In part, the importance of supervision for these workers seems to be that all of us need to feel that our work matters, that someone cares enough to listen to what it is we are putting time, energy and effort into. However, there can be unique challenges to those in non-clinical roles, including the hope that the work is influencing the wider system and wanting to achieve systemic change. Workers can move into management posts wanting to take on the systems, make changes and achieve very noble goals, only to find themselves frustrated by bureaucracy and caught between personal and organisational values, as well as organisational, economic realities. In project and policy roles, workers may also be passive recipients of responsibility. For example, policy officers can feel helpless after a critical incident or failure, unable to change the policies fast enough to prevent more harm, or unable to garner the political will to support what they see as a necessary change. This can take its toll, as a sense of inertia or inability to bring about broader systems change can be its own kind of burden. Supervision that helps people focus on the bigger picture of the goals and intentions of their management project or work, rather than just the task-based detail, can assist people in maintaining not only their focus and drive but also their sanity and sense of making a worthwhile contribution.

Personal / Professional cross over

This is an area that, depending on theoretical orientation, not all supervisors will wish to explore. In the author's definition of this aspect of supervision, it is not personal counselling, and clear boundaries should be drawn via referrals when individual counselling is needed (which at various points in life, it is). However, it is the author's strong belief, informed by trauma, attachment and psychodynamic orientation, that who we are, and what we bring to the work personally has a significant impact on professional practice. Whether we call it transference/ countertransference, the impact of an empathic engagement or

vicarious trauma, the work changes us. Our inner experience and our views of the world (Pearlman & Saavatine, 1996, Cairns, 2002) are replaced by the work we do, the stories we hear, the things we are exposed to. If workers are going to stay healthily engaged in their work, and integrated within themselves, this impact needs exploring and reviewing.

Not only does the work change us, but we change the work. A worker currently going through a significant life event, like a transition to parenthood, a divorce, a bereavement, isn't neutral in their interventions and decisions (if we ever are). Rather these personal experiences influence what we are interested in, determine some of our approaches and can even change our focus. If we are real about worker accountability in decision making, then the author would argue that the impact of personal life events should always be on the table for exploration as a supervision topic.

Similarly, the impacts of race, ability and gender on our practice are also rich areas for exploration. This is not simply for those from minority groups. In essence, those from the dominant culture also need to be consistently challenged to examine how their bias, their assumptions, their race and identity can impact their work and practice. This includes considering normative assumptions through a lens of white fragility and privilege when working with vulnerable to disadvantaged populations. Supervision should not be so comfortable as to not challenge us around the impact of these assumptions and biases.

In the welfare sector, we also talk abstractly of boundaries, as if everyone has agreed to a set of norms or 'stop points' and yet any group exploration of these boundaries will reveal significant points of difference. Issues of gender, culture and race come into these discussions, as well as the need to explore the use and role of self-disclosure and humour for those in clinical settings, as both reactionary and defensive mechanisms.

It is naïve to think that some of the work is not going to intersect with lived experience, either past experience of the issues coming up clinically, or current experience. We are also living interacting human beings – the cross over will be an issue at times for both supervisee and supervisor.

If the personal/professional interaction is "off the table" as it sometimes is, particularly in line management supervision, a whole area of influence on the work is ignored and unexamined. And yet creating safe enough environments in which to be able to discuss these impacts, and in particular to address areas where we feel vulnerable, is not easy or common (see for example Kettle, 2015). As Weld points out (212:34), to "go into a room with someone who may hold greater experience, or perceived status than yourself, and freely talk about possible mistakes you have made in your work is no easy feat."

Operational / Systems issues

Part of surviving and thriving in a workplace can be the chance to explore and discuss workplace dynamics and challenges in human interactions in a safe and somewhat detached way. Colleagues do not always get along, nor do they always share all the same values or views on how the work can be done. Personality clashes and differences in conflict style can cause all manner of misunderstandings, as anyone who has worked in teams will know. Supervision should provide a place not to complain about dynamics, but explore them in constructive ways, considering causes, our role in them and how to shift dynamics to more constructive and helpful places. It is also worth considering whether parallel process dynamics can be at play in which the dynamics of clinical work can be replicated in the workplace (see Webb, 2011 and Cousins, 2018). This can include looking at how to enact and encourage the expressing of organisational and professional values where this may not be occurring.

In a literature review undertaken by Ashley-Binge and Cousins (2019) relating to vicarious trauma, one of the findings was that it was often not the "sad stories" that took the most toll - workers in the sector know that is what they are signing up for. Instead, a more significant impact can be where the organisational values are not actually in place, or where the worker is experiencing micro-management and bullying, yet being told the solution is "self-care". Supervision can provide an opportunity to identify and discuss structural disassociation – the part of the worker that needs to compartmentalise and keep going, at least for a time, where the value fit is not there and the impact on practice and the worker, and where there is a need to invoke this defensive mechanism.

Career Planning / Professional development

Another element to be considered in supervision is the area of professional development. This is not merely about identifying the next short the course the worker might like to attend. Instead, it is about whether or not the worker feels they are growing professionally. This could include exploring areas of practice for growth through various methods, such as mentoring, reading, further study or even career emphasis change. Finding spaces to think out loud about possibilities and consider options for ongoing learning and challenge can also be a useful supervision focus.

The percentage of time spent in each of these elements will vary in each supervisory relationship and will depend upon both supervisee need and supervisor approach. It is worth paying focussed attention to deliberating discussion and reviewing the focus, either individually or in supervision at various points in the provision, to ensure the mix is as it should be. Appendix 1 is provided to assist with these discussions.

Purposes of Supervision

What does supervision provide? What are the goals and from whose perspectives? Being clear on its purpose for different stakeholders will assist us in assessing its effectiveness. Some of the various purposes including:

Organisationally

The goals and purposes of supervision from an organisational perspective are often about checking on workload, policy and procedural adherence (when in-house) as well as reducing organisational risk by exploring clinical decisions, and also addressing worker vicarious trauma. There is often a wish to provide a process that will assist with staff retention and support the worker. However, the purpose of organisational provided supervision will often be heavily dependent on the organisational context (Kettle, 2015).

Clients

Supervision can be seen as a way to check worker skills, biases and methods, hence supposedly offering a form of

quality control on behalf of the client.

Professionally

There are various ways in which supervision may be intended to support the worker's particular profession and their professional growth, ensuring (potentially) some professional consistency and competence. As Kettle outlines (2015), although the evidence base on supervision is limited, the available evidence points to proper supervision being associated with job satisfaction, organisational commitment from staff, and growth.

Individual

As outlined, there can be benefits clinically, personally and professionally, mainly when supervision can be provided in safe, reflective spaces. It can challenge and grow the worker, providing an opportunity for transformation, discovery and professional growth. It can also provide a forum for discussing organisational survival, how the service goals and values fit for the worker, as well as discussions on how to work with colleagues. Safe supervision can be an excellent place to explore career hopes and goals, worries with imposter syndrome, and to be accountable for monitoring vicarious trauma responses. As already outlined, it is the author's proposition also that a valuable part of supervision can be the visiting and revisiting at intervals. This personal practice framework underpins their work and approach, refining and updating it as it changes over the career of the worker.

As a result of both these different purposes, there can be many competing agendas overlaid in this one interaction, and the quality of the supervision and the safety can both significantly affect whether these purposes and goals are realised.

Learning Styles

If a worker is to get the most out of supervision, there can be a great benefit in understanding, and being able to articulate the implications of their own learning style. It is also useful for the supervisor to understand both the supervisee's learning style and their own. This can open up the discussion about the kinds of questions, activities and format of supervision that will most challenge and benefit the supervisee. Appendix 2 includes the VARK learning style questionnaire, to assist with this and discusses some implications of the different styles for supervision.

The initial session/s

Ideally, an initial session would focus on expectations, and on establishing the elements and approaches to supervision, including discussion of past supervision experiences. It is also an opportunity for both supervisee and supervisor to get to know each other and begin the supervisory working relationship. Options could include setting a structured agenda for sessions, agreeing on a session-by-session guided approach, and discussion of the logistics of sessions.

Initial sessions are also very much about establishing a rhythm and a norm. No two supervisory relationships are alike. Each party influences it in unique ways, and relationship alchemy is created that is unique to this interaction.

A note on safety and trust

While it is not the intention of this article to address the dynamics, games and power differentials that can be enacted and interfere with safe and open supervision, it is essential to acknowledge that the degree to which a supervisee can benefit from supervision will depend on their own past experiences, whether these impact trust and openness, as well as the ability of the supervisor to establish and then continuously demonstrate, a safe supervision environment. O'Donoghue et al. (2018) say a supervision relationship that is characterised by trust, support, honesty, openness, has the ability to collaboratively navigate power relations as well as respect for social and cultural differences.

Where a supervisee feels unsafe or is worried about the potential for criticism, payback or a lack of confidentiality, supervision will remain surface level. There may well be attendance and a level of compliance, but many of the goals of supervision will remain unrealised. While attending supervision may be a form of worker self-care, this will depend on the level of safety of what is on offer.

Conclusion

The author hopes that in exploring supervision in this way and providing the tools below, there is a greater chance of workers articulating their needs, their struggles and exploring options for better supervisory provision. This will, in turn, will assist them in becoming a more integrated worker who is supported to be reflective and considered in their practice.

A supervisor should aim to ensure all elements of supervision are included over time, noting how each supervisory relationship develops its own style, co-created by the participants. It is the role of the supervisor to create review points to ask about whether supervisees needs are being met, although this can also be initiated by the supervisee if not forthcoming from the supervisor.

In terms of skill set, there is a need for more research about what makes for a good supervisor and competent supervision, and some of the Emotional Intelligence literature is adding to considerations in this area. However, more welfare specific research is needed.

Klauber, from whom the author received supervision for a time, outlines an excellent litmus test for an excellent supervisory space (*Forward* in Bradley and Rustin, 2008):

"Bion's concept of containment … is one way of describing the establishment of a setting that is accepting but not passive, thought-provoking without being directly challenging, inclusive without being seeming to make everyone say or think the same thing. If this is achieved, then something transformative can happen."

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APPENDIX 1 - PLANNING ELEMENTS OF SUPERVISION TEMPLATE

Element	Degree of focus	Areas / Reasons
Educative	%	Areas for learning and growth:
Admin	%	Agency required; leave; work load planning and tasks
Clinical / Content	%	Cases
Personal Professional	%	Vicarious Trauma
Workplace / Team Interactions	%	Challenges / Dynamics to manage

Learning Style/s of Supervisee:	Implications for supervision:
Learning Style/s of Supervisor:	Implications for supervision:

Questions for early in the supervisory relationship

- What have been my past experiences of supervision? What works for me, what hasn't and why?

Review questions for a comfortable supervision relationship

- Is this too comfortable? Do I regularly feel challenged to see things differently?
- Am I still growing professionally? Is there a risk of confirmation bias, where I have sought out someone who will simply confirm my own world view?

Review questions where there are challenges / the supervision is not meeting your needs

- Is it safe to raise my needs with this supervisor and try to renegotiate the relationship?
- Is it realistic that all my supervisory needs are met in one relationship or do I need to look at setting up alternative and complimentary relationships, such as through peer supervision or external supervision?

LINK for the VARK Questionnaire

https://vark-learn.com/the-vark-questionnaire/

Therapists' Perceptions of Client Outcomes and Therapeutic Alliance in Online Counselling

Joshua Ryan Kubler

A phenomenological inquiry with 4 voluntary Australian online counsellors was conducted to understand their experience of forming a therapeutic alliance and monitoring client outcomes online. Interpretive Phenomenological Analysis was used to analyse semi-structured interview transcripts. Results found that a therapeutic alliance could be formed online and for most therapists' the process was alike to their face-to-face processes. All participants reported to monitor client outcomes online. Therapist processes for monitoring client outcomes significantly differed based upon each therapists' personal preference. A broader implication that emerged from therapists' experiences was that therapist attitudes and personal preferences may have a more significant influence on their experience of online counselling, than the medium itself. Recommendations included additional information technology training for counsellors seeking to practice online and for the Australian Government to invest in the improvement of internet stability and connectivity in Australia.

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Therapists' Perceptions of Client Outcomes and Therapeutic Alliance in Online Counselling

The decision to engage in online counselling in Australia is becoming popular due to accessibility, affordability and convenience of online services such as BetterHelp and Supportive (Marcelle & Davis, 2017). These online platforms connect clients with high-quality therapists, who hold a membership with a professional association, and who utilise non-traditional face-to-face (F2F) methods. A widely accepted definition of online counselling is the provision of mental health services to a consumer using synchronous or asynchronous methods via the internet (Mallen & Vogel, 2005; Mallen, Vogel, & Rochlen, 2005). Synchronous methods are conducted in real-time using either instant messaging or video conferencing tools (Mallen & Vogel, 2005). An asynchronous method has a latency in response as the recipient may not receive the communication immediately, such as that of an email.

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Online Counselling

Factors that contributed to growth in online counselling are the introduction of video conferencing systems and widespread access to the internet. The first online support platform, Ask Uncle Ezra, was the first online support platform and was offered to Cornell University students for free in 1986. Fee-based services were established online in 1995 and included Shareware Psychological Consultation, Help Net and Shrink Link (Skinner & Zack, 2004).

Logistical benefits to online engagement include cost-effectiveness and reduced waiting times for therapy (Griffiths, Lindenmeyer, Powell, Lowe, & Thorogood, 2006). Factors associated with the increased use of online services include ease of access, anonymity and a reported disinhibiting effect (Hanley, 2009; Suler, 2004). BetterHelp clients were reported to have more positive experiences with their counsellors online than in F2F environments, as found from analysis of Working Alliance Inventory (WAI) scores (Marcelle & Davis, 2017). Clients who have positive engagements with counsellors are more likely

to remain engaged in therapy (Thompson, Bender, Lantry, & Flynn, 2007). This means that a therapeutic alliance is pertinent to maintaining client engagement in therapy.

Research has established that online therapies are equally as efficacious as traditional F2F therapies for treatment outcomes (Barak, Hen, Boniel-Nissim, & Shapira, 2008; Mallen et al., 2005). In addition, there are advantages to therapists practising online. Consideration needs to be given, however, to limitations, disadvantages and ethical considerations unique to non-traditional environments. For example, anonymity is a positive feature that draws clients to engage in online therapy. However, anonymity may disempower counsellors to meet their duty of care in the event of crisis and risk (Richards & Viganó, 2013). Internet stability can interfere with the therapeutic process and poses a challenge to how the client and counsellor can navigate the disjointedness associated with unexpected connection interruptions (Baker & Ray, 2011). According to the Australian Bureau of Statistics [ABS] (2018), "households located in major cities were more likely to have internet access at home (88%) than those in remote or very remote parts of Australia (77%)." Internet accessibility in Australia had steadily increased since 2004 and has since plateaued since 2014 (ABS, 2018). An important concern is the quality of connection in regional areas of Australia as this would likely negatively impact the performance of video-based platforms.

An inquiry into the presence, or absence, of trust in online therapy, found that trust was more present and more accessible to clients within an online therapeutic relationship due to disinhibition, feeling safe and a more neutral power balance (Fletcher-Tomenius & Vossler, 2009). Online connections can be formed using technologies that include (video-based platforms) or exclude visuals (text or phone-based interactions). Research has investigated client experiences of online therapy, however, has largely neglected therapist experiences of forming and maintaining a therapeutic alliance online. Fletcher-Tomenius and Vossler noted that there was limited research that takes a phenomenological approach to understand in-session experiences of the therapist. A review of literature on Google Scholar, ProQuest and PubMed databases identified limited qualitative and quantitative studies evaluating therapist perceptions, over the past 10 years, of forming and maintaining a therapeutic alliance online. However, a notable increase in such literature was identified over the past 12 months among doctoral dissertations and peer-viewed studies in-press in a follow-up review of literature following this study.

The strengths, limitations, ethics and intervention effectiveness of online counselling has been established in contemporary research studies (Anstiss & Davies, 2015; Barak & Grohol, 2011; Finn & Barak, 2010; Harris & Birnbaum, 2015). A gap exists, however, in research that expands understanding of therapists' experiences of client outcomes and the therapeutic alliance in online practice. The formation of a therapeutic relationship online shares components with F2F settings while also having unique processes such as addressing technological ruptures and the relational dominance of the therapist (Cipolletta, Frassoni, & Faccio, 2018). Investigations into the formation of therapeutic relationships are inevitable due to the increased online footprint of counselling services and counsellors.

A review of available research related to the present study in peer-reviewed journals was minimal with one study investigating therapists' perceptions of trust online (Fletcher-Tomenius &Vossler, 2009). It seemed that literature neglected considering the therapists' perspective when working with online clients. Clients were the primary focus in studies, suggesting that the consumer's experience of counselling services has a greater importance to research (Cook & Doyle, 2002; Leibert & Archer Jr., 2006). The purpose of this study is to explore the phenomenon of online counselling with practising therapists, to determine any differences between online and F2F counselling and the perceived effect technology has on monitoring client outcomes and the strengths of the therapeutic alliance.

Research Question

What are therapists' perceptions of establishing a therapeutic alliance and monitoring outcomes with online counselling clients, in comparison to the therapists' F2F experiences?

Aims and Objectives

Rationale

The research question was developed from my interests in practising counselling online. In particular, I am interested in the experiences counsellors have of forming a therapeutic alliance and monitoring outcomes online. From a review of contemporary research literature, I am informed that an effective therapeutic alliance can be established online. In this study, any preconceived notions, on my part, of the efficacy of online counselling will be bracketed through non-directive questions in the semi-structured interviews.

Aims

The study aimed to examine practitioner experiences in forming and maintaining a therapeutic alliance with non-crisis clients as well as the process for monitoring client outcomes in online environments. Using qualitative research methods, data will be analysed to identify the strengths and weaknesses of the topics and inform recommendations for supporting practitioners, developing policies and future directions for research.

Objectives

To gather and analyse emergent themes in practitioner experiences of the formation and maintenance of a therapeutic alliance. Furthermore, to identify common methods and experiences of practitioners' in monitoring client outcomes in an online setting. The primary outcome was to establish a research basis for recommendations therapists considering online clinical practice. Identification of strengths, weaknesses and areas in which individual therapists, registering bodies, or policy-makers can enhance service provision, based upon the collective experiences of the phenomenon under investigation.

The next section reviews the current literature on the topic and describes the methods used in the study. Following this, emergent findings are presented. The final section discusses the implications of the findings to the counselling field.

Literature Review

Attention has been drawn in recent decades to the importance of developing quality interpersonal exchanges between clients and counsellors (Miller, Hubble, Duncan, & Wampold, 2014). A promising component of the therapeutic

relationship is the therapeutic alliance, defined as the emotional bond between a client and counsellor and the agreement on therapeutic goals and tasks required to achieve such goals (Hatcher & Barends, 2006; Horvath, Del Re, Flückiger, & Symonds, 2011). A therapeutic alliance is the single most reliable predictor of client outcomes. A positive correlation with better therapeutic outcomes has been linked to the strength of that alliance (Horvath, Del Re, Flückiger, & Symonds, 2011). An essential component to take note of is the perspective from which the therapeutic alliance is measured. Alliance can be measured from the perspective of a counsellor, client or an observer. Research indicates, however, the most reliable predictor of outcomes is the client's perception of the alliance (Horvath & Symonds, 1991; Trichenor & Hill, 1989). Further analysis consistently replicated and demonstrated a moderate effect size for the alliance-outcome relationship, with stronger effects positively correlated to a decrease in presenting symptoms and reduced likelihood of disengaging in therapy (Wampold, 2001). Wampold further argued that the relationship accounts for more variability in outcomes than the entirety of other contributing factors.

Research has firmly established the therapeutic alliance as a primary ingredient for successful therapy. This knowledge further supports training counsellors from a person-centred framework, to equip them with the foundational skills for building an alliance. Therefore, a single question remains, "What is needed for practitioners to be able to establish an equally viable, reliable and effective alliance in an online environment?"

Cook and Doyle (2002) conducted a small-scale quantitative study with 15 participants who were recruited through online practices. The aim was to identify any differences in an alliance between online text-based therapies and a F2F representative sample. The Working Alliance Inventory (WAI) was implemented to measure alliance in both samples. Analysis indicated that both WAI subscale and composite scores were higher than those in the F2F group. These findings clearly indicate that an alliance can be formed as effectively online as in F2F interactions. Despite indications from these findings that strongly suggest that clients were able to experience a positive relationship and alliance with their therapist online, the study had a poor design due to the small sample size that negatively affected statistical power. Implications are that an effective therapeutic alliance can be established online. However, larger sample sizing is required to strengthen statistical validity for this quantitative design.

Research suggested that a therapeutic alliance was establishable in a similar way to F2F environments (Reynolds, Stiles & Grohol, 2006). The study included a total of 48 dyads that consisted of 16 therapists and 17 patients. A total of 98 independent ratings on the Agnew Relationship Measure (ARM) and Session Evaluation Questionnaire (SEQ) were obtained from the dyads. Results of the study indicated that evaluations for online sessions were as strong as F2F sessions. The study provided preliminary support that online counselling sessions can be as effective as F2F sessions.

Not all research has found an alliance of the same strength between online and F2F counselling. A study conducted by Leibert and Archer Jr. (2006), collected information from 81 clients who self-reported on therapeutic alliance and satisfaction in online counselling services. The information collected was compared to previous F2F findings. Participants in that study were satisfied with both their treatment and the relationship in online therapy. However, satisfaction was higher for participants who had engaged in F2F therapy. Such findings may influence a reader to feel that the medium is less effective. The study reinforced the finding that a meaningful relationship can be formed online. Findings recommended that larger samples be utilised in future research as current studies have limited generalisability. Factors that have contributed to this include small sample sizing and poor research designs. There is limited data available to support efficacy or effectiveness, and current results are considered preliminary as a result.

The present study used a qualitative methodology and a moderate sample size of four (4), which is appropriate within phenomenological research. Sample sizing in qualitative research should be large enough to facilitate a contextually rich understanding of the phenomena, while also being small enough to focus on case-orientated analysis (Sandelowski, 1995). An important factor in producing contextual richness is the structure of the open-ended questions that are used (Ogden & Cornwell, 2010).

A study was identified that focused explicitly on experiences of counsellors in online environments. Bambling, King, Reid, and Wegner (2008) employed a focus group methodology with 26 online counsellors from Kids Help Line service in Australia. The primary benefit reported was the emotional safety for the client engaging online. This was attributed to reduced physical proximity to the counsellor. Paradoxically, the main disadvantage was also reduced proximity as this resulted in reduced non-verbal cues and communication difficulties that hindered the counsellor's ability to assess the needs of a young person adequately. The study focused on youth accessing an Australian helpline service. The results provided validation of counsellor's experiences that can, in turn, lead to the development of strategies to improve online practice.

Conversely a recent study reported a preference for counselling in F2F environments as opposed to utilising online technology to engage with clients amongst counsellors (Nagarajan & Yuvaraj, 2019). However, the study focused on the problems associated with online technologies, and research questions may have been biased towards favouring F2F engagement. Interestingly, nine counsellors reported that the formation of a therapeutic alliance online is not dissimilar to that experienced in F2F environments. The counsellors expressed that they felt it took slightly longer to form an alliance online.

A recent empirical paper explored practitioner experiences of delivering counselling online and found that practitioners viewed the formation of a therapeutic relationship to be both the same and different to F2F environments (Wong, 2018). A common theme was that the positives of online therapy far outweighed the negatives. In another study, therapist perceptions of forming an alliance online were evaluated using an online survey. Therapists felt an alliance was able to be formed online, although, rated alliance as being more important in F2F environments (Sucala, Schnur, Brackman, Constantino, & Montgomery, 2013). Additionally, therapists reported less confidence in their ability to develop an alliance online when compared to F2F practice. The therapists' professional orientation may contribute to a lack of confidence, as only 3.8% of the 106 clinicians were counsellors. Such findings are relevant to the current investigation as it demonstrates preliminary support that counsellors who practice online feel that a therapeutic alliance can be formed online. Furthermore, the research design used in Wong's research reflects methods used in the present study.

Research Methods

A preference in counselling research is the use of the qualitative methodology. Qualitative inquiry has become influential for use in real-life topics and to explore problems in the counselling field (Larkin, Watts, & Clifton, 2006; McLeod, 2011). Further, McLeod asserts that qualitative inquiry offers flexible and sensitive methods for exploring meanings and generating fresh insights into old issues. Phenomenology in counselling research has been used as a way to gain a deeper and richer understanding of topics which could not be achieved through a quantitative survey.

Recruitment

Participants were included voluntarily using mixed recruiting methods. A recruitment email was sent to MindStar, Supportive, BetterHelp, the Australian Counselling Association (ACA), the Queensland Counselling Association (QCA) and the Psychotherapy and Counselling Federation of Australia (PACFA) seeking permission to distribute recruitment material to their members. Furthermore, direct recruiting of suitable counsellors identified as being eligible and snowballing techniques were utilised.

Inclusion Criteria

All participants were required to hold current membership as a counsellor with either the ACA or PACFA. Furthermore, to participate, counsellors were required to be practising in Australia with online clients and also to have previous experience working with clients in F2F environments. The present study sought to evaluate therapeutic alliance formation with longer-term clients online, and therefore feedback on short-term online crisis interventions was excluded. This requirement ensured that therapist experiences were represented by individuals who had been formally trained and recognised as having the required experience to hold a membership with the ACA or PACFA.

Sample Sizing

Qualitative frameworks and phenomenological studies utilise smaller sample sizes than quantitative studies. Morse (2000) noted that the size of a sample is dependent on scope, topic, data quality and research design. For qualitative enquiry, a limited sample size has been deemed preferable to a larger study that might seek to generalise findings to a larger proportion of therapists (Higginbottom, 2004). McLeod (2011) has suggested that a sample size of six participants is common and widely accepted amongst counselling researchers. For this project, a sample size of four participants was finally achieved after some challenges in the recruitment process. A criticism of qualitative research is that the findings are not generalisable due to the small sample sizes. Unlike quantitative research, however, data collected through qualitative enquiry can be rich and meaningful and is therefore regarded as reflective of a natural environment rather than an artificial one (Given, 2008).

Characterised by its in-depth subjective nature, a qualitative approach lends itself well to better understanding the needs and concerns of receivers of professional support (Greenhalgh & Taylor, 1997).

Data Collection

The most applicable method of data collection for this project was semi-structured interviews, as the intention was to speak directly with therapists to arrive at a more informed understanding of their experiences and perceptions. Furthermore, a semi-structured interview is coherent with the way a counsellor works through engagement in conversation to better understand the individual experience. All interviews were audio-recorded and subsequently transcribed for analysis. Each participant was invited to read copies of their transcripts and were invited to rescind or change comments that were made during the interview to more accurately reflect their experience.

Data Analysis: Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) is an inductive process of de-textualising and re-textualising the data. The analyst separates the data from its original context and assigns codes, then analyses it for units of meaning; then reduces, reorganises and reintegrates the data (Starks & Trinidad, 2007). The process of coding involves assigning data codes, examining the codes, grouping codes together, and then searching for patterns of meaning. Through this process, a double hermeneutic occurs. This means the researcher attempts to make sense of the participant's attempts to make sense of the phenomenon experienced by participants. A two-way relationship occurs between the researcher and participant when attempting to understand the phenomenon. The result is the fusion of horizons in what is known as the hermeneutic circle of understanding. This means the researcher and participant co-construct the data (Laverty, 2003).

A critical element in IPA is the process of bracketing. The researcher is required to put aside prior knowledge and assumptions about the phenomenon to attend to participant accounts with an open-mind (Gearing, 2004).

In this project, a bracketing journal will be utilised to monitor thoughts, feelings and emotions the researcher is experiencing. Bracketing has similarities with counselling practice as the researcher must attend to data, analysis and interpretation without preconceptions of their values, beliefs, emotions and interests (Tufford & Newman, 2012). The data analysis process was based on Shosha's (2012) research methods where: significant statements were identified in transcripts; meanings were formulated from the statements; categories, clusters and themes were assigned; and the exhaustive description was reduced based upon the research question.

Ethical Considerations

The research intended to understand the experiences of therapists offering online support. Therefore, recruitment was requested voluntarily through contact with suitable organisations within Australia and using a snowball technique.

An important ethical consideration was confidentiality of the semi-structured interviews, recordings and data. All data was treated confidentially, and all information that could identify a therapist was de-identified to protect therapist anonymity. Participant are referenced according to a pseudonym to protect their identities. An informed consent form was a requirement for all participants to inform them of the purpose and process of research and data handling. Precautions were taken to ensure that data collected from participants was managed in accordance with the University of the Sunshine Coast Data Management

Procedures. Ethics approval was received for the project by the Chairperson of the Human Research Ethics Committee of the University of the Sunshine Coast (S/19/1301).

Findings

The researcher manually coded and then imported qualitative data into NVivo. Frequency counts identified two emergent superordinate themes, "similarity of practice" and "monitoring client outcomes". Four sub-themes (alikeness, building rapport, verbal check-ins and outcome measures) were identified, see Table 1:

Table 1

The two superordinate themes with their sub-themes across all participants. Numeric values indicate the number of instances a theme occurred in a transcript.

	Emily	Julie	Martin	Susan	Instances of Occurrence
THERAPEUTIC ALLIANCE SIMILARITY					
ALIKENESS	1	1	2	5	**9**
BUILDING RAPPORT	4	1	1	2	**8**
MONITORING CLIENT OUTCOMES					
RATING SCALES	4	1	0	3	**8**
VERBAL CHECK-INS	0	0	3	1	**4**

Similarity of Practice

Alikeness

All participants reported that the therapeutic alliance was establishable in online counselling environments. Most participants described the process of forming a therapeutic alliance online as being alike to the F2F process. Martin said:

[Building a therapeutic alliance online] is still very similar. You know, you're trying to build a relationship with someone. If they were coming face-to-face, I would ask them where they're from? What they're doing? How old their kids are? What the name of their dog is? And all that sort of stuff. So you have some general chit-chat, and over the phone, it's actually as easy. So the relationship-building from that point of view is very similar and can be pretty much seen as a similar thing. (Line 57)

Susan reported that, "I treat my sessions the same. I feel like you don't have to do it [building an alliance] any differently" (line 218). Another participant said, "as far as the therapeutic alliance . . . I don't see much difference" (Emily, line 315). Although one participant reported that forming a therapeutic alliance online is more challenging than in F2F settings in their experience. However, they indicated that maintaining a therapeutic alliance online is viable, "once the connection is made [F2F], then it is okay" (Julie, line 134).

Building Rapport

Participants reported that the process of building rapport with a client in an online setting

was similar to the processes used in traditional F2F settings. Emily reported that the reality of building initial rapport with a client online was better than anticipated, "I guess I was probably thinking it would be difficult to create a rapport and make that connection with people. But in reality, I haven't really found that. I've actually found it to be, um, quite good" (line 141).

One participant provided a case example of her experience of building rapport with a client that had previously had negative experiences with therapists:

Halfway through I said, "you know what? We're not going to do this. Can you just tell me about what you love? Things that really interest you." And he told me about his Marvel, DC and Star Wars comics. I asked him to bring some into the next session. . . . And that type of thing you would do, whether it was online or not online. (Susan, line 247).

In this verbatim, Susan stated that the examples of relationship-building processes are a regular component of counselling that would be done regardless of the counselling medium.

Monitoring Client Progress

All participants reported that monitoring client progress was a regular component of their therapeutic practice. Two sub-themes emerged about monitoring client progress, "rating scales" and "verbal check-ins".

Rating Scales

Half of the participants reported using standardised outcome measures as part of their regular counselling practice both online and F2F. The measures reported included the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) (Miller, 2019). Julie discussed the implementation across different online mediums:

I'll do the Outcome Rating Scale and then the Session Rating Scale. We do that every session. Some clients don't mind it. Some clients absolutely hate it. I can do that if I'm seeing them face-to-face. If I'm seeing them on the screen we can do it that way so they can move a little indicator along to where they want it to be. If I'm doing it on the phone, I just have to ask them the

questions on the phone and write down their responses. (Line 165)

On the other hand, Susan acknowledged that the ORS and SRS were used infrequently as part of her online practice, "it's something my supervisor wants me to do. Every so often I do use the Outcome Rating Scale and Session Rating Scale" (line 287).

Verbal Check-Ins

Half of the participants reported using non-standardised feedback measures to monitor client outcomes. The reported non-standardised feedback measures had similarities to questions on the ORS and SRS. However, it was facilitated as a verbal check-in with the client and did not make use of scaling. Martin discussed the verbal process of checking in with a client in online-based sessions:

I always do check-ins, like you know . . . was this useful? What do you take away? Are we still on the right track? Am I still covering what you would like to be cover? So that feedback stuff happens anyway. (Line 93)

Susan described the process of checking-in with clients about therapeutic progress as being done consistently, despite not using standardised measures, "in terms of outcomes, I don't think that I have a standardised way that I do it. But I am checking in fairly consistently" (line 303).

Discussion

Therapeutic Alliance

A significant theme that emerged from therapists' experiences of forming a therapeutic alliance in online counselling environments was it was alike to their F2F experience. Most participants emphasised there was consistency in the process of building a therapeutic alliance online and F2F. An implication is that the medium does not have a significant impact on therapists' experiences of forming a therapeutic alliance in online environments when either a visual or auditory cue is present. An exception may be text-based sessions due to the complete absence of sensory information. Furthermore, disruptive communication can occur in asynchronous text-based sessions, as Martin reported that clients often send additional comments prior to receiving a response. It must be acknowledged that only one participant commented on text-based sessions. Therefore, further investigation into this medium is required.

A therapeutic alliance is comprised of three crucial elements: agreement on therapeutic goals, agreement on tasks and the development of a personal bond (Bordin, 1979). Early stages of therapy focus on establishing trust and rapport with a client. A person-centred framework utilises congruence, unconditional positive regard and empathy to establish a bond with the client (Seligman, 2006). Overall, participants in this study had positive experiences with alliance formation online. However, Julie perceived that online counselling 'suspends reality'. Her experience of technology was artificial and she did not perceive it to be an authentic experience for clients or herself. Although, Julie noted that an alliance can be formed online, however, it may take longer to establish than in F2F sessions. Martin reported that an alliance formed online was as effective as a F2F counterpart when facilitated via video or phone-based sessions. The participants' experiences imply that a therapists' attitude towards technology may more significantly impact a therapists' perception of alliance formation in an online environment. Therefore, factors such as personality, personal preferences, therapeutic framework and professional orientation of the therapist have a greater influence on their experience of alliance formation online.

In general, most therapists reported a preference to engage with clients F2F despite the positive experience of alliance formation. Therapists attributed their online engagement to convenience, reaching more clients and delivering continuity of care.. An interesting comment made by Julie was that online counselling fosters a stronger commitment to the therapeutic process, "the convenience of [online counselling] facilitates a more regular committed relationship, because it's as convenient as it can be for them" (line 222).

Monitoring Client Outcomes

Therapists reported being consistent with monitoring client outcomes in their online counselling practice. In particular, the participants reported monitoring client and session progress regularly. However, the process of monitoring outcomes differed significantly between participants. Research promotes the implementation of ORS and SRS measures regularly with each client (Campbell & Hemsley, 2009). Two participants reported using these standardised measures to assist in monitoring their session and client outcomes. There were significant differences in the reported frequency of use between the two participants. Julie reported using the measures consistently at each session with her clients, utilising an electronic version for video-based sessions and a verbal scale for phone-based sessions. Susan reported to use the measures infrequently in her practice and preferred to use verbal check-ins to gain feedback on progress.

Martin and Emily did not include the outcome measures as part of their practice. Both participants utilised verbal check-ins consistently with their clients each session. Their decision to not use a standardised measure to monitor outcomes was not specific to their online sessions and extended to F2F clients. A verbal check-in with the client was the most comfortable process for these participants to obtain feedback. An implication for therapists is that monitoring client outcomes can be facilitated online. Therapists use the same tools and processes online as in their F2F sessions. Therefore, the medium is less likely to impact upon a counsellor's decision to utilise a formal feedback measure. Instead, the decision to utilise a standardised measure is based on the counsellor's personal preference. Susan reinforced that the decision was a personal preference when she said, "it's something that my supervisor wants me to do. Every so often, I do use the ORS and SRS" (line 287). While Susan occasionally reported using outcome measures, she had a preference to use verbal check-ins in a non-standardised measure.

Limitations and Opportunities

Small sample sizing in the present study made it difficult to claim data saturation for participant experiences. Recruitment was unsuccessful in private and government agencies that

facilitated online counselling. Counsellors in private practice were successfully recruited via professional association distribution channels. A limitation of the study was the unwillingness of agencies to forward recruitment material to counsellors. A hypothesis for the lack of engagement amongst counselling agencies is a plausible concern that the results of the study may negatively impact their direct business or funding.

The study collected informative data regarding therapists' experiences of technological problems. However, this was outside of the scope of the research aims. In general, therapists had reported that internet instability was a cause of anxiety in their online practice. While research acknowledges the barriers of internet instability to facilitating effective online therapy, it has not directly explored the phenomena of interruptions from the therapists perspective. Further investigations into this topic may assist in improving the well-being of online counsellors facing technological problems.

Recommendations

A finding from the study was that therapist preferences were more likely to impact their experience of forming a therapeutic alliance and monitoring client outcomes online. Therefore, it is recommended therapists maintain self-awareness of personal and therapeutic preferences, as well as attitudes towards different online mediums. Each participant had a preference for the online medium that was suitable for them. Martin preferred video-based sessions, while Susan reported a preference for phone-based sessions.

Additional training specific to online counselling would not likely improve the formation or maintenance of a therapeutic alliance with online clients. Therapists indicated there was a negligible difference in forming a therapeutic alliance online compared to F2F. An emergent concern amongst therapists' was technology reliability (e.g. connectivity, drop-outs and disconnections) during sessions. Improving therapists understanding of information technology (IT) systems may improve their ability to resolve technology-based issues mid-session. It is recommended that education providers of accredited counselling courses offer elective subjects in IT. While this recommendation does not directly relate to the research question, it has broader impacts on the maintenance of a therapeutic alliance in online counselling.

The Australian Government would, ideally, prioritise the investment of additional resources to stabilise the quality of the internet in Australia. Maintaining a stable internet connection is essential for therapists to form a therapeutic alliance with clients.

Conclusion

A literature gap pertaining to therapists' perceptions of forming a therapeutic alliance and monitoring client outcomes in online counselling was explored in the present study. A qualitative inquiry utilising IPA methodology explored four therapists' experiences. All participants stated that a therapeutic alliance could be established in online-based counselling settings. Three of the participants stated that the process of forming an alliance was alike to their F2F experience. Furthermore, all participants reported monitoring client outcomes in their online practice. However, significant differences in each therapists' process of monitoring outcomes were evident. While two participants employed the ORS and SRS measures, most utilised non-standardised verbal check-ins with their clients to evaluate the therapeutic progress. The findings imply that a therapists' preconception and attitude of technology use in online counselling may determine their experience of forming an alliance with a client online, more so than the impositions of the technology itself.

Furthermore, all therapists monitored client outcomes in their online practice. The tools and processes did not significantly differ between their online and F2F session practice. Therefore, therapist preferences were likely to have a more significant role than the technology itself.

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A Research Study on Parental Psychological Control, Childhood Anxiety, and Self-Perception in Later Adulthood

Zoe Tziannis

While previous literature reports an association between experiences of parental psychological control and childhood anxiety, there is some evidence that further research is required to establish the relationship of these two concepts on self-perception later, in adulthood. This qualitative study therefore focused on adult experiences only, by examining the relationship between a person's perceived experiences of parental psychological control in childhood, self-reported childhood anxiety, and self-perception later, in adulthood. Self-perception was explored through participant's descriptions of their self-esteem and self-worth, competence and coping style, and autonomy and independence. Data from semi-structured interviews amongst six participants (four female, and two male) was analysed by utilising an inductive thematic analysis. Results supported a relationship between a person's perceived experiences of parental psychological control, self-reported childhood anxiety, and current self-perception in adulthood. Limitations, implications, and recommendations for future studies were discussed.

Keywords: *parental psychological control, childhood anxiety, self-perception in adulthood, thematic analysis*

Introduction

There is considerable research in relation to controlling child-rearing styles, and their relationship to the psychological development of children. There is also empirical evidence to suggest that psychologically controlling parenting may create a psychological strain towards the healthy development and functioning of a child, particularly towards the child's cognitive state, and emotional well-being (Bilal, Sadiq, & Ali, 2013; Schleider, Vélez, Krause, & Gillham, 2013). Barber (1996) particularly claims that parental psychological control may be categorised as a separate dimension of child-rearing behaviours that involves a constriction, and a lack of encouragement of a child's psychological autonomy, as well as an invalidation and manipulation of a child's emotional experience (as cited in Wei & Kendall, 2014).

Research by Pereira, Canavarro, Cardoso, and Mendonça (2008) supports this, suggesting that high parental psychological control (in the context of a poor emotional climate), may be perceived by the child as an attempt by their parents to restrain personal autonomy, and to retain power within the parent-child relationship. The regulation of feelings, emotions, and opinions of the child is therefore a key characteristic of psychologically controlling parenting (Ozdemir, 2012; Soenens, Vansteenkiste, & Luyten, 2010). Scanlon and Epkins (2015) suggest that shaming, guilt induction and love withdrawal are all inclusive features of the covert form of control that psychologically controlling parents typically display towards their children. Consequently, psychological control has been associated with parental criticism, parental rejection, and a lack of emotional warmth (Settipani et al., 2013) (as cited in Scanlon & Epkins, 2015).

Literature Review

There is empirical support for a relationship between psychologically controlling parenting, and children's internalising symptomatology including anxiety symptoms (Scanlon & Epkins, 2015). According to Spielberger (2014), 'The term anxiety is used to describe an unpleasant emotional state that is characterised

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Zoe Tziannis is a prior Counselling and Psychotherapy student at the Australian College of Applied Psychology. Her interests include mental health and well-being, client-centred and strengths-based therapy, child welfare practice and working with vulnerable children, and child-centred play therapy. She has studied this topic because she wanted to increase her understanding of her personal exposure to the later-life effects of psychological control within her own family, particularly within the context of self-perception in later adulthood.
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by subjective feelings of apprehension and worry, and is evoked whenever an individual perceives a stimulus or situation as harmful, dangerous, or threatening' (p. 482). It is important to highlight that childhood anxiety may present within the child in various forms, as a result of the child's psychologically controlling parenting experience. This includes social anxiety, which is supported within various research findings (Festa & Ginsburg, 2011; Segrin, Givertz, Swaitkowski, & Montgomery, 2015; Lewis-morrarty et al., 2012).

It has been evidenced that child-rearing styles that are marked by high psychological control, and are characterised by intrusive strategies in order to manipulate the child's thoughts, feelings and activities, are especially correlated to youth anxiety (Schleider et al., 2013). It is theorised that parental psychological control leads to childhood anxiety by reducing the child's experience of mastery towards the challenges presented within their environment (Niditch & Varela, 2012). To support this, research by Affrunti and Ginsburg (2011), demonstrated that parental controlling behaviours restrict a child's access to their environment, and they communicate to the child that there is an overbearing amount of threat that the child will not be able to cope with, or master on their own. This consequently reduces the opportunity for the child to develop competence and mastery and control within their environment, heightens their anxiety, and creates worry about their abilities, which may further facilitate negative self-schemas (Affrunti & Ginsburg, 2011; Ballash et al., 2006; Schleider et al., 2013). These negative child outcomes could result in low levels of parent–child closeness and self-worth, and high levels of depression and anxiety for the child (Nelson, Padilla-Walker, Christensen, Evans, & Carroll, 2011) .

Research by Kincaid et al. (2011), further supports the relationship between parental psychological control, childhood anxiety, and its negative impacts towards the emotional well-being of the child. These researchers establish that for youth with higher levels of internalizing problems, the intrusive and critical style of psychologically controlling parenting may deprecate the child's self-worth, leading to the development of negative self-schemas such and feeling unworthy and unlovable (Pettit et al. 2001), and increases in worry, guilt, and withdrawal. Prior findings further suggest that parental failure to promote autonomy to the child, may also increase the chances of internalising problems for the child by undermining the child's development of independence, and competence (Kunz & Grych, 2013).

Other researchers (Verhoeven, Bogels, & Bruggen, 2012; Kunz & Grych, 2013; Stone et al., 2013; Laurin, Joussemet, Tremblay, & Boivin, 2015; Affrunti & Woodruff-borden, 2015; Borelli, Margolin, & Rasmussen, 2015) have moreover revealed that psychologically controlling parenting behaviours display a significant role for the development of childhood anxiety symptoms. The research by Stone et al. (2013), only investigates a sample of children ranging from ages 4 to 8 years however, implying that results cannot be generalised to other age cohorts. Laurin et al. (2015) utilise a distinct set of terminology in their study when referring to controlling parenting, such as the term 'over-protective parenting', as opposed to 'psychologically controlling parenting'. This heightens the likelihood for ambiguous research findings, because it becomes difficult to clarify any differences between the variant set of terms that are used to describe parenting styles that are characterised by parental control. Furthermore, the rare longitudinal study by Borelli et al. (2015), could not implicate direct causality within its findings. These inconsistencies present as shortcomings towards the prior literature.

Although the widespread findings discussed above share strong commonality, there still remain gaps amongst various cohorts that are presented within the existing literature. It appears that there may be some study design limitations within prior research relevant to this topic. For example, some studies appear to be limited to particular age cohorts, or appear to lack the inclusion of cultural diversity. This makes it difficult to generalise the research findings, and to clearly determine whether psychological controlling parenting uniquely affects children of various ages, and cultures. Single-informant studies are overused within this research field, which creates difficulties in inferring cause-and-effect relationships due to the lack of longitudinal approaches. Additionally, the topic would be increasingly understood through the utilisation of more qualitative study designs. The reason for this is because it is important to derive more meaningful information on people's lived experience, perceptions, or interpretations of these childhood experiences, rather than merely focusing upon cause-and-effect relationships.

Mechanisms of transmission within these studies are also often poorly understood which may create additional inconsistency within the presented research. Further research regarding the joint effects of the various variables presented in the literature therefore need to be better examined. The diversity and complexity of the conceptualisation of relevant terms for 'controlling parenting' moreover create uncertainty, and ambiguity within prior findings. Lastly, there is a need for developed understanding regarding how childhood experiences of parental psychological control, and childhood anxiety, relate to a child's later life outcomes in adulthood, including self-perception styles. It is therefore important to note that this study will only examine adult experiences that are relevant to the research topic.

Parental psychological control within childhood has been associated with psychological vulnerability later, in adult life, with increased levels of dependency, lower self-esteem, and lower coping abilities (Bilal et al., 2013). Although there is substantial empirical support demonstrating the relationship between parenting behaviours and a child's internalising symptomatology, it remains unclear whether the child's emerging self-schemas that are driven by parental psychological control (such as low self-esteem), and childhood anxiety symptoms, are carried through to their later, adult life. Gaps particularly remain within the literature regarding the relationship between the child's perceived experience of parental psychological control, childhood anxiety, and their self-perception later, in adulthood (Scanlon & Epkins, 2015). This validates the motivation to explore these associations, because it contributes valuable information towards counsellor understanding and awareness of how parental psychological control, and childhood anxiety symptoms relate to later adult functioning, and adult life outcomes.

This research study therefore aims to identify the relationship between parental psychological control, childhood anxiety and self-perception later, in adulthood. The study relies on participants' perceived experiences of parental psychological control, and anxiety symptoms within childhood. Self-perception in adulthood is explored through participants' self-described self-esteem, competence and coping styles, and autonomy and independence.

Methodology

A qualitative research methodology was utilised in this

research study to explore how people make sense of, or perceive their childhood, and later life experiences relevant to psychological controlling parenting, and childhood anxiety symptoms. Interviews were conducted and analysed using thematic analysis to gain a heightened understanding of participants' subjective experiences of reality, meaning making, and lived experience, as opposed to cause-and-effect relationships (Charmaz, 2006).

Materials and Method

Participants

Individuals aged over 25 years and who identified as experiencing childhood anxiety and psychologically controlling parenting were invited via recruitment advertisements distributed through various Australian College of Applied Psychology (ACAP) Facebook groups, the ACAP student lounge, and on the volunteering section of the website, Gumtree Australia. These advertisements invited the respondents to contact the researcher for further information about the study. Six respondents agreed to be interviewed about their experiences, and interview times were arranged.

The six participants (4 female, and 2 male), were aged between 25 and 52 years. All participants lived within Australia, with the following countries of origin: Australia, Chile, Scotland, and Vietnam.

Procedure

The Navitas Professional Institute Human Research and Ethics Committee (HREC) approved the research study, which permitted the researcher to advertise, and recruit participants for the study. Interested respondents were directed to a Participant Information Sheet to ensure that the respondent had read, understood the conditions of the study, and the consent process. Informed consent was then obtained by proceeding respondents, which involved signing a consent form electronically, and directing it back to the researcher. The researcher shortly after organised a suitable time and date to conduct either a Skype, or face-to-face semi-structured recorded interview with the participant.

The face-to-face interviews were conducted in confidential counselling rooms, at the ACAP Melbourne campus. Prior to the interview, each participant was provided a brief overview of the interview schedule by the researcher, and the interview was conducted shortly afterwards. Skype was the preferred method of interviewing, Amolto call recorder for Skype software was used to record the interviews, and most interviews lasted for approximately 30 minutes, to 1 hour. All recorded interviews were safely stored onto a USB, and were contained within a secure folder on the researchers' personal computer. Interview transcripts were stored in the same manner.

Materials

Semi-structured interviews were used in this research study. This method of interviewing allowed for a holistic approach, and was able to elicit data that was grounded in the experience of the participant (Galletta, 2012). The semi-structured interviewing technique also allowed the opportunity for participants to respond in a deep and coherent manner, whilst having the latitude to be explorative (and unrestricted) during the interview process (Hesse-Biber, 2017).

There were a total of six questions within the interview schedule, which consisted of both open and closed ended questions. The first set of questions commenced with participant demographics, and asked participants to describe some events that incorporated experiences of perceived parental psychological control within their childhood. This followed by whether participants could elaborate on how childhood anxiety, may have contributed to these described childhood experiences. It should be noted that definitions of the key concepts 'parental psychological control' and 'anxiety' were provided to participants prior to being asked to respond to the first set of questions, to avoid any misinterpretations of common terminology.

The second half of the interview asked questions relating to self-perception styles in the participant's current adulthood, as a result of these perceived childhood experiences. Participants were invited to talk about these current self-perception styles relevant to their self-described self-esteem and self-worth, competence and coping styles, and autonomy and independence. Please refer to Appendix B for a detailed copy of the interview schedule that was used in the recorded interviews.

Data analysis

The research study used an inductive thematic analysis in order to develop appropriate codes and locate meaning in the data, thereby allowing for a more comprehensive understanding of the concepts of interest (Boyatzis, 1998). Braun and Clarke's (2006) six phases of thematic analysis were used; namely, the familiarisation and transcription of the verbal data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report.

When all participant interviews were finalised, the verbal data from the audio recordings was transcribed. This process incorporated frequent audio recording pauses by the researcher in order to develop a deep, and concise understanding of the spoken content before commencing the coding process. Familiarisation with the transcribed data was then ensured, and this involved multiple and repeated transcript reading attempts, and sufficient note-taking of any common, or interesting concepts. Through the close examination of the transcribed data, the researcher then utilised open-coding techniques to generate an emergent set of categories, otherwise referred to as initial codes (Ezzy, 2002). The data analysis' coding process required meaning-making, and in order to eliminate any preconceived biases and to increase clarity during the interpretation of the data, bracketing interviews were held between the researcher, and their research associate (Tufford & Newman, 2010; Rolls & Relf, 2006). These bracketing interviews focused on regular discussions about the researcher's impressions of the data with their research associate, whilst being open to new suggestions, or to any alternate interpretations. This ensured the validity and reliability of the data analysis.

Themes and sub-themes were later developed from these emergent categories, which were assigned names and definitions (informed from the data).

Results

Three primary themes, each containing three sub-themes, were identified in this thematic analysis. Sub-themes were accompanied by transcript quotes (refer to Appendix A for additional quotes). Themes and sub-themes were labelled as follows:

Theme 1: Parental psychological control aspects;
(a) Dismissal and rejection
(b) Controlled emotional state
(c) Lack of validation.
Theme 2: Anxiety in childhood;
(a) Physical sickness
(b) Withdrawal and social avoidance
(c) Internal pressure.
Theme 3: Self-perception in adulthood;
(a) Self-esteem and self-worth
(b) Coping, control and competence
(c) Autonomy and independence.

Participants were de-identified by allocating a number to the prefix RP (Research Participant). Labels ranged from RP1 to RP6.

Theme 1: Parental psychological control aspects

Participants commonly agreed that psychologically controlling parenting towards them as children, could be typically characterised as dismissive, invalidating, manipulative and controlling of their emotional experience.

1.1 Dismissal and rejection. Participants' comments coded to this sub-theme highlighted a perceived lack of emotional warmth from psychologically controlling parents towards their children. This was evident in experiences of parental avoidance, dismissal and rejection, and coldness towards the child's thoughts and emotions. RP1 and RP2 described their parent's instant rejecting or dismissive attitude towards their thoughts and emotions as children. RP3 felt that her parents avoided and dismissed expressions of her thoughts and emotions because they considered this to be a disrespectful and offensive act, as the following quotes demonstrate:

Anytime I wanted to talk about something, they'd try to avoid it and they told me another thing (RP3. 100), and I expressed my feelings but they saw that as something against them and offensive (RP3. 129 - 130).

1.2 Controlled emotional state. A controlled emotional state for some of the participants was typically characterised by a restriction of freedom towards the child's self-exploration of their thoughts and emotions. Participant RP1 mentioned having no input within parental discussions regarding her life and believed that she was not allowed to feel emotional due to her father's rejecting demeanour, while RP3 felt that she was not allowed to explore her feelings with her parents and that fights would escalate if she did. RP5 stated that his parents controlled his emotions by telling him to stop feeling a certain way, inducing self-guilt and a lack of freedom to self-explore his thoughts and emotions, as shown in the following quote:

There was never any consideration from either side that they might be wrong, it was 100% you're wrong, so being able to try to resolve that in my own mind was awful (RP5. 144 - 146).

1.3 Lack of validation. Participants perceived parental invalidation tendencies, when their parents criticised, denied, ignored or ridiculed their feelings or perspectives, as children. RP1 mentioned that whenever she confided her feelings as a child, her father would reiterate that she was being irrational. RP2, RP3 and RP5 all described parental tendencies to deny whatever they would express by denigrating their thoughts and emotions. For example, RP2 spoke about her mother as follows:

Her way of dealing with that was to basically deny everything, so to say that I was a liar, and that none of those things ever happened (RP2. 38 - 39).

RP3, RP4, RP5 and RP6 perceived a minimal effort from their parents to understand their emotions as children, and RP3 and RP6 described their parents' tendency to shame, ridicule, or belittled them as a child, as RP6 states the following:

There was no-one to kind of explain it to me, it was just a whole attitude of 'Don't be so bloody ridiculous' (RP6. 60 - 61).

Theme 2: Anxiety in childhood

Anxiety symptoms due to the parental psychological control, were characterised by physical sickness, social avoidance and internal pressure within the participants, as children.

2.1 Physical sickness. Participant RP1 remembered physical anxiety symptoms such as feeling 'knots in her stomach' as a child, while RP2 described wanting to throw-up when verbally describing her emotions as a child:

The thought of discussing emotions or feelings would basically just make me want to throw-up (RP2. 189 - 190).

2.2 Withdrawal and social avoidance. Participants RP2 and RP5 described their childhood anxiety symptoms as creating withdrawal and social avoidance strategies. For RP5, feelings of physical sickness became an excuse to avoid uncomfortable situations. Anxiety symptoms led to a lack of social relationships, not belonging or feeling uncomfortable in groups, and the inability to relate well to others, as RP5 explained:

Mum tried to get me involved in activities and stuff like that when I was a kid, but I felt very uncomfortable and self-conscious, like you go to one session and then you just stand in the corner feeling different (RP5. 207 - 210).

2.3 Internal pressure. Participants RP2 and RP5 shared the commonality of facing the internal pressure of performance anxiety and adhering to high parental expectations in childhood, with RP2 describing this as:

I carried a lot of the not feeling good enough thing so that made me really anxious, so particularly through school, the thought of not getting straight A's was terrifying (RP2. 158 - 160).

RP3 alternatively described the internal pressure of feeling 'hated' due to her parent's demeanour towards her as a child, including the fear and threat of physical punishment. Internal pressure was similarly described by RP4, where physical punishment was inflicted upon him by his parents through a behaviourally controlled manner. RP6 lastly described the internal pressure of feeling terrified as a child due to the lack of parental emotional warmth and security.

Theme 3: Self-perception in adulthood

Self-perception in participants was explored through self-described self-esteem, coping, control, competence, autonomy and independence styles, as adults. Comments generally indicated lower self-esteem, coping and competencies at some point within their later, adult lives.

3.1 Self-esteem and self-worth. All participants perceived low self-esteem at some point of their adult lives, largely described as insecurity, self-consciousness, and a lack of confidence. Other descriptors included fear of failure (RP2, RP5 and RP6), and feelings of inadequacy, not being good enough or at the right level, fear of judgement, and approval seeking (RP1, RP2, RP5 and RP6) in later adulthood. RP6 described these doubts:

What I found I'd do a lot of times when I hated it, is you know if you cook someone a meal you'd be like 'Oh my God, was it okay? Was it good enough?' (RP6. 143 - 145).

3.2 Coping, control and competence. Avoidance, delay, or withdrawal of life tasks was evident amongst RP1, RP2, RP5 and RP6, and described as a coping, control and competence strategy:

I probably have a withdrawal style and if things become really rough, my first instinct is always to withdraw and kind of pull back away from it (RP1. 228 - 230).

Participant RP3 explained that she lacked competence towards emotional expression particularly in adult relationships, while RP2 and RP6 demonstrated a lack of control within adult relationships. RP2 and RP6 utilised motivation strategies in order to cope with daily life, and RP4's coping skills developed through the practice of optimism and through resilience levels in adult life. RP5 emphasised a lack of control, or direction within his environment.

3.3 Autonomy and independence. The majority of participants offered feelings of autonomy and independence towards daily life. RP1, RP4 and RP6 related independence to living alone, as RP4 explained:

I guess I'm quite independent, I live out of home and I get by (RP4. 174 - 175).

Participants RP2, RP3, and RP6 stated their adaptation to managing life tasks independently. RP5 alternatively commented on his reliance on others and on his reluctance towards declining tasks that disinterest him:

If there's something that someone wants doing, then I feel very uncomfortable saying no, even if it's something I'm not particularly interested in (RP5. 495 - 497).

Discussion

This study aimed to identify the relationship between parental psychological control, childhood anxiety and self-perception later, in adulthood. Self-perception in adulthood was explored through participant's self-described self-esteem and self-worth, competence and coping styles, and autonomy and independence. Results supported a relationship between a person's perceived experiences of parental psychological control, childhood anxiety, and their self-perception later, in adulthood. This research study also supported prior research by demonstrating similarity and consistency within the two common concepts of this study known as parental psychological control, and childhood anxiety. It particularly supported prior literature regarding the negative impacts of psychologically controlling parenting towards a child, and the relationship between parental psychological control, and childhood anxiety.

As similarly stated by Ozdemir (2012) and Soenens et. al. (2010), results in this study supported findings that the regulation of feelings, emotions, and opinions of the child is a key characteristic of psychologically controlling parenting, and is thus restrictive of a child's psychological autonomy (Wei & Kendall, 2014; Pereira et. al., 2008). Similar to the research findings of Wei and Kendall (2014) and Scanlon and Epkins (2015), the results of this study demonstrated that psychologically controlling parenting may be perceived as a form of parenting that is dismissive, invalidating (including shaming and guilt-inducing tendencies), manipulative, and controlling of a child's opinions, and emotional experience.

It was evident in this study that psychologically controlling parenting behaviours also related to childhood anxiety symptoms for the child, and these results replicated the findings of previous researchers (Affrunti & Woodruff-borden, 2015; Borelli et al., 2015; Kunz & Grych, 2013; Laurin et al., 2015; Stone et al., 2013; Verhoeven et al., 2012). Results in this study supported prior research findings relating to the relationship of parental psychological control, and childhood anxiety, within the domain of social anxiety. It was demonstrated that higher levels of parental psychological control, related to increased levels of social anxiety symptoms in children (Festa & Ginsburg, 2011; Lewis-morrarty et al., 2012; Segrin et al., 2015), including withdrawal, and social avoidance tendencies.

Participants in this study also perceived the experience of their childhood anxiety as associated to physical sickness, and to internal pressure. Internal pressure was related to performance anxiety for a few participants, and this was associated to fears of failure or not adhering to parental expectations, and to perfectionism in childhood. This is supported by findings from Elliot and Thrash (2004) and Soenens et al. (2005), who also found linkages between psychological control, fear of failure, and maladaptive perfectionism (as cited in Luyckx et al., 2007).

Although prior research found consistency and similarity regarding the relationship between parental psychological control, and childhood anxiety symptoms, these findings were limited to the relationship that these two concepts have within childhood. However, the findings did not clearly address how the experience of these two concepts within childhood, relate to the child's later life outcomes. For this reason, this study addressed this inconsistency and therefore explored the relationship between parental psychological control, childhood anxiety, and self-perception later, in adulthood. This relationship was supported in this research study.

Psychologically controlling parenting behaviours that were perceived as dismissive, rejecting, controlling and invalidating, and associated feelings of childhood anxiety involving physical sickness, social withdrawal and internal pressure, were associated with lower perceptions of self-described self-esteem, competence, and coping style, in later adulthood. Results from this study therefore suggested that typical self-schemas that a child experienced as a result of parental psychological control within childhood such as low self-esteem, and low coping abilities generally persevered later, in the child's adulthood. For example, for some of the participants, withdrawal tendencies persisted later, in adulthood. This is relevant to the research of Kincaid et al. (2011), who suggest that withdrawal tendencies may become prevalent within early-onset childhood, as a result of the child's experience of parental psychological control, and childhood anxiety.

Participant perceptions of lower self-esteem, competence, and coping styles later, in adulthood, was an interesting finding. It appeared that their perceptions of their competence, and coping styles, were significantly influenced by their perceived levels of self-esteem. For example, some participants stated knowing that they were competent through being able to manage life tasks, though convinced themselves otherwise, as a result of their low self-esteem levels. However, results did suggest that participant self-perceptions of low self-esteem, and low competence and coping styles, had potential for development or improvement through factors such as lived experience, resilience, optimism, and intrinsic motivation levels later, in adulthood. The self-determination theory (Deci & Ryan, 1985) may explain these findings, since it proposes that inherent human growth tendencies, and the innate psychological needs

for human competence, relatedness, and autonomy, are the basis for the self-motivation to foster constructive social development, and personal well-being (Deci & Ryan, 2000).

Unlike their perceptions on self-esteem, and competence and coping styles, most of the participants unexpectedly perceived their autonomy and independence levels ranking rather higher as opposed to lower, in adulthood. Since the restriction of personal autonomy is a central characteristic towards the relationship between parental psychological control, and childhood anxiety (Barber, 1996) (Wei & Kendall, 2014), participants were expected to perceive their autonomy and independence styles as lower, in later adulthood. This is because the findings suggested that childhood self-schemas persist later, in adulthood. It is therefore unclear whether participants may have misconceived, or misinterpreted these two concepts, since there are various meanings or conceptions that could be attributed to the constructs of autonomy and independence. Since participants appeared to limit their conceptions of independence to either life adaptation, or to living alone, this may have also contributed to the unexpected results. Participants may have also perceived the construct of autonomy as being similar to the construct of independence, which may have created further ambiguity within results.

Limitations

This research study presented with considerable limitations that may have created ambiguity, or inconsistency within the findings. It should be restated that this study relied on participants' perceptions regarding their experiences of parental psychological control, childhood anxiety, and self- perception later, in adulthood. This suggests that the accuracy of these subjective childhood experiences, cannot be determined. There may have also been misconceptions relating to the definitions of the self-perception constructs, and therefore may have been interpreted in unique, or individual manners for some of the participants. This may explain the unexpected results from one participant who uniquely perceived his autonomy and independence levels as being lower, compared to the other participants.

Secondly, it is important to present cultural aspects as another limitation towards this study. There was a lack of cultural diversity, meaning that results cannot be generalised. It is worthwhile to also note that there may have been cultural discrepancy regarding the interpretation of the concept 'psychological control', versus the concept of 'behavioural control'. This misconception became evident in areas where some participants talked about physical punishment, suggesting that they may have confused this parental act as a form of psychological control.

Furthermore, it was unclear whether parental psychological control was also seen as a positive form of parental guidance and discipline as opposed to only being viewed negatively, when comparing different cultures. Age, and gender variations were not measured or accounted for, and the research study may have presented with an over-representation of female participants. Prior counselling experience, mental health conditions, and substance dependence were moreover not controlled, as well as other life influences that may have contributed towards self-perception in adulthood, other than parental psychological control, and childhood anxiety.

Implications and future recommendations

Despite the shortcomings in this research study, the findings have posited advantageous implications for both the counselling field, and to the development of future research. Firstly, the study informs new knowledge for current researchers regarding how childhood experiences shape, and impact a person later, in adulthood. Secondly, the study informs developed counselling understanding regarding the relationship between parental psychological control, and childhood anxiety later, in adulthood, which may increase counsellor awareness of what factors, or life influences relate to self-perception styles in adulthood. This may inform developed counsellor understanding towards a client's presenting issues in adulthood, and may further inform the various ways that a counsellor could beneficially work with clients of this nature. It is important to furthermore mention that findings within this research imply that life factors such as resilience and optimism levels, have the capacity to foster positive change towards negative self-perceptions styles later, in adulthood (in respect of the self-determination theory).

Future recommendations for this study would suggest that the limitations that have been described above be controlled for, in any attempts to replicate this study. It would firstly be important to measure, and regulate any other life factors that could be contributing to self-perception styles in adulthood, other than the childhood experiences that were explored in this study. In order to develop the understanding of, or compare cultural, gender, and age variations within this research topic, it is particularly important to consider the possibility of controlling for these cohorts in future research. Cognitive abilities, or the presence of mental health illnesses should be controlled for, as these factors may largely influence or distort participant cognition styles. External influences such as substance dependence should also be controlled for, for the same reason. Lastly, it remains unclear whether any prior adult counselling experiences may have advantaged some participants, compared to others who had never sought adult counselling services. This should therefore be another consideration for future research.

The contribution of its research findings, and importance of this research study towards the counselling field, should be restated. This research study has contributed to the field by helping to develop an increased counsellor understanding of how childhood experiences may determine, or influence the human experience later, in adulthood; particularly, how childhood influences may have contributed to a person's self-schemas later, in adulthood, including their beliefs and generalisations about the self, and their psycho-social experiences. The findings of this research study aim to encourage counsellors to enhance their awareness of human development, by reflecting on other potential life factors that may influence self-perception levels in later adulthood. For example, counsellors could enhance their understanding regarding how optimism, resilience, and motivation levels relate to, or influence self-perception in later adulthood.

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Appendix A

Themes and sub-themes	Transcript Codes
Theme 1: Parental psychological control aspects	
1a. Dismissal and rejection	*Whenever I would have a discussion with my dad, at any time I would get emotional about anything, it would be shut down straight away and it's like 'Well I can't talk to you if you're being emotional like this' (RP1. 45 - 48)*
1b. Controlled emotional state	*They always did not allow me to express my feelings… or when I expressed my feelings I would get very upset, and I then would become angry so we would sort of start to fight and always yell (RP3. 104 - 106)*
1c. Lack of validation	*That was something that she did quite often, if I said that she was quite dismissing of my feelings or my thoughts in general (if they were negative towards her), or if I said that I felt upset by something she had said, she'd say 'Well that's not right', and kind of just move on (RP2. 54 - 57)*
Theme 2: Anxiety in childhood	
2a. Physical sickness	*I can remember always having knots in my stomach all the time when I was little. I remember my mum would always rub my belly because I always thought I had a bad stomach. I look back now and I realise that it was actually anxiety and nervousness (RP1. 108 - 112)*
2b. Withdrawal and social avoidance	*As a child, as I reached mid to late teens, I felt more of the social anxiety starting to come out, like really not liking any kind of groups, or only being able to handle say like maximum 2 or 3 people in a group setting at a time (RP2. 173 - 176)* *I think that I had extremely bad social anxiety and stuff like that as a kid, which caused me to probably take a lot of time off school and say I was sick or had a headache, when I didn't necessarily have that much of a headache (RP5. 203 - 206)*
2c. Internal pressure	*I was very anxious about doing or performing in front of other people… like I really liked drawing but I never drawed in front of other people because if I put a line in the wrong place, it wasn't perfect. I'd never write any creative pieces in class and I'd just leave a blank page because if I wrote something embarrassing or not perfect, I would feel like I failed or very humiliated (RP5. 224 - 230)* *Anxiety and fear was 100%, I often cried and panicked and stuff like that. I didn't handle those things well. Yeah um, I was always afraid of the punishment, or the screaming or whatever (RP4. 78 - 80)*
Theme 3: Self-perception in adulthood	
3a. Self-esteem and self-worth	*I probably shy away from maybe a few things that I wish you know, I probably would have liked to have done but I've never kind of felt that I could aspire to do that because you know, for whatever reason I don't have the ability, or led to believe I don't have the intelligence (RP6. 191 - 194)* *There is just that part in my head that tells me 'No, it's not quite enough' (RP1. 157 - 158)* *It feels interesting because really, I do quite well in university and work and that kind of thing, but I am constantly feeling that really tight chested anxious, like genuinely anxious feeling of this isn't going to be good enough, they're gonna fire me or just something stupid like that (RP2. 248 - 251)*
3b. Coping, control and competence	*Even for me to go to Bali on my own, that was huge… absolutely huge! Before I felt like I always needed someone to hold my hand to go to places to do something, whereas now I don't… and I do think it's made me a lot stronger overall (RP6. 198 - 201)* *I dropped out of school even though I was the top of my class all the time, but now*

	I'm back at school so I've managed to sort of overcome it, but it's definitely taken a few years away from me having to cope with that. I look at it it now sometimes and think that I could have done this already 5 years ago (RP1. 135 - 140) *I'm just only now completing a Bachelor's degree having attempted to do one 3 times in the past and not being able to continue it because I couldn't get a whiff of my need to be perfect (RP5. 382 - 384)*
3c. Autonomy and independence	*I'm very independent because my parents allowed me to learn and they forced me to do things on my own growing up (RP3. 300 - 302)* *I feel quite independent because I feel like I transitioned into doing a lot of things by myself (RP2. 391 - 392)* *I think I'm quite reliant on others, yeah I don't feel independent, I don't feel financially independent (RP5. 474 - 475).*

Appendix B

Interview schedule

1. Please provide your age, gender and country of origin.

2. Key features of parental psychological control include intrusive parenting, rejection and a lack of emotional warmth from a parent towards their child.
   Psychologically controlling parents particularly control a child's emotional state of beliefs and internally pressure the child's feelings, which restrict freedom for the child to explore things on their own. Parental psychological control is also widely based upon the child's perception of control.
   (Nb. This statement will be read out to participants first making sure that they understand it, and then the following open-ended question will be asked).
   I'd like you to think about any specific parenting behaviours and events in your childhood where you feel this definition of parental psychological control could apply, and describe them to me. For example, events and instances where you felt powerless, felt self-doubt or shame and/or lacked freedom to explore the world on your own?
3. Anxiety is described as an internal feeling of worry, nervousness or unease relating to a threatening event.
   You've just described some examples of parental psychological control from your childhood. Now I'd like you to think about whether these examples could be related to feelings associated with anxiety in your childhood. Please describe this.
4. There is some evidence that psychologically controlling behaviours reduce the opportunity for a child to develop competence, and mastery and control within their environment, which heightens their anxiety and creates worry about their abilities.
   Please briefly share how you personally relate to this statement in your current adult life.
5. Please now rate the difficulty level towards mastering adult life on your own as a result of your experience of parental psychological control as a child, on a scale from 1 to 10 where (1 = not difficult at all, 5 = mildly difficult and 10 = very difficult).
6. The child's heightened insecurity and worry may further facilitate negative world views about the self.
   a) Please describe how you currently perceive your self-esteem/self-worth as an adult.
   b) Please describe how you currently perceive your competence and in-dependency as an adult.
   c) Please describe how you currently perceive your coping style and your current thoughts on your autonomy (freedom) style as an adult.