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Editorial

Volume 14, Issue 2 - 2020. Dr Ann Moir-Bussy

Greetings to all our readers and apologies for this second issue of 2020 being a little late. And what a year it has been for so many with the pandemic spreading so widely across the world and still raging at the beginning of 2021. We pray you are all keeping healthy and safe and navigating these difficult transition times.

We have in this issue a series of very interesting and informative articles. We are delighted to begin with how music therapists provide safety for children who have had traumatic experiences. Cindy Lai, Grace Thompson and Katrina McFerran, experienced music and expressive therapists, present a critical interpretive analysis examining multiple perspectives on how safety is described in the music therapy literature. They find the positive aspects that are referred to, but also that there is little information evaluating and describing the participants' responses and feedback, recognising the need for further research in order to understand this phenomenon.

James Yu, from Hang Seng University in Hong Kong discusses Hong Kong undergraduate students' perceptions of creative class work in counselling and psychology courses. This is a qualitative study and students shared their appreciation of creative class activities and shared concerns that reflected values and characteristics of the local culture.

Continuing on from her in depth research into caring for loved ones living with Alzheimers, Judy Boyland and co-authors examine the implications for counselling and psychotherapy. She poses key questions for therapists working in this vital area and how best they can support the caregivers who are often tested to the limits of emotional and systemic survival.

In the next article, Valerie Ringland brings a critical insight into the healing of trauma in sexual violence in Indigenous communities. She discusses the importance of healing being a collective responsibility to transform culture and the value of healing not only for victims, but also for bystanders (family and friends), and offenders. Herself, a survivor of sexual abuse, presents as the indigenous trauma healing tool, the concept of empathic dialogue, and engaged in a researcher-participant role to gather vital data with potential for public policy and practice.

Kunzang Chophel, Ph D candidate at Charles Darwin University, and from Bhutan, recognizes mindfulness as central to counselling practice. After participating in a Post Graduate Diploma of Guidance and Counselling program that was delivered in Bhutan in collaboration with Naropa University, Chophel offers a beautiful reflection on mindfulness practice, known as being 'brilliant sanity" This is indeed an inspiring article.

Our final article is from Bernard W.S. Fan, another Ph D candidate and at Curtin University in Western Australia. He is also a Rural Family Counsellor, Gambling Counsellor and Alcohol and Other Drug Counsellor in Australia. Here he explores the factors that lead to the development of a gambling problem and what is essential for motivation to change gambling patterns of behaviour. The author intends to follow this research with a quantitative study to test the new grounded theory he has found.

Editors

Dr Tarquam McKenna
Deakin University
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University of Sunshine Coast

We already have submissions coming in for the first issue of 2021 and encourage you all to please consider sharing your reflections and research in order to support counsellors and psychotherapists internationally. There is so much valuable work being undertaken and it vitally important to continue to publish examples of practice that demonstrate efficacy and sound evidence of the effects of such practice.

There will also be a special issue coming out in mid-2021 – *International Counselling and Counselling Supervision* with Dr Nadine Pelling as guest editor. It is an issue not to be missed.

May 2021 bring much needed healing to all those affected by COVID 19 and all those who have lost loved one. Let us be inspired by the words of the poet Rumi and as counsellors be the vehicles of that healing:

Dr Ann Moir-Bussy
Editor

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Examining How Music Therapists Describe Providing Safety for Children and Adolescents Who Have Had Traumatic Experiences: A Critical Interpretive Synthesis

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This paper presents the result of a critical interpretive synthesis (CIS) that examines how safety is created, explained and represented in the current literature of music therapy trauma recovery programs. Creating a sense of safety is fundamental when providing programs for people who have had traumatic experiences. However, minimal music therapy literature has presented detailed descriptions of constructing safety in the program. The investigators examined a total of twenty-two manuscripts with the intention of gathering multiple perspectives on how safety is described. We first identified the meaning of safety and different vocabulary used by the authors to represent safety taking account of the clients' state of mind, the relationship with the therapist and/or the peers, and the environment. We discovered that the therapists' decisions about using different engagement strategies might have the most impact on creating a sense of safety in programs. These engaging strategies included providing structure, active listening, giving the participants control over the activities and offering choices.

Moreover, it appears that when a trusting relationship was established in the program, a sense of safety may be created. However, there was little information provided in the manuscripts describing or evaluating the participants' responses and feedback about their feelings of safety. To conclude, we suggest the lack of detailed descriptions of how safety is created demonstrates the need for more studies to understand the phenomenon better.

Keywords: *safety, critical review, children, adolescents, childhood trauma*

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Providing a sense of safety is central when working with people who have experienced trauma. However, the notion of safety may have different dimensions and is difficult to define. In reviewing the popular trauma-informed care theory (SAMSHA, 2015) to find the descriptions as the first step when establishing the program and that both physical and psychological safety is considered a high priority. However, one of the limitations with this explanation is that it does not explain in more detail what safety means. Only one trauma-informed program provided a more detailed explanation about safety (Bloom, 2017). The Sanctuary Model suggests there are four levels of safety when dealing with people who had been through trauma, as detailed here.

- Physical Safety: being safe in one's body and an environment free of threats.
- Psychological Safety: being safe with oneself and being able

to display self-control, self-discipline and self-protection.
- Social Safety: being in a safe environment and feeling secure, trusted and supported by others.
- Moral Safety: being safe in an environment that has a structure supported system.

These descriptions present safety in different aspects and provide directions for us. However, we had not yet found a convincing elaboration of safety until we came to Haigh's (2013) article explaining the five principles of creating a therapeutic environment. He describes safety as a containment; "the structural features which embody the principle of containment, and make a therapeutic environment feel safe, are about support, rules and holding the boundaries" (p.9). This suggests that containment is implicated in all aspects of safety (physical, psychological, social safety and moral safety), as well as emphasising a supportive and structured environment.

Rather than providing descriptions of safety, some leading theorists have focused on explaining different strategies to create safety. Herman (2015) seems to emphasise a trusting client-therapist relationship and supported peers relationships to create safety for survivors. Van der Kolk (2014) describes relaxation and mindfulness breathing techniques to provide a sense of security for the participant. Porges (2009), Perry and Szalavitz (2006) highlight the importance of providing a safe working environment with no threatening objects is essential to create safety.

These descriptions from the broader field of trauma studies provide a foundation for looking more closely at safety in music therapy trauma recovery programs. Within our own field, some authors have provided more detailed explanations than others, who tend to mention safety but not elaborate further. For example, a number of authors broadly state that music therapy has the potential to create a 'safe space'. Christenbury (2017), Kim (2015) and Felsenstein (2013) have all claimed that music provides a non-threatening environment for traumatised children and adolescents. Christenbury (2017) also mentioned that making music may provide feelings of safety for the participants as they felt accepted and supported. However, this concept of safety is rarely defined further beyond these affirmations. Schneck & Berger (2006) suggest that the nature of music from a psychological perspective is very interactive and a majority of people use music to express their thoughts and feelings when speaking is difficult. This perhaps contrasts with the traditional understandings of safety, because it suggests that music opens things up, rather than containing or holding them.

An initial reading of the literature suggested that safety is only implied and is interpreted diversely in the music therapy literature. Although music therapists claim to create a safe and trusting environment for clients to express their feelings, they do not explain how this is achieved. However, this cursory observation may not be substantiated by a more systematic examination. The possibility of more carefully investigating this topic raised our curiosity. This article demonstrates how we interrogated the literature in the hope that clearer guidance about how safety was generated within music therapy programs would be discovered.

The main research aims to be examined through a critical interpretive review of the literature were:

1. To understand how music therapists describe safety.
2. To understand what engaging strategies music therapists used in creating a sense of safety.
3. To understand whether some music therapy methods may be considered to create safety.
4. To better understand the individual-therapist relationship and how this may relate to creating safety.

Design

Critical Interpretive Synthesis

The researchers were guided by an approach called Critical Interpretive Synthesis (CIS), which is a systematic approach to the analysis of both qualitative and quantitative studies described by Dixon-Woods and colleagues (2006). The methodology is focused on answering certain research questions rather than providing descriptive reviews. CIS aims to present the whole process of review with the searching of articles, critique, analysis occurring concurrently, defining and applying codes and categories and refining the research question (Dixon-Woods et al., 2006). This approach importantly acknowledges the researcher's interpretations and reflexivity in critiquing the data (Dixon-Woods et al., 2006).

The CIS presented in this article includes three steps: approaching/searching the literature, gathering the data according to the questions and analysing and interpreting the findings into a synthesis.

Searching the Literature

The search began with a variety of mediums starting with google scholar and the university databases. The combination of the following keywords was used in identifying the articles: 'safety', 'trauma and/or complex trauma', 'music therapy', 'music', 'adverse childhood experiences', 'ACE', 'abuse', 'youth', 'children', 'adolescents', 'adolescents or violence'. Our first approach was to identify relevant studies which are music therapy literature that presented a different aspect of safety and were conducted both nationally and internationally. Results of twenty-two articles were selected, and this literature provided either group or individual recovery programs for musical activities that incorporate children or young participants.

The date of publications searched ranged from 2004 to 2019 and included papers published by authors from the United States of America (10), UK(2), Canada (1), South Africa (2), South Korea (1), Israel (2), Scotland (1), Germany (1), Sweden (1), and Venezuela (1). These articles presented several disciplines, including music therapy, Guided Imagery and Music (GIM), art therapy, sound recording, relaxation, counselling, and play therapy. A list of the articles included is shown in table 1.

Table 1

Articles Included in the Synthesis

Author/s	Year	Title
Albornoz	2011	The effects of group improvisational music therapy on depression in adolescents and adults with substance abuse: A randomized controlled trial
Amir	2004	Giving Trauma a Voice: The Role of Improvisational Music Therapy in Exposing, dealing with and Healing a Traumatic Experience of Sexual Abuse

Barron et al.	2017	Pilot Study of a Group-Based Psychosocial Trauma Recovery Program in Secure Accommodation in Scotland
Carruthers	2014	Safety, Connection, Foundation: Single-Session Individual Music Therapy With Adolescents
Chin et al.	2018	Art and Music Therapy with adopted children under five
Choi	2010	A Pilot Analysis of the Psychological Themes Found During the CARING at Columbia—Music Therapy Program with Refugee Adolescents from North Korea
Christenbury	2017	I Will Follow You: The Combined Use of Songwriting and Art to Promote Healing in a Child Who Has Been Traumatised
Davis	2010	Music and the Expressive Arts With Children Experiencing Trauma
Dos Santos & Wagner	2018	Musical Elicitation Methods: Insights From a Study With Becoming-Adolescents Referred to Group Music Therapy for Aggression
Felsenstein	2012	From uprooting to replanting: On post-trauma group music therapy for pre-school children
Flores et al.	2016	Drumming as a medium to promote emotional and social functioning of children in middle childhood in residential care.
Ho et al.	2011	The Impact of Group Drumming on Social-Emotional Behavior in Low-Income Children
Hussey	2003	Music Therapy With Emotionally Disturbed Children
Kim	2015	Music therapy with children who have been exposed to ongoing child abuse and poverty: A pilot study
Perryman et al.	2019	Using creative arts in trauma therapy: The Neuroscience of Healing
Robarts	2011	Supporting the development of mindfulness and meaning: Clinical pathways in music therapy with a sexually abused child
Rudstam et al.	2017	Trauma-focused group music and imagery with women suffering from PTSD/complex PTSD: a feasibility study
Schrader & Wendland	2012	Music Therapy Programming at an Aftercare Center in Cambodia for Survivors of Child Sexual Exploitation and Rape and Their Caregivers
Strehlow	2009	The use of music therapy in treating sexually abused children
Stuart	2018	Musical Ripples and Reflections: The Story of Charlie, His Music and His New Foster Family
Viega	2013	"Loving me and my butterfly wings" A study of hip-hop songs written by adolescents in music therapy
Zanders	2015	Music Therapy Practices and Processes with Foster-Care Youth: Formulating an Approach to Clinical Work

Approach to Data Extraction

Gathering the Data

We extracted data under the following subheadings: author details and publication year, the title of the articles, age of participants, number of participants, settings, countries of the programs, music therapy methods, safety-related words, types of research methods, description of the relationship, the cause of trauma and description of the participants' behaviours and their presenting issues.

Data were sorted into spreadsheets, according to each sub-question:

- What words do authors use when describing the concept of safety?
- What music therapy methods do authors use when creating safety?
- What were engaging strategies used by the authors when creating safety?
- What types of individual -therapist relationships may relate to creating safety?

Analysis and Results

Safety Related Words

There were a number of words used by the authors which seemed to point towards notions of safety or creating a safe environment. Twenty words were extracted from the literature and compiled in a table to see how frequently each one was used (Table 2).

Table 2

Most Commonly Used Words from the Literature that May Indicate Safety

Words	Number of Articles
Trust	9
Safe	9
Support	7
Connect	5
Secure	4
Calm	3
Stable	3
Control	3
Accept	3
Relax	3
Engage	3

Predictable	1
Settle	1
Authentic	1
Structure	1
Comfortable	1
Organised	1
Being understood	1
Non-threatening	1
Focus	1

Identifying Different Aspects of Safety in the Literature

Following our initial data extraction, we decided to focus specifically on a few aspects of safety (physical, psychological, relational, environmental) as described by Bloom (2017). Next, we examined whether there were any patterns in the ways authors described strategies for creating safety which led to the discovery of some similarities. Finally, we looked at the descriptions of how relationships were established between the therapists and the clients as the initial soft analysis of the literature suggested that these were thought to be one of the key features in creating safety. Based on the evidence found, we categorised four dimensions: physical, psychological, relational, and environmental safety (Table 3).

Table 3

Four Aspects of Safety

Four aspects of Safety	Physical Safety	Relational Safety	Psychological Safety	Environmental Safety
Words	Calm Relax Settle	Accept Authentic Connect Engage Support Secure Non-threatening Trust Being understood	Control Focus Stable Comfortable	Safe Structure Predictable Organised

Physical Safety. For our analysis, this dimension included words that described how safety feels in the body, such as 'relax', 'settle' and 'calm'. We noticed that the authors explained the participants' physical state-based mostly through their second-person observation. Zander (2015) and Ho et al. (2011) described the participants as 'calmer' because the body was relaxed to collaborate during music therapy activities. However, being calm may not necessarily mean that the individual felt safe. Albornoz (2011) stated the music improvisation helped the group members to be 'relaxed' in the program. There were no detail descriptions to present the connection between relaxation and safety. Robarts (2009) spoke about the participant's appearance as 'settled' and engaged better in the quiet play. However, Robarts (2009) did not explain how the individual was engaged in this activity or how his/her physical movements indicated that they were settled.

Relational Safety. Words seemed to describe how participants felt in relation to the therapist and/or the group, such as 'accept', 'connect', 'engage', 'secure', 'support', 'trust' and 'being understood'. It also included words that seemed to describe the therapists' response to the participants, such as 'authentic' and 'non-threatening'.

We identified three articles that used the word 'accept' to describe safety. It pointed in two different directions; either participants were accepted by the therapist (Perryman et al., 2019; Stuart, 2018) or participants were accepted by the peers in the group (dos Santos & Wagner, 2018). However, we are not convinced that being accepted may be a form of being safe in the program. Next, we looked at 'connect' and 'engage'. Carruthers (2014) and Rudstam et al. (2017) emphasised how the connection between the group members may establish a sense of safety through sharing and discussing music activities. Others talked about how being connected and engaged in the music playing with the therapists, or the group may improve feelings of safety in the programs(Chin et al., 2018; Hussey et al., 2008; Stuart, 2018). We understand based on the information presented that when the participants were actively engaging or sharing in the music activities may indicate that they felt safe. However, the authors did not explain how they evaluate the participants' reactions towards to the therapists and the group. The words 'secure' and 'support' were used when authors describe how the participants felt secure with the therapists in the program may helped their expression in instrumental playing (Amir, 2004; Strehlow, 2009; Viega, 2013). Viega (2013) stated that the participant felt safe to express her feelings in her songs when she was supported by the therapist in the song-writing process. It seemed when the participants felt secure and supported, and they were able to musically interact with the therapists and the group. Once again, there was no clear explanation of how the authors discovered the participants were feeling safe. We assumed the authors examined the individual's program participants to understand if they felt safe to express their thoughts in the activities. Although, many authors suggested that when the participants trusted the therapists or the group a sense of safety may be created (Choi, 2010; Perryman et al., 2019; Strehlow, 2009; Viega, 2016; Zanders, 2015). We were disappointed that very little evidence was found to understand why safety can be created by trusting therapists.

Last, we looked at being 'understood', 'authentic' and 'non-threatening'. We found the authors stated that a sense of safety might be created when the participants' feelings were understood by the therapist (dos Santos & Wagner, 2018), and the therapists were authentic towards the participants (Perryman et al., 2019), and the therapists provide a non-threatening environment (Hussey et al., 2008). However, no appropriate references to explain exactly how the authors measured the feelings of safety when those techniques were used.

Psychological Safety. Words that may describe fundamental states of being including cognitive and regulatory states, such as 'stable', 'focus', 'control' and 'comfortable'. According to the description in the Sanctuary Model (Esaki et al., 2013), psychological safety also referred to oneself knowing how to self-control, self-discipline and self-protection.

In understanding 'control' and 'stable', Strehlow (2009) and Christenbury (2017) demonstrated that giving out some form of control to the individual over the session may help him/her to establish their own form of security. This may position the individual to act as a leader or co-leader in the program. We

suspect that this may be a way to display some form of self-control and self-discipline. Dos Santos & Wangner (2018) also have findings stating that a sense of cohesion and safety was established by letting the young participants lead the program, making their own choices of the activities and discussing their thoughts and reflection. These findings helped us to understand how the authors evaluated and examined their participants. Next, we found 'stable' referred to a stable environment (Felsenstein, 2013) and the stability within the individual's body (Rudstam et al., 2017; Zanders, 2015), which referred to a therapeutic space and the others presented as the one's physical state. Then, we looked at 'focus' and 'comfortable'. These authors explained how the participants felt when interacting (Ho et al., 2011) and sharing thoughts in the program (Christenbury, 2017). These descriptions presented that when the individual felt a sense of safety, they were able to either actively participate in the program or lead activities.

Environmental Safety. Words that may explain how the therapists create and prepare the environment for the program included 'safe', 'structure', 'predictable' and 'organised'. We drew our understanding of environmental safety to Haigh's (2013) theory of space is full of support and rules and boundaries. We found some studies indicated that the word 'safe' reflected a safe space for their participants to interact with the therapists or the group members (Chin et al., 2018; Christenbury, 2017; Flores et al., 2016; Stuart, 2018; Viega, 2013). Most of the authors noted that when the participants were communicating and interacting with the therapist or the group meant that they felt safe. We examined the use of 'structure,' 'predictable', and 'organised,' and these words pointed directed to creating a therapeutic environment (Felsenstein, 2013; Flores et al., 2016; Robarts, 2009.) This information seems to be in conjunction with Haigh's (2013) perception of safety that provides a predictable, structure and organised space may be appropriate to elicit safety in the environment.

As previously mentioned, there was little evidence in the articles of how music therapists create safety in the programs. Instead, we identified broad statements and assumptions (Table 4).

Table 4

The Statements about Safety

The statements	Authors/year/ page no.
1. My therapeutic aim was to provide **a safe environment** where participants could express their feelings and emotions through music while having a positive individual session experience.	Carruthers, 2014, p.50
2. I strive to create **a comfortable, safe, and successful music therapy experience** for my clients.	Carruthers, 2014, p.50
3. Drum playing can target feelings of anger and aggression, **providing a safe context for expression**, and simultaneously communicating these feelings to the staff.	Dos Santos & Wagner, 2018, p.398
4. This created the **safe, secure and stable environment** necessary for participants to engage in free self-expression and positive interaction.	Flores et al., 2016, p.263
5. The child can explore difficult issues and painful feelings associated with abuse and become able to share these issues and **feelings in the safe environment** of music therapy sessions.	Kim, 2015, p.30
6. My role is to support her, listen, and provide a **safe framework** in which she may find stillness	Robarts, 2009, p.390
7. Music can work with dynamic expressive and sensory levels of experience in a relationship from which trust, **a sense of safety**, and new patterns of healthy attachment or intersubjectivity can begin to develop.	Robarts, 2009, p.381
8. Sometimes the music was selected to be supportive and help restore **a sense of safety**, and sometimes more evocative, to stimulate strength and/or become in touch with feelings.	Rudstam et al., 2017, p.213
9. GrpMI sessions have the **potential to create safety and to build strength**, thus helping the client to access and tolerate feelings.	Rudstam et al., 2017,p.205
10. I offered Charlie many opportunities to explore and expand his sense of self and others, as well as **provide a safe space** for him to experience being in a relationship with another.	Stuart, 2018, p.3

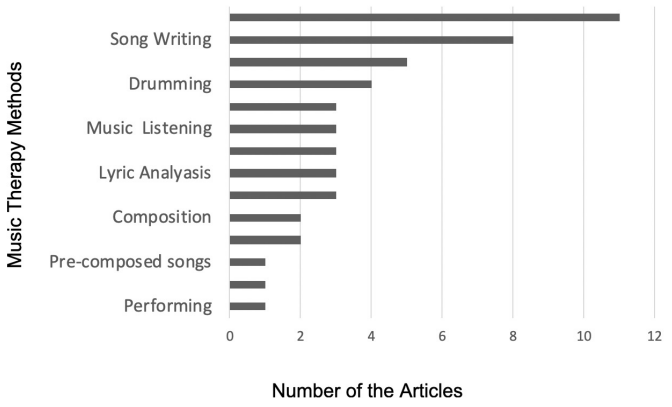
As we can see from the statements, the authors used music to create a safe space, environment, framework or expression. However, the lack of detailed descriptions of how safety was created demonstrates that more studies are required to understand how music therapy and music therapists provide safety in trauma recovery programs. Next, we looked at the music therapy methods to exam how safety was provided.

Commonly Used Music Therapy Methods

We identified commonly used music therapy activities in these twenty-two articles. They were as followed: improvisation, songwriting, instrumental playing, drumming, relaxation, music listening, music and imagery, lyric analysis, composition, singing, pre-composed songs, preferred song singing and performing (Figure 1).

Figure 1

The Music Therapy Methods that Used to Create Safety



Common Directions when Providing Music Therapy Methods. No evidence was found between the link of creating a sense of safety and the use of these music therapy methods. Therefore, the full details of the music therapy activities will not be discussed here. We will present directions as the authors described in the articles to provide clues for creating a sense of safety.

Provide Emotional Expression. The emotional expression discussed here means the individuals' emotions, feelings and thoughts while participating in the activities and it also implied to thoughts and feelings about past traumatic events (Carruthers, 2014; Christenbury, 2017; Strehlow, 2009; Zander, 2015). Providing emotional expression may be the main direction as we found in nine out of twelve methods (improvisation, songwriting, instrumental playing, lyric analysis, singing, performing, singing preferred songs, music listening, relaxation and music and imagery). The authors feel essential or the "need" for the participants to express/ share their emotions or feelings/ thoughts through music therapy methods (Choi, 2010; Felsenstein, 2012). However, the authors did not explain expressing emotions as a way to connect with creating a sense of safety. We suspect the authors felt expressing self-feelings may mean being safe and comfortable in the program.

Provide Relaxation. Providing relaxation was found in five methods (drumming, musical games, music listening, relaxation, music and imagery). Although the articles failed to explain the connection between relaxation and safety, the authors seem to agree with the idea that is providing methods which elicit relaxation is important for young people who have experienced significate trauma. Being relaxed and feeling safe is often a foreign concept for this client group. Stuart (2018) and Christenbury (2017) demonstrated drumming, and musical games helped their participants to relax and became more playful with their peers. Rudstam et al. (2017) described the participants felt relaxed and connected with themselves through music and imagery. Barron et al. (2017) had a similar finding when providing relaxation; the participants felt relaxed and were able to reconnect with themselves. Schrader & Wendland (2012) described relaxation as being a self-calming strategy in music listening. These statements gave us some clues about relaxation and safety, maybe the body and the mind require connection and calmness to relax and to feel safe.

Establish Collaborative Leadership with the Participants. Activities such as improvisation, instrumental playing, performing, songwriting and preferred song singing emphasised establishing collaborative leadership provided opportunities for equality and gaining a sense of control over the environment (Albornoz, 2011; Amir, 2004; Carruthers, 2014). This indicates that the participants may act as a leader or a co-leader in the activities (Schrader & Wendland, 2012). The participants, as described by the authors, felt respected and may be safe enough to create their music in the programs (Albornoz, 2011; Schrader & Wendland, 2012; Viega, 2013). However, we doubt being a leader or a co-leader represents feeling safe in the program. This information fails to demonstrate or provide more details on how safety was formed by being a leader. Next, we reviewed the strategies when the therapists were facilitating the programs to gain more information on safety.

Therapists' Engaging Strategies

The explanation for the strategies used that focuses on making the environment secure and creating a sense of safety for the individuals is discussed below. Four different categories emerged that gathered similar ideas about the engaging strategies present in the literature. These strategies are: offering choices, giving the participants control over activities, active listening and providing structure (Table 5).

Table 5

Engaging Strategies

Strategies	Descriptions	Literatures
1.Offering Choices	Providing different options for activities the participants could choose from.	Carruthers (2014); Chin et al. (2018); Christenbury (2017); Kim (2015); Peeryman et al. (2019); Zander (2015)
2. Giving the Participants Control over the Activities	Giving the participants some or all control over activities and enabling them to act as leaders in that certain activities.	Alboronz (2011) ; Amir (2004) ; Barron et al. (2017) ; Carruthers (2014); Christenbury (2017) ; Felsenstein (2012); Rudstam et al. (2017); Strelow (2009) ; Dos Santos & Wagner (2018); Viega (2013)
3. Active Listening	The therapists paid full attention to the participants and were engaged in the conversations.	Alboronz (2011); Amir (2004); Barron et al. (2017); Carruthers (2014); Davis (2010); Peeryman et al. (2019); Robarts (2009); Rudstam et al. (2017); Strelow (2009)

4. Providing Structure	The therapists act as a leader for the activities in the program.	Carruthers (2014); Chin et al. (2018); Chio (2010); Davis (2010); Felsenstein (2012); Flores et al. (2016); Ho et al. (2011); Hussey et al. (2003); Kim (2015); Robarts (2009); Schrader & Wendland (2012); Dos Santos & Wagner (2018); Strelow (2009); Stuart (2018); Viega (2013) ; Zander (2015)

Offering Choices. Offering choices was identified in six articles and all in the individual therapeutic settings. Christenbury (2017), Kim (2015) and Chin et al. (2018) found when participants were presented with choices between two activities or more, and they were more engaged in the program. The participants felt they had been respected, and their voices were heard by the therapists (Peeryman et al., 2019; Zander, 2015). While the authors did not identify offering choices as a way to create a sense of safety, we can infer that safety might be enhanced or established through this strategy.

Giving the Participants Control Over the Activities. "Control" is a key feature when engaging with the participants who experienced trauma (Amir, 2004; Flores et al., 2016). The authors stated that when the participants have some form of control to lead the activities or collaborate with the therapist, they felt supported, trusted and became more confident in the role of leader/ facilitator (Albornoz, 2011; Amir, 2004; Flores et al., 2016; Kim, 2015; Zander, 2015).

These authors all emphasised on the importance of participant-led play where the individual acted as a leader and had the control of the musical activities. This is similar to the findings of the music therapy method section, as both identified that establishing collaborative leadership enhanced a sense of control. It seems promising that giving out control may create a sense of safety.

Active Listening. Active listening was a technique found in nine articles. Some authors described when the therapists were actively listening to the participants. They felt supported and respected by the therapist (Peeryman et al., 2019; Strewlow, 2009). Others mentioned the participants felt less anxious when being heard with full attention from the therapists (Carruthers, 2014; Barron et al., 2017). The description of being supported and respected really interest us as these vocabularies seem to present a state of being trusted and being safe. However, the articles did not adequately discuss how being an active listener to improve a sense of safety for the participants.

Providing Structure. Providing structure is the most common strategy that was adopted by the therapists. It was found in fifteen sources of literature, from both individual and group settings. Many authors stated that child participants found clear, structured programs especially easy to join in and relax (Chin et al., 2018; Felsenstein, 2012; Schrader & Wendland, 2012; Flores et al., 2016). This approach helped them to feel comfortable to express their feelings through instrumental playing (Davis, 2010; Choi, 2010; Chin et al., 2018). Stuart (2018) mentioned that a steady, concrete and playful structure provided participants with a sense of trust and security. A structure provided by the therapists when engaging the participants may create a safe environment for the participants as the authors describe how the individuals relaxed and expressing their feelings in the programs. However, this study did not present a direct link between relaxation and creating safety.

To sum up, we clearly noticed some keywords that were used to describe safety, such as 'supported', 'being in control', 'respected' and 'safe'. However, further investigation and research is required to better understand how music therapists make decisions in selecting different strategies that they feel will create safety. For example, it is not clearly described whether the therapists depend on their intuition and/or their experiences. These reflections could not be found in the limited current music therapy literature. Next, we looked at the relationship that the therapist and the participant established in the program to understand how safety was created.

The Relationship

Our focus here is to investigate the client-therapist relationship and/or peer's relationship contributed to creating safety in the program. There were ten groups and twelve individual programs, and each had a different aim and focus. We looked at these differences and examined the relationship statements that were made at the start and at the end of the program, to understand how safety was related.

Group Programs. The ten group programs had a focus on creating an environment for the members to actively interact with each other musically and verbally and freely express their thoughts and feelings in the sessions (Barron et al., 2017; Choi, 2010). Flores et al. (2016) and Schrader & Wendland (2012) stated that group member gain self-confidence through music-making and they felt supported by the group. Barron et al.(2017) and Felsenstein (2013) reported that group members felt a sense of belonging and intimate relationships were formed through group communication after the musical activities. Feeling a sense of belonging or supported by the group and have an intimate relationship with the group may have the tendency to present that safety was formed. However, these authors did not provide clear explanations of how this was linked to safety. In contrast, Rudstam et al.(2017) presented some insight, when they purposely choose the same gender (female) therapists for the sexually abused participants, and the group members actually all felt connected and safe with each other in the program.

Based on these findings, we can see that the group participants express and interact better in a supported environment. Perhaps the most serious disadvantage of these findings is that no evidence was found to describe the connection between peer relationship or the client-therapist relationship and creating safety in the music therapy group settings. Before proceeding to examine the individual program, let us now consider the relationship statements made by the authors both at the start and the end of the program to create safety.

Authors described situations at the start of the program as tense (Choi, 2010), challenging (Flores et al., 2016), intense (Felsenstein, 2013), the clients felt excluded and conflict (Choi, 2010). An exception was Rudstam et al.(2017), who claimed their

participants felt safe due to the gender of the group (all female members and therapists). Whereas at the end of the program, the authors explained the participants felt trusted (Felsenstein, 2013), accepted (Dos Santos & Wagner,2018), relaxed (Albornoz, 2011) and secure (Viega, 2013) with the therapist. One key feature was found when we examined this change. It was the highly structured program and boundaries set by the authors which allow the child participants to be more comfortable playing music with peers (Davis, 2010; Choi, 2010; Felsenstein, 2012; Viega, 2013). Boundaries also allowed group members to discuss or lead some activities to ease the tension (Barron et al., 2017; Flores et al., 2016). These statements may suggest that the authors feel structure and boundaries are the two factors to create safety in the group setting. The limitation with this is that no articles provide a full description of how safety is related through a structured program. Turning now to investigate the individual programs.

Individual Programs. Unlike the group design, these individual programs had longer program durations from several months to several years. Christenbury (2017) and Strehlow (2009) provided detailed session progress notes or descriptions of the participants, which allowed the readers to better understand how the therapeutic relationship was formed. The individual programs focus more on developing a trusting relationship between the therapist and the client (Carruthers, 2014; Zander, 2015; Stuart, 2018). The authors generally agree that traumatised young participants developed a lack of trust in people (Amir, 2004; Christenbury, 2017; Strehlow, 2009). Therefore, providing an environment that elicits trust is important. To establish a trusting relationship, we discovered that the therapists were more involved and willing to communicate and explore the needs of the participants, give them time to make choices and have control over some activities (Carruthers, 2014; Stuart, 2018; Zander, 2015). Moving on now to consider the relationship statements.

The findings are pretty similar to those in the group settings, the authors described the situation at the start of the program, as unsafe (Stuart, 2018), tension (Christenbury, 2017), tense (Zander, 2015), fearful (Strehlow, 2009) and uncomfortable (Robarts, 2009). While at the end of the program, the participants felt trusted (Christenbury, 2017; Zander, 2015), accepted (Chin et al., 2018; Robarts,2009) and safe (Christenbury, 2017; Stuart, 2018) with the therapist. One strategy that we found by many authors to create a sense of safety was to provided more space and time for the participants to become familiar with the therapists and the environment and offered opportunities for them to explore or make choices (Zander, 2015; Christenbury, 2017; Stuart, 2018). However, this finding does not specify the connection between allowing the participants time in the program and create a trusting client-therapist relationship and creating safety.

Group programs tend to focus on establishing an interactive and supportive environment more than the individual program. Whereas individual programs focus more on creating a trusting client-therapist relationship. Both settings presented little descriptions for creating a sense of safety.

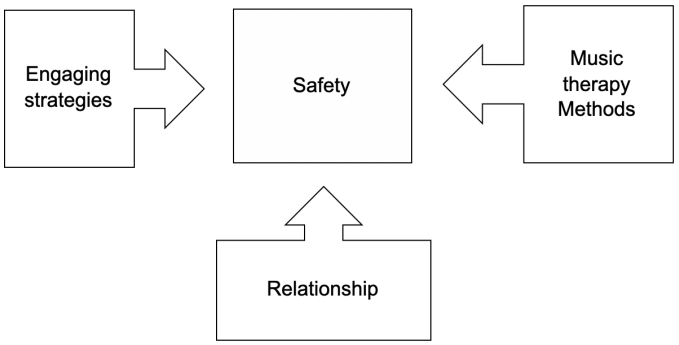
Synthesis & Conclusion

The result of this critical interpretive synthesis has been the construction of some perspectives of how music therapists create safety. Although, we could not find any specific music therapy methods or the engagement strategies that are best suited to providing safety. We learnt that the therapists were flexible to adjust the way they lead the program accordingly to the young participants' situation on the day. The music therapists also observe the participants' anticipations and musical responses and interpreted these messages into the meaningful expression to understand whether they felt safe or not. However, these may not be the precise feelings that the participants were experiencing. We suggested that the lack of information yields a need for further investigation and research in this field. The participants' insights and thoughts would be important and valuable for professionals to understand and learn how to structure a safe music therapy program.

As we come to the end of the investigation on how music therapy literature discusses creating safety in the programs, we found that safety may be created through three features (Figure 2).

Figure 2

Three Features of Creating Safety in the Program



From our analysis, the therapist appears to play an important role in providing suitable engaging strategies and music therapy methods for the participants in creating a sense of safety. We discovered that the authors pay careful attention to the needs of the participants and examined the individuals' actions and reactions' towards each activity and the environment, in order to select their interaction methods. They also pay attention to the participants' feelings and non-verbal expressions. We understand therapists have abilities to evaluate their participants; however, when dealing with traumatised individuals, the therapists may require extra sensitivities when providing the programs as the participants' responses were usually unpredictable and are not generally easy to communicate. Little is known about how the therapists recognised the signals of the participants and adjusted their strategies and methods or even the way they interacted with the participants. However, based on the information provided in this CIS, it is still not clear how exactly safety was created by the music therapists.

Based on the findings from this CIS, we recommend the importance of filling in the gaps in the current literature to guide the music therapy researchers who are interested in providing programs with young people who have had traumatic experiences. We propose that interviews of both the therapists and the participants may provide insights into how and what might be needed to create and feel safe in programs. Further, we suggest perhaps future research can include more descriptions of the individuals' background (age, personality, family framework,

type of traumatic events, duration of the past trauma experiences) as this information may affect their response and reaction towards the music therapy program. The future studies can also include more detailed program process notes (the individuals or groups' mood states, responses and relationship with the music activities, themselves, the peers and the therapists). This information will be crucial and important to understand how the therapists make their decisions on providing different engaging strategies and music therapy methods and how they establish a trusted and secure relationship with the participants. Moreover, it will help the readers understand how music therapists construct their programs in terms of creating a sense of safety.

Footnotes

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Student Perception of Creative Classwork in Counselling and Psychology Courses: A Case Study of Hong Kong Undergraduate Students

James Yu

This qualitative study examined how Hong Kong college students experience creative activities in counselling and psychology courses. Thematic analysis based on in-depth interviews with six participants showed that role-play, drama demonstration and fictional story writing were useful in facilitating their professional development and personal growth. The participants nonetheless provided specific suggestions and expressed concerns that take into account of the local Chinese culture. Overall, the findings highlight that students' perception of creative classwork is shaped by the local cultural context.

Personal creativity, broadly defined as the ability to generate ideas, identify patterns, create solutions, explore possibilities and develop insights, is an essential component in the work of counsellors and mental health professionals (Rouse et al., 2015). From a pedagogical standpoint, class activities and assignments that include a creative component have been recognized as an effective strategy to actualize the learning outcomes in counselling and related psychology courses. For instance, Sheldon (1996) reported that psychology students are generally interested in creating and performing skits as a form of theory or concept demonstration. Ho and Ho (2002) outlined the benefits of using dramatic monologue in teaching abnormal and developmental psychology courses. Creating and analyzing fictional characters with biographical content (Carlson, 1992) as well as role-playing as people with psychological disorders (Poorman, 2002) or as client-therapist dyad (Corsini, 2017) were also typical examples of creative classwork. Furthermore, creative tasks using role-plays and fictional stories are common for learning about concepts where perspective-taking is considered to be important, including cultural, racial, gender, sexual orientation, social class, professional and ethical issues (e.g., Bleske-Rechek, 2001; Madson & Shoda, 2002; Kernahan & Davis, 2007; Fariña, 2009).

What is the role of such creative activities in fostering students' personal and professional development? What are the unique factors and concerns to be considered when they are implemented in a different cultural context? The present qualitative investigation seeks to provide insight to these questions based on in-depth interviews with six college students and alumni in Hong Kong.

Teaching psychological theories and counselling approaches in Hong Kong presents a unique case for exploring the potential cultural issues related to teaching these subjects internationally. Unlike mainland China and Taiwan, the teaching of psychology and counselling in Hong Kong higher education is mostly conducted with English as the primary medium of instruction. However, local students are inclined to think about and process the relevant theories and concepts with their native Chinese language. Accordingly, they are often preoccupied with the cognitive demand to connect psychological concepts with relevant local phenomena. Due to the shortage of mental health and counselling providers to meet the society's rising needs for such service (Yu & Okpych, 2013), as well as the variable training standards established by different professional bodies (Seay, 2010; Yuen et al., 2014), a portion of Hong Kong graduates with psychology or counselling degrees are readily employable in the frontline as programme workers, welfare workers, behavioral therapists, psychology assistants, and junior counsellors in public and private sectors. Therefore, it is important to examine local undergraduate students' experience of personal and professional growth.

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Method and Procedure

An invitation letter to participate in this study was emailed to the listserv of students and alumni majoring in psychology or counselling from five different colleges in Hong Kong. Fifteen individuals replied to indicate interest to participate. At the end, six participants from three different colleges were able to attend face-to-face interviews within the proposed timeframe. As shown in Table 1.1., two participants were male and four were female, three of them were college seniors and the other three were either working or further studying in a relevant field. A total of six semi-structured individual interviews were conducted, using a set of interview questions as template (*See Appendix I). The transcribed data were organized and analyzed based on Braun and Clarke's (2006) model of thematic analysis in psychology: 1) data familiarization 2) initial coding 3) generating themes 4) reviewing themes 5) naming themes 6) writing up. Participants were assigned with pseudonyms to safeguard confidentiality from data analysis to report writing. Their basic background information was outlined in the table below.

Table 1

	Pseudo-nyms	Gen-der	Age	Major of Study	Study / Job Status
1	A(dam)	M	22	Psychology	College Senior
2	B(rie)	F	24	Counselling	Social Work M.A.
3	C(arrie)	F	24	Psychology	Playgroup Counsellor
4	D(iana)	F	22	Psychology	College Senior
5	E(dmond)	M	23	Counselling	Social Welfare
6	F(lora)	F	22	Counselling	College Senior

Core Themes and Sub-themes

Theme 1: Role-play is an effective classwork insofar as it is not based on real-life content

Role-play is a widely adopted classroom activity in psychology and counselling courses. In addition to its entertaining aspect, role-play activities related to mental health and treatment have been considered to be an effective way to enhance students' basic counselling capacities such as empathy and active listening (Anderson et al., 1989; Poorman, 2002) as well as assessment and conceptualization skills (Balleweg, 1990).

In this study, the participants unvaryingly preferred role-playing hypothetical scenarios to simulated real-life situations (e.g., acting the role of a student's parent). The former was perceived as a safe and more comfortable role-play format in terms of its potential emotional impact, confidentiality and privacy issues. The participants emphasized that it would be anxiety-provoking to bring real-life experience into the activity. They shared similar concerns about the possibility of private information getting spread around. Carrie shared her experience of a role-play exercise in an Abnormal Psychology course where the class tutor acted as a counsellor and her groupmates as a made-up family in which a member was suffering from a psychological disorder:

It was great that the lecturer instructed us to make up a family story. We knew there were classmates who had similar experience in life, but it would have been unsafe to bring it to the centre stage of the class. Many classmates were watching and we were not yet professionals. People gossip and talk about this kind of things. There is strong stigma about mental illnesses in our society. Students might feel comfortable to share with their close friends or even with professors privately, but not in front of a class because it might bring shame or scrutiny that you won't know.

Given the prevalence of emotional disturbances related to academic performance among Hong Kong college students (Lun et al., 2018), it was interesting that the participants did not express any concerns about being graded in role-playing exercises. They believed that students are generally rewarded for good effort in a way that is similar to in-class participation. However, they shared the concern about disclosing family contents that are highly stigmatized in the local culture. To avoid potential shame and embarrassment, they believed that it would be a better learning experience if role-playing activities or assignments are based on hypothetical scenarios. This finding was consistent with the literature on the widespread shame-based (Chang & Holt, 1994) and relationship-based "face" concerns (Wong & Tsai, 2007) in Chinese cultures.

On the other hand, the participants perceived role-playing activities as a form of practical rehearsal that is useful for enhancing basic counselling skills. Adam and Flora shared their experience of participating in a similar activity in an introductory level counselling course. They found that the activity was not only fun and entertaining, but also provided a much-needed platform to practice counselling microskills. It was perceived as a form of transition from knowledge and theory comprehension to actual practicum or internship practice.

Brie also shared her experience in a role-play exercise in a course titled Child Counselling. The assignment required each pair of students to role-play the interaction between a parent and a teenaged child that characterizes a specific parenting style, as well as to discuss how such relationship might contribute to the child's later cognitive, behavioral and emotional problems. She reported that her dyad was very interested in designing the interaction and watching the demonstrations from other groups. Furthermore, she was somewhat surprised by the insight they learned from this activity:

Just having a fun activity to do would be good because we have a lot of papers to write. We enjoy something entertaining once in a while, but I remember this activity because I learned a lot. We know that most students drew on their experience when planning for this role-play, but the good thing is that no one needed to declare whether their ideas were based on their actual experience or imagination. It could be confidential if we wanted it to be. Some groupmates who were close friends would voluntarily share their real experience with each other, so in a way it allowed some of us to know each other deeper. As far as I know, most students did not automatically look into themselves when these attachment or parenting styles were taught. This assignment encouraged us to do that in a safe way. It was the first time I had an answer in my mind about what parenting style I experienced as a child.

The participants also agreed that role-playing exercises are especially valuable for those who opt for practicum training in senior year. They agreed that it is appropriate to increase the intensity, complexity and rigor of such activities as students

proceed into the latter half of curriculum (i.e., sophomore and senior years). To elaborate, Flora aptly put it in the following way: *I think when we were freshman or junior having fun collaborating with other classmates was acceptable. Maybe role-playing at this stage should count less of the overall grade. But it would still be good learning. It can help us build comfort about future roles, like a counsellor or social worker. It can also help us understand the perspective of individuals that we don't understand, like the people with certain disorders or disability. Later on, I think it is more important to see if we are practicing the skills correctly. I think it can be a bigger project that takes many weeks of preparation, such as role-playing a clinical interview session.*

Theme 2: Drama demonstration facilitates creativity and reflectiveness, but the level of acting required is a potential concern

Compared to role-play which allows more room for improvisation, creating and performing a drama or skit requires more coordinated teamwork and well-rehearsed live delivery. Use of skits to enhance students' learning experience in psychology classes has been a well-documented method (Sheldon, 1996). Overall, the participants in this study agreed on three major sub-themes. First, drama performance is intended to be a fun assignment but not everyone enjoys being on the spotlight. Second, Chinese students are more anxious about the relatively vague guidelines forachieving an ideal grade in a drama assessment. Third, the nature of this type of activity allows students to be creative and culturally reflective.

Diana described her experience in completing a group project in a psychotherapy theories course. Students in this course were asked to conduct a myth analysis based on Freudian theories or Jungian archetypes. They were given a choice to perform their chosen myths in the form of a brief drama. Interestingly, all the groups in her class opted for the drama format and put a lot of creativity into the preparation and performance. Diana remarked:
That was a memorable class because our group had a lot of fun putting our performance together and we were very entertained watching other groups performing their skits. Some event made their own props and costumes. Our professor allowed us to act out the myth we selected which was more amusing than verbally presenting the myths. We did not know the details of these ancient myths whether they were Eastern or Western. This activity led us to research more about them. We decided to act out the Pangu creation myth. Although the skit was kind of more like an entertainment piece, unlike a serious artistic performance, we enjoyed creating something together. Many students knew very little about these myths, so I think we all learned something new. We understood more about these ancient myths and how they impacted ancient people for generations in our cultures.

Brie and Edmond shared an experience of performing a short drama for a course about adolescent development. They were instructed to conduct a movie analysis on the developmental issues in teenagers and select a short scene from the movie for skit performance. Students were given a choice to perform the scene in its original, modified, culturally adapted or generation-specific version. Those who selected Western movies were encouraged to create a culturally comparable version. Brie was in an all-girl group performing a scene in a popular Hollywood teen movie, *Mean Girls*, which highlights the importance of look, style and interpersonal and dating rules for female friendships in high school in early 2000s. Brie explained in the following:
We performed the scene in its original form because we felt that it was really interesting and not many of our classmates saw this movie before. But it really helped us to think about how some of the same female politics are the same here, but some are very different especially in our generation. For example, sexy dressing was not a good way to become popular and get positive attention in high school here, even if you have a very beautiful body.

Edmond was in an all-boy group performing a scene from a local movie which is based on a true story over twenty years ago where a high school boy was bullied and beaten to death by his peers. His group modified the scene to include more examples of verbal and physical bullying that they had witnessed or experienced in high school. Edmond explained in the following:
We gained a lot of awareness from this activity. It was an intense experience because we were acting out a true story. Someone actually experienced this! We modified the scene to include other forms of abuse and bullying that were damaging toa teenager's development. Not everyone who got bullied would end up with physical damage but the consequences were always bad. We hoped to include examples of other damaging effects, like suicide attempts or joining street gangsters. These happened a lot here.

In terms of potential concerns, the participants agreed that shy or introverted students are doubtlessly anxious about being in the spotlight as amateur actors or actresses. They recommended that instructors should allow some students to take up backstage responsibilities as an alternative. Regarding the benefits for personal and professional growth, they had a slight difference in opinion about drama creation and performance. Adam, Carrie and Flora never experienced this type of activity in college, but they believed that it is primarily an entertaining group work for demonstrating psychological theories and concepts. Given that it is not the same as drama therapy, they felt that its impact on their personal and professional growth was indirect and limited. In contrast, Brie, Diana and Edmond reported gaining personal insight and professional perspectives from their respective drama assignments. However, they reported that a few groups were quite disappointed with their grades. According to Edmond, he approached a female friend from another presentation group after the grades were released online:
It is very typical for us to share our grades with each other. We do this in every course, basically. But my friend was not happy and her group was quite shocked about their grade. She said it was not a very bad grade, but they were confused about what they did wrong to earn a lesser grade than other groups. I asked her because I knew her group really enjoyed this assignment as well. She did not tell me the exact grade and it was almost as if she was too embarrassed to talk about it after I disclosed my grade. For a fun assignment, we often thought grading would be easy such that every group would be a winner.

Alternatively, Edmond suggested that instructors might consider making it a no-grade assignment or an effort-based assessment. Several participants also expressed concerns about the grading criteria for assignments involving a skit component. They noted that some students were used to having a sense of control over their grade through diligent studying endeavour. Accordingly, a drama performance as a gradable component was definitely out of their comfort zone. They believed that the positive learning experience could have been forgotten by those who received an unsatisfactory grade, highlighting that Hong Kong culture inevitably emphasizes reputable results or outcomes in the form of grades, awards and other tangible recognitions.

Theme 3: Analysis of fictional stories is better than self-analysis

Traditional self-analysis (Sawatzky et al., 1994; Manthei, 1997) in a written assignment is useful for enhancing self-understanding and application of theories. In some cultures, nonetheless, it can be anxiety provoking for students to provide a real-life depiction of themselves in which the content involved might be in conflict with their cultural or religious values such as filial piety and familial pride. Alternatively, analysis of fictional characters can be a viable alternative. Adam shared his experience of creating a fictional story to capture how various unconscious defensive mechanisms work in the life of a fictional character:

Ultimately, it was more meaningful for learning about defenses if we used them to understand our lives. I meant it for lifelong learning. But for an assignment, we only had weeks to get in touch with our memories and examine our past experience. If we must do this on the basis of real experience, it would have been a challenge to make the content fit the theories. I liked the fictional aspect because it could have been entirely based on my actual experience, a mixture of real, imagined and observed events, or entirely based on fantasy and imagination. I think students were at different stages mentally; some probably gained more by reflecting on what they observed in others, and some were more open to explore themselves indirectly through fictional biographies rather than their own stories.

All participants preferred this type of reflective analysis to be based on fictional characters rather than autobiographical content. Self-analysis was perceived as a very personal revelation which should be done with close supervisory support. In fact, research showed that there are cultural differences in psychological mindedness which underlies our readiness to examine and reflect on ourselves (Kirmayer, 2007). A few participants also stated that self-reflective skills are not emphasized in primarily and secondary school education in Hong Kong. As a result, some students would rather do more academic writing assignments and quizzes instead of reflective analysis projects.

In terms of potential benefits, the participants generally converged on two major sub-themes. Firstly, creating a fictional character is an intriguing and less anxiety-provoking way to reflect on themselves, but the degree to which one can gain useful insight from the activity is unpredictable. Secondly, analyzing fictional stories is a good initial practice for case conceptualization because it is easier to apply theories to understand a fictional character. Brie described her view as follow:

I think most students in my cohort believe that a fictional character created by ourselves is like a reflection of the self. It is like projection. We project bits of ourselves to the character. I am quite sure some of us are not used to looking into ourselves in a direct and persistent way. The appeal of analzying a character is a good start. In my group project, we created a dysfunctional family with five characters and analyzed how the family dynamics affected the mental health of different members. We presented the storylines in class as part of the assignment. Maybe a couple of us were adamant that the characters they created had nothing to do with their own experience, but they still felt that there was a kind of resonance with the characters. For me, I knew I was projecting some attachment issues on my fictional character, but the unexpected insight I got from this was the realization that my character was expressing more hurtfulness and anger than I did. The insight was valuable.

With regard to the reason for perceiving analysis of fictional biography as less anxiety provoking than self-analysis, Edmond provided the following remark that accentuates the underlying cultural and familial considerations:

If you analyze yourself and it has to be written, then you are putting yourself out there. First of all, you can be wrong with the theories used. Then, if you are truthful, perhaps you did something bad before or there was some dirt in your family history, I can't say most students have this kind of trust with their teachers. If you do self-analysis, you have to own up to everything that you write in the paper. What if it was something shameful? What if it was something stigmatized, like your parents were mentally ill? What if some fantasies were very strange and you knew how others here would generally think about them? What if your parents accidentally see the paper, like about what you think they fell short as parents? That would create a huge conflict and threaten the family's bond.

The participants perceived that self-analysis inevitably includes disclosure of private information such as past wrongdoings, aberrant family backgrounds or unmet needs in their development. They believed that their parents would have been upset or hurt if they are aware of such content and narrative, which would make them feel guilty about causing emotional disturbance in the family. Although they agreed that self-analysis practice is crucial for developing self-understanding and psychological insight, it was suggested that such activity is better conducted in the form of small clinical seminar, process group or individual supervision. A few participants were concerned about the extent to which grading might be affected by poor imagination and creative writing skills. In fact, research showed that our ability to create a complex and rich fictional story is related to personality variables (Maslej et al., 2017). The participants suggested that it would be better to minimize the weight of fictional writing skills in the grading rubrics and emphasize adequate and creative application of theories and concepts.

Conclusion

This qualitative study was based on six college students and alumni in psychology or counselling who were motivated, committed and reflective lifelong learners. The participants were generally appreciative of their learning experience from creative class activities, which were conducive to their professional and personal growth in different ways. They also made suggestions and shared concerns that reflect values and characteristics of the local culture, as evidenced by their preference for role-playing hypothetical situations, analyzing fictional characters and performing drama as a no-grade activity. Research showed that culture inevitably shapes our experience of self-expression (Tafarodi et al., 2004; Kokkoris & Kuhnen, 2014). Despite having an overall positive perception or experience of these activities, the participants were somewhat concerned about doing anything that might lead to personal shame, contradict filial piety or threaten their grades. Receiving an undesirable grade to some extent was perceived as an invalidation of a meaningful learning experience.

This study has implications for teaching psychology and counselling courses in Chinese, Asian and other non-Western cultures. Overall, the findings suggest that specific creative activities such as role-play, drama demonstration, and analysis of fictional biography, can potentially provide a stimulating learning experience for Chinese students. From a broader perspective, this observation serves as a reminder that students' perception of creative classwork is inevitably shaped by their cultural backgrounds. Course instructors teaching in non-Western

countries are advised to openly discuss with students about their thoughts and concerns, some of which are likely to be culturally-rooted, prior to the implementation of such activities.

Appendix I: Interview Guiding Questions

What are your views and experiences in (i.e., role play/drama/fictional biography) during your major study?
What were the course(s) in which you participated in these activities?
What was the impact of these activities, if any, on you course-specific learning process (e.g., learning outcomes)?
What were the pros and cons about the ways in which these activities were constructed and conducted?
What was the impact of these activities, if any, on your development or growth as a professional in relevant fields?
What modifications to these activities would you recommend lecturers/professors to consider making?

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The Impact of Caring for a Loved One who has Alzheimer's Disease: Implications for Counselling and Psychotherapy

Judith R Boyland (PhD), Ann Moir-Bussy (PhD), and Peter Innes (PhD).

When a loved one has Alzheimer's disease, resilience of the caregiver is tested to the limits of emotional and systemic survival. Research findings that underpin the collective narrative profiled in the thesis *A holistic snapshot of the impact of caring for a loved one who has Alzheimer's disease: The collective reality from onset to end of life and beyond* go beyond the primary base level of description. They encapsulate the essence of lived reality and pre-empt a need for action within and across local, national, and global communities.

Implications for clinical counsellors, psychotherapists, and professional supervisors are posed in questions for contemplation:

- When a client seeks support, is what presents on the surface of initial presentation what is at the core of the issue?
- Is there a major lifestyle factor underpinning the client's presenting distress?
- Is what the clinician sees on presentation really what emerges in the fullness of therapeutic intervention?

Keywords: *Alzheimer's, axiology, dynamic transformations, epistemology, identity shifts, intrinsic variables, ontology, resilience, triangulation of methodologies*

Context

As human beings, we are all creatures of habit and as much as we might thrive on challenge, adventure, and risk taking, there is in each of us some sense of comfort in knowing who's who, what's what, and where we fit. Our knowing is our constant and tied up with that constancy, is a certain degree of comfort and security, keenly balanced with our developed levels of resilience in the face of turmoil and conflict.

I'm OK. You're OK. We're OK.[1] God is in her heaven and all is right with the world. However, what happens when that security is totally shattered has potential to be expressed in secondary trauma – a polyvagal response as the body keeps the score (Porges, 2014, 2015; van der Kolk, 2014; Wyder & Bland, 2014).

With reference to Professor Judith Murray's model of loss and grieving (2005; 2016), my *world* that is, is turned upside down and inside out. Ever so slowly yet ever so surely it becomes my *world that was* and my *new world that is* and *my pathway to the future* become shrouded in the cloud of my unknowing.[2] However, rather than being focussed through the mystic's vision of a spiritual relationship with his God, the cloud of the caregiver's unknowing presents as a foreboding darkness that overshadows the vision of a mortal relationship with a care receiving loved one: "But now thou askest me and sayest, 'How shall I think on Himself, and what is He?' And to this I cannot

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answer thee but this: 'I wot not.' (Underhill [Ed.], 2003, p. 14)

The caregiver is in the throes of a deep and dynamic internal transformation where the *pathway to the future* is a confused, convoluted, dichotomous maze. Someone I love has Alzheimer's. Such is the scenario confronting caregivers whose care receiving loved one has a life-changing condition marked by cognitive degeneration and loss of physical, behavioural, and social function. Coping is inexorably linked with resilience: which is all about discovering and engaging methods of successfully managing the demands of caregiving.

Methodology

Under the overarching umbrella of a qualitative paradigm, defined by Gergen (1999/2009) as "imagination in action" (p. 71), design, data collection, and analysis strategies were implemented within a framework of social constructivism which, according to Lincoln and Guba (2000), embodies an epistemology whereby the truth of related knowledge lies in created findings that are both transactional and subjectivist. The action model chosen incorporated processes of intuitive and narrative inquiry intertwined with elements of transpersonal and heuristic approaches.

A hybrid methodology was believed to be the most effective tool to achieve the aim and to answer the research question. The triangulation of methodologies enabled the research question to be explored from multiple perspectives, increasing the credibility and validity of the results, while explaining more fully, the complexity of human behaviour, and honouring the richness, diversity and sensitivity of experience (Cohen, L., Manion, L., & Morrison, K., 2005; Holstein and Gubrium, 2005).

Findings

Preparation for data analysis began with manually transcribing recorded interviews. It was in this personalised revisiting and re-engagement that common themes began to crystallise, and the collective narrative began to evolve. At the completion of inquiry, 34 participants, aged between 10 years and 90 years, had shared their stories across a time frame spanning 10 months (October 2015 to August 2016). Numbers included 23 primary caregivers or caregiving partnerships, four significant support persons, and five persons touched by vicarious connection. At the time of dialogue, primary caregivers and primary co-caregiving teams had collectively given 201 years of care, underpinned by unconditional positive regard.

Findings drawn from the body corpus of data that underpin the research are encapsulated in a collective narrative that profiles *A holistic snapshot of the impact of caring for a loved one who has Alzheimer's disease: The collective reality from onset to end of life and beyond.* These findings push through and go beyond the primary base level of description and project implications relevant to participatory therapeutic approaches taken in counselling and psychotherapy where a focus is on building resilience.

Coping

As explained in the report of Daly, McCarron, Higgins, and McCallion (2013), coping is about "sustaining our place": moving from experiencing and interpreting threats to place to developing and implementing actions that are aimed at not only sustaining place, but also overcoming loss of social contact and risk of marginalisation. It was suggested by Daly et al that this is done through developing a toolkit of enabling factors that comprise protective, defensive, and inter-relational strategies conceptualised as "nurturative protecting" and "inter-relational labouring" (p. 505). Strategies include confirmation and upholding respect for personhood; claiming place rather than being dependent on others to grant or bestow; prioritising needs of both care receiver and caregiver; working to preserve dignity; nurturing *Self* and nurturing *Other*; acknowledging limitations; and recognising that at times, there is the need to prioritise I over *You*. Participants in the Daly et al. study also addressed the benefits of holding hope, developing strategies to manage emotions, respite, contingency plans, constructing a support network inclusive of other caregivers who could identify with similar emotions and challenges, and learning as much as possible about Alzheimer's disease and dementia.

Another key aspect to coping was identified by Fortinsky, Kercher, and Burant (2002), Gallagher et al. (2011), and Semiatin and O'Connor (2011) as "self-efficacy": a notion that reflects the work of Bandura (1977) and is often referred to in every-day conversation as the "self-fulfilling prophecy". For participants in this study of caregivers in south-east Queensland, each shared story presented with a "eureka moment" of discovery and as each unfolded, it reinforced the individual's sense of journey: an internal journey marked with a stamp of constant flux, as the caregiver became more deeply immersed in the realities that define a world of caregiving. As explained by Rosalind:

> I feel it is my duty to look after him. I'm his carer. That's all I am and that's my whole life. It's the isolation that is so awful. I sometimes feel that I don't know who the real me is, any more. Or where the rest of me is. I'm losing me. I look in the mirror and I say to myself, "[Rosalind], where have you gone?"

The *Self* that is revealed, is a reflection of the realities that are embodied in lived experience and as storytellers discovered and shared their own "aha" moments, the principal researcher was also led to discover images and meanings that were relevant not only to the investigation of the research question, but also to the realisation of an intrapersonal transformation related to inside experience as caregiver for a loved one who had Alzheimer's. For caregivers, the experience of caregiving is more than a task. It is also an intensely personal and relational experience. The journey is evolving, and begins with an intuitive knowing that, in Alice's words, "There's a process going on here". This significant person in my life is doing weird and strange things. Something is so very wrong. Something is not OK.

A process of dynamic transformation

As caregiving activities begin to replace the "normal" activities of daily life, values, principles, expectations, and obligations begin to be reconciled. Change is in the air and life is spiralling out of control – defined by caregiving and impacted by the emerging needs of a loved one who has Alzheimer's. *How-I-Be* in this new world (the ontology of caregiving), impacts and is impacted by *what I do* and *why I do what I do* (the axiology of caregiving) which, in turn, impacts and is impacted by what I learn and *my accrual of knowledge* (the epistemology of caregiving), which impacts *what I do* and *why I do what I do.*

Caregiving: A construct of dynamic transformation

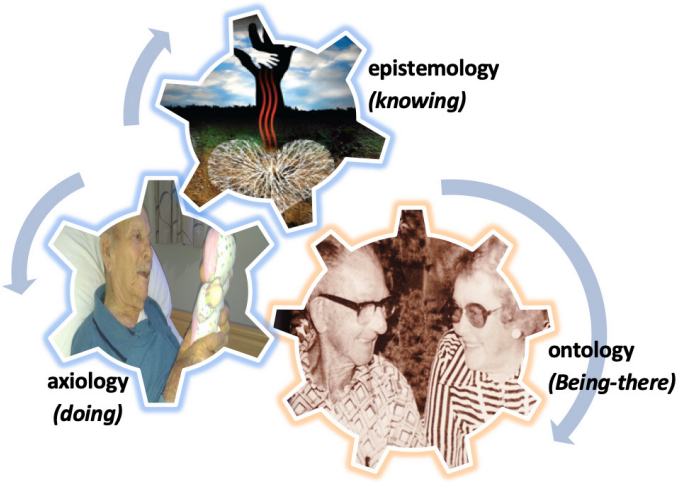

Figure 1: Caregiving: A construct of dynamic transformation: The infinite loop of dynamic transformation is set in motion as *knowing* activates *doing* activates *Being-there* activates *doing* activates *knowing* activates *doing* …….. (Boyland, 2018). Image for *knowing* is supplied by and used with permission of Wendy Watego-Ittensohn. Photos for *doing* and *Being-there* are supplied by and used with the permission of families.

A cycle of dynamic transformation begins rotation. Movement is directional, interactive, and constant. The model of a three cogged rotating machine serves to illustrate that the doing of caregiving is influenced from alternating directions: from one direction by what is known and from the other direction by what is experienced. While doing is pivotal in the process of caregiving, it both influences and is influenced by movement in the caregiver's knowledge base and movement in the caregiver's emotional and somatic sense of *Self* while "Being-there", totally immersed in *the world that is*. The infinite loop is set in motion. There is no turning back and the cycling will continue until it begins to slow progressively[3] or until there is *catastrophic failure*[4]. The cyclical model of the *infinite loop* is simple. The journey through the transitional rotations[5] is complex. The individuality of each evolving story and each caregiving journey is expressed in words shared by Rosalind and Antony; each of whom had cared for a parent who had Alzheimer's, before now caring for a spouse who has Alzheimer's. As Rosalind explains, "No two patients are the same. [Owen] is so different from Mother. He is moody and anxious and cantankerous. With mother, it just crept up and she just became more eccentric as the years passed by". Antony simply states:

> I thought I was beyond surprises. But my darling [Eva] was different again from both Father and Mother. I just kept learning and every day was a new day and every day I did what needed to be done. And that was my whole life. That was all I lived for.

Epistemology of caregiving

Epistemology is about a way of knowing and caregivers instinctively know that the knowledge they accrue through lived experience is their reality. Knowledge that they gather through testimony from a diverse array of sources also impacts their reality and there are times when they can be undermined in a serious way by their own thoughts and actions or by the words and actions of others. The very experience of caregiving for a loved one who has Alzheimer's disease results in a turning upside down of all prior knowledge relating to caregiving. When the condition is slowly and progressively impacting the cognitive and functional capacity of the care receiver, all expectation about connections leaves the caregiver looking backwards and looking forwards while, at the same time, being lost in a maze of "now time" that is an ever-changing space: a space that is constantly shifting and clouded over by the unknown. The only constant, is the total absence of constancy.

The undermining of all that is known presents as a problem of epistemology. It is a learning process and there is no simple and universal following of direction that relates to what one "should do" in the situation where the presenting symptomatology and corresponding issues line up with a defined medical model of pathogenic reality. For such a very long time there is no variation to measured levels of intrinsic variables; no biomarkers against which subtle behavioural changes can be measured; no circulation problems; no breathing problems; and no bleeding. Nothing is broken and until the final stages of transition, there is no deformity. Every step of the caregiving journey takes the caregiver into uncharted territory: a place that is shadowed by a cloud of unknowing.

Some 73 years ago, Malinowski (1945) claimed that knowledge gives foresight and that with the gaining of foresight comes empowerment. 66 years later, Anderson (2011) spoke of the power of intuition and highlighted the concept of listening with the senses and with awareness that is open and attentive. While Malinowski and Anderson speak with reference to the researcher's gathering of knowledge as a source of data, the positions they present apply equally to the gathering of knowledge in any circumstance. The accrual of knowledge is, primarily, experiential and evidence-based. That is, the internalisation and evaluation of an experience is based on the sensory and emotional response to what is presenting within the confines of the world in which we live and function.

Reflecting on the principles positioned in these writings, it could be said that implication is closely aligned with perception. From the position of care receiver, what is presenting externally and what is observed on the outside is in opposition with the inside experience. From the position of caregiver, there is engagement with a loved one who outwardly appears to be the same person right up to the final stages of degeneration: which could be a transitioning that spans in excess of 20 years. In extreme circumstances of early onset, this journey could be 50 years of transitioning (Summers, 2014; 2015; Gupta, 2015). The process of transitioning is marked with fluctuations in empowerment and disempowerment accompanied by fluctuations in buoyancy that is encapsulated in resilience, and in a sinking sensation that issues from an absence of resilience.

From the professional position of a third party support person, the challenge is to link observation with intuition and foresight. For it is only through the transpersonal linking of the senses that the total experience can be identified and defined; and it is only when the presenting symptomology is identified and defined as being related to something deeper and more sinister, that the professional clinician can tap into support strategies that empower and promote growth in resilience for the struggling caregiver who is trying to stay afloat.

While amazing progress is being made in diverse avenues of research,[6] at this point in time and under general circumstances the condition can be neither fixed nor reversed. It does not go away and the loved one who has Alzheimer's does not get better. As Aaron shared with his son, Richard, in the early stages following diagnosis, "I'm the one with the brain problem and your poor Mum has to live with it". For Hal, the journey he shares with his mother knows no stability and it is his perception, that with the passing of each day, he is very quickly learning, "Both of us are on the slippery slope to nowhere".

The *Self* of this *Other*, who is known and loved, is not there in the same way. The persona of the presenting *Self* is becoming a stranger who has invaded the exterior shell of one who is known and loved and the caregiver's established sense of connection is gradually stripped away. As Lavinia reads from her journal, she shares:

> Gradually, I moved from companion to minder and that was the sad bit. I was missing the person I loved as [Oswald] was getting frailer mentally and physically every week. What used to be so good isn't good any more. The time comes when I have lost my relationship with my husband. I am now his "mother". I am no longer his "wife". What I'm missing the most is being Someone Special to a Special Someone.

Yori tells of how expectations about caring for a loved one are "rolled inside-out"; Elizabeth speaks of relationships being "turned upside-down"; and Vince refers to the "topsy-turvy" state of thoughts and emotions. It is about change that moves from the inside to the outside at a functional level and from the outside to the inside at a relational level. The change is transitional, the impact is transformative, and both are evolving amidst the chaos of a world that is constantly changing. In the lived experience of negotiating one's way through the cycles of transition, it becomes about distancing, invisibility, truth, and reality. The impact of accruing knowledge, adjusting actions and reactions, and Being-there as the caregiver, is defined by Eleanor as she states:

> I don't know who I am any more. I don't know who [Rod] is. He is not who he used to be and who he is, is changing all the time. He has a terminal disease but he's not sick. He is dying but he looks the same: so alive and well, but just not so sharp. Nothing has changed but everything has changed. There are times I just look at him and I say to both of us, "I don't know if I can do this." I am so scared of what lies ahead and for what could be such a long, long time.

Caregivers' Dissemination of Accrued Knowledge

Accrued knowledge is disseminated through behaviours associated with the doing of caregiving and through dialogic interchange with others. There is no element of luck underpinning the disseminated knowledge that relates to caregiving and the impact of caregiving: it is pure and true expression of lived experience. Actions and reactions reflect levels of gratification relating to the fulfilment (or lack thereof) of the caregiver's own intrinsic and basic needs[7] as a human being whose life is immersed in a world of caregiving. Old knowledge is enhanced or replaced with new knowledge. Old beliefs and expectations are transcended by what is presenting in the shifting sands of time.

The cogs that denote *knowing*, *doing*, and *Being-there* continue to revolve: keeping the *infinite loop* in motion. And, as the gap between *the world that was* and *the world that is* widens, the dynamic transformation of *Self* and *Other* continues to evolve.

Axiology of caregiving

As a way of doing, axiology is underpinned by a transitional knowing. Reflecting the position of Lincoln and Guba (2000) from a constructivist perspective, "doing caregiving" from a place of love moves towards a praxis of participation where the focus of concern is on liberation from degenerative oppression and freeing of the human spirit from the torments of the degenerative process. Actions are purposeful and the means is justified by the end.

Drawing on hypotheses posed by Lewis (1946/1962) and Wittgenstein (1922/2017) in relation to the generalisation and valuation of characteristic properties associated with a subject, it could be ascertained that when caring for a loved one in any circumstance of illness or injury, there is love, concern, consultation with professionals, and following direction. There are moral and social constructions and in general circumstances, the expectation is that if one follows the rules, all will be "OK".

However, for the caregiver whose journey is with a loved one who has Alzheimer's, there is an underlying mismatch between moral and social construction conventions and because the experience of caring for a loved one who has Alzheimer's disease is unlike any other experience of caregiving, expectations are also different. The sense of moral fabric is disoriented and the sense of *Otherness* in relationship is undermined, as voiced in the words of Angelica:

> My motivation was my sense of duty and my sense of responsibility. I was always a little embarrassed and as time went on, my embarrassment became worse. I was frustrated and angry and tired and cranky and also a little bit frightened. And so to protect him, I closed in and I tried to hide his behaviour. I became isolated. But I could never bring myself to the point of being able to say, "I can't do this anymore". After all, I am a nurse.

Positions internally constructed by caregivers are played out in action according to perceptions and interpretations: exemplified in Isabella's and Iris' initial motivation to care for a parent in a self-sense of obedient compliance. This is in stark contrast to the motivating force that drove Alex, an 18 year old grandson, who is formally registered as the informal co-caregiver for his Nan, Helen: and he wouldn't have it any other way.

Caregiving actions not only define the construct of caregiving in aesthetic terms, they also reflect the values that underpin them – moral, ethical, spiritual. Tension is created between these axiological dimensions, as a strong sense of duty underpins the action pathway through the maze of emotional, relational, and functional transitions. As the action component of the data set is woven into construction of the collective narrative, the landscape that emerges is highly internal and personal – the care receiver needs to be cared for and the caregiver needs to care.

Ontology of caregiving

Turning now to the ontology of caregiving, which is about a way of "Being", it is helpful to reflect on Siegel's notion of the neurobiology of "we" (Siegel, 2008) where he explores the

transformative power of "Being-in-the-world" and references the concept of *I* as being more accurately expressed as a concept of *We*. In what Heidegger (1927/1962) defined in "ontologico-Temporal terms", *Being* is about "presence" ("Anwesenheit") (p.47) – "Being-present-at-hand" or "Being-present-in-the-world" (p. 245). In that presence, one is "concernfully absorbed" (p. 247) with what Murray (2005; 2016) refers to as *the world that is.* It is "Being-there" and it is about defining impact and confirming the internal relation between "human being" and "world". The emerging hypothesis suggests that the way of Being-in-the-world of caregiving is incomprehensible in isolation from *knowing* about caregiving and *doing* caregiving. In essence, *Being* is about Being-there.

Thus, it is implied that understanding the way of Being-there or of Being-in-the-world impacted by caring for a loved one who has Alzheimer's, is also incomprehensible in isolation from an insight into the world where one is totally consumed by the actions of caregiving. And herein lies its transformative power, as reflected in words shared by Yori:

> I guess the hardest thing is adapting to the advancing baby mode – clean his bottom, shower him, catch his dribble, wipe his nose, shave him, and dress him. Some days are very difficult and in finding the compassionate in the Self, one also learns to be very, very patient. It's OK if it doesn't get done today. Most importantly, I've learned the value of tolerance and understanding and appreciation and how helpful that is for both of us.
>
> I never imagined that I would be looking after a grown-up baby. I had to learn and I did learn new skills. I always had him around to do the 'blokey' stuff. Now I do everything. I mow the grass, I change the washers in the taps, and I do the house maintenance. I look at him as he stares and I wonder, "Who are you and where are you? Give me my husband back". And as he changes with the coming and the going of each passing day, so do I.

Ontology of caregiving as a repositioning of identity

As the tapestry of the collective narrative grew, it became evident that as degenerative transitions merged and as the processes of everyday living shifted and changed, there was corresponding movement in conscious awareness. No longer was there a sense of security in knowing "who *I* am", "who *You* are", and "where *We* fit in the world". Repositioning identity became inexorably linked with loss of freedom, redefining of roles and relationships, social isolation, social stigma, and preservation of dignity. Gratification of higher order needs became secondary to the need for survival on multiple levels – emotional, physiological, and spiritual.

Such dynamic transformations reflect the words of Jenkins (1996/2004/2008) who postulated the notion that identity is not fixed. Rather, suggests Jenkins, it evolves with life experience, self-awareness, self-reflection, and interactions with others. That is, identity has a relational value which involves knowing "who's who" and hence "what's what" (p. 5). One can only begin to imagine the internal tensions when an adult child is asked by a parent, "When did you become my mother?" (Alice). One might also ask how Being-there presents for a wife of 40+ years when she is referred to as, "That lady next door – oh, you know, what's her name?" (experience of Angelica, as reported by Rosaline), or the wife of 48 years who is referred to as, "That young hussy who tried to climb into bed with me" (experience of Alexas, as reported by Elan).

As the caregivers journey with their loved ones, their position of knowing who they are in relation to others continues to cycle through the *infinite loop*. Friends become as strangers, as those who were thought to be friends, withdraw. "What would be nice", says Rousillon, "would be if some of my so-called friends could pick up the phone and just say, 'How are you going?' Just a minute or two slows the cycle and says that someone cares".

In other circumstances, anonymity of being just another person in the crowd is replaced with moments of Being-there in the spotlight of embarrassment, as the social behaviours of the care-receiver transition to behaviours that are anti-social, attention seeking, sexually inappropriate, and embarrassing. Embarrassment was the experience for Audrey when Ratcliffe said to a young mother pushing a toddler in a stroller, "That kid should be pushing you".

Given the changes in lived experience and the ways in which others treat both caregiver and care receiver – be that with empathy, sensitivity, and respect; or be that in ways that reinforce social stigma – perhaps the getting of wisdom could be said to come with building resilience and the development of a stronger sense of *Self*. Maybe the hypothesis is, that for the caregiving journey (or any life journey experience) to have a positive outcome, one needs to pass through a dying process or a shedding of one's "old skin" in a process of dynamic transformation. One may also need to develop an added layer of resilience. Being able to acknowledge and accept that life is what it is, in any present moment in time, demonstrates that when love underpins all that is *good*, *bad* or *ugly*, one can compose a sense of *Self* that rises above the transformative energies of degenerative transitions. *Being-there* acquires a "meaning of reality" (Heidegger, 1927/1962, p. 245).

Summary of discussion

What is significant in the selected scenarios that have been profiled is simply a glimpse into the uniqueness of Alzheimer's disease and the co-related uniqueness of the caregiving role. Alzheimer's is different from other diseases in its presenting symptomology, the progressive nature of cognitive and functional degeneration, changes in the architectural structure of the brain, and the duration of time spanning the trajectory of transitional changes and the trajectory of care. Also of significance are aspects of incidence and prevalence that identify Alzheimer's disease as a modern-day epidemic impacting social and economic resources on a scale of concern that is unprecedented at global, national, and state levels (Alzheimer's Association, 2018; Alzheimer's Australia, 2017; Queensland Department of Health, 2015).

With Alzheimer's disease, observable change is subtle and caregiving need is unpredictable. Diagnosis is generally made with reference to behavioural changes that can take decades to become consciously and consistently observable: for example, Adam's diagnosis followed eight years of his undergoing various processes leading to confirmation. For Brian and Heather Fischer whose story was profiled on *Four Corners,* July 10, 2017, Brian's diagnosis was a process that spanned 11 years.

The epistemology emerging from this investigation is that the impact of caregiving for a loved one who has Alzheimer's

is timeless, constant, intense, inconsistent in levels of intensity, isolating, lonely, oppressive, and internal. In their darkest moments, caregivers may be feeling as if set adrift in a fathomless sea or tumbling aimlessly amidst the shifting sands. They may be feeling lost in a maze of emotional turmoil or overwhelmed by an enveloping cloud of unknowing.

Just as change in the care receiver's brain is a long, slow process, so, too, is change within the *Self* of the caregiver. It is a "flight through the darkness" (Isabella) as one journeys through *Wayi*, (Ephesea). For Isabella, this image "summons up a world of contradictions" and she explains:

> The dichotomy is that as I grow to understand more, I love him more. And because I love him more, I believe that I will be less distressed to know that he is out of the darkness that has enveloped his life.
>
> When I loved him less, I missed him more and now that I love him more, I miss him less: and that is something that I really need to think about. I value that we both had to go through this darkness to get to the light. I've always had a father but we had to go through this for me to be able to get close to him and to have an understanding of him: where he came from and what he had to give up as such a little boy so that his family could survive. Maybe our journey has been into the darkness and out again.

Running parallel with these thoughts expressed by Isabella, there is also a point of consideration that all may not be as it appears to be. Reflecting on the observed reality of behaviours defining that which is cognitively, physically, and functionally degenerative, Ephesea speaks from a transpersonal and spiritual space. She defines Alzheimer's as *Wayi*, which in Jandai Aboriginal languages means "to let go". From a position of *Wayi*, Alzheimer's becomes "the sacred journey and the letting go of all bodily attachments, physical and emotional: beginning the journey of re-entering into the spiritual world from which we came" (Ephesea). For the caregiver, it is the letting go of relationship with a very special person, who is so loved.

Entwining the epiphanic and transcendent descriptors of a f*light through the darkness* and *Wayi*, maybe it could be said that moving through the Alzheimer's maze is the sacred journey through the darkness. In that space there is a letting go of all that holds one to that which is of the human experience while opening the door to transcendence into the spiritual realm where life began. It is going home. And when life has spun full circle, the journey for the care receiver is complete while the impact for the caregiver lingers on. For the caregiver, there is always a part of that journey through the trajectory of care that is never completed and even when the care receiver has transitioned through *Wayi*, there are fragments of impact that, for a lifetime, will lie embedded deep within.

Flying through the darkness

Figure 2: Flying through the darkness: Visual reframing of the Alzheimer's journey that impacts both care receiver and caregiver. Painted in acrylics on canvas by Isabella during initial dialogue, 23/10/2015 (Boyland, 2018).

As caregivers travel along the many pathways that define their journey, raw and confronting reality is exposed as it is lived. Finally, the point is reached when maintenance of well-being is at risk and what Powers (1998. 2005) defines as "intrinsic variables" begin to approach near lethal levels. It is at this point when a caregiver might seek help and present for support in managing stress associated with the reality of lived experience: with little or no realisation that at the very core of the distress is an embodiment of secondary trauma.

Implications for counselling and psychotherapy

Considering implications that have emerged from analysis of the data set that profiles the collective narrative, one implication that calls for action is the need to challenge professional clinicians[8] and those in mentoring positions[9] to appreciate and to not minimise the potential scope of role related impact on well-being. With emphasis on "duty of care", professional responsibility demands validation of approaches and techniques used in therapeutic practice focused through a diagnostic framework for identifying and working with secondary trauma. An indirect implication that emerges from the research findings is the need for clinicians and professional supervisors to develop an acute sense of discernment in relation to the diversity of presenting scenarios that could be triggered by change related circumstances that impact identity and identity shifts. Associated impact could be a cycling of dynamic transformation set in motion by a shift in the client's values base, a disruption to lifestyle, or polyvagal disturbance to maintenance of emotional well-being and balance of intrinsic variables. When a client seeks support, the clinician has an ethical duty of care to not only "do no harm" but to also be conscious that in a contextual reframing of Alice's comment, "There's a process going on here"; and that all may not be as it appears to be on the surface level of initial presentation.

Being in *the world that is*, is what brings a client to the counselling room. And while the *world that was* can never

be reclaimed, it is the clinician's ethical responsibility and professional privilege to walk with clients as a *pathway to the future*[10] is created. In the best-case scenario, the stepping stones to wellness are stamped with a footprint of resilience that denotes a balancing of needs gratification and confirms that the light at the end of the tunnel is not a big train. It is a lantern that diffuses the darkness, as a new day is born.

Footnotes

[1]Notion of OKness developed by Eric Berne, 1966.

[2]With reference to the work of the unknown mystic of the fourteenth century. (Underhill [Ed.], 2003)

[3]Additional help and support is tapped – for example: "hands on" support, respite, emotional support such as counselling, or care receiving loved one is admitted to formal, residential care.

[4]Death of caregiver or death of loved one who is the care receiver.

[5]Each complete rotation equates with progression through one transitional stage in accord with Riesberg's global deterioration scale (Reisberg, Ferris, de Leon, & Crook, 2007).

[6]Refer to Bredesen, D. (2017) and Petrovsky, N. (2016).

[7]Refer to Glasser, W. (1984; 1999).

[8]For example, counsellors and psychotherapists.

[9]For example, professional supervisors, clinical supervisors, mentors, and educators.

[10]As stated above, world that is, world that was, and pathway to the future are concepts developed by professor Judith Murray (2005; 2016) in relation to developing a model of loss and grieving.

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A Case Study on Sex Offending: Indigenous Healing in Qualitative Research

Valerie Schwan Cloud Clearer Ringland

Indigenous theory brings a new perspective to sexual violence research. It considers healing the trauma of sexual violence a collective responsibility to transform culture and equally values healing for victims, offenders, and bystanders (family and friends). Voices of traditionally silenced community members, in this case, sex offenders and family members, offer unique and vital perspectives on sexual violence and healing. The indigenous trauma healing tool of empathic dialogue was used with sex offenders and their family members, with the researcher-participant in the dialogues as herself a survivor of child sexual abuse. The data and results of five empathic dialogues are reported, along with potential implications for public policy and practice.

Introduction

The impacts of sexual violence are numerous. Common challenges for survivors include low self-esteem, self-blame, guilt, shock, confusion; denial; suicidal ideation; PTSD; depression, flashbacks, substance abuse, chronic diseases, and sexually transmitted infections Morrison, Quedara & Boyd, 2007). Perpetrators face life-shattering consequences such as imprisonment; lifetime status as a registered sex offender; expulsion from university; public humiliation; family shaming; and, attempted retribution (Consequences for perpetrators, n.d.). More work has been done on supporting survivors of sexual violence to heal than on supporting perpetrators. Interviews with men who have been violent with women have found they carry a deep sense of self-hatred (Kaufmann, 1999). A lack of empathy is a primary challenge for sex offenders (Borduin & Schaeffer, 2001; Hanvey, Philpot & Wilson, 2011). Another factor is the obsessive-compulsive judging to "measure their worth and compare themselves to everyone else and always come up failing" (Prendergast, 2004, p. 19). Increasingly, there is a call to address the secondary trauma of friends and family members who support survivors and/or perpetrators in healing, and have healing needs of their own Morrison, Quedara & Boyd, 2007).

Indigenous Theory

A decolonization framework in research is a means to "redress the constructs used by academics and governments" (Sherwood 2010, p. 121). Indigenous theory is within the framework of decolonization, where the word "indigenous" may be used to describe specific people whose beliefs, traditions, and ways of living originate within a cultural group and place, *or* a view of the world as a web of life that is inherently interconnected and operates in cycles (Cervantes & McNeill, 2008). For this research project, the latter definition applies. An indigenous approach to healing that honors the inherent interconnectedness of all beings asks us to make as much space in our hearts for everyone involved in sexual violence, whether as an *offender*, *victim*, or *bystander* (a family member or close friend suffering secondary trauma).

Empathy, compassion, and inclusion is a new framework for researching sexual violence, as research on sex offending has traditionally focused on criminological deterrence and psychological deviance. Voices of traditionally silenced community members, in this case, sex offenders and family members, offer unique and essential perspectives on sexual violence and healing. In indigenous theory, when we offend or are offended against, we are out of balance with ourselves, our families and communities, and our Creator. "The use of judgment and punishment actually works against the healing process. Ross (1996, p.253) argues that "An already unbalanced person is moved further out of balance," in which he cites a Hollow Bone Reservation position paper on restorative justice. We need to experience a sense of empathy with our human family and all beings and engage in healing that re-evaluates aspects of our cultural identities and individual sense of self. "A return to balance can best be accomplished through a process of accountability that includes support from the community through teaching and healing" (Thibodeau & Nixon, 2013).

Such a process is exemplified by an Ojibway community in Canada called Hollow Water. In Hollow Water, the survival of an individual is synonymous with that of the community; ultimately, the entire universe is considered family, which creates a unique framework for healing (Garret & Herring, 2001). A group of community members who sought, in the 1980s, to address

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alcoholism, unemployment, and housing shortages, realized that 60-70% of the community had experienced sexual abuse dating back three generations and that 35-50% of offenders had been victimized (Sawatsky, 2009). They formed a team and trained each other in skills from wilderness and addiction therapy to policing and traditional tribal teachings. In working with the Canadian legal system, a thirteen-step process emerged for dealing with sexual violence in their community. When asked about an offender, one team member said, "He's always going to be here. His kids are here. Don't give up on this person. Keep at him until [he] understands that our focus is to one day have a healthy community" (Sawatsky, 2009, quoting a community worker, p. 116). After twenty years, one study found that the sex offender recidivism rate in Hollow Water was six times lower than the national average. There was a backslide in progress due to changes in team members, a decrease in State funding, and changes in legal personnel. The community had begun healing and prevention responses, including a traditional fasting ceremony and vision quest for purification, a wilderness therapy program, and communal dances (Sawatsky, 2009).

Research Questions

How do indigenous theory and the use of the trauma healing tool of empathic dialogue as a form of qualitative research interview enrich our understanding of sexual violence, trauma, and healing? What are the met and unmet needs for healing and support of registered sex offenders and their family members?

Methodology

This is a case study of sexual offending within an indigenous framework inspired by Hollow Water. A case study is a qualitative research methodology where an issue is examined in a contemporary context bounded by place and time (Creswell, 2012). The interviewing methodology was based on the indigenous trauma-healing practice of empathic dialogue (Atkinson, 2002), which uses empathic listening and storytelling to promote healing (See Figure 1). Empathic dialogue aligns with feminist interviewing, emphasizing the importance of flattening the researcher-above-the-subject hierarchy of classical science (Oakley, 1981) and, instead, creates an honest dialogue between equals (Campbell, 2002). The researcher is a participant and observer open to answering questions and sharing, mindful that the focus of the interview is to create a safe space for the subject. Expressing and using emotions facilitates an honest process of inquiry that creates common ground between researcher and subject and clearer, fuller research results (Campbell, 2002). Such interviews are also opportunities for giving voice in publication and, as such, are acts of social justice. Indigenous theory further suggests that empathic dialogue can create opportunities for spiritual growth and healing (Atkinson, 2002).

Figure 1. Healing trauma through empathic dialogue

This study consists of N=5 individual interviews, which were conducted from 2016-2017 in Texas between a researcher who is a survivor of child sexual abuse and subjects who were either registered sex offenders or close family members of registered sex offenders. Through these interviews, I intended to provide subjects a safe, healing space for storytelling. To answer the question of whether the empathic dialogue itself was healing, the final interview question was: "How do you feel?". Throughout the research process, I did my utmost to connect with an inner sex offender, to better understand where I was judging, shaming, and violating against myself and others, as well as my inner bystander, to understand better where I was not speaking up, offering support or maintaining healthy boundaries. Since I was the researcher observer-participant in these interviews, I refer to myself in the first person. I use the terms "empathic dialogue" and "interview" interchangeably.

The first research subject and I were connected through a mutual acquaintance. During a phone screening, I outlined my theory and research interest. The subject described treatment he had undergone, affirmed he had been prosecuted for all sex offenses committed, and said he considers participating in the research as part of his social amends-making. Upon completion of an IRB process, we met for an interview in 2016 for over three hours. In 2017, he connected me with an organization he was part of so that I could expand the study through snowball sampling. The Executive Director of the organization said he spoke so highly of our interview that she wanted to participate and also that others would. Following IRB approval, she sent out my message requesting study participants. I received more interest than I could accommodate. I chose to interview four more subjects, one more sex offender and three bystander family members. They were able to meet in person because physical presence is valued in the indigenous theory of healing. I transcribed the interviews, then read through them in one sitting. I pulled out quotes about individual stories relevant to the research questions, printed them out, and organized the strips of paper into piles. Six categories of results emerged.

Data

The data consisted of N=5 interviews, which were empathic dialogues between me as a participant-observer researcher, and each subject. Participants' stories of sexual violence are outlined below. They are referred to as Offender A, Offender B, Bystander A, Bystander B, and Bystander C. I, as researcher observer-participant, am the Victim.

Offender A was a male computer programmer in his 40's. Growing up, his grandmother physically and verbally abused him. His family was with the Church of Christ. His mother said masturbating would make him gay, his father believed that

sex brought disease, but he had a lot of sexual curiosity. At six, he kissed another boy's penis; at eight, two 14-year-old boys forced him to masturbate them; at 16, the teacher he most respected gave him alcohol, touched his penis, and tried to seduce him. By 18 he hit himself while masturbating, convinced "there must be something wrong with me." At 19, he found his mother in an alcoholic coma. His parents told him about affairs and other marital issues. He started partying and had a crisis of faith: "I remembered too many times saying, 'God help me not to get drunk tonight,' and I got drunk anyway…It's like I'm at war with myself." He entered in-patient treatment, joined AA, NA, and the Unity Church. He got a girlfriend, cheated, became depressed and suicidal, and was told he had repressed memories of child sexual abuse. He went into treatment for that, broke ties with his family, changed his name, and moved. He married, had two children, and began sexually abusing them. When he touched his daughter's 11-year-old friend's breasts, her scream "broke the spell." He felt immense self-hatred: "This is just like it was for me when that teacher fondled me." He joined Sex Addicts Anonymous ("SAA") and confessed to abusing his kids so they would get help. He went to prison for five years plus three years' probation. He said: "I had feelings that I knew were inappropriate about children, almost from the time I was a child," and he never felt safe enough to talk about them. He has reached a place of self-forgiveness and tries to participate in society.

Offender B is a male welder in his 50's whose mother sodomized him from age three to six. His grandfather was an alcoholic who stopped drinking after raping his mother when she was a girl. At eight, his mother served him alcohol, and he was soon addicted. By the age of ten, he and a friend regularly drank when the friend's ex-convict father passed out, and the friend's mother also bought them some. At 13, he stole a bicycle, went to juvie, and left school: "I went to work as a flat roofer…the people I was working with were alcoholics, so it was beer thirty from the time I got into the work truck…I started smoking cigarettes when I was 13, methamphetamine…sticking needles in my arm when I was 14, cooking the stuff at 18." He drank so much that he passed out once when he was found and was brought into a hospital. A doctor said he had more alcohol in his system than water: "So what did I do when I left the hospital? I celebrated by getting a drink. And that's why in AA it's called insanity." He married, had children, and sodomized his daughter when she turned seven. He felt it was wrong but could not stop, so he went on the run. He ultimately turned himself in, read the Bible "front to back in like a week," pleaded guilty and went to prison for 10 years. Determined to become a better person, he studied Christianity, messianic Judaism, Islam, and other spiritualities, including a meditation program called Avatar, which he still follows. Upon release, he received help from an SAA sponsor, then met a retired police officer who is an "accountability partner" and "father figure." A few years ago, his daughter contacted him: "It was amazing." He helped her understand and stop her own addictive behavior. He now runs his own welding business.

Bystander A is a retired teacher in her mid-50's and mother of a man convicted for possessing child pornography. Her son realized he was gay in middle school, felt it was "social suicide," and was "disgusted by the whole idea." The family went to a Methodist Church where being gay was not celebrated. He got into pornography, which involved adolescent boys, because "his sexuality was stuck there, although the rest of him grew up." While working a pet store and living with his parents, he awoke one morning with rifles in his face as he had downloaded a file that was part of a sting operation. An FBI SWAT Team searched the house, questioned everyone, and confiscated his computer and phone. Their attorney said not to talk about it, so for a year and a half Bystander A did not even tell her sister. When she did tell her family, they were supportive. Her son was suicidal, depressed, and self-punishing: "Once in a while he would go off the deep end, he would drink a lot of beer and smoke and take a Xanax, and at one point he had burned himself, 'This one's for mom, this one's for dad...'" She spent time with him since he was unable to play video games, watch TV, or do much outside of work. A counselor "helped him accept who he was." He was promoted. After two and a half years, he was indicted for possession of child pornography. Family, friends, and neighbors wrote letters and testified for him. He went to prison for a year-and-a-half and spent six months in a halfway house. "My kids always come first…they're my life's projects. I told [my son]…' If you wanna ask me if I would have you all over again knowing what I know now,' I said, 'Yep, in a heartbeat, it's all right, 'cause you're a good guy.'"

Bystander B is a mother in her 60's with a son who had sex with a minor. Growing up, her family was emotionally closed. When her son started smoking marijuana and drinking alcohol in high school, she thought he would outgrow it. At 22, he did drugs at a party and had sex with a sixteen-year-old. Her mother reported that to the police. He was put on probation and sent to sex offender treatment. Bystander B told the probation officer and treatment provider he needed drug treatment and was told he would receive it, but he did not. Upon testing positive, he was sentenced to eleven years in prison. Though she found it unfair: "I am not the main one involved. It's his journey, not mine." During seven years in prison, he "turned his life around." He "found Christianity," joined the choir, and earned degrees in welding and woodworking. He is on parole living in a trailer outside Bystander B's house, and eats dinner with her daily. Bystander B could not find a support group for sex offenders' family members, so she started a non-profit sex offender advocacy and support organization. She is the Executive Director and receives no pay. The organization has over 600 members on an email list, holds monthly support groups across Texas, does legislative advocacy, holds an annual conference, files civil rights lawsuits, and provides support to sex offenders who are leaving prison. The work has become a calling, and she has no regrets.

Bystander C is a hospice nurse in her mid-50's and wife of a registered sex offender who works in the oil fields. She knows he was wrongly accused. His thirteen-year-old niece visited, asked to move in the night before she was to go home, then called the police the next morning, saying Bystander C's husband touched her crotch and breasts through her clothes. Bystander C wonders if the girl's step-father was abusing her, as he was on his way to pick her up when she reported the alleged abuse. Bystander C's husband had a "troubled family." His parents were verbally and physically abusive and divorced when he was twelve. When he was 21, his younger sister committed suicide, which "destroyed their family." Bystander C's family supports her husband, and so does their daughter, who had just graduated from high school when her dad was accused. Instead of sending her to college, Bystander C and her husband spent more than half a million dollars on his defense, with support from friends, neighbors, and her family. Bystander C and her daughter received counseling, and her husband did 300 hours of community service. The niece moved away at 17, and her mother relinquished parental rights so she could marry her 22-year-old boyfriend. When he was

deployed, she moved back, and four years after the indictment, they went to trial. Five of the niece's friends testified that she was a liar: "10 o'clock at night, and it was Saturday…[the jury was] deadlocked, and the judge kept sending them back and said, 'If you don't do this, we'll just be right back here Monday,' and lo and behold a half-hour later they came back with a guilty verdict…[My friend and I] were just screaming." The jury suggested five years' probation, which the judge doubled. Bystander C describes life since the accusation as being in a constant state of fear and punishment. She was unable to work for over two years after the conviction, and they moved cities to leave abusive treatment providers and restrictive living ordinances. She takes solace in the fact that this experience did not break her, her husband, or their daughter. As a Christian, she wrestles with forgiveness.

I, the researcher/Victim, am an attorney and social work researcher in my mid-30's. I told each subject during the phone screening that I experienced incest during childhood, and at the beginning of each interview, I briefly shared my story and invited questions. An uncle sexually abused me from a young age, my mother was abusive, and I was cared for by a nanny until school. I had little sense of direction or self and was a "good girl" who followed rules. While studying engineering as my parents wanted, serious health problems in my digestive, reproductive, and hormonal systems emerged. Somehow I graduated and went to law school. I was drawn to children's rights and restorative justice. I spent over a month bedridden the first year and suffered a concussion in my second. As my health started to improve, I felt I needed space, so after law school, I moved overseas to advocate for children's rights. I suffered burnout, took a break, and started recovering memories of sexual abuse from infancy to adolescence, as well as multiple memories of reporting and not being believed. As part of my healing process, I engaged in this research project.

Results

Six themes emerged during data analysis: Social Context, Victimization, Church and Spirituality, Healing, Unmet Needs, and Interview Impact.

Social Context

All subjects discussed context, from family of origin to Church and community, to popular culture generally. Two compared the way sex offenders are treated to that of people with AIDS: "People think there's just some things that a human... if they've done it, they can't come back from… there's something inherently wrong." Bystander C said social judgment felt like a Scarlet Letter, citing the *SEX OFFENDER DIVISION* police car that visits her home. Bystander B said that the best way to kill a legislative bill was to show how much it would cost to enforce. Subjects said popular culture portrays everyone on the registry as dangerous predators. Most laws affecting sex offenders were purely punitive or designed to help people feel secure from "stranger-danger." Offender A said: "There is such a visceral contempt, disgust, and I've felt it myself…before I committed these offenses, I was like…' burn 'em at the stake.'" Subjects felt that the majority of sex offenders were "not bad guys," but people who had made mistakes and ought to be able to "complete their punishment and move on." Many commented about sex in popular culture, like 'Better Sex in 10 Days' headlines on magazines that even children can see at the grocery checkout.

Most subjects had adverse experiences in childhood: "You alter [a child's] growth pattern with sexual abuse…I believe that's why people that have been sexually abused as children are more apt to addiction." Bystander C said: "[My husband and I] had been together a couple of years when he was like, '[T]his is what a mom's supposed to be like?'" Offender A said: "One of the things that led up to my offending against the kids is that I didn't have…much in the way of social connections." All subjects grew up with Christianity: "I remember being afraid of Hell."

Many talked about feeling "fundamentally flawed" and seeing sex as dirty and bad. Some talked about substance abuse and the numbing effect it had on their behavior. Offenders were also impacted by the school. Offender A said: "Teachers commended me for being curious, as opposed to 'Go away you're bothering me' which is…what I got from both of my parents," but felt betrayed when a trusted teacher touched him and the principal did nothing. Offender B checked out of school when a teacher put him down in first grade. Offenders lacked positive role models, especially males.

All subjects talked about addiction, from alcohol and drugs to sexual exploration. Offender B said: "Alcohol was a big part of my life, and it contributed to who I was with the sexual assault of my daughter." Offender A was once caught "peeping on my sister" and felt "really ashamed." Bystander A's son and Offender A used pornography as an outlet for their sexual shame. Offender A wanted to have sex more than his wife: "I don't like the way I treated her in retrospect." Three subjects reported the offender had not interacted with the criminal justice system until the sex offense, and Bystander A felt that as a result, her son had not learned to understand the consequences. Bystander B remembered getting into trouble as a teenager: "[My friend and I]…snuck out the window. I got grounded." She reflected that her mother had not asked who the boys at the party were, nor thought to call the police.

Victimization

"Our biggest challenge is trying to dispel the myth that people on the registry aren't human; they're monsters." All subjects felt victimized by the sex offender registry and laws regulating sex offenders: "You just feel like you're stuck under a microscope to have people…looking at everything in your house, and having to account for your every minute." Subjects talked about men in their organization who had met a girl at a bar or an 18-and-older club who felt like victims of entrapment when they found out she had used a fake ID: "I don't think these girls understand that you could be ruining someone's life *for life*." They talked about renewing their driver's license every year, having to get a "Sex Offender" stamp in their passport if they wanted to travel, struggling to avoid driving in school zones, needing criminal background checks to access databases necessary to run their own business, and how each county and city and state had different ordinances affecting sex offenders and different processes for registering as visitors or residents. Many felt victimized by the criminal justice system:

> It's just a horrible game… I still have nightmares... [about] court all the time…I thought that there was justice, and now I feel that there is none…it changes your whole view of politics and the whole legal system.

Bystander A said she "is not a big fan of law enforcement

anymore," and that "with computer crime, they can just stay in their office, it's like fish in a barrel." She likened the punishment her son received to "hitting a gnat with a bomb" and felt "if you give them something reasonable, they might learn more from it." Offender A said the laws on sex offense crimes were "not terribly unreasonable" but lamented not being able to participate more fully in the community after prison. Offenders' arrests were "humiliating" and "dramatic." It was hard to wait years to see if a case would proceed. Bystander C went to court with her husband every 4-6 weeks for over four years, causing them to miss a lot of work while he remained on curfew and the price of his bail bond increased. She found the courtroom biased, with a "Victim's Room," which the jury walked past before deliberation, and said that the prosecution "harassed our witnesses when they were sitting in the hallway." Subjects commented on how little say victims have about which cases move forward, how much difference a judge, jury, and district attorney make, and how labels such as "high risk" are applied without standards. "One of our members was given the high risk at court, and it was a Romeo-Juliet thing, one victim, one girl," said Bystander B. Most took plea bargains and felt there needed to be a wider range of sentencing options. They talked about the financial impact of hiring lawyers, counselors, doing psychological tests, probation programs, and paying the commissary for offenders in prison. They reported challenges getting a housing plan approved when an offender left prison and struggles with employment.

"Before all this happened, [my son] thought that people in jail deserved to be there, they're bad people, but now, he says that really 90% of them were just people who made a bad choice, got caught and they'll be fine afterwards." Offenders reported "reckless" treatment in prison; one almost lost a toe that turned green and went untreated for a year. Prisoners are prohibited from masturbating, which Offender B said damaged his prostrate and caused "immense physical pain.", Support was limited: "They say on the one hand, oh, we want you to stay connected with family and friends, but usually the only ones they approve visitation for are a significant other or family, friends are turned down." It was "overwhelming" when an offender got out of prison with the short period of time to register, get a driver's license, meet their parole officer, begin treatment, and other requirements. Bystander B said: "[My son] is lucky he had me, because I gave him a ride…I wonder about these guys who get out, and they have to take the bus. They don't even know what the bus routes are, they can't get on the computer." After her son was released, when she took him to meet his parole officer, he was so upset he "sobbed on my shoulder for about 15 minutes," because "he hadn't been able to show emotion for three-and-half years." Subjects reported the criminal justice system is "just a mess. It destroys families… there's no healing involved."

Church and Spirituality

All subjects spoke about Christianity, God, and a search for spiritual meaning in their experiences. Bystander C said the hardest part was "losing your trust in God, thinking there is no God." Bystander B's son found Christianity in prison, prays regularly, and is part of a men's group at Church. Bystander C's son went to Church with her for the first time since leaving prison and was "overwhelmed by all the people who knew he was gay and knew he went to prison and what he did and hugged him." Her faith never wavered. Offender B said, "Without Christianity, I don't know if I could've made it. It's a belief system about changing who you are." He now follows a meditation system called *Avatar* and is a sponsor for others in 12-step programs. Offender A sees a Higher Power as: "a group of people that have identified a problem and collectively want to overcome [it]… sharing and supporting each other." He recently joined a discussion group on philosophy and ethics.

Healing

Subjects reported that healing required relationships with others. Bystander B spoke highly of a support group for family members of drug addicts she and her husband had attended, and Bystander C said counseling helped her process things. Subjects were grateful when a sex offender was treated "like a human." Offender A said his treatment provider was: "very humane and intelligent…' Yes, these offenders play games and try to get away with stuff, but they're not evil and broken.'" Bystander A felt a boyfriend had "probably saved [her son's] life because he would go spend the night with him when he was feeling down." All subjects struggled with depression and grief, and offenders felt guilt and shame for what their families had been through. "We lost so much time and life and money, and so much has been wasted…now I take two different anti-depressants. I didn't need that before all of this." All Bystanders had dogs, and one regularly talked to hers.

All subjects talked about acceptance and forgiveness: "Whatever you did in the past, it can be forgiven." Offender B talked about a "horrific" recurring vision in prison of his family in a glass box with a monster "tearing them apart…tearing their hands off, pulling their heads off of them, eating their guts," and realized, "I was looking at a reflection of myself." Bystander C said about her niece, "I'd like to think that we could forgive her… if I saw her, I don't think I would kill her at this point. I don't know if I could've said that five years ago." All subjects looked for things to be grateful for. Bystander C said: "One of the associate attorneys…had worked in the DA's office…he really worked hard on this case...and [after my husband] got convicted, he quit [practicing law]." Bystander A said, "Depending who's at the mail at prison," she "was able to send [her son] feathers" from his pet bird, and "one of the guys there made him a dreamcatcher." Offender B felt the social worker who helped him as a teenager in juvie had prevented him from committing much worse crimes.

Subjects reported being humbled: "I had the image that when I had my children, if you raise them right, they're gonna grow up and be perfect people…And I had no doubt about it, that I was raising my kids right. Funny, little did I know." Bystander A said: "It's just been an ordeal…Oh God, it was horrible!" Part of healing was letting go of life making sense. Bystander C said, "You can't understand what's not explainable, but it's still hard to deal with… It's *old*. I don't wanna talk about it anymore, but… there are no days that we don't think about it, that it's not affecting something." Bystander B agreed: "I try not to analyze it anymore because it's so painful to look through all that." Offender A said: "The process of being in prison, and sort of being taken down to this brute level of humanity, I think it's what I've heard people describe about being in basic training…I had a strange sense of coming to terms with who I am." He "felt a sense of reconciliation," that while he had caused a lot of harm, "a distinction between what I did and who I am became crystal clear…I was able to forgive myself but without excusing myself…I had nowhere to go but up…[which] was a relief." Offender B said he tells victims he

meets in SAA that abuse "is not personal"; that sexual, drug and alcohol abuse is "an addiction overruling the person."

Part of healing was accepting responsibility for the past and trying to develop a sense of mastery for the future. One offender owned an oil consulting company, two were welders, another was trying to work at a pet store, and one had a computer business. Offender B said:

> My road to recovery was intense; it wasn't just for the alcohol, drug, and sexual abuse; it was for mental rebuilding; you have to get into a state of mind that you can't participate in these activities… anxiety has been the root of my problems and my acting out. [Now I use meditation to] deal with the anxiety… without an addiction attached.

Having something to look forward to was important; subjects shared dreams of traveling and moving to the countryside, seeing children with loving partners, seeing each other's strength, and helping others. Offender B said, "I've got a lot of potential to…come up and make good yet." Finding ways to be of service was a universal desire. Bystander B said, "We try to help as many people as we can to re-integrate, to feel like they're worth something. They are worth something." Finding a network of others who were dealing with similar challenges was healing. "Even though it was an uphill battle," being part of an organization advocating to improve laws impacting sex offenders felt worthwhile. Subjects were strong and resilient: "We've been run over by a big truck, and we got up." Bystander A said: "We may be down, but we're not out."

Unmet Needs

"I wish the public understood that it could happen to someone they love…and stop grouping everybody into one big ball. I wish they'd look more on re-entry, re-integrating, figuring out why the person did that to begin with." Offender B felt there was no holding politicians accountable that the laws they passed were actually based on fact or were seen to be working. All subjects talked about the impact of being on the registry:

> If you commit murder, and you get out on parole… you can live wherever you want, you can travel… you sell heroin… get millions of people addicted… it's ruined people's lives, and they've died… you get out of prison…and you live your life. This, you don't. You're punished forever. And I don't think that you should have to be punished forever.

Offender A said: "Whenever I tell people I'm a sex offender, it's just throwing the past in my face…I'm no longer that person." He said if someone was unsure he was trustworthy, they could speak with his daughter: "I believe people should either be on civil commitment or should be completely out of the system like any other offender." Offenders needed self-discipline, awareness, and honesty to heal. Offender B said that without an accountability partner to be totally honest with, it was impossible to recover. Subjects pointed out that the psychology of sex offending and of re-offending is complex: "I mean, it's a simple and easy explanation to say, 'I was abused that way as a kid'… [but] it's not nearly that simple. The things I did are worse than anything I experienced." Offender A needed "ongoing therapy… because if I can talk about it and be honest, then I have less chance, I believe, of acting on it." He added, "From a recovery perspective, just like alcohol…I might be able to have one drink and get away with it…it might be okay for me to teach a Sunday school class, but I'm not gonna try it. Why would I take the risk?" Subjects felt that sex offender treatment could be more tailored: "People [] that perpetrate offenses against young children… [have] different needs."

Most subjects told stories about people they knew on the registry and wanted people to know that being on the registry did not mean someone was guilty, dangerous or predatory: [My son's] a good guy who got caught up in the wrong thing." They said it was so hard to talk about sex offending that they lived in fear of being ostracized, losing a job, and punitive laws. Subjects pointed out that "stranger danger is very rare, and you're not going to prevent those…you're hurting families of people who are registered…you're passing a law to make people feel safe, [but] it's not doing anything." Bystander C felt that she and her husband had effectively entered prison together when was put on the registry: "There's not really much we that we can do," she said. "We can't go to Church because what Church doesn't have some kind of babysitting room?", most of their friends have children or grandchildren, and their daughter was generously waiting until her dad was off parole to have a baby. Bystander B said: "I met a man who was married to the girl…he was 24 and she was 15 when they met…They just celebrated their 23rd wedding anniversary," yet he is still on the registry. Bystander A agreed "the things they're in for are ridiculous…One guy, his daughter…had used his phone to take pictures of herself… but the phone was registered in his name, so he's the one who went to prison." After her son gets out of the halfway house and is on parole, he will not be able to see his nieces without an official chaperone, which she said was "just stupid" since he was allowed unsupervised visits in the halfway house.

All subjects talked about how hard romantic relationships were for offenders: "I don't know where these guys go to meet someone…to me, you're putting yourself out there for rejection." Bystander C said: "It's affected our sex life." She said counseling did not help: "There's nothing you can say or do that would take it away or make it better." Subjects cited the importance of caring treatment providers, and of "guys who leave their treatment group and go home and commit suicide." Bystander C said: "When you go into sex offender counseling, the whole point of it is to repent for your sins, so you have to say, 'I did this, and I'm a bad person, and these are things I did wrong, and the risks that were there, and if I'm ever in this situation again, this is what I need to do.'" Subjects were grateful for treatment providers who found fun things for Offenders to do. Bystander B lamented: "there are no avenues for people to get help," that a man had gone to therapy for inappropriate feelings toward his step-daughter and the therapist reported him, but he was released because he had not done anything. Offender A said before offending that he "felt afraid to tell any kind of therapist because…I didn't want my career destroyed, I didn't want my kids taken away."

Some subjects wanted more education in schools about the laws and consequences of sex offenses. Bystander B wanted girls to learn what could happen to a guy if they lied about their age. Bystander A had invited police officers to teach her middle school students that what they put on the internet or sent in text messages was traceable, and the consequences of that: "If the laws had been in the 60s and 70s the way they are now, half the male population would be in jail or have a record." Bystander C was passionate about jury duty: "If it was one of your family members, you'd want a good person on the jury." Bystander B felt that Victim's Rights groups needed to speak out more: "Texas is spending billions of dollars on the prisons, on the public registry… and what do they do for victim's healing?" She wondered why

there were no public service billboards encouraging responsible partying. She suggested that law enforcement and attorneys speak up about problems with the registry and unfair applications of sex offender laws. She knew of multiple "high risk" offenders who were "living in cars" and did not think that was contributing to public safety or their welfare. Offender B felt strongly that requiring family participation for adolescents in juvie was important for preventing abuse later in life: "Parents have to be active in the program" so that kids are not sent "right back on the street in the adverse situation" using use drugs and alcohol to "numb [their] conscience [and] the drive to be a productive person."

Interview Impact

All subjects were positive about the interviews, and two people who only participated in the screening process told me that conversation alone had been helpful. Offender A said the interview had given him an opportunity to "continue to re-evaluate and examine the process by which I became an offender and the process by which I remain abstinent from offending… an opportunity to share very honestly with someone that I don't know…a safe place to talk." He said having that safety was valuable because it is hard to talk about, even though he has practiced in treatment. He cried a few times during the interview and left quickly to avoid more crying in front of me at the end. He read over the interview transcript and initial paper I wrote, as his interview was a pilot project for this study, and permitted me to share them with his ex-wife in case it would help his children. She said there were things she was able to hear through me she could not have heard from him directly that she was grateful to know. That first interview was powerful for me, as I had not previously spoken with an honest sex offender, and I felt it was powerful for him because he had not spoken so candidly with a victim. Offender B enjoyed himself, laughed numerous times, and at the end of the interview said, "I feel good," and asked for advice about his poison ivy rash.

Bystander A felt she had "make a positive impact" by participating in this study, cried a number of times, and said she was grateful for the opportunity. Bystander B was very peaceful during the interview, asked many questions to understand indigenous theory, and said at the end: "I feel good that I met you; I think it was fun talking to you. I think it was kinda inspirational, and I wish there were more people doing things like you are, that are more willing to look at this in different ways." Bystander C said listening to her story helped because "it gets really old rehashing it over with the same people…I feel a little bit relieved that I can talk to you. You can understand; you can see the big picture." That our meeting was a one-time interview, and we would have no ongoing relationship allowed her to share more openly than she otherwise would have. She thanked me for doing the study and said: "Maybe it will do some good, and help you, and you can help other people, and see what we can do to help everybody on all sides of it, cause it's so painful all the way around."

All subjects had done a lot of emotional and spiritual work. At one point during the dialogue, Bystander C said, "It's a mental screwing that we got…because you can't make sense of it," then asked me, "What's it like to look at a victim from a different angle?" She appreciated experiences I shared that mirrored hers, such as questioning spiritual beliefs, struggling with forgiveness, feeling gratitude things were not worse, a negative impact on my sex life, and being able to help others. Bystander B was the only one who agreed with me that stopping punishment altogether was a good idea. Offender B asked me to explain why I was doing this research and offered to put me in touch with his daughter if it would help. With most subjects, I expressed that while my road has been hard, I felt grateful that being in the Victim role allowed me to be on the righteous side of social judgment and that I felt a responsibility to learn from them, offer healing space, and speak out about injustice, which led to this research project.

Discussion

From an indigenous theoretical perspective, we need to start looking at sexual violence as a cultural issue requiring community involvement to prevent, address and heal. A recent article put forward five evidence-based suggestions for sex offender registry reform: (1) do not register juveniles, (2) registration duration should be guided by risk assessment research, (3) relief and removal procedures need to function, (4) judges should be given discretion, (5) residence restrictions should be removed (Levenson, Grady & Leibowitz, 2016).

In Texas, the first sex offender registration laws went into effect in 1991 and since then have been amended every session. Registration dates back to offenses committed in 1970 in any jurisdiction, and it is a felony not to comply with registry laws. Implementation of laws is done at the local level, and jurisdictions often pass ordinances such as "child safety zones" prohibiting registered sex offenders from visiting public parks, buildings with daycare centers, or driving past school zones and require sex offenders to do things like spending Halloween in the sheriffs' office. There are state laws prohibiting them from many businesses and trades and from living on college campuses (Texas Sex Offender, 2017). As a comparison in the U.S., California began its sex offender registry in 1947 (California Sex Offender, n.d.). On October 6, 2017, the governor signed SB-384, allowing low-risk sex offenders to be removed from the registry 10 or 20 years after serving their sentence, which affects 90% of registrants. The bill was introduced at the request of the L.A. County District Attorney and law enforcement officials who said the registry, which had grown to 105,000 names, had become too large to manage and was undermining public safety (McGreevy, 2017). As of October 15, 2017, there were 122,707 on the Texas registry, more than 90 percent low risk, with a dozen added daily.

Financial and public safety concerns about the registry are real: in 2016, the Texas Department of Public Safety spent over $1.4 million and had 21 employees managing the registry full-time, and when the Houston Police Department needed to respond to Hurricane Harvey in 2017, 10 of their 14 officers were supposed to be monitoring 5000 residents on the registry, only 500 of whom were considered high risk (Floyd, 2017).

> In 2011, Texas began a so-called deregistration process… to remove those who were unlikely to re-offend from the list and…save taxpayers money. Focusing police attention on truly dangerous offenders would also improve public safety… [So far] only 58 sex offenders have been permitted to deregister…less than one-tenth of 1 percent of the current registry. (Dexheimer, 2016)

Texas's registry requires reform, and a commitment to improving the deregistration process would be a solid first step affecting the 122,707 people on the registry, their families, friends, and communities while freeing police to deal with actual

crimes and crises. Researchers, victims' groups, prosecutors, and law enforcement may need to work together to educate the public and provide Legislators with information to amend the laws appropriately. Given the impact on adolescents, I agree with the subjects' suggestion to teach about sex crime laws and internet safety in school. Subjects also had ideas about public service campaigns to prevent sexual violence, and I am sure victims' groups do too. Also, an evidence-based risk assessment tool would help ensure that "high risk" offenders are dangerous and "low risk" were not. If we do not engage in reform, as Bystander B said, "With twelve people added every day, it won't be long before everybody knows someone on the registry."

As for whether an empathic dialogue itself is healing, all subjects expressed that the experience was therapeutic. Given research on the healing power of empathy in therapy, it is not surprising that being deeply listened to and witnessed is healing. For me, the dialogues were illuminating about life experiences in some ways familiar to my own, in some ways not. Interviews were painful and uplifting reminders of human fortitude. Offender B admitted he "liked the escape" of drugs and alcohol. If I struggle with an addiction, it is workaholism. Workaholism is defined as working compulsively with little enjoyment (Spence & Robbins, 1992). A nascent body of research linking sexual violence victimization with workaholism suggests that some victims of sexual violence cope by channeling hypervigilance and attention to detail, inability to relax, desire for control, and accustom to overwhelm into work (*See, e.g.,* Tudiver, McClure, Heinonen, Scurfield & Kreklewetz, 2000; Chouliara, Karatzias & Gullone, 2014; Carleton, Mulvogue & Duranceau, 2014). While completing my dissertation, this certainly gave me food for thought.

Conclusion

As Tiwa healer Beautiful Painted Arrow has said, "For the true human, the first thing is to find out how to listen" (Rael, 2015, p. 15). When we really listen to each other, we see commonalities everywhere, even between a victim of sexual violence, a sex offender, and a bystander family member. Everyone deserves to be heard and support to heal and make amends. The stigma our culture has developed with sex offenders is something carried in each of us. Bystander C said when her husband "talked with one guy that he had worked with and found out he went through a similar thing…that's the first person that he told about [the sex offense] that didn't change the way he'd think about him." Bystander A said: "Just let my son start over." It reminds us that we are not our worst act and that we are all learning and living together. We can become aware of thoughts that dehumanize us, such as 'He's a monster.' We can look for the humanity in everyone and help people find it in themselves when they are dissociated and lost. We can commit, as professionals and community members, to put more effort into supporting offenders and their family members. Moreover, suppose we do not feel moved to stop judging and punishing, as indigenous theory suggests. In that case, we can stop punishing people "forever" and treat sex offenders how we treat other felons, which is still quite harsh.

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Being "Brilliant Sanity"-My journal reflection on mindfulness practice

Kunzang Chophel

"I found the root to mindfulness is being brilliant sanity."

Background

The term "Brilliant sanity" was coined by Tibetan meditation master Chogyam Trungpa Rimpoche (1939-1987), the founder of the Shambala tradition with its origin in Tibet and, later, the founder of Naropa University in 1974 in the United States. Trungpa used several English wordings to capture the Sanskrit word 'Tathagatagarba,' which refers to the unconditional sanity or basic healthiness inherent in everyone. In the Buddhist tradition, this is known as "Buddha nature," our basic enlightened or awakened- hence brilliant -nature. In Shambala teaching, it is known as "basic goodness." What does this mean? It means that no matter what physical or mental state of being we are in, depressed, confused, clear, stupid, wise, frightened, psychotic, we are by nature fundamentally sane. Whether we are sick or well in the conventional sense is inseparable from this fundamental nature and is, therefore, workable just as it is. This is the core path emphasized for the practice of contemplative psychotherapy and said to have been born from two parents: the wisdom traditions of Buddhism and Shambala and the clinical traditions of western psychology, especially the humanistic school at the Naropa University; a Buddhist-inspired and nonsectarian university and the birthplace of the modern mindfulness movement.

The term brilliant sanity was later used as the book's title by Francis J. Kaklauskas Susan Nimmanheminda, Louis Hoffman, and MacAndrew S. Jack (2008). Brilliant Sanity: Buddhist Approaches to Psychotherapy, Boulder, Colorado; published at University of Rockies Press in USA. Most of the book contents are still used to deliver the Master of Arts in Contemplative Psychology (MACP) program at Naropa University by creating an "enlightened society" based on bravery and gentleness, which each person's inherent wakefulness can be acknowledged and nurtured. Later in 2011, the book's same content was also adopted by the Royal University of Bhutan for the Post Graduate Diploma of Guidance and Counselling (PgDGC) program, delivered in collaboration with the Naropa University to the first batch of School Guidance Counsellors in Bhutan.

I was one of the fortunate recipients of the PgDGC program at the College of Education in Samtse. The entire two years of the mixed-mode program were based on contemplative psychotherapy - theory and practice with particular emphasis on intensive mindfulness meditation. A hallmark of the program was the transmission of wisdom and the practice of compassion-committed, at the heart of what it means to be a fully awakened human-of being. "Brilliant sanity" is elaborated in three primary qualities: openness, clarity, and compassion. By then, I had just begun my career as a School Guidance Counsellor in Bhutan. Although mindfulness was introduced in schools in 2008 in Bhutan as part of the Gross National Happiness (GNH) program, yet the mindfulness program for the PgDGC was framed slightly differently within a psychotherapeutic paradigm akin to the approaches to contemplative psychotherapy; the so-called blend of the eastern Buddhist tradition of mindfulness and western psychology theories, which amazed me. Since then, I was not only fascinated by the term brilliant sanity but developed a passion for mindfulness practice as well and went to the extent of practicing it with my clients in therapeutic sessions, with the belief that every human being, irrespective of their background, possesses a quality of basic sanity- 'Brilliant sanity,' a Buddha-nature, or the innate potential of basic human goodness within.

My intention in this reflection is to highlight Brilliant sanity's essential features through the theoretical knowledge and practical experience I have gained from the contemplative psychotherapy tradition. I have understood from the contemplative tradition that it comes from the sitting practice of mindfulness/ awareness meditation to develop a highly sophisticated understanding of the mind's functioning in sanity and confusion. From western psychology comes the investigation of human development stages, a precise language for discussing mental disturbance, and the intimate method of working with others known as "psychotherapy," where Brilliant sanity I found was the root teaching.

The feeling of ambiguity, a beginner's mind

As I began my inner journey with the practice of contemplative psychotherapy with mindfulness as the core value and inner wisdom discovering the sanity within myself, I started to get a feeling that the combined concepts of east and west, the so-called contemplative psychotherapy, with my work as a counselor is an epitomic match, and I was curious to know more about the in-depth wisdom of Brilliant sanity. On the other hand, I was confused, and I did not really see how to go about

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it. I had so many questions in my mind, such as. Should I have my clients meditate instead of going to counseling? Should I teach my clients to meditate? What if they were not interested in meditation? Wouldn't that be aggressive of me to require it as a therapist? As a novice mediator and a counsellor, I was utterly stuck. I wondered how the two things might go together?

As the PgDGC program combined a retreat cum theory and practice lead by Dr Karen Kissel Wegela, a western born Buddhist scholar, author, and a professor at graduate contemplative psychotherapy program, who had been teaching the integration of Buddhist principles and psychotherapy at Naropa University for about 35 years, my ambiguity towards luminosity of mind became more apparent. It was so exciting for me to meet her, to be a part of the program, and to share my passions at once in the entire retreat of the mindfulness meditation program at the college. Since then, my spirit of mindfulness practice remained consistent for the entire retreat program and later became the core value of my personal life and professional wellbeing.

In the following year, when I ended up moving to Drukgyel as a full-time school guidance counsellor and began counseling and the practice of mindfulness meditation in school. I found the brilliant sanity stood out to me; a reminder of that in myself, it means kindness, spaciousness, allowing things to happen the way they need to happen, clarity through stepping back and seeking perspective, and I started loving to be able to offer those things to my clients. In working with two students who had struggled with depression and trauma for years after the significant car accident that occurred in 2012 in which three students died on the spot, I came to know it is kinder and more effective to let my clients go at their own rhythm. I was not ready to directly address the clients' trauma, but I trusted the brilliant sanity of their own self-chosen pace.

From then, I was able to practice mindfulness consistently as a strategy for self-care and prevent burn-out for myself and the clients in the therapeutic sessions. Since then, I have had many opportunities to go for several retreat campaigns coordinated by the Royal University of Bhutan presided by various professors from the Naropa University, joined by other Buddhist monks and scholars who came as tutors for the residential graduate exchange program at Samtse College of Education. I must say that it was a very enriching and in-depth learning experience for me as a counsellor. I have learned that the integration of Buddhist psychological principles with the practice of psychotherapy is called "Contemplative Psychotherapy," which is a bit of a misnomer since to "contemplate" means to "think about." Like meditation itself, Contemplative Psychotherapy is about experience: seeing, hearing, smelling, tasting, feeling, and recognizing thoughts as thoughts without getting caught up in them. It is somewhat attuned with the pace of our own nature of mind by simply being fully aware, spacious in the present moment, and through befriending our own emotions.

The Awakening - We have "Brilliant sanity," but we do not always know it.

Mindfulness practice in the close context of Brilliant sanity, as I realized, is said to be established in four ways: 'watching the body as body,' then 'feelings as feelings,' the 'mind as mind' and conceptual 'qualities as qualities.' A mediator must be 'determined, fully aware, mindful, overcoming his longing for, and discontent with the world' (Trungpa, 1984). As I continued learning more and more, I realized that the first focus is breath. 'Just mindful, he breathes,' the Buddha says of a monk. 'As he breathes in a long breath, he knows he is breathing in a long breath; as he breathes out a long breath, he knows he is breathing out a long breath.' Shallow or deep, he inhales and exhales, 'experiencing the whole body' while 'watching the way things arise and pass, so 'his mindfulness is that there is a body' becomes 'knowledge and recollection in full degree' (Trungpa, 1994).

Gradually, the more I practiced and be myself of my own qualities of who I am, I realized that the "root teaching" of the program is "Brilliant Sanity." I was intrigued by this term. It means that who we most fundamentally are 'Is brilliant sanity.' Professor Dr. Wegela taught in the retreat that it is our nature; it is what we are, no matter what we might be feeling at any moment. We are brilliantly sane if we feel happy; we are brilliantly sane if we feel depressed. We are even brilliantly sane if we feel crazy and totally out of touch with reality. Brilliant sanity describes our human nature, who we most basically are. We are not always in touch with our brilliant sanity, but it is still there and available for us to tap into. Usually, we experience glimpses of brilliant sanity and do not even recognize it. It is never easy to describe brilliant sanity because, while it is something we can experience, it is not something we can capture in words.

Brilliant sanity can be understood better from the three main essential features of the path to contemplative psychotherapy, adopted from the first family of the five "Buddha families" of the Buddhist tradition. The first Buddha family, the "Buddha," is related to the element of space and to the recognition of brilliant sanity, which includes spaciousness or openness, clarity, and compassion described below:

Openness or spaciousness means that we can experience whatever comes to us through our sense perceptions, our emotions, or our thoughts. "Well, of course, we can," you might say. The idea here, though, is that often we turn away from our experience. We usually pull away from intense feelings or awkwardness or discomfort of all kinds. We try to distract ourselves because we simply do not want to include some things in our experience. For example, we might drive by the scene of a car accident and avert our gaze. We do not want to feel the feelings that might come up. It is almost as though we think we could hurt our very beings by feeling anything negative. In the brilliant sanity sense, openness means that we CAN feel all our experiences; pleasant ones, painful ones, and neutral ones. It does not mean that they will all become pleasant or even neutral. They will still be just what they are. Openness means that we do not have to shy away.

Clarity means that we can bring mindful awareness to all our experiences. Not only are we able to be open to them, but we can also receive them with a sense of accuracy and precision. To return to the car accident example, clarity means that we might notice glass on the road, a policeman directing traffic, and other details at the scene. We could also notice the fear that arises in the body; the catch in the throat, the tightening in the chest. We could also notice the thoughts that are running through our minds; imagining someone who might be hurt or killed, the thoughts of our children and beloved ones we always want to protect. All kinds of experiences might arise, and we could recognize them without distortion.

Compassion is the desire to alleviate suffering and the ability to recognize our connection with others. When we are truly

present with others, we might even feel their pain. Compassion is the willingness to do so. I have always found this the most intriguing quality of brilliant sanity. It suggests that we do not have to learn compassion; we are compassionate. We need only to learn how to stop avoiding our compassionate, tender hearts. Returning once more to the car accident, our compassion might manifest as stopping and offering help if there is no one already taking care of people who might be hurt. Paradoxically, it might also show up as our turning away. We turn away because we feel connected; we feel pain when we see others in pain. That, too, is evidence of our tender hearts.

These three qualities of brilliant sanity; spaciousness, clarity, and compassion; are inherent in the client, in the therapist, in everyone, and thus I have learned that these are the most important qualities that I, as a psychotherapist, need to have the ability to connect with someone by being completely present.

Therapeutic application

In Contemplative Psychotherapy, a counselor's goal is to help the clients connect with or re-connect with their brilliant sanity. A counselor's job in a therapeutic alliance is to recognize the brilliant sanity that the clients are already showing and help them recognize it. A counselor can build a client's resilience based on their strength, which is a brilliant sanity in nature. Beyond that, counsellors can also work to identify and manage the obstacles to experiencing brilliant sanity, our own, and that of the clients.

Thich Nath Hanh said the present moment is the only time over which we have dominion. And he said, the most important person then is always the person you are with right now, the one who is right in front of you, for who knows if you will have dealings with any other person in the future, not even in the next moment. That is the miracle of mindfulness. Siegal (2010) supports the similar concept in the therapeutic session of being present, which involves the experience of openness to whatsoever arises in reality, being open to now, to whatever is. We come to acknowledge our own proclivities and, in that awareness, free ourselves to move from peak to plateau with ease and will.

What did the Buddha prescribe to treat our confusion? According to Dr. Wegela, the first three Noble Truths taught by the Buddha parallel the ancient Indian medical model of diagnosis, etiology, and prognosis. With the fourth Noble Truth, the last one, we come at last to the treatment, tells that the Fourth Noble Truth is The Truth of the Path. The idea of a "path" is that we cannot do it all at once. We need to find a way to proceed step by step toward discovering our awakened natures, our brilliant sanity, which we counselors do by strictly following the process of counseling in the therapeutic sessions.

Basic mindfulness posture and discipline in practice

Throughout the retreat, I have learned a few basic body postures practiced vigorously during the entire retreat, a kind of discipline to be maintained, especially during the formal retreat. This is beyond the therapeutic practice and nothing to do with the clients in the counselling session. Still, it is a fundamental discipline for serious practitioners that needs to be adhered to. However, I have tried these positions in the psycho-educational classes with the students in high schools for the purpose of calm abiding and to enhance the mental wellbeing of the students in general, but not solely as part of the therapeutic practice.

1. Noble Upright Seated Position: Legs crossed half lotus with hands gently on the lap with the forefinger touching the thumb.
2. Noble Upright Seated Position: palms rested gently on knees with a sense of balance and softness in the hands. (Double earth witnessing mudra)
3. Noble Upright Standing Position: hands raised palms facing you at a comfortable height and angle with minimal effort and tension.
4. Noble Upright Position seated in a chair: knees bend vertically, feet facing straight and resting flat on the floor in front position.
5. Noble Silence: a discipline maintained throughout the retreat, no exchange of speech, but entirely being silent with awareness, openness (spaciousness), clarity, and compassion)
6. Walking Meditation: walk with noble silence, slow steps noticing every movement of the steps by being fully aware, open, and watching our own breath as we move around.
7. Aimless Wandering: move aimlessly and connect with the nature of our own mind with the serenity of the nature around and appreciating the beauty (the calmness) of both outer and the inner world. Accepting nature and letting it be there in a way as it is in its own rhythm.

Conclusion

In conclusion, I found the root to mindfulness practice is being brilliant sanity in contemplative psychotherapy. The training and the practice of mindfulness helped me let go of any ideal notions of how I work as a therapist should proceed and perceive the session as fostering mindfulness so that I am better able to be present with my clients; to recognize their sanity as well as their pathology, to be open to exchange and also let go, and better able to acknowledge our own obstacles and the blind spots which makes possible our essential interconnectedness. The principles and the practices of mindfulness/awareness and compassion help the contemplative psychotherapist cultivate his/her own brilliant sanity and that of their clients. Knowing the fundamentals of who we really are and recognizing our own mind's nature through openness is like the sky where all the things occur, such as the weather. Just as the sky is not disturbed by the weather, our mind is not affected by the clouds, hailstorms, pleasant and unpleasant emotions that come and go. The mind itself is spacious, empty. This quality is not graspable; we cannot hang on to it or even touch it. Yet, what I understood from the wisdom of brilliant sanity is recognizing my own experience of being in the state of awareness/awakened. From the Buddhist perspective, an understanding of emptiness as a space with nothing in it is incomplete. Emptiness is more than just a vacuum, more than the absence of experience. It is also a quality of awareness or wakefulness. Joining experience with awareness is clarity, the perception of things as they are without distorting that perception in any way. It sounds quite simple, but it is quite difficult. We generally filter our experience through our expectations, thoughts, preconceptions, and so on, which happen in the present moment. When the obstacles to spaciousness and clarity are dissolved, the impulse towards

compassionate action arises naturally. Weggela (1994) states that when we hear a child's cry, our first instinct is to help. It is only in the flicker of the next moment that we can quickly come up with reasons why we should not interfere and why we should hold back. If we look closely at our experience, that first reaction is a compassionate impulse, before confusion arises, an inherent warmth and tender-heartedness (pp. 28-29).

The Buddha's teaching on becoming more present in our lives is to take a gradual path, just like a string of a guitar, "not too tight, not too lose"; the middle path. I have always seen this wisdom as truly kind teaching and recommend my clients take these noble paths when their minds are overwhelmed by negative emotions. Instead of expecting ourselves quickly to be more present, just because we have heard about it, we treat ourselves with gentleness and friendliness like a feather touching the bubbles of water softly by taking an unhurried approach; befriending our emotion, rather than seeing it as a problem to be avoided. The path that the Buddha described is to bring mindfulness to all aspects of our lives. We can bring mindfulness to whatever we are doing or experiencing in the present moment. Instead of creating suffering by trying to avoid our direct experience, we pay attention by being brilliant sanity.

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Factors in determining the development of problem gambling and motivation to quit gambling addiction among offenders

Bernard W. S. Fan

This study explores the factors in developing a gambling problem and in motivating to change their gambling addiction among offenders in Australia. In the pathways to their gambling problems, there are several contextual factors contributing to their gambling disorder. Personal, family, social, economic, environmental factors, cultural values, attitudes, and beliefs attribute towards gambling and trigger events. Some problem gamblers may finally resort to crime to pay their gambling-related debts and continue their gambling to chase their previous losses. They may be caught in a vicious cycle of problem gambling, illegal behaviours, and recidivism. It is hypothesized that the contextual factors, including cultural values and family environment of the problem gamblers, will influence risk factors of developing problem gambling and motivation to later quit their gambling addiction. Glaser and Strauss' Grounded Theory of Qualitative approach was applied in this study. The researcher interviewed fifteen problem gamblers with criminal histories. After gathering and analysing data, a theoretical model was designed to explain the pathways of developing their problem gambling and their motivation to change among problem gamblers with histories of committing offences.

Introduction

Gambling is an everyday social and relatively low-risk activity for most people. A few terms describe people with gambling problems, including problem gambling, compulsive gambling, pathological gambling, and gambling disorders (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2013). In Australia, problem gambling has been defined as a lack of control by the gambler over their gambling behaviour, resulting in adverse personal, economic, and social consequences in gamblers and their families' lives (Productivity Commission 1999, p.17). In the pathway to their gambling problem, there are many factors contributing to their gambling disorder, including ecological, sociological, biological, cognitive, behavioural, and personality. Although different models explain the pathway of development and maintenance of problem gambling, they do not explain why some gamblers motivate to quit while some gamblers relapse after abstaining for an extending period. This paper fills the gap of current theories that cannot explain why the same situations can trigger gambling or be motivated to quit.

Background and rationale

A literature review has been done to summarise on theoretical models of problem gambling in explaining pathological gambling (Lesieur & Rosenthal 1991, Sharpe and Tarrier 1993, Griffiths & Delfabbro 2001, Blaszczynski & Nower 2002, Raylu & Oei 2002, Sharpe 2002, Rickwood et al. 2010, Upfold 2017, Menchon et al. 2018). Lesieur (1984) developed a grounded theory of the compulsive gambler's spiral of options and involvement model. Rosenthal and Lesieur (1996) hypothesized that gamblers have two characteristics: escape seeker; and action seeker. Jacob (1986) proposed a general theory of addiction to explain various addictive behaviours, including gambling. Griffiths and Delfabbro (2001) argued that gambling is a multifaceted behavior involving biological, psychological, and sociological components that interact together to contribute to the gambling behaviour. Therefore, no single theory can explain the etiology and maintenance of gambling behaviour. Griffiths and Delfabbro (2001) have proposed a comprehensive biopsychosocial approach to explain gambling addiction. Blaszczynski and Nower (2002) have further elaborated the biopsychosocial approach of gambling and identified different

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gamblers in their Pathways Model of Problem and Pathological Gambling (Blaszczynski 2000, Blaszczynski & Nower 2002).

Despite different models explaining the development and maintenance of problem gambling, they do not explain why some gamblers relapse after abstaining for an extending period. Some researchers have postulated models to explain the process of relapse (Brown 1987, Marlatt & Witkkiewitz 2005). Brown (1987) postulated that gambling is very exciting and a form of arousal, which becomes cognitive expectancy and reinforcer of gambling behaviour for an abstained gambler. Although the reinforcement schedule of gambling has been broken after an extending period of abstinence, abstaining gamblers are triggered by internal mood states and cognitive expectancy of the former pattern of gambling experience in addition to external environmental situations and playmates of former gambling. All these internal and external stimuli will be relapse-provoking situations that produce pleasant arousal and relief from boredom (Brown 1987). Marlatt proposed that relapse results from an interaction between a person's internal factors and external factors. Internal factors include affect, coping, self-efficacy, outcome-expectancy, while external factors consist of social influence, access to the substance, and cue exposure. Marlatt assumed that if gambler attributes to internal, global, and uncontrollable factors, risk of relapse increases. If the individual attributes to external, unstable, and controllable factors, the risk of relapse reduces (Marlatt & Witkiewitz 2005). It is assumed that individuals will be influenced by stimuli from relapse-provoking situations and drive them to meet their cognitive expectancies of the former pattern of gambling behaviour. Stimuli and relapse-provoking situations are built up over some time during their abstinence and drive the gamblers to hang on to relapse.

Chantal et al. (1995) reported motivation is a crucial determinant of gambling involvement. The motivation for change reflects the readiness for change along the stages of change. Both internal and external elements drive motivation for change. Internal or intrinsic factors include cognitive, attitude, and awareness of the negative consequence of the addiction behaviour. In contrast, external factors cover the influence of other people and life crises on the gamblers (Evans & Delfabbro 2005). According to the Self-Determination Theory (SDT), the study showed that high autonomous motivation for quitting, such as awareness of gambling addiction problems, improved self-image, and a desire for a new life, predicted higher readiness for change.

In contrast, high external motivation for change, such as family pressure, reflected the lower stage of change. Intrinsic and autonomous forms of motivation are significantly associated with treatment success (Kushnir et al., 2016). However, research has reported contradictory results that external factors are more associated with higher motivation for change. Evans and Delfabbro (2005) reported that external factors such as physical and mental health, financial pressure and effects of gambling on relationships, and losing one's home, which put them in a life crisis, were the important reasons for seeking help while internal elements of feeling shame and denial of their gambling problem, belief of own self-control without professional assistance were their resistance to quit gambling and their main barriers to seek help. Help-seeking more likely occurs in response to external factors of gambling-related harms such as financial problems, relationship issues, and psychological distress (Suurvali et al. 2010, Gainsbury et al. 2014).

Gambling studies have reported inconsistent findings on the influence of internal and external factors on problem gamblers' prognosis. It shows that internal factors interact with gambling's external factors, attributing gamblers to either gamble more intensely or motivating them to quit. Internal and external situations can trigger more gambling, as reflected in the problem gambler's higher IGS score (Turner et al., 2013). However, internal and external conditions can also motivate gamblers to change their habitual gambling behaviour and quit (Kushnir et al. 2016, Evans & Delfabbro, 2005).

Therefore, there may be some elements in influencing the role of internal and external factors in contributing to the maintenance and relapse of gambling or motivating them to quit their gambling. This paper postulates a grounded theory that explains a mechanism in navigating the internal and external elements to be either motivation to quit or trigger situations for gamblers to relapse.

Methods

In this research, Glaser and Strauss' Grounded Theory of Qualitative approach has been applied (Glaser and Strauss 1999), and a qualitative research tool for in-depth interviews was employed.

Participants

The target participants were problem gamblers with gambling-related offences, which were mainly money-generating crime. This study was conducted in the Perth Metropolitan area of Western Australia. Recruitment of participants was done voluntarily. The promotion of the research was done through non-profit gambling treatment organisations.

There was a total of fifteen participants who completed the interview, including seven males and eight females. Their ages ranged from 24 to 55, with a mean age of 35.87 and a median age of 35. Eight were separated, three were single, three were de facto in the relationship, and one was married. Ten participants had children. Six participants were Indigenous Australians, five were Caucasian Australians, one was Vietnamese Australian, one was Albanian Australian, one was a decedent of a Pakistan father and an English mother, and one Caucasian Australian participant whose stepfather was an Italian.

Procedure

All interviews were undertaken in the interview room of the referral organisations. There was a window at the interview room's door to see through and check the persons' safety inside the room and other safety mechanisms.

Since this research relied on participants' self-reports, the researcher did not know the participants' background or previous illegal activities before. Therefore, this study depended on the willingness of the participants to explore the details of their convictions. The researcher also needed to maintain confidentiality. The researcher was careful to make sure that the survey questions did not cause participants any distress. All participants were followed up by their case managers from the referral organisations. This made sure that the participants were not left vulnerable after the participation in this research.

The interviews were audio-recorded by an electronic device, an MP3 player. To protect the anonymity of the participants,

participants' real identities were replaced with pseudonyms. The participants were also told to avoid divulging specific information such as names and details of specific criminal events for which they or any other third party had been arrested (Israel 2004). Note-taking was also conducted for those interviews. The researcher noted all essential data given by the participants.

The participants were asked about their demographic backgrounds, including their age, country of birth, and family constellation. The researcher interviewed the participants according to the scheduled semi-structured interview.

Measures

Instruments

The researcher has designed a semi-structured interview schedule, based on his clinical experience, literature review, and knowledge in this research topic, to guide and encourage participants to reveal relevant information. The interview schedule aims at collecting the gamblers' demographic data, their interaction with their families, their pathway of problem gambling development, and their journey to illegal activities.

Qualitative Measures

Glaser and Strauss' Grounded Theory of Qualitative approach was applied (Glaser and Strauss 1967& 1999, Strauss and Corbin 1998). The program has canvassed the core variable of the cultural value of problem gamblers with different country backgrounds. The participants were interviewed and asked their cultural values, which are central and influential in the development and triggers of their gambling, motivation, and barriers to change their gambling addiction. Software Nvivo was used to code and develop categories that contribute to an evolving theory.

Data analysis process

Interviews were audio-recorded, and then all interviews were transcribed from the audio record verbatim. Each interview transcript was assigned a number and was printed out in a physical copy. The researcher read the transcript multiple times. Then, the researcher conducted data analysis of the transcript. The researcher followed Glaser and Strauss's(1967) and Strauss and Corbin's(1998)Constant Comparative Method to undertake the collected data's qualitative analysis. There are four stages of constant comparative method. The first stage involved open coding by comparing incidents to each category. The second stage involved axial coding in integrating categories and their properties. The third stage involved selective coding and delimiting the theory. The final stage consisted of writing the theory.

In the process of iterative analysis, the researcher moved back and forth through the data to find, compare and verify the patterns, concepts, categories, and dimensions of phenomena. The transcript was coded according to the themes of the phenomena. After identifying the relationships between the themes, the researcher tried to merge similar themes and developed hypotheses of the theory. Finally, a new grounded theory was developed from the hypotheses.

Results and Findings

Stage 1: Comparing incidents to each category – open coding

The first stage was an initial open coding of interview data. Analysis of data was started by coding each incident into as many categories as possible by constant comparative analysis. The researcher started coding in terms of types or continua of the category. This constant comparison of the incidents generated theoretical properties of each category.

During the process of constant comparison analysis, coding of categories of each incident was noted on margins of the transcript verbatim. Then, Software Nvivo was used to obtain a systematic coding of the data. During the initial open coding of data, 538 incidents were coded, and 86 categories emerged.

Stage 2: Integrating categories and their properties – axial coding

As coding continued, the constant comparison accumulated knowledge of the properties of categories and began to group similar categories according to the properties of categories. The continuous comparative analysis examined the trend and patterns of categories.

The category integrated with other relating categories into themes through constant comparisons. Finally, axial coding integrated the categories of open codes together. After achieving eighty-six categories from the initial open coding, the categories were integrated with other categories through constant comparisons. This constant comparative analysis integrated the categories into the next level of sub-themes. Axial coding and continuous comparative analysis integrated the initial eighty-six categories into fifteen sub-themes. Further axial coding and constant comparative analysis of the 15 sub-themes were integrated into seven major themes: offences, substance abuse, well-being, relationships, contextual factors, the prognosis of gambling addiction, risky situations and quit.

Stage 3: Delimiting themes and theory – selective coding

As themes developed, significant modifications of themes became fewer and fewer through the comparative analysis. Later modifications were mainly on the order of clarifying the logic, taking out non-relevant properties, elaborating details of properties through integration and reduction. By reduction, uniformities in the original set of categories or their properties were discovered and then integrated into significant themes. By further reducing themes and analysis with literature, major themes then formulated a set of higher-level abstract concepts and hypotheses. There were 16 hypotheses developed from the seven major themes.

Hypothesis 1: The gambling pathway is non-linear and dynamic depending on the interaction of internal, external, positive, and negative factors.

Hypothesis 2: Cultural and environmental factors can either be a protective factor to quit or trigger a relapse.

Hypothesis 3: Emotion can be a positive motivation to quit or negative triggers to relapse

Hypothesis 4: Emotional state and gambling prognosis is dynamic and reciprocal.

Hypothesis 5: Addiction as a coping strategy to numb physical and psychological pain.

Hypothesis 7: Risky Situations can be triggers to gamble

Hypothesis 8: Risky Situations can be a motivation to quit
Hypothesis 9: Supporting relationship acts as a buffer to protect gamblers from relapse.
Hypothesis 10: Non-supporting relationship increases gamblers' vulnerability to relapse
Hypothesis 11: Relationship is a mediating factor navigating the gamblers either to motivation to
quit or to relapse to gambling behaviour.
Hypothesis 12: Motivation to quit and relapse to gamble is on a continuum.
Hypothesis 13: The same factor can act as barriers to quit or support to quit.
Hypothesis 14: Offences can be the cause or consequence of gambling.
Hypothesis 15: Financial pressure of gambling motivates gamblers to commit offences. Financial
benefit from violations relieves gambler's financial stress and mitigates the chance
to gamble on the other hand.
Hypothesis 16: Stress of committing crime increases the risk to gamble.

Stage 4: Generating a new grounded theory

At the final stage, all hypotheses are integrated into synthesis and develop a new grounded theory. Anew grounded theory is generated to fill the gaps in the literature in explaining a substantive area. Through a systematic constant comparative analysis, properties of categories, themes, and hypotheses are generated and integrated towards a new grounded formal theory, as shown in figure 1.

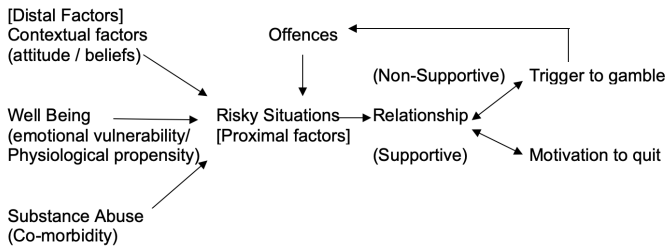

Figure 1. A grounded theory of Family Attitude Navigating Model of Gambling Problem

A proposed Family Attitude Navigating (FAN) Model on the prognosis of a gambling problem

Most theoretical models have tried to explain the pathways to gambling problems and identify the essential elements contributing to gambling disorders. However, few studies explain what elements trigger gamblers to relapse after a long period of abstinence and what factors motivate gamblers to quit their gambling addiction. Therefore, there may be some elements in influencing the role of risky situations, internal and external factors in contributing to motivation to quit or trigger relapse to gamble. The purpose of this paper is to fill this gap. It postulates a grounded theory that explains a mechanism in navigating the risky situations to be either motivation to quit or trigger to relapse.

Gambling development is non-linear and dynamic depending on the interaction of internal, external, positive, and negative factors. Problem gamblers may be motivated to quit after years of gambling, and then they may be triggered to relapse after months of abstinence. Therefore, their prognosis of gambling is not unidirectional nor static but dynamic, depending on the interaction among different elements. There is a reciprocal relationship between gambling behaviour and triggering factors. There are two essential natures of factors in contributing to gambling: distal and proximal factors. Distal factors are indirect risk factors which create tendencies and vulnerabilities that predispose individuals to gambling problem when combined with proximal risk factors. Proximal factors are direct factors that have a more immediate impact on the likelihood of developing a gambling problem (Hing & Russell 2019).

Distal factors

Three critical distal factors form the basic and predisposition towards gambling development. Three distal factors include contextual factors, well beings and co-morbid of substance use.

Contextual factors form the latent affinity of gamblers towards gambling addiction. Family environment and cultural background carry much weight in shaping the attitudes toward gambling behaviour. Through social learning, problem gamblers begin their gambling from initial family or social gatherings with gambling activities. Family members and peers are important role models in shaping children's gambling behaviour. Most gamblers learn gambling from their family members or peers. They develop a positive attitude towards gambling and may result in higher levels of gambling involvement. Besides positive gambling attitudes, gamblers also learned gambling as coping strategies, which further put them at risk of developing their gambling problem.

However, a positive attitude toward gambling alone is not enough for people to develop a gambling problem. One study reported no significant correlation between the attitude and beliefs towards gambling and its severity. However, there was a significant association between gambling attitudes and beliefs and the trigger situations to gambling and a significant association between trigger situations and gambling severity. The results indicated that attitudes and beliefs to gambling did not directly influence the severity of the participants' gambling problem. Attitudes and beliefs were associated with gambling triggers but not associated with the severity of the gambling problem. The triggers were significantly related to the severity of the gambling problem (Fan, 2017). This study suggested that cognition and attitudes are not the key facilitators in contributing to a gambling problem.

Moreover, this finding contradicts Battersby's study that reported cognition of craving and urges being the main mediating factor in contributing to relapse (Battersby et al. 2010). In this new grounded theory, cognition factors of craving and positive attitudes towards gambling are distal elements towards gambling propensity but not the proximal factors to gambling behaviours. Therefore, it hypothesised that contextual factors might cultivate a positive attitude and belief towards gambling. Then, a positive attitude and beliefs towards gambling may spur the interaction with risky situations.

On the other hand, contextual factors, such as cultural background, may either cherish favourable or unfavourable bias towards gambling behaviour. For example, gambling is legalised in Australia, while gambling is banned in many Muslim countries and discouraged in Italy's orthodox Catholic culture. Therefore, people of different cultural and religious backgrounds may first

develop an unfavourable attitude towards gambling. However, they may shift to favourable attitude towards gambling after being accustomed to local culture when they move to a new environment.

The second distal factor is the gambler's well-being. Well-beings include both emotional and physical well-being. Emotional well-being can be a positive motivation to quit or negative triggers to relapse. Emotional state and gambling prognosis are dynamic and reciprocal. Emotional well-being is intrinsic and internal factors can be positive or negative in nature. Negative emotions, such as boredom, anxiety, stress, or depression, might trigger gamblers to numb their feelings or seek emotional arousal through gambling behaviors. Negative consequences of gambling can contribute to a negative emotional state. This can place gamblers in a cycle of gambling and negative emotional states. However, negative emotional states, such as shame, regret, and guilt, can also inspire gamblers to contemplate their gambling behaviours and motivate them to quit. Therefore, negative emotional states can insert either a negative or positive effect on the problem gamblers' prognosis.

On the other hand, a gambler with positive emotional states such as proud, delighted, euphoric, ecstatic, and thrilled can also contribute to continuing gambling or to relapse. Simultaneously, successful abstinence strengthens positive emotions such as calmness, gratitude, and blessedness, which in return increase their self-efficacy and confidence in keeping abstinence, and the gambler will be less likely to resort to addiction behaviour. Therefore, emotional well-being has a reciprocal relationship with gambling behaviours.

Moreover, the physiological state is not confined to personal propensities such as impulsivity or anti-social personality, and gambling behaviour. The reciprocal interaction between addiction behaviour and physical well-being is as significant as the emotional state. A negative physical state, such as sickness, being hospitalised, and injury, can trigger people to addiction behaviour, including gambling, dissociating, and numbing their pain. Therefore, emotional and physiological well-being contributes to some people being emotionally vulnerable and physically susceptible to resorting to gambling as a coping strategy to numb psychological and psychological pain.

The third distal factor is co-morbidity with substance use. Substance use might contribute to reduced volitional control and increased risk of gambling. It is expected that problem gamblers have co-morbid substance use disorders – most commonly with alcohol and methamphetamine. The relationship between substance use and gambling is dynamic and reciprocal. Therefore, substance use can increase gambling behaviour, while gambling may also drive gamblers to take drugs. Substance use drives gamblers to gamble more because of a few reasons. Substance use reduces the volitional control of the gamblers to continue their gambling behaviour. Substance use can influence gamblers' affect, such as being euphoric, elated, joyful, excited, thrilling, and feeling high. These positive affects drive gamblers to enjoy gambling activities, dissociating from the consequence of gambling or losing the volitional control of their gambling. Gamblers commonly report that after they have alcohol and or methamphetamine, they gamble more.

On the other hand, gambling increases substance use among gamblers. Firstly, the negative consequence of gambling causes gamblers to feel stress and anxiety. Gamblers may resort to using drugs and alcohol to relieve their stress and anxiety. On the other hand, some gamblers reported using methamphetamine to keep awake to gamble continuously over a few days without sleep.

So contextual factor cultivates the propensity towards gambling, well-being contributes to emotional and physical vulnerable towards gambling. At the same time, co-morbidity of substance use disorders can reduce the volitional control towards gambling. These distal factors form the base and susceptibility of the gamblers to the development of problem gambling. However, distal factors alone do not guarantee the development and maintenance of gambling addiction. Despite propensity and vulnerability towards gambling, gamblers still need to meet the proximal risky situations which trigger their gambling behaviour.

Proximal factors

Risky situations are the high-risk situations that are the immediate precipitators of initial lapse and the determinants of relapse. Risky situations might contribute to gamblers participating in gambling activities and threatening gamblers' decisions to control their gambling behaviour. Risky situations can be internal and external factors such as negative emotion, positive arousal, self-image, peer pressure, financial pressure, shame, relationship conflicts, facing legal issues, and financial crises. The Centre for Addiction and Mental Health designed the Inventory of Gambling Situations (IGS), which covered eight categories of high-risk situations of gambling (Littman-Sharp, Turner & Toneatto 2009). The eight categories of high-risk situations in IGS include: winning and chasing, pleasant emotions, need for excitement, conflict with others, social pressure, testing personal control, urges and temptations, negative emotions, worried about debts, and confidence in skills.

Risky situations are proximal factors that may trigger the immediate risk of gambling, but risky situations do not necessarily result in gambling. Some gamblers have acquired cognitive and behavioural skills to cope with risky situations. However, their coping skills do not necessarily guarantee they will be immune from relapse. Some gamblers relapse shortly after treatment. There is another essential element in mediating risky situations to influence the prognosis of gambling behaviour.

Relationship factor

The mediating factor in determining gambling behavior's prognosis is the relationship between problem gamblers and their families. The prognosis of gambling depends on the family's interpersonal dynamics and the interaction between the gamblers and their families. The relationship between problem gamblers and their families can be supportive and non-supportive. Supportive relationship acts as a buffer to protect gamblers from relapse. Non-supportive relationships can increase gamblers' vulnerability to relapse. Relationships are mediating factor influencing motivation to quit or to relapse to gambling behaviour.

In terms of relationships, it is the interaction between the gamblers and their families or Concerned Significant Others (CSOs), including spouse, children, parents, siblings, extended family members, relatives, friends, or colleagues, who provide essential financial and emotional support to the gamblers. Relationships are not confined to emotional expression but also include behavioural interaction. Relationships and gambling are dynamic and reciprocal. Therefore, relationships influence the prognosis of gambling, while the prediction of gambling also

influences the relationship between the gamblers and CSOs. It is not a unidirectional relationship between families' interaction and gamblers' prognosis. There exists an interaction between the gamblers and their families. Families can change from non-supportive interaction to supportive interaction towards problem gamblers when problem gamblers show progress in abstinence. On the other hand, the relationship between gamblers and their families can shift from supportive to non-supportive when gamblers relapse to gamble. It is proposed that there is a reciprocal role of family on recovery and dysfunction on problem gamblers.

In this hypothesis, the relationship is termed as supportive and non-supportive rather than positive and negative, as most theories labelled. It is because the negative relationship generally implies unfavourable, aggressive, criticising, harsh or hostile attitude towards gamblers but excludes the families' non-hostile attitude such as withdrawal behaviour towards gamblers, such as overprotective, emotional over-involved, sacrificed behaviour, indifferent and detaching behaviour. While the positive relationship may only imply favourable acceptance, empathy, compassion, or unconditional love towards gamblers but excludes families' firm, constant remind, and supervision towards gamblers may also be stressful. Moreover, the loss of family members, including parents, children, siblings, or cousins, can also influence gamblers' prognosis depending on the interaction and relationship between gamblers and their families. Loss of family members, especially children, will be trauma to gamblers.

On the other hand, the loss of parents or dying parents can motivate gamblers to quit. Dying parents may exhort gamblers to change their addiction behaviour. In this study, it is hypothesised that the relationship between gamblers and their families mediates the prognosis of the gamblers. Supportive relationship acts as protective buffers for gamblers from relapse and motivation to quit. In contrast, the non-supportive relationship increases the gambler's vulnerability to relapse or increases their barriers to seek help.

This dynamic interpersonal element is the role of families' attitudes and interactions towards the problem gamblers. If families express negative attitudes of criticism, hostility, emotional over-involvement, withdrawal, and detachment towards their problem gamblers, these negative attitudes and behaviour will cultivate a non-supportive relationship. This non-supportive relationship will put extra tension on the vulnerable gamblers who may resort to gambling as a way to cope with the stress and results in their relapse. On the other hand, if families express positive attitudes of warmth and positive remarks, their positive attitudes will be supportive towards gamblers for recognising their efforts in abstinence and encouraging problem gamblers to abstain and quit gambling.

Therefore, despite facing the same internal or external factors, family members can have different effects on the problem gamblers' prognosis depending on the family's attitude and interaction towards the problem gamblers. For example, as the problem gambler faces external stressors, such as financial pressure, or if the family members express negative attitudes such as criticism and hostility, the stressful family environment will become a risky situation which can further deteriorate the relationship and impose pressure on the vulnerable problem gambler who may relapse to gamble to seek the emotional escape of the crisis. In this situation, internal elements of feeling shame and belief of their own strategies to solve their financial problem by gambling can be barriers for the gamblers to seek help. Although gamblers feel shame, guilt, and remorse, they disconnect these emotions and defend or deny these feelings in response to their spouses' blame (Lee 2002). Therefore, families' negative attitudes and interactions can impact the gambler's internal feelings and external stress of life crisis to relapse to gambling.

On the other hand, if the family members express a positive attitude such as warmth and positive remarks, they can provide a supportive relationship, encouragement, and calming effect towards the problem gambler to abstain from gambling. In this situation, external factors of life crisis and internal factors, such as awareness of the consequence of gambling and improving self-image, can motivate problem gamblers to quit gambling and sustains behavioural change of abstinence. Moreover, supportive relationship can become protective factors, such as family cohesion and family connectedness, to buffer the influence of risky situation such as peer pressure and becomes a protective factor against high-risk behaviours. This Family Attitude Navigating (FAN) model postulates a mechanism of the family's attitude and relationship in navigating the risky situations to either motivation to quit or trigger to relapse.

Finally, excessive gambling loss increases their debts and reduces other options available for resolving their debts as all their legitimate ways to borrow money are exhausted. Exhaustion of their money source drives them to commit offences to generate money to pay their gambling-related debt and continue their gambling. However, the financial pressure of gambling motivates gamblers to commit offences. The financial benefit from offences also relieves gamblers' financial stress and mitigates the chance to gamble on the other hand. Moreover, the stress of committing a crime also increases the risk to gamble.

The negative consequence of gambling, especially exhaustion of money, drives some gamblers to commit a crime to make money to pay the gambling-related debt and to continue their gambling addiction. The nature of crime usually is money generated crime such as thefts and receiving, fencing stolen goods. Gains benefit by fraud, burglary, and embezzlement. The most common crime among the participants in this study is the possession of a prohibited drug, possession of prohibited drugs with intent to sell or supply, and drug trafficking because of two reasons. First, those gamblers already used drugs and had a connection with drug dealers. Second, drug dealing is the fastest way to make money. Some gamblers even reported that they did not rely on gambling for money after making money from drug dealing. Therefore, the financial benefit from drug dealing relieves gamblers' financial stress and mitigates the need to gamble for money as before. However, some gamblers also reported that they felt extremely stressed during the journey of drug trafficking, which drove them to resort to gambling to relieve the stress of being caught by police. Therefore, offences can be both cause and consequence of gambling. Committing a crime also becomes a risky situation when gambling.

Therefore, it speculates that key family relatives and CSOs expressing a negative attitude towards their gambling family members can contribute to a non-supportive relationship, which mediates the risky situations and trigger problem gamblers to relapse. On the other hand, the CSOs who are more prone to express a positive attitude towards problem gamblers can contribute a supportive relationship that mediates risky situations and motivates gamblers to seek treatment and to restrain from gambling. The vulnerability-stress model explains that relatives

who expressed a negative attitude are more emotionally arousing to the patients. In contrast, relatives who express a more positive attitude tend to have a calming effect on their family members. Stressful life events and social, environmental stress can interact with the patient's pre-existing vulnerability characteristics and produces psychotic episodes (Nuechterlein & Dawson 1984). Therefore, it postulates that when the CSOs are critical and hostile towards problem gamblers, their negative attitudes may be stressful to problem gamblers. The stressful family environment may trigger problem gamblers to relapse of gambling. Centre for Addiction and Mental Health (CAMH) Inventory of Gambling Situations (IGS) has identified that "Conflict with others" is one of the triggers to problem gambling (Littman-Sharp et al. 2009). Rosenthal and Lesieur (1996) hypothesis that some problem gamblers are "escape seekers" and they resort to gambling as a way to escape to numbing or oblivion. The negative attitude of CSOs towards problem gamblers may unintentionally contribute to their relapse. CSOs' negative attitudes could be a trigger for problem gamblers to relapse in order to escape the adversity of family environmental stress. Therefore, it supports the Co-dependency theory that the family's loss of control over emotion will associate with the drinker's loss of control over drinking. Moreover, when CSOs are too emotionally over-involved or over-protective towards the problem gamblers, for example, helping them to pay their gambling debt continuously, their over-emotional involvement (EOI) also contributes to the maintenance and relapse of their family members' gambling behaviour. CSOs' over-protective attitude associating with the relapse of problem gamblers explains the Co-dependency theory that the family's tolerance of unacceptable behaviour is associated with the drinker's substance abuse.

On the other hand, when the problem gamblers can be abstinent, it is encouraging for the CSOs to respond positively towards problem gamblers. CSO's positive attitude is rewarding for the gamblers in return. Moreover, CSOs' positive attitude enhances gamblers' emotional well being and provides them with social support as a buffer against relapse. These positive attitudes explain the variation of prognosis of gamblers. Therefore, the family attitude navigating the trigger situations of both internal and external factors into the direction of either relapse of gambling or motivations to quit their gambling addiction. The emergent Family Attitude Navigating (FAN) model of CSOs on the prognosis of problem gamblers is shown in figure 1. The Expressed Emotion theory does not indicate a unidirectional relationship between relative's attitudes and relapse. There exists an interaction between the patients and relatives. Rating of expressed emotion is not necessarily static over time as well (Vaughn 1989). It explains the possibility of the CSOs changing from a negative attitude to a positive attitude towards problem gamblers when problem gamblers show progress in abstinence. It is proposed that there is a reciprocal role of family on recovery and dysfunction on family members with gambling addiction.

Discussion

There were a few limitations to this research. The first is the criticism of offenders' retrospective accounts. Natarajan (2000) suggested that offenders might downplay or exaggerate their roles in their offences. Incarcerated offenders might exaggerate their accounts, lie or avoid telling the truth about their offences. Not all incarcerated offenders trust people working in the prison environment. The inmates may not be willing to explore their history with people whom they do not know. Therefore, an interview of inmates may not be able to explore in-depth data related to their gambling-related crime. There are also challenges to gain access to incarcerated populations.

Theoretical sampling is recommended in grounded theory research. Theoretical sampling enables the researcher to choose participants who have experienced the phenomena under study. By doing so, a researcher can choose the target samples, providing a more in-depth understanding of the emerging patterns, dimensions, and categories of data, ensuring interviews focus on exploring the data to the point of saturation. Thus, recruiting appropriate participants through theoretical sampling enables the use of smaller sample sizes (Thomson 2011).

In light of the above considerations, this study was modified to recruit problem gamblers with offence histories based in the community, not incarcerated in prison, or still in parole conditions. The researcher recruited fifteen participants, meeting the minimum acceptable number of samples for qualitative research (Guest et al. 2006).

There are no rigorous criteria for sample size in a qualitative study. Qualitative research is labour intensive and time-consuming. The large sample size is often impractical. Moreover, the recruitment of a specific sample target is further restricted by the particular environment and situation. For example, persons with an addiction problem are usually challenging because they often hide behaviors accompanying stigma, shame, and guilt (Scull & Woolcock 2005, Feldman et al. 2014). Some are reluctant to discuss their gambling problem. However, there is a concept providing a guiding principle in determining the sample size in qualitative research.

The concept of saturation is the guiding principle in determining the sample size during their data collection. New data added to the theme and overall theory from interviews of each different sample. However, there is a point of diminishing returns, and it reaches saturation when a different sample's interview does not provide new data, and it becomes "counter-protective" (Mason 2010). The point of theoretical saturation and sample size depends on three conditions: the scope of research, the sensitivity of the phenomena, and the researcher's ability (Thomson 2011). A broader research scope, such as on the general population, requires more data and samples for interviews.

On the other hand, a narrow research scope focusing on a specific target population requires fewer samples. If the nature of the phenomena to be examined is less sensitive, such as values or beliefs towards particular issues, it will be easier for the participant to explore. Then it can reduce the sample size. Moreover, a more open and trusting interview environment can encourage a participant to talk about it and to share their sensitive nature of thoughts through in-depth interview. Finally, the experience and knowledge of the researcher influence the sample size. A researcher with more experience and expertise in the field of research will require fewer participants as they can guide and encourage participants to reveal data (Thomson 2011). Previous experiences enable the researcher to narrow the focus and guide to the essence of the phenomena and thus reduce the number of interviews (Thomson 2011). Mason (2010) also stated that data elicited from ten interviews conducted by an experienced interviewer could be sufficient than if interviewed by an in-experienced interviewer (Mason 2010). In this research, the researcher has clinical experience working

with clients with addiction problems and criminal offences background. He has acquired interview training in the past, and he has also undertaken qualitative research before. His clinical experience and knowledge in this research topic have equipped the researcher with critical skills in the initial designing of the interview schedule and also enabled the researcher to guide and encourage participants to reveal accurate information during interviews. Moreover, interviews were done in the organisations where those participants received services. This interview arrangement provided a familiar and trusting environment for participants to discuss their sensitive nature of experience through in-depth interviews. All participants were willing to talk about their gambling histories and divulged their gambling-related offences. The data collection reached saturation when the researchers interviewed the thirteenth and fourteenth participants. The last three participants revealed similar information that the previous participants had disclosed.

The sample size for grounded theory methodology is suggested between twenty and thirty (Creswell 1998, p.64). In a review of fifty research articles, Thomson (2004) reported sample sizes ranging from five to 350 people for grounded theory research (as cited in Mason 2010). Thomson (2011) reported an average sample size of twenty-five for grounded theory in an analysis of a hundred studies. Atran et al. suggested a minimum sample size of as few as ten participants were able to establish a reliable consensus according to an analytical tool called “Cultural Consensus Model” (as cited in Mason 2010). The research reported that a sample of six interviews was sufficient to develop significant themes and saturation occurred within the first twelve interviews (Guest et al. 2006). It is suggested that a small study with “modest claims” of a specific group, for example, addiction, meets saturation sooner than a study of a general population (Mason 2010). Since this study’s target focuses on a specific group of problem gamblers with offences histories, a saturation of data collection is expected to achieve quicker to collate data for significant themes to develop a ground theory in this study.

The researcher has done some previous studies on a related topic based on a lot of literature review. That knowledge stimulated the researcher to logically deduce core variables from a multitude of other logico-deductive models. This may limit the formulation of a new grounded theory emerging from raw data and lead to applying the collected data into some compliance scheme. During this logico-deductive analysis process, the researcher may classify categories and themes according to compliance structures. Within the limitation of preconceived scope and scheme for the theory, the researcher has developed a well-integrated and logico-deductive new formal grounded theory from the raw data, which was specific to this sample of participants who have a gambling problem and criminal history. Formulation of this new grounded theory helps to fill the gap of the existing theory, which cannot explain the prognosis of gambling behaviour among those gamblers with offence history.

This qualitative study has generated a new grounded theory of a family attitude navigating problem gamblers’ prognosis. To verify a new theory, a quantitative study is needed to provide empirical evidence to test the theory’s hypothesis. Therefore, quantitative research is planned to test the theory’s validity and reliability in the next stage.

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