AUSTRALIAN COUNSELLING RESEARCH JOURNAL

Australian Counselling Research Journal

Vol 15 | Issue 1

2021

Editorial

Volume 15, Issue 1 - 2021. Dr Ann Moir-Bussy

Welcome to our Autumn edition for 2021 and we hope the year is progressing well for all our readers as COVID still rages in so many countries. We hope you will enjoy the excellent articles that have been presented for this issue and we are grateful to all our contributors for sharing their knowledge and wisdom.

It is also with sadness that we share the news of one of our Editorial Board, Professor Tom Seay, and after this Editorial we have a short piece shared with us by a colleague and friend of his, Brian Wlazalek.

This issue begins with a critical exploration of "Whose voice is privileged?" in counselling education. By drawing on the work of Paulo Freire, Henry Giroux and Bell Hooks. Simon Hinch reflects on his own teaching and his own practice and use of narrative therapy, reflecting on the similarity that narrative practice holds with the critical pedagogy of the above authors. As he notes," many parallels can be drawn between narrative practice and the collaborative, power-sensitive and social justice focused practices of the critical educator". This is an insightful manuscript for all those in counselling education. We contend that the transformative path that liberatory practice building on the legacies of critical pedagogy, with Freire, Girous and Hooks strongly impacts on communities and individuals. In this sense the work of critical counselling is a community of minds coming together for healing.

In his Ph D, Alec Hamilton explored how different health professions, including counselling, conceived the notion of *presence* in their work with those they served. Therapeutic presence is vital in the building of the relationship with clients, not only in counselling but also in other health professions. It was a privilege to work alongside Alec as he researched the literature across four health professions, and then proposed a *Fields of Presence Model*. His finding is indeed useful for anyone who wants to understand how to deepen their relationships with clients through presence.

Jo Christmas, who has a background in Psychology, working in Palliative care, HIV and AIDS and Occupational Health has just completed her Master of Counselling. In *Defence of Anger* is a very interesting exploration of the emotion of anger which counsellors may experience, Jo reflects deeply on her own experience of anger as a student counsellor and how it became for her an important and valuable resource.

On a different note, Sam Everingham and Katrina Hale explore the characteristics, traits and personal satisfaction of 30 surrogates who carry for unknown intended parents in Australia and New Zealand. The study reveals that many surrogates are often emotionally ill-prepared for the process and receive very little support. Some insight was gained into the range of demographic and personality types who engage as altruistic surrogates.

Editors

Emeritus Professor Tarquam McKenna
Victoria University
Dr Ann Moir-Bussy
Adjunct - Charles Darwin University

Understanding the importance of cultural identity in clients is crucial in effective care and relationship building in counselling. Daryl Mahon offers a model of multicultural treatment that seeks to learn from the client themselves what are their important cultural identities, values and beliefs. This Pluralistic Multicultural Orientation Treatment "extends the current multicultural competency framework by integrating four interdependent but interconnected interventions to create a conceptual model". Practitioners could well find this a valuable resource to add to their current multicultural practices.

Our final paper is concerned with Building Resilience in Transcultural Australians (BRiTA. Ahangari, Khawaja and Ileana explore how feasible it is to deliver the BRiTA program online through zoom. Preliminary results were positive, opening up further options of accessing a range of preventative programs in different settings. The authors were grateful to the Queensland Transcultural Mental Health Centre staff for their support in the program. Building a notion of collective responses in individuals and families is the work of many counselling education traditions. In this edition we are aware especially of the need too attend to linguistc, cultural and spiritual diversities. The capacity to work alongside our diverse communities is embedded in this edition.

The quality of the manuscripts in this issue is high and we commend the authors for their work and for sharing their research and experience. At the same time, we invite more of our readers, educators and practitioners to come forward and to contribute to the growing body of evidence that demonstrates the effectiveness of the counselling profession. The next issue will be late spring early summer, so do submit manuscripts by October.

Wishing you all a safe and healthy passage through winter here in the southern hemisphere and for all in summer in the north and in particular, healing and new health from COVID. Sadly, death is on such a massive scale in many countries because of the pandemic that at times it may seem easier to put it out of sight. I am encouraged by the words of the African writer Ben Okri –

In a world like ours, where death is increasingly drained of meaning, individual authenticity lies in what we can find that is worth living for. And the only thing worth lining for is love. Love for one another, Love for ourselves. Love of our work. Love of our destiny, whatever it may be. Love for our difficulties. Love of life. The love that could free us from the mysterious cycles of suffering. The love that released us from our self-imprisonment, from our bitterness, from our greed, our madness-endangering competitiveness. The love that can make us breathe again. Love of a great and beautiful cause. A wonderful vision. A great love for another, or for the future. The love that reconciles u to ourselves, to our simple joys, and to our undiscovered repletion. A creative love. A love touched with the sublime.
(Okri, B, 1997, A Way of Being Free. P.56-57)

Dr Ann Moir-Bussy
Editor

Vale Professor Tom A. Seay

Professor Tom Seay was a valued member of our Editorial Board and for almost five years an esteemed colleague of mine at Hong Kong Shue Yan University. Tom died 3 weeks ago after being diagnosed with leukemia only a month before. We are grateful for his friendship and for his ongoing work and input to our journal. A close friend of his, Brian Wlazelek, and colleague from Kutztown University in Pennsylvania has written this Obituary for us.

Thomas A. Seay

At this time, we mark the passing and celebrate the career and life of Thomas A. Seay, Ph.D. (1942- 2021). Dr. Seay was a consummate educator and advocate in the field of Counseling Psychology with numerous publications, presentations and professional endeavors. Dr. Seay was Professor Emeritus of Kutztown University of Pennsylvania, where he helped develop a graduate program in Counseling and a course of study in Marriage and Family Counseling. Retiring after a 33-year career, Dr. Seay launched a second chapter in his professional career by joining the faculty at Hong Kong Shue Yan University as Professor and Director of the Master's Degree of Social Science in Counseling Psychology and Acting Director of the Ph.D. program in Counseling Psychology. He returned to the United States in recent years to enjoy the company of family and friends and the peaceful setting of his farm for a second retirement. An esteemed scientist-practitioner, respected educator, trusted colleague, intrepid traveler, and steady friend, Dr. Seay will be missed.

Table of Contents

Volume 15, Issue 1 - 2021

Message in a Bottle - Collective Narrative Practice as Critical Pedagogy in Counselling Education

Simon Hinch

Narrative Therapy and Collective Narrative Practices provide distinct methods through which local knowledge, skills and salient experiences can be evoked and shared with others in ways that support the development of preferred identities and overcome the isolating effects of problems. Furthermore, narrative practices also share a similar ethical stance with the critical pedagogy of Paulo Freire and Henry Giroux and Bell Hooks. Given this, many parallels can be drawn between narrative practice and the collaborative, power-sensitive and social justice focused practices of the critical educator. It is at this intersection between narrative practice and critical pedagogy; that the practice Innovation described in this paper lies. This practice innovation sought to use collective narrative practices to develop a rich and vibrant community of practice that supported collective learning, the development of critical consciousness and the storying of course participants professional identity as counsellors and family therapists.

The individualising force of post-industrial society and the social inequity evoked by neoliberal ideology has significantly impacted the tertiary education sector. Counselling education is in no way spared this. The same forces that influence the profession and practice of counselling and the subjectivity of those who receive its services are equally at work in developing pedagogy in academic contexts. The academy can be understood to be not only subject to economic and cultural forces such as those outlined above, but also to play a significant role in the production and maintenance of these structures as outlined by Saunders (2007):

'Colleges and universities occupy a special role in the hegemonic project as they have become one of the few legitimate knowledge producers and disseminators. As such, they are extremely powerful actors in the creation of hegemony (and at the same time could have immense power in a counter-hegemonic movement).' p4.

Given this, in the same way, counselling and psychotherapy can be understood as a site of resistance to hegemony or maintenance of the status quo (Pavon-Cuellar et al., 2017; Lamarre et al., 2018; Rustin, 2015). So too can tertiary education and, in particular, counselling education, be seen as a location in which the gears of social change can be oiled and put in motion, or instead brought to a grinding halt. This is particularly the case when we think of the experience of learning and the pedagogy that informs this as a mechanism through which not only skills and knowledges are shared and developed, but also a process that facilitates the construction of both personal and professional identities that privilege particular knowledge's, and inevitably marginalising others. As such, we can begin to see that counselling education in both content and process can act powerfully to maintain and replicate dominant discourses and power relations. Or conversely, open up spaces in which taken for granted assumptions can be explored in critical and context informed ways, where the specific individual and collective knowledges of both students; and in the context of counselling education; clients, can be uncovered and richly storied to form a central element in a therapists clinical training (Giroux, 2011).

It is this that the present paper intends to explore, turning its gaze specifically towards the way in which collective narrative practice methodologies might be used to develop learning communities that act to privilege the multiple and often marginalised knowledge of both clients and trainee therapists and do this in ways that highlight the unique experiences, skills, and preferred identities that emerge in response to the challenges that arise in this particular practice context.

Corresponding Author: Simon Hinch
Email: simon.hinch@qut.edu.au
Tel: 07 3138 0999
Queensland University of Technology, Brisbane

Australian Counselling Research Journal ISSN1832-1135

The Traditional Model of Counselling Education – Who's Voice is Privileged?

Through the work of critical educator Paulo Freire (1993, 2001), we will begin to explore some of the traditional or structuralist accounts of learning and education. These accounts have provided the discourse from within which much counselling pedagogy, both past and present, has been developed.

Central to Paulo Freire's work is a critical examination of how both the content and form of pedagogy can maintain and reinforce structural oppression by replicating the wider community's existing power relations within the educational context. More specifically Freire (1993) outlined, what he termed, the *'banking model of education',* which he understood as an inherently authoritarian and hierarchical educative process by which learning; and education are seen as an activity by which a teacher inserts, or somehow implants their knowledge directly into a passive and somewhat vacuous student. This process was seen as inevitably privileging the singular knowledge and voice of the educator, which were often sanctioned, produced, and in service of existing social structures and institutions, but also fundamentally ignoring the existing knowledge and voices of the students, as outlined by Freire below:

'In the banking model of education, knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider know nothing. Projecting an absolute ignorance onto others, a characteristic of the ideology of oppression negates education & knowledge as processes of inquiry' (Freire, 1993, p45).

Moreover, this 'Banking Model' of education is strongly supported by other mainstream accounts of education and learning, which are, according to Wortham & Jackson (2012)

'…. individualist, in that the individual is seen as the object and locus of educational enrichment…' p6.

This, according to the authors, is due to certain assumptions about the individual and knowledge itself, and directly informs the nature and type of educational practices privileged and valued within any individual institution. More specifically, these assumptions are commonly grounded in empiricist epistemologies that highlight the idea that universal truths can be found, known and transmitted directly to the student. Hence positioning the educator as the 'holder of legitimate knowledge, expertise, and subsequent power' (Nelson & Neufeldt, 1998; Jaeger & Lauritzen, 1992).

Furthermore, these epistemological positions tend to privilege particular 'ideal' forms of knowledge, which are seen as relatively stable, able to be decontextualised, and assume a fundamental separation between people where each mind acts as an essentially sovereign and autonomous unit. (Wortham & Jackson, 2012). These bodies of legitimised knowledge which assume a self-contained individualism emerge, according to Gergen (2001) within communities of knowers, and *'favour particular visions of the good'* which can act to reinforce existing power relations, in terms of both pedological practice and the privileging of dominant discourses.

As such, in the context of counselling education this often leads to educators positioning themselves as not only the holder of legitimate knowledge and skills regarding the correct practice of counselling and psychotherapy based in both professional experience and relevant empirical research, but also as those who are singly qualified to be able to evaluate the practice competencies and quality of trainee therapists work with their clients, inevitably marginalising the voice of the clients who are the centre of the endeavour.

It is these power relations that provide the foundation from within which dominate therapeutic and psychologising discourses regarding function, dysfunction, change and pathology can be uncritically transmitted from educator to student and from student to the client, influencing the subjectivities that are developed in both and providing the frames from within which practice itself and reflection upon it can occur, as outlined by Hare-Mustin (1994):

'Both the process and content in the mirrored room are limited by the discourses that are brought into the room. Thus, there is a predetermined content to therapy – that provided by dominant discourses. Conversations can be oppressive, not so much by what it includes, but by what it excludes.' p33.

As such, these authoritative and individualistic models of education tend to replicate dominant ideology and therapeutic practice and impede the active interrogation of it. This can occur through the marginalisation and devaluing of both clients and student's unique perspectives and experiences, minimising the generation and appreciation of multiple perspectives, and a subsequent reduction in the relevance of collaborative and relational pedological practices. Limiting both educator and student's opportunity to participate in the fundamentally relational, dialogical and constructivist pursuits of:

'socially considering, questioning, evaluating and inventing information' (Nelson & Neufelt,1998, p79).

These pursuits being essential in the process of exposing the operation of power embedded in assumed and singular truths across both counselling and educational contexts; and the development of the critical consciousness, sociological imagination and learning communities that are required to evoke multiple voices and advance an active promotion of social justice and social change. Furthermore, as stated by Giroux, 2011;

'Pedagogy must address the relationship between politics, and agency, knowledge and power, subject positions, learning and social change, while always being open to debate, resistance and a culture of questioning'. p147.

Responding to Traditional & Structuralist Models of Education – Making Space for Multiple Voices

This 'culture of questioning' to which Giroux (2011) refers is one of the central tools that educators have in resisting dominant discourse in counselling education and the subsequent marginalisation of local client and student-generated knowledge. Furthermore, the dialogue that this creates can also be seen as a primary mode through which learning can occur (McNamee, 2007). This same 'culture of questioning' is also the ground upon which narrative practice builds conversation intended to deconstruct dominant and often thin problematic discourse and develop richer, multi-storied and often preferred descriptions of peoples, lives, and identities (White, 2016). Then, we can see that there are relevant parallels drawn between a critical pedagogy such as the one that Giroux (2011) describes above and the various principles and methods of narrative practice . To explore some of these parallels further, we will begin with a quote from Epston & White (1992):

'Training and Supervision has raised dilemma for those

teachers/supervisors who have concerns that the training context might encourage participants to surrender hard-won knowledge's and submit to the authority of the teacher/supervisor, concerns that participants could be incited to discipline themselves and shape their 'life as therapist' according to certain specifications, concerns that participants might fashion their lives as recruits…..' p84.

Posture & Relational Positioning

White's quote above speaks to an important parallel found in the relational positioning or 'posture' of critical educators, narrative therapists, and community workers. This begins with a shared willingness to become aware of and transparently acknowledge the privilege and power that their role, and broader social position, might assign them. This acknowledgement of these relationships' politics can then make space for an awareness of how they may act to privilege or marginalise specific knowledges and begin to take actions to reduce this power gradient.

Many Narrative practitioners have written about this process of positioning oneself in relationships in ways that do not impose dominant knowledge upon those who consult them. None more clearly than White (1997), who explores 'decentring' as an ethical practice of accountability that seeks to resist the replication of power relations and a tendency for these to be 'rendered invisible', making them difficult to address. White (2005) further outlines decentred practice as a relational stance that centres the knowledge and stories of those with whom we work, rather than that of the therapist or, as the case may be, educator. This decentred position can include the telling and re-telling of the stories of people's lives, re-authoring conversations, practices of transparency, structuring forms of acknowledgement, and taking it back practices (White 1997).

When we take these ideas into the context of Counselling education, we can see the importance of Counselling educators being willing to decentre their knowledge to create a collaborative, relational context where power is as much as possible distributed among all parties involved and unexamined social discourses that are present in the teaching context can be openly explored. What this can then make possible, via carefully scaffolded practices, such as those outlined by White (1997) above, and the practice example provided below, is the collective generation of diverse knowledge and skills that can be applied to the relevant learning domain (Reynolds, 2014; Giroux, 2011).

A Context of Opportunity, Constraint, and Ethical complexity

Before I offer an account of the practice innovation itself, I wish to situate myself and my practice context. This is, in my view, particularly important as the specific context and the related roles and relationships it entails act as a source of opportunity, unique constraint and ethical complexity, all of which have coalesced into the specific form of this practice innovation. As alluded to above, I find myself in the privileged position as a Counselling Educator in a Master of Counselling program and lead supervisor in a Counselling and Family Therapy teaching Clinic. This Clinic is unique in that each year we have our course participants break up into several 'therapeutic teams' who then go out into diverse community contexts to engage in collaborative, constructionist and reflecting team-based therapeutic practices. This is at odds with the more traditional and individualised approaches to counselling placements where course participants work in isolation with clients and use individual clinical supervision as the primary approach to evoking learning and reflection on this experience.

This team-based approach to practice, as outlined above, provides a small group, led by a team supervisor, who work together across the year, engaging in therapeutic conversations with clients that attend each team's respective location, and a community in which collective and reflective learning can take place, much like the practices as outlined by White in 'training as co-research' (White, 1997). With these small teams practising in diverse locations, much rich learning unique to the specific context can occur with various client groups. Yet this diversity of location and practice context provides a unique learning opportunity for each team and brings unique constraints.

The Genesis of a Project

In my role as lead supervisor, I have the unique opportunity of working with up to five therapeutic teams across a year. As part of this role, I have always appreciated being able to listen to the numerous rich stories of learning and practice from each of these teams. As an audience to these stories, I have often experienced a sense of excitement regarding the possibilities that these stories of learning represent. How might they contribute to the learning and practice development of others via the sheer diversity of experience and in terms of the commonalties that emerge across what is often a challenging yet rewarding year for course participants? Yet this excitement has often been tempered by the constraint that both geographical distances between teams and the time available across the year have placed on the advent of these possibilities. It is, however, not only me who has been subject to the effects of these limitations. Course participants have also experienced these effects and have in prior years expressed a sense of disconnection from other course participants and a feeling of loss regarding the collective and collaborative learning they have experienced in the program when more regularly connected with the larger group.

In late 2019, the current practice project had its genesis via several consultations with course participants. These consultations explored course participants knowledge regarding responding to the challenge of *'distance, separation and isolation'* in their learning and how therapeutic teams might in the future, stay more connected with each other, share their diverse practice experiences, and maintain a supportive learning community which privileged the voices and local knowledge of course participants and the clients with whom they were in service. In these initial consultations, we began to explore how course participants might share some of the knowledge generated from these conversations with those in the program's future years.

Generating an initial Collective Document – Voices from the Past

Collective narrative Documents have a rich history of use across various context and practice domains. Central to these documents is the collective articulation of a group's diverse skills and knowledge in response to particular problems that they are facing (Denborough, 2008). These practices are embedded in the broader tradition of Therapeutic Documentation

in narrative practice, where they have commonly been used as a process to thicken preferred stories and identity conclusions (Fox, 2003). Additionally, there exists a significant literature regarding the many creative ways in which these documents can be shared between clients, intending to reduce the isolating effects of problems and share unique and local skills and knowledge's regarding responding to these problems (Gerlitz, 2015; Denborough et al., 2006; Hernandez, 2008) Furthermore according to Handsaker (2012) this process of sharing or joining stories is understood as a political act:

'of resistance to the damaging effects of individualism and isolation' p3.

While Handsaker (2012) is writing here specifically regarding counselling practice, it can be easily argued that the same politic of isolation and separation are at work across various domains, none more so than in the context of tertiary education. So, with this in mind, an initial collective document was crafted to share across time to future course participants as a small act of resistance to both the effects of isolation and the tendency of structuralist models of counselling education to marginalise the knowledge of both clients and course participants. The course participants collaboratively decided that this collective document would take the form of a fifteen-minute recorded conversation from eight willing participants, exploring the following questions:

- *What has been the biggest challenge or constraint to their learning and practice throughout the year?*
- *In what ways had they been able to respond to these challenges and constraints and maintain a connection to the ethics of postmodern practice?*
- *What were some of the most important things that they had been taught by the clients with whom they worked?*
- *What did they learn regarding working as a therapeutic team across the year?*
- *What other ideas did they want to share with future course participants, and what questions did they have for them?*

Importantly these questions were left with the group who were invited to develop the document in their way, with the invitation that all group members voices be present in some form within the recording. The intention here was to scaffold a document in a way that evoked what may be shared experiences between those making the document and those who would be witness to it. This ensured that a diversity of experience and narrative was represented, valuing multiple perspectives and the subsequent stories; a central aspect of narrative practice and critical pedagogy.

Responding to voices from the past.

To stay connected to this ethic of accountability referred to earlier in the paper, from the first meeting with the new year's course participants, my intention was to decentre my knowledge regarding what the upcoming year would be like; my expectations of them as practitioners; and the shape their learning experience could take. In previous years, I would have provided my accounts of the year ahead. This time, I was gifted with the rich knowledges and stories of the previous year's course participants in the form of a 15-minute recorded collective document. The presence of this document allowed me to act as a messenger for these voices from the past, who offered a warm welcome and rich description of relevant knowledge and skills for the year ahead. As such, early in our first meeting for the year, this document was shared with the new year's teams, who were asked, in collaboration with their colleagues, to listen and collectively respond to this message regarding what had resonated with them and the curiosities that this evoked. Each team was asked to develop a response that could be forwarded back to those graduates from the previous year if desired.

A Commitment to Collective Ethics – Whose ethics are these anyway?

Following the sharing and witnessing of the above-mentioned collective document, we set about exploring the ethical commitments that might inform course participants therapeutic practice across the year ahead. This notion of ethical commitments acting as guidelines for practice has been articulated clearly in the work of Madsen (2014) in addition to Reynolds (2013), who explores the relevance they have to not only our relationships with clients but also our relationships with our professional colleagues. Reynolds (2019) explores the importance of developing collective ethics to support practices of accountability and safety to foster cultures of critique. A prerequisite for the critical pedagogy that this project was striving to evoke.

While in previous years, I may have outlined the 'ethical expectations' I had of the teams and reinforced dominant discourse regarding the 'practices of professionalism' that they were to follow. On this occasion, grounding myself in a commitment to scaffolding spaces in which diverse course participants knowledge could emerge, I invited each team, initially in pairs and then as a whole group, to explore those ethical commitments that they were hoping to stay connected to across the year. These conversations were scaffolded via several questions informed by Vicki Reynolds (2011) work, to richly describe and trace the history of the ethical principles that each person brought with them and how these might be enacted within the context of the therapeutic team. These questions can be seen below:

- *What are the ethics that drew you to this work?*
- *What ways of being with others do you value and hold close to your heart?*
- *What ethics are a necessity regarding this work, and which would you be unable to work*

without?

- *What are the ethics or values that are present in our work when we are doing work that clients experience as most useful?*
- *What is the history of your relationship with these values, and how have they shown up in your life?*
- *Who are the people in your life that have been instrumental in the development of these values?*
- *What are the Ethics or values that you hold collectively as a group, based on the conversations you have had so far?*
- *How can we support each other to maintain a commitment to these collective ethics both in our work with clients and interactions with each other?*
- *What do you think a commitment to these collective ethics will make possible for your team across the year?*

The intention here was to begin the process of evoking and storying a diverse range of ethical commitments, both between and within teams, to further assist in the generation of a sense of 'communitas', which, while difficult to define, is pointed

to by Buber (1961) as cited in Turner (1969) as:

'…. being no longer side by side (and, one might add, above and below) but with one another of a multitude of persons. And this multitude, though it moves towards one goal, yet experiences everywhere a turning to, a dynamic facing of, the others, a flowing from I to Thou'.

This process was further extended and deepened via an invitation for each team to develop a collective document of the ethical commitments discussed that could be shared with other teams and referred to later in the year.

Definitional ceremonies and Therapeutic Documents

Following course participants spending time exploring the ethical commitments that they were hoping would guide them across the year, and the subsequent development of collective documents that could be circulated. Each team was then invited to share this document with the other four teams acting as outsider witnesses. Through this both the preferred stories and related identities relevant for the team at the centre of the 'definitional ceremony' could be acknowledged and a re-telling of these stories experienced (White 2000; Russell & Carey, 2004). This was achieved through the witnessing teams being invited, in small groups, to openly reflect on what the collective document had evoked for them, how it had resonated with their own experience and the way they had been changed by hearing it (White, 2007). Following this the team at the centre of the process was then asked to extend or elaborate regarding what they had heard and anything that had emerged from this re-telling. These definitional ceremony and outsider witnessing practices were relevant in acknowledging and thickening each team's preferred stories and commitments and allowed each team to begin practising the reflecting team processes they would be using to engage many clients throughout the year ahead.

Following this definitional ceremony, the facilitator decided to offer a therapeutic document in a narrative letter to each course participant. Therapeutic Documentation, which we have briefly explored previously in this paper, has, according to Fox (2003), a rich and diverse history of use in the context of narrative practice. Ranging in purpose from acting as case notes or a record for organisational or group consultation, enhancing the therapeutic relationship, offering a re-telling of the client story in new words, positioning the client as a witness, and extending the conversation to thicken the clients preferred stories and support the 'maintenance' and 'endurance' of the stories told (Douglas et al., 2016). As such the above-mentioned therapeutic document was written intending to acknowledge and extend upon both the shared and, diverse knowledge's the teams had expressed regarding the ethical commitments that were to guide their therapeutic practice across the year. A printed copy of this letter was handed to each student with some modifications made to each letter, based on individual input from the course participants. The generic version of this letter is outlined below:

2nd March 2020

Dear 2020 Reflecting teams

Firstly, I just wanted to say thank-you for your engagement and participation in our orientation workshop a few weekends ago. I was inspired by a sense of excitement and enthusiasm that seemed to be present in the room. Additionally, while there may have also been some understandable anxiety or uncertainty loitering around, I was struck by the clarity and detail that each team brought to the question of 'our collective ethics' and by the rich and diverse responses that were offered. This had me wondering how this clarity and diversity regarding the ethics guiding your work might serve you across the year. It also had me wondering about the way that this might also help us be of service to the people with who we will be working?

Any way as we discussed I wanted to provide the following document as a summary and extension of the work you began at the orientation. As I mentioned above, I was struck by the diversity of ethics that were outlined by each group and the different metaphors that were used to express these.

One group choose the image of a tree as a metaphor for their group ethics, another chose a rainbow, another a mind map, and others. This sense of creativity had me wondering about the ways that this might make itself present in your work with your clients, and how this might bring a particular and unique flavour to each of your teams. Extending this, I wonder if I were to interview some of your clients at the end of the year, what you would hope they would tell me and others about their experience of working with your team? What, if they could remember only one thing, would you hope they took away from spending time with you all?

While I was struck by the richness of ideas offered by all groups. I was also interested in the collective ethics that seemed common to all teams. I wondered what this type of unity and diversity could make possible across the year for our collective learning, and individual development as therapists?

Anyway, with that said, there seemed to be among others, four primary shared ethical positions that were as follows:

- *The importance of vulnerability*

This had me wondering what vulnerability might make available to us in our groups and what supports we might need to engage in it? I also wondered what vulnerability might make possible in our relationships with our clients?

- *The importance of accountability*

This had me curious about what we are individually and collectively accountable for in regard to our teams, our clients, and our own inner world?

- *The importance of Fostering nurturing relationships (this was called many different things by different people)*

This had me thinking about how we might do this? What are I wonder the small acts that can support us to develop these types of relationships and what might they bring to our experience throughout the clinic year?

- *The importance of a sense of hope & believing change is possible.*

This had me wondering how we maintain this sense of hope

and belief in change? What do you think might come and try and steal us away from this position? And how might support each other and our clients to hold this position even when the going gets tough?

I think this might be an appropriate place to leave this document for now. Please know I am very much looking forward to hearing about how your relationship with these ethical position's changes over the year. As well as the diverse ways they will be enacted in service of the people with whom we work.

Warm regards

To enact this and the other practice examples articulated above, the methods engaged in must be positioned based on principles that allow for the existence and valuing of multiple perspectives and interpretations of experience, rather than any sense of a singular or correct knowledge. This then brings us into the realm of epistemological positioning and its fundamental relevance when creating learning contexts, which can act to support collective learning and invite questioning of the existing status quo, and in the context of therapy, the evocation of double descriptions or multi-storied accounts.

Narrative, Learning & the Construction of Knowledge

'to teach is not to transfer knowledge but to create the possibilities for the production or construction of knowledge' (Freire, 2001 p30)

In the epistemological position alluded to by Freire (2001) above, we find a further parallel between approaches to critical pedagogy and narrative practice. This is a position that understands knowledge as something that is not 'out there' to find and that can be 'transferred' between minds, but rather something that is communally and collectively constructed through language and in dialogue or, socially constructed. As such this position invites a questioning of taken for granted assumptions and truths as it understands knowledge as time, place, and context dependant. This then makes space for valuing multiple perspectives, or interpretations of experience, bringing into question assumptions regarding the hierarchy of knowledge that provides an educator or therapist their traditional position of expertise (Gergen, 2001, Freedman & Combs, 1996, 2002).

With this in mind, the interactional process of questioning and dialogue, and the subsequent community-based production of knowledge, can in and of itself, be understood as a pedological or learning process (Vygotsky, 1978; Gehart, 2007). Additionally, closely related to these concepts is significant literature that explores the connection between these ideas and narrative processes, which are understood by Fisher (1984) and Clarke & Rossiter (2008) to be a primary way in which we make meaning from our everyday experience and develop coherence from what would otherwise be isolated and random experiences. Furthermore, according to Scherto (2014), given that narrative always involves an audience, how we make this learning visible to others also becomes salient, returning to Clarke & Rossiter (2008):

'…conversation is where the learning is happening. The telling of stories makes the learner not the receiver but the actor, moving from a cognitive understanding of an idea, principle, or concept and linking it to their own experience'.

Extending on this is the notion of re-storying, which takes these ideas of narrative learning and explores the value of inviting learners to share personal stories or narratives in ways that emphasise particular aspects of their experience. Slabon et al. (2009) define a re-storying process as:

'…. learners re-writing or re-telling of a personal, domain relevant story based on the application of concepts, principles, strategies and techniques covered during the course of instruction' p9.

This definition of re-storying also emphasises the process of these student-generated stories, being shared with other learning participants and subsequently reflected upon, modified, and developed with the intent of generating learning that is domain specific, yet also personally relevant to the learners and as such more easily internalised (Slabon, et al., 2014).

While this definition of re-storying does have a somewhat different emphasis to the practice of re-authoring provided by Russell & Carey (2004) and Freedman & Coombs (1996), It does clearly have parallels in that it includes the notion of the re-telling of relevant stories that are witnessed and responded to by others, with the intent of generating reflection, re-descriptions and diverse knowledge grounded in the local experience of participants. It is these ideas regarding the use of dialogue, narrative learning, and re-storying, when combined with a number of narrative practices as outlined by White (2007), Denborough (2008) and Freedman & Coombs (1996), that form the heart of the next phase of this project.

Messages in a Bottle

'walked out this morning I don't believe what I saw, a hundred billion bottles washed up on the shore, seems I'm not alone in being alone, a hundred billion castaways looking for a home'.

Sting – message in a bottle

The best laid and most elaborately scaffolded plans to continue the exploration of course participants ethical commitments and clinic learnings, using a variety of in-person community forums and narrative practices, were, along with all client work and life, as usual, to quickly take an unexpected turn. The presence of COVID-19 and its varied effects brought about the need for much reflection, revision and consultation regarding the process and content of the practices previously planned. If this project were to stay in line with the changing context, energy and needs of the community it was developed to serve, one needed to let go of current expectations regarding the process and engage with an ethic of responsiveness. Central to this ethic of responsiveness was an individual consultation with each of the teams regarding their knowledge of how best to maintain and use the community of practice developed earlier in the year.

Emerging from these consultations was the development of a number of questions that would be distributed to each group, with the intention of supporting the authoring of a collective document that represented what each team would like to share with others regarding their experience of learning and life so far throughout the year. These questions were framed to evoke stories of practice that highlighted both the constraints to this process and the ways that each team had found to respond to these challenges, both individually and collectively. These

questions are outlined below:

- *What is an image or metaphor that you might use to describe your journey as an individual and as a group so far in your experience working in the Clinic?*
- *What have been your greatest learnings about yourself and your group?*
- *What have been the greatest Obstacles that you have faced individually and collectively so far in working in the Clinic?*
- *What have you done to overcome or resist the influence of these obstacles so far?*
- *How have you managed to stay connected to the collective ethics you expressed earlier in the year and how has this shown up in your relationships with each other and with your clients?*
- *What has been the greatest challenge in maintaining/ developing post structural positioning in your work?*
- *How have you been able to overcome this challenge and what skills, abilities, intentions, and values have you drawn upon to do so?*
- *What are some of the histories of these skills abilities, commitment, and values and when else have they made themselves present in your lives?*
- *What is one significant thing that you have learnt about counselling, people, relationships, and change?*
- *What questions might you like to ask another one of the Clinic teams?*

Based on these questions some teams chose to develop a PowerPoint presentation, another a poster and others choosing to engage in a recorded team conversation which I was invited to facilitate. These collective documents, some excerpts of which are provided below, were then made available in a shared online space so teams could witness and respond as per desired. This was done with each group's consent and the intention of 'enabling the contribution' of each team to the others in the cohort and supporting the maintenance and continuation of collective learning through the community of practice that we had begun to form earlier in the year. Notably, the 'contribution' referred to above is outlined in detail by Denborough (2008) below:

'The difficulties that people are facing, however will not be theirs alone, and their experience of hardship can offer a contribution to others in similar or related situations' p3.

It seemed that this process of sending messages in a bottle, and contributing to others, in the context of COVID-19, took on even more importance than it may have in previous years. At this time, course participants were not only isolated due to geography, but many were also struggling with the experience of multiple losses and disappointments due to the expectations that many had carried with them into the year, both in terms of their learning but also in terms of their life outside of the academy. The common nature of these struggles can be seen in the two excerpts of the recorded collective documents below, with a common exploration around the effects of 'expectation' and 'unpredictability' in both life and therapeutic practice. Additionally, what can also be seen is the richness and diversity of each group's unique responses to these struggles both as individuals and as a group. It is here, at the intersection of both shared experience and a diversity of response, that novel dialogues and subsequent learning can emerge.

Excerpt 1.

S. So if there was a metaphor or an image for your experience of learning so far in the Clinic what might it be?

L. the idea of a journey and in the past the journey has been like climbing up and mountain, but this time I thought of a river or like we are on a sailing trip, all of us, in our sail boat, and we have this destination and this plan of how we are going to get there, and the things we are going to need to do to get there, but all of a sudden we hit dead water, no wind…we couldn't go anywhere, and you know just the challenges that we all had to face with this COVID Stuff and how we navigate this dead water…and how we create momentum and work together to get moving, rather than stay still and wait for the winds to blow again…and try and reach our goal…

S. that's a beautiful metaphor, is it ok if I ask you a little bit more about it….?

L. Yeah Sure

S. So you mentioned dead water, so I'm interested in what dead water invited for you individually but also for you all as a team, I guess I'm curious about that…

L. I think initially despair.

S. Sure

L. um you know, just the question of how do we keep going in this situation? but then I suppose it's around determination that we were just not going to sit here and wait for the wind to blow let's see what we can do and come up with creative ideas…I guess the practice way was to do some supervision with each other that helped at least keep us buoyant….and keeps that learning process going so we weren't just stuck waiting for things to change….

S. It's interesting as you said that there was despair and then determination kicked in, like it was a response to despair and I'm interested in that because for some that may not happen, and I'm interested was that something that you personally brought or that happed in the team as a whole that you supported each other to develop?

L. I think it was a collective thing…it was our combined efforts, and I suppose there is some personal stuff as I suppose I'm not one who will you know, sit a wallow for too long, and I guess that's part of who I am, but I think that's part of who all of us as a team, we are not just going to sit here, were going to make the most of what we have, which I think is a credit and testament to us as a team,

S. so there was s shared commitment to agency in this…

L. Yeah, yeah

S. So I want to make a link here, and it might be a stretch, but I will ask, and we will see how we go…so given these learnings across the year in the context of Covid-19, I wonder what it is that this has taught you about doing therapy?

L. Well, for me it's taught that therapy can be really clunky and unpredictable and its really good learning to sit in the uncomfortable and unknown and I think probably that it might feel like you're struggling against the current, but this doesn't mean you're not moving forward.

Excerpt 2.

S. If there were some things that you wanted to share with the other teams regarding your learning both as a team and individually what would those things be….?

D. I think for me one of the biggest findings is that counselling is messy, what I watch is not how it is in real life, just like life I guess, it is messy, and maybe not resisting this?

S so therapy is messy like life is messy. So, what does learning that do for you…what does it make possible for you….

D. I guess surrendering and just accepting some things are the way they are…things are going to come up and there not going to fit with my expectations of how things will go, and I know the COVID- 19 situation is probably a perfect example of this with you know, expecting to be in Clinic, not meeting face to face, and yet here we are meeting together anyway contributing to each other….

S. yeah yeah for sure, so I'd like to come back to this idea of one of your responses being surrendering to the way things are, and I'd love to hear how you and maybe others do this, or if there are other responses to a similar experience in the group? I'm also interested in what I hear is a commitment to contributing to each other in the group and what others experience in this regard? what about others in the group and this experience of messiness in life and practice?

R. Yeah, well even the construct of messy is positioned against a pre-existing notion that things should be a certain way. You know life is just life, um the expectations that we attach we have been born into….and then when it doesn't fit with this our upset arises you know…You know if we could simply see life as it occurs, then things would be different. But there is this sea of expectations, you know discourse…

S. So, what other ideas are floating around in this sea of expectations….

R. One for me was about ten years ago recognising I didn't have to be like all other men, you know like the expectation was that men were macho, the provider, the protector, these sort of expectations that were reinforced by other men, women, and the media in my life…

S. so, these notions that we are expected to live up to in some way shape or form and if we don't, we tend to judge ourselves….so I'm interested in you J, what are some of the expectations that might float around you guys in terms of your work as a person or as a counsellor or therapist.

J. So I think for me one of these was that there was a responsibility for me to be the one to create change in the session…. maybe an over responsibility…

Returning to the Beginning & Paying it forward

'We shall not cease from Exploring, and the end of all our exploring will be to arrive where we started and know the place for the first time'.

T.S Elliot

In service of nurturing our learning community, further opportunities for the circulation and sharing of practice stories were sought as the year progressed. Once COVID-19 restrictions began to soften, the idea of a coming together for in-person community forums was readily offered and taken up by several course participants, with the understanding that these could be at any stage the last time they could meet as a broader group for the rest of the year. While not all team members were able to be present, there were representatives from each team in attendance. Allowing a diversity of voices and experiences to be shared and expressed.

This meeting was structured as a *definitional ceremony* where a small group of course participants took turns being interviewed regarding a number of questions which scaffolded the collective document developed the year prior. These questions are included again below:

- *What has been the biggest challenge or constraint to their learning and practice throughout the year?*
- *In what ways had they been able to respond to these challenges and constraints and maintain a connection to the ethics of postmodern practice?*
- *What were some of the most important things that they had been taught by the clients with whom they worked?*
- *What did they learn regarding working as a therapeutic team across the year?*
- *What other ideas did they want to share with future course participants and what questions did they have for them?*

Furthermore, there were a series of additional questions utilised to engage in an exploration of relevant learnings and narratives regarding professional identity, ethics, and the relationship these had to participate in ongoing community dialogue. These questions included the following:

- *What do you think your clients and teammates have appreciated most about your contributions across the year?*
- *How have you been able to stay connected to your ethical commitments across the year?*
- *Who do you think would be least surprised that you were able to stay connected to these commitments?*
- *What are the most important things you have learnt about yourself as a result of your participation in the therapeutic team?*
- *What might these learnings make possible in your practice as a therapist in the future?*

This notion that there is a connection between identity, community participation and learning is an interesting one. According to Wenger (1998), when we understand learning as the social and communal construction of knowledge, what also becomes salient is the ongoing negotiation of both individual and collective identity that this entails. More specifically:

'Learning[thus] implies becoming a different person with respect to the possibilities enabled by the systems of relations…. learning is not merely a condition for membership, but is itself an evolving form of membership…Thus identity, knowing and social membership entail one another.'(Lave & Wenger, 1991, p 53).

Taking this a step further, Winslade (2002) and Winslade et al. (2000) outline the notion of counselling training itself being able to be conceptualised as a process of storying professional identity, and through which the process of counselling education becomes the co-authoring of preferred identities. It can then be seen that the educator's responsibility is to offer methods of inquiry and practices of acknowledgement that develop particular and preferred professional subjectivities, as stated below:

'We believe it is possible to structure a context that provides opportunities for the storying of professional identity, and this keeps us, as practitioners of counsellor education, alert to the moments that can arise for story development.' (Winslade, 2002, p 35).

With this in mind, the stories told, circulated, and

witnessed within a learning community and the questions and rituals that scaffold such a process have significant potential to facilitate the construction of particular forms of personal and professional subjectivity. This then raises an important ethical question regarding whether the identities or subjectivities that are produced in course participants include a valuing of and willingness to deconstruct and evaluate the dominant socio-political discourses that are impacting both themselves and those with whom they are in service, and as such, engage in a critical and anti-oppressive approach to therapy. This is the 'critical consciousness' or 'conscientisation' which a truly critical pedagogy aspires to evoke (Waldgave et al., 2003; Freire, 1993).

While this process begins with minimising the supremacy of the educator's voice and assumptions and facilitating contexts for the voices and knowledge's of course participants and those they serve to move to the centre of the dialogue, it also requires an active engagement with other intersections of power, not only that between 'teacher' and 'student'. The following quote from Freire(1993) highlights the issue to which I am referring:

'Discovering himself to be an oppressor may cause considerable anguish, but it does not necessarily lead to solidarity with the oppressed… true solidarity requires fighting at their side to transform the objective reality which has made them beings for the other' p23.

This quote underlines that for therapy or education to be transformative on both an individual and collective level, those discourses regarding gender, race, class, sexual orientation, and other similar sites of oppression which are often present but hidden, need to be made visible. This is one way in which a therapist or educator can remain accountable to those human begins who are the most marginalised in our society. This is outlined clearly by Waldgrave et al. (2003) below:

'we are talking about ways of working that seek to give space to the marginalised, that seek to create the possibility of meaningful, respectful dialogue across power differentials. We are trying to speak the language of partnership…. what we are seeking are partnerships of accountability which facilitate the responsibility of dominant groups to deconstruct their dominance.' p101.

While this practice project did act to engage collaboratively and respectfully with course participants and privilege their knowledges and skills throughout. In the early stages, what was *not* done adequately was the active deconstruction of discourses that maintain the structures of oppression that make themselves present in therapeutic practice and our world. Simultaneously, dialogue regarding power, gender, race, different abilities, and sexuality did make themselves present at times. This needed to have been centred more throughout the process via additional questions that invited course participants to reflect on these aspects of their experience and learning. Subsequently facilitating the production of personal and professional identities that are preferred by course participants and can oil the gears of social change in the world outside of the academy.

So, with this critique in mind, following the final definitional ceremony and community forum outlined above. Each team was asked if they would be interested in developing a collective document for those in the forthcoming year. To this invitation, each group readily agreed and provided several further questions that could more directly address the various intersections of power in their practice experience and invite reflection around this in the next years clinic cohort. These questions included the following:

- *What do you see as the most important thing that you have learned across your clinic year regarding the role of power and privilege in counselling practice?*
- *What is important about this learning in particular, and how might it be sustaining as you move forward into your post-graduation future?*
- *What do you see as the most important thing that you have learned regarding the effects of your own position of power and privilege in the role of Counsellor?*
- *In what ways do you see your gender, Culture, Class or age or ability context as relevant to this position of power and privilege?*
- *In what ways have you learned to respond to this particular position of power and privilege in your work with clients?*
- *How might these learnings make possible both personally and professionally as you move into your post-graduation future?*
- *What is one thing that you wish you had known at the start of your clinic year that you know now?*
- *What Questions do you have for next year's Course participants?*

So, with the theoretical and practice-based examples outlined above, it seems clear that narrative practices developed with therapeutic intent, grounded in rituals of inquiry and dialogue, could also be utilised as a critical pedagogical approach to learning, both in individual and collective contexts. It is here then that I wish to return to the initial purpose of this practice innovation and paper; finding ways to develop connection between disparate counselling students and to foster a context where the diverse experiences of course participants and their clients could be shared and reflected upon, opening space for local and unique client and student knowledges and identities to be storied, critically explored, and the subsequent fostering of a *'supportive generative learning community'* (Gazzola et. al. 2018 p 44).

In conclusion, I would like to offer a quote from Hooks (1994), a prominent academic, theorist and social activist, whose work has invited me to question the view of counselling education as simply a process of training therapists to be successful within the limitations and injustices of the neoliberal marketplace. Additionally, it has also functioned to reminded me of a potentially an even more critical goal as a counselling educator. The practice innovation described in this paper has sought to achieve must produce counselling graduates who can work well within the existing systems, but those who also can question the status quo and courage to change it:

'The Academy is not a paradise, but learning is a place where paradise can be created. The classroom with all its limitations, remains a location of possibility. In that field of possibility, we have the opportunity to labour for freedom, to demand of ourselves and our comrades, and openness of mind and heart that allows us to face reality even as we collectively imagine ways to move beyond boundaries, to transgress. This is education as the practice of freedom.' p207.

References

Carolyn, M., Rossiter, M. (2008). *"Narrative Learning in the Adult Classroom,"* Adult Education Research Conference. https://newprairiepress.org/aerc/2008/papers/13

Denborough, D. (2008) *Collective Narrative Practice: Responding*

to Individuals, Groups, and communities who have experienced Trauma. Dulwich Centre Publications. Adelaide South Australia.

Denborough, D., Koolmatrie, C., Mununggirritj, D., Djuwalpi M., Dhurrkay, W., Yunuping, W. (2006) Linking Stories and Initiatives: A narrative approach to working with the skills and knowledge of communities. *The International Journal of Narrative Therapy and Community work,* 2006 No.2

Douglas, B., Woolfe, R., Strawbridge, S., Kaskate, E., Galbraith, V. (2016) *The Handbook of Counselling Psychology.* Fourth Edition. Sage Publications.

Epston, D., White, M. (1992) *Experience, contradiction, Narrative & Imagination: Selected papers of Michael White and David Epston 1989-1991.* Dulwich Centre Publications. South Australia.

Friere, P. (1993) Pedagogy of the Oppressed. Penguin Random House Publishing. UK.

Friere, P. (2001) *Pedagogy of freedom: Ethics, Democracy, and Civic Courage.* Rowman & Littlefield Publishing. Maryland, USA.

Freedman, J., Combs, G. (2001) *Narrative Therapy with Couples…and a whole lot more!* A collection of papers, essays, and exercises. Dulwich Centre Publications. South Australia.

Freedman, J., Combs, G. (1996) *Narrative Therapy. The Social Construction of Preferred Realities.* W.W. Norton. New York, NY.

Fisher, W. (1984) Narration as a Human communication paradigm. The case of public moral argument. *Communication monographs,* 51.

Fox, H. (2003) Using Therapeutic Documents a review. The International Journal of *Narrative Therapy and Community Work,* 26, 2003 No.4

Gerlitz, J. (2015) Linking Lives: Invitations to Clients to Write Letters to Clients. *The International Journal of Narrative Therapy and Community work,* 2015, No.3

Giroux, H. (2011) *On Critical Pedagogy.* Continuum International, New York, NY.

Gehart, D. (2007) Process as Content: Teaching Postmodern therapy in a university setting. *Journal of systemic therapies,* Vol.26. No. 3, 2007, pp.15-28.

Gergen, K. (2001) *Social Construction in Context.* Sage Publications, London.

Gazzola, N., LaMarre, A., Smoliak, O. (2018). *Social justice and advocacy: Critical issues in counsellor education.* In Audet, C., Paré, D. (Eds.), *Social justice and counselling: Discourse in practice* (p. 43–56). Routledge/Taylor & Francis Group.

Hare-Mustin, R. (1994) Discourses in a mirrored room: A post Modern analysis of Therapy. *Family Process.* 33:19-35, 1994.

Handsaker, R. (2012) Opening up the Counselling Room: The joining of stories as a Political act. *The International Journal of Narrative Therapy and Community work,* 2012 No.3.

Hernandez, R (2008) Reflections Across time and space: using voice recordings to facilitate long distance definitional ceremonies. *The International Journal of Narrative Therapy and Community work,* 2008 No.3.

Hooks, B. (1994) Teaching to Transgress. New York, Routledge.

Jaeger, M., Lauritzen, C. (1992) *The Construction of Meaning from Experience.* Paper presented at the Annual Meeting of the National Council of Teachers of English (82nd, Louisville, KY, November 18- 23).

Lamarre, A., Smoliak, O., Cool, C., Kinavey, H., Hardt, L. (2018) The Normal, Improving and Productive Self: Unpacking Neoliberal Governmentality in Therapeutic Interactions. *Journal of Constructive Psychology,* 0(0), 1-18.

Lave, J., Wenger, E. (1991) *Situated Learning: Legitimate peripheral participation.* Cambridge University Press. New York.

McNamee, S. (2007) Relational Practices in education. Teaching as conversation. In H. Anderson, H; Gehart, D. (Eds.) *Collaborative therapy: Relationships and Conversations that make a difference* (pp313-336) New York Brunner-Routledge.

Madsen, W. (2014) Applications of the Collaborative Helping Maps: Supporting Professional Development, Supervision and Work teams in family centred practice. *Family process* Vol. 53 No.1 2014.

Nelson, M., Neufldt, S. (1998) The Pedagogy of Counselling a Critical Examination. *Counsellor Education & Supervision;* Dec 1998; 38, 2.

Nyland, D., Tilsen, J. (2006) Pedagogy and Praxis: Postmodern spirit in the classroom. *Journal of Systemic Therapies,* Vol. 25, No. 4, pp21-31.

Pavon-Cuellar, D., Orozcu Guzman, M. (2017) Politics of Psychoanalysis in liberal and neoliberal capitalism. *Psychotherapy and Politics International,* 15(2), e1412.

Reynolds, V. (2014) Centring Ethics in Group Supervision. Fostering Cultures of Critique & structuring safety in group Supervision. *The International Journal of Narrative Therapy and Community work.* 2014 No.01.

Reynolds, V. (2019) *Justice Doing: at the intersections of Power.* Dulwich Centre Publications. South Australia.

Reynolds, V. (2011). Resisting burnout with justice-doing. *The international Journal of Narrative Therapy and Community Work.* (4) 27-45.

Rustin, M. (2015) Psychotherapy in a neoliberal world. *European Journal of Psychotherapy & Counselling,* 17:3, 225-239.

Russell, M., Carey, S. (2004) *Narrative Therapy. Responding to your Questions.* Dulwich Centre Publications. Adelaide South Australia.

Saunders, D., (2007) The Impact of Neoliberalism on College Students, *Journal of College and Character,* 8:5.

Slabon, W.A., Richards, R.L., Dennen, V. (2014) Learning by restorying. *Instr. Sci* 42, No. 4, 505–521 (2014).

Scherto, G; Goodson, I. (2014) *Critical Narrative as Pedagogy.* Bloomsbury Publishing.

Turner, V. (1969) *"Liminality and Communitas," in The Ritual Process: Structure and Anti-Structure.* Chicago: Aline Publishing, 1969, pp. 94-113, 125-30.

Vygotsky, L.S. (1978). *Mind in Society.* Cambridge, MA: Harvard University Press.

Waldgrave, C., Tamasese, K., Tuhaka, F., Campbell, F. (2003) *Just Therapy- a journey: A Collection of papers from the Just therapy team, New Zealand.* Dulwich centre Publications. Adelaide SA.

Wortham, S., Jackson, K. (2012). Relational Education: Applying Gergen's work to Educational Research & Practice. *Psychological studies,* 57 (2), 164-171.

White, Michael (2005) *Workshop Notes.* Published on www.dulwichcentre.com.au September 21st, 2005.

White, M. (1997) *Narratives of Therapist Lives.* Dulwich Centre

Publications. South Australia.
White, M. (2007) *Maps of Narrative Practice.* Norton & Company. London.
White, M (2000) *Reflections on Narrative Practice: Essays and Interviews.* Dulwich Centre Publications. South Australia.
Winslade, J. (2002) Storying professional Identity. *The international Journal of Narrative Therapy and Community Work.* (4) 33-38.
Winslade, J., Crocket, K., Monk, G., Drewery, W. (2000) *'The storying of Professional development'.* In McAuliffe, G; Etiksen, K. (eds), *Preparing Counsellors & Therapist: Creating constructivist and developmental programs* (pp.99-113) VA. Association for Counsellor Education & Supervision.
Wenger, E. (1998) *Communities of Practice. Learning, Meaning, and Identity.* Cambridge University Press. New York.

A Conceptual Analysis of a Model of Presence within the Context of Five Health Professions

Alec Hamilton[a*], Ann Moir-Bussy[b]

Background: Therapeutic presence has been acknowledged as a vital component of the therapeutic relationship within health professions.

Methods: This article reviews the 'presence' literature of four health professions; nursing, psychology, psychotherapy, counselling, and occupational therapy and explores the development of a new model of presence – The Fields of Presence Model.

Outcomes: The fields of presence model we propose, views presence as a continuum from Absence to Self-Presence, Physical Presence, Partial Presence, Full Presence, and finally Transformative Presence. Each field of presence builds on the previous one, increasing the depth of presence, building out of absence towards the transformative potential of presence. As the level of practitioners' presence builds so does the potential for the successful development of a therapeutic relationship with their client.

Conclusion: The authors suggest that the fields of presence model significantly capture the various professions' conceptions of the therapeutic relationship and propose that the model is a useful addition to health professionals' understanding of presence and helpful in the teaching and training of students and practitioners from a wide range of helping professions.

Keywords: *Counselling, Health Science, Psychology, Presence, Therapeutic Presence.*

1. Introduction

The influence of presence within relationship-based therapeutic disciplines is an emerging and critical area for research focus. The focus on an *other*, in the process of change, development, growth, and improvement (Schofield, 2008) underscores the role of presence within relationship-based professions within the health sciences, including nursing, occupational therapy, psychology, counselling, and psychotherapy. Through an examination of how these relationships develop we discover the impact of 'presence', and it is through being present ourselves that we discover the impact of the relationship. Presence is a powerful inner and outer relationship (O'Donohue, 2011) and is dependent on one's level of consciousness; 'Where there is a depth of awareness, there is a reverence for presence. Where consciousness is dulled, distant or blind, the presence grows faint and vanishes' (p. 37). The perspective that emerges from the literature is that the relationship-based professions investigated view presence as an important element in working with clients.

The concept of presence has been presented as sitting between two ends of a continuum. At one end presence is a 'mystical, metaphysical concept …hard to define, hard to quantify, and seemingly non-quantifiable' (Smith, 2001, p. 306), and 'a

Corresponding Authors: Alec Hamilton, Ann Moir-Bussy
Email: alec@myhealthandmind.com.au
[b]Charles Darwin University.
Address all Correspondence to:
Alec Hamilton
Matthew Flinders Anglican College
1-47 Stringy Bark Road, Buderim QLD 4556

Australian Counselling Research Journal ISSN1832-1135

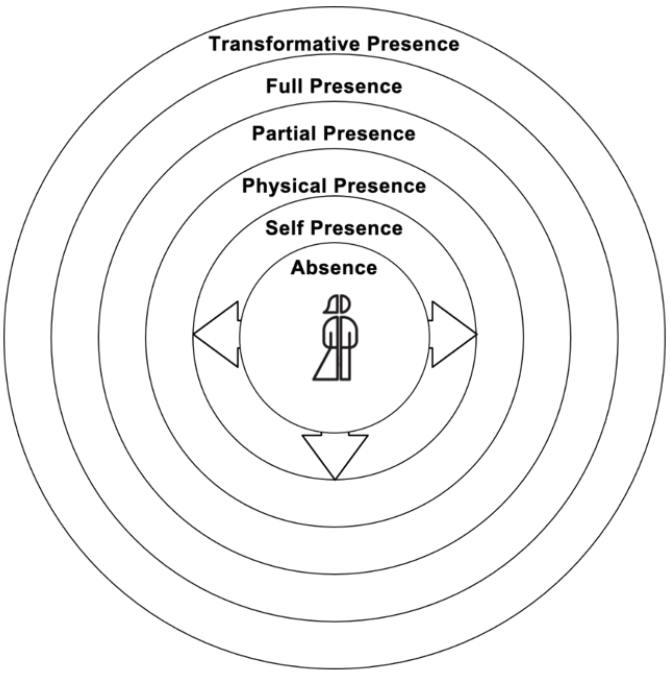
wholistic subjective experience that loses its essential nature when analysed in an objective manner' (Geller, 2001, p. 57). At the other end, presence is something to be quantified and measured. For example, McMahon and Christopher's (2011), 'mid-range theory of nursing presence' was designed to assist nurses to determine the correct 'dose' of presence required for each client. In a similar vein, Taylor developed the Intentional Relationship Model (IRM) (Gorenberg & Taylor, 2014; Taylor, 2008), of which presence is an aspect, to help occupational therapy practitioners develop positive therapeutic relationships. Both models present a formula for building therapeutic relationships that focusses on how the practitioner, the client, the context, and the interpersonal interaction influence the therapeutic relationship.

In this paper, we explore the 'fields model of presence' as developed in the first author's PhD thesis (Hamilton, 2019) and how the common themes arising across the relationship-based health science professions; nursing, occupational therapy, counselling, psychotherapy, and psychology[1], can be viewed within the context of the model. We examine how presence has the potential to develop as the depth of relationship[2] increases. We propose that presence within this type of relationship can flow from a place of absence to a place of transformation (see Fig. 1), an intersubjective experience that can only exist within a deep interpersonal relationship. The applicability of the 'fields of presence' model to the professions is developed through a discussion of each field and a summary discussion of the presence literature from nursing, occupational therapy, psychology, psychotherapy, and counselling.

2. Fields of Presence

Our model of presence builds on and extends, the work of Osterman and others (Osterman & Schwartz-Barcott, 1996; Osterman et al., 2010) who conceptualised presence as developing across four levels: Presence, Partial Presence, Full Presence and Transcendent presence. To this structure, we have added two additional aspects; Absence and Self-Presence. The resultant model is illustrated in Fig.1 and represents the six fields of presence. Presence can be viewed as fields and comprise "the region in which a particular condition prevails" (Oxford English Dictionary, 2018). We have chosen to describe the six elements as fields, as the term captures the 'sphere of activity' that occurs within relationships and our desire to represent the fluid notion of presence over time and context. The six fields of presence are outlined below. Each field is described, and the nature of the practitioner-client relationship that develops within each of the fields is explored. The model presented here proposes that each field builds on the previous one, increasing the depth of presence, building out of absence towards the transformative potential of presence. The following discussion briefly outlines each field and the background for its inclusion in the model.

Fig. 1. The six fields of presence



2.1. Absence

We begin the model with *Absence*; this acknowledges the potential in a relationship for an individual to be 'not present' either with others or themselves. Absence is reminiscent of situations where the practitioner is unaware of their actions and responses, where they act without thought (Geller, 2017). Offering 'Absence' as the first wave of presence emerges from contemplating the philosophical perspective of presence. Sokolowski (1980, p. 641), building on the thoughts of Husserl and Heidegger, commented that absence needs to be acknowledged when discussing presence; it is the idea of absence that allows for the recognition of presence. Kierkegaard (1843/2004) also recognised the importance of the link between absence and presence, commenting that 'The unhappy one is absent. But one is absent when living in the past or living in the future…. It is only the person who is present to himself that is happy' (Kierkegaard, 1843/2004, p. 214). We propose that absence is important to acknowledge as it stands in counterbalance to the individual's ability to be present to them *self* and others.

2.2. Self-Presence

Absence moves towards presence as we become aware of our selves, *Self-Present,* and our awareness is inward focussed illuminating our inner lives. Buber's notion of the 'I-I' individual (Kaufmann, 2013, p. 14) describes this phase of presence. The person only recognises themselves once they form a relationship with *their self.* 'It is in addressing himself [*sic*] in the role of an other [emphasis added] that his [*sic*] self arises …. [he] becomes an object to itself' (Mead, 1932, p. 168) and an awareness of the self emerges. Self-presence is a precursor and a prerequisite for building a relationship and working in relationship-based professions.

2.3. Physical Presence

Awareness of an other develops in the transition from Self-Presence to the awareness of the outside world. In the initial moments, this awareness grows in recognition of the other's *Physical Presence.* Osterman and Schwartz-Barcott

(1996) describe physical presence as those situations where practitioners are 'there in the context of another'. However, their presence remains inwardly focussed, without an interpersonal connection to the person outside of themselves. Physical presence is characterised by Buber's 'I-It' (1947/2002), subject-object relationship. The I-It relationship occurs where interest is taken in the other; however, the other is only acknowledged as a vehicle for the emergence of 'I'. There is no connection or relationship beyond awareness of self and other, only physical presence. This field of presence is captured within Heidegger's use of the term *Vorhandenheit*, 'presence-at-hand' (Ricoeur, 1992, p. 309). McManus (2012) explains that *Vorhanden* are objects just within hands reach, and we are unmoved by them; they are present to us, but stand outside engagement. These objects stand in contrast to objects that are 'ready-to-hand' or 'available' to us, objects within our awareness (Carman, 1995, p. 434).

2.4. Partial Presence

As we become aware of the presence of an other, this recognition facilitates a shift towards connection to the other, and the object now becomes 'ready-to-hand', and we become *Partially Present*. The practitioners' presence begins to shift towards both within themselves and focussed on their being physically present in a relationship. The other is still viewed as an 'object' within the relationship, a tool ready-at-hand. The object has come into awareness and is present; it can, but has not yet to be grasped. The object, the other, remains a tool to be utilised. While there is an interaction, there remains a level of disconnection, a separateness to the other. Freire (1970/2014, p. 93) describes this notion as acting 'for', 'about', or 'on', rather than acting 'with'. When we act on, we oppress, and this 'denies the possibility of dialogue' (Gadotti et al., 1994, p. 52) and the full potential of a deep interpersonal relationship. The desire to work and connect with the other moves presence into the next field.

2.5. Full Presence

When we are fully present, we begin to act with an other, and a deep interpersonal relationship can start to develop. *Full Presence*, therefore, occurs when the practitioner is present within themselves, physically present, interpersonally focused and connected '*with*' the other. When we are fully present, we are in the 'here and now' of the interaction, developing an interpersonal relationship that is responsive and reciprocal.

A fully present relationship, described by Buber (1947/2002) as an 'I-Thou' relationship, is characterised by 'openness, directness, mutuality and presence' and genuine dialogue (Buber, 1947/2002, p. xii). 'The realm of the Thou emerges when I am in full presence to the being to whom I relate… the realm in which I relate with my whole being' (Gordon, 2001, p. 117). This is a 'reciprocally beneficial merging of beings though one in which both parties maintain their identities (their 'I') (sic) while remaining aware of the other as also subject (as 'Thou')' (sic) (T. D. Smith, 2001, p. 305). Presence within this field is not an object that one can grasp, it is something that is 'gathered', 'welcomed', 'invoked' and 'evoked' (Marcel, 1950, p. 20). Within this inter-subjective relationship, there remains a *self* and an *other*; however, the boundary begins to soften, and the separation between the two becomes less defined.

2.6. Transformative Presence

The final field of presence, *Transformative Presence*[3], occurs when we are physically present, interacting '*together*' in a manner that shifts focus and awareness from the self to an interpersonal interaction characterised by mutuality and the potential for a collectively focused transformative experience. The main difference between *Full* and *Transformative* presence is described within the concept of divided and undivided consciousness (Welwood, 2000). When consciousness is divided, as in full presence, the practitioner is still 'grasping, [and] strategising', and there remains a split between the practitioner and client (p. 87). When consciousness is undivided, all grasping and strategising is lost, and it is impossible to see a separation between practitioner and client. Transformative presence facilitates experiences that are 'both personally and epistemically transformative' (Paul, 2015, p. 761). These transformative experiences have the potential to change our hearts, our minds and for some, our entire being (Tisdell, 2012). When the practitioner *and* the client experience transformative presence, there is potential for both to be transformed.

2.7. Bringing the fields of presence together

The six fields of presence (Fig 1.) combine to form a series of concentric fields, moving out from absence toward presence an *other* and building towards a presence that transforms. From Heidegger's (1927/2001) perspective, presence emerges from absence when we become aware of ourselves and when we are 'within-the-world' where *Dasein* occurs (p. 246). Binswanger (1994) describes three modes of *Dasein*; which characterise the movement from self-presence to transformative presence. The individual firstly becomes present in the world, developing an awareness of themselves. As awareness expands, the person has the potential to move towards an *other*, developing the intimacy of Buber's I-Thou relationship. If the relationship develops, the individual's presence builds from simple physical presence to full presence, 'being with' (Ghaemi, 2001, p. 57), where a connection exists, yet the two, self and other remain. Finally, there is a union with an *other*, 'the uniting of the I and the Thou in the dual We' (Binswanger, p. 293), the 'being with' *and* 'being together' (Ghaemi, 2001, p. 57) of transformative presence.

The model acknowledges that every relationship has the potential to be within any of the fields of presence, with each field operating at different times for different purposes. The ideal is not transformative presence but the appropriate degree of presence for the context, the client, and the reason for the formation of the relationship.

The following sections outline the methodology utilised to explore presence in the nursing, occupational therapy and counselling, psychotherapy, and psychology literature and how the literature might be linked back to each of the fields of presence and the model as a whole.

3. Methodology

The extent to which the literature supports the fields of presence model draws upon the approach of 'summarising and aggregating' (Major & Savin-Baden, 2011, p. 652) rather than interpreting the different professions' conceptualisations of presence. The focus was on analysis and synthesis to build a picture of the concepts across the various fields. This form of 'collecting' research sits on Major and Savin-Baden's continuum of qualitative research, bringing together information to represent

and build an understanding of the concept. The review of the literature arose from the primary author's PhD thesis.

The search engines/databases Google Scholar, ProQuest, and Ovid were used to access and draw upon a relevant sample of literature. The search criteria were limited to qualitative articles and books that focused on models of presence within the relationship-based professions. The search terms 'presence' with disciplinary terms locating 'health science'[4], 'nursing', 'psychology', 'psychotherapy', 'counselling', and 'occupational therapy' and their derivations (e.g., counsel/lors/lers/ling) were employed. The results were limited to English language books, journal articles, dissertations, theses, and reports published in the last five years. Review and 'synthesis' papers within and outside these dates were also utilised as it was felt that they built the picture of presence and the aggregated previous models. Review papers were found through the searches or from additional searching of citations in the initial sample. The initial selection of articles was based on a review of the abstract. Articles that did not discuss a framework or model of presence were excluded. In total, 42 papers were examined, including 14 authors from the counselling/psychology/psychotherapy literature1, nine from Occupational Therapy and 19 from Nursing. Each paper was initially read in full, and the textual comments and associated references related to the fields of presence were highlighted. A total of 777 textual comments/references were identified linked to 307 references. The comments were then coded according to which of the fields of presence they matched (see Table 1). Where possible, each of the 307 papers was read to determine if the context of the quote/reference matched the associated field.

Table 1

The Fields of Presence discussed in each professional groups' literature.

Professional Group	Absence	Self-Presence	Physical Presence	Partial Presence	Full Presence	Transformative Presence	Grand Total
Nursing	3	30	44	39	154	80	350
Occupational Therapy	3	18	3	21	111	5	161
Counselling / Psych*	5	48	19	43	114	37	266
Grand Total	**11**	**96**	**66**	**103**	**379**	**122**	**777**

4. Models of Presence within Relationship-Based Professions - Summary of the Literature

As early as 1936, researchers highlighted the need to focus on the key features of what works in psychotherapy (Luborsky et al., 2002; Miller et al., 2013; Rosenzweig, 1936). In the early 1950s, Peplau (1952) highlighted the importance of nurses needing to have the 'presence of an intelligent listener' (Peplau, 1952, p. 29). In 1962 Vaillot (pp. 37, 203) discussed 'therapeutic use of self' and the importance of 'presence' in nursing. In the late 1950s and early 1960s, Frank (1958, 1961) also discussed the idea of the common factors in psychotherapy and explored therapeutic use of self within the context of occupational therapy. Although the authors represented different areas of practice, they all highlighted the importance of presence as a core aspect of practice. In the following sections, we explore the key themes and ideas chronologically within presence literature from each professional group with an aim to interrogate the fields of presence model presented above.

Bugental (1978), one of the first writers to explicitly discuss the notion of presence within psychotherapy, argued that presence is 'the one essential ingredient of therapy' (Hycner, 1993, p. 122). Bugental suggests that, in the process of building the therapeutic relationship, the client and practitioner move through and around various levels of interaction. Presence from this perspective is not merely 'being physically there', it is about being 'fully available to the other person as possible, at this very moment…. a consciousness which fully attends to the 'beingness' of the other person' (p. 122). Bugental believed that to achieve a fully therapeutic experience each person in the relationship had to relate to themselves (self-presence), to each other (full presence), the physical world, both in the past and in the here and now (Krug, 2009, p. 3).

In a latter discussion of presence undertaken by Benner et.al. (1998), presence was viewed as requiring both interpersonal skills and technical knowledge set within a relationship. Presence was seen as requiring 'not just the performance of technical skills', the mechanistic 'doing for', but also necessitated the practitioner 'being present with' the client (p. 133). This more complex view of presence is reinforced in Smith's (2001) 'chronological overview' of the 1960s to 1990s nursing literature. However, Smith noted that the conceptualisation of presence had resulted in some tension between two counter-point views. Rather than joining the aspects of presence as Benner et al. had done, the literature was suggestive of a dichotomy in the various views of presence: those who emphasise the 'task centred', and somewhat 'mechanistic, utilitarian perspectives of presence' and those who highlight the interpersonal nature of presence (Benner et al., p. 314). Despite this apparent dichotomy, Smith believed presence was a willingness to fully engage oneself in the relationship (self-presence), 'being there' (physical presence), 'fully engaged' 'with' full presence. Ultimately developing a connection that potentially achieves 'transcendent togetherness' (transformative presence) (pp. 314, 318).

Godkin's (2001) three-stage hierarchical model utilises the six dimensions of presence developed by Doona et al. (1999). Godkin attempted to bring the mechanistic and the interpersonal aspects of presence together into a single model. Godkin acknowledges the need for the nurse to be physically present with the patient; however, this level of presence, 'Bedside Presence', involves more than just filling the space. Bedside presence requires the nurse to have an awareness of self, and the desire to form a relationship with *another*. This level of presence is described as typifying the presence developed by novice practitioners and lay workers who will focus on the more mechanistic and routine aspects of being present. Godkin's second level of presence, 'Clinical Presence', involves a reciprocal relationship that sees the practitioner 'sensing' the interacting, and 'going beyond the scientific data' and connecting with the 'patients' perspective'. This level represents practitioners who can be fully present, those who are transitioning towards more in-depth and more expert practice. Finally, when the practitioner can move beyond clinical presence, they 'actively choos[e] to be with the patient', determining 'what will work and when to act', thereby developing a 'Healing Presence'. This is the territory of the expert practitioner who is skilled in developing rich and transformative interactions.

During the time Godkin and Smith were articulating their views of presence in nursing, Geller (2001) developed a model focussed on presence in psychotherapy. Geller believed

that while presence was a challenging concept to define, it was important to attempt to articulate its 'ineffable quality' (p. 57) to understand this crucial therapeutic quality. She suggests that while reductionistic, an organisation structure consisting of three 'essential aspects' captures the core process of presence. The three elements include (p. 60): 'Preparing the Ground', setting up the session and a recognition of the effects of absence; the 'Process of Presence', developing the skills of presence; and the 'Experience of Presence', which involves full 'immersion', 'expansion' of awareness and expertise, 'grounding' in the experience and 'being with'.

In accord with Geller's belief in the necessity to prepare the ground for a present relationship Lanyado (2004, pp. 6–11) highlighted the value of a 'holding' environment. Lanyado suggested that to be present; the practitioner needs to set up a holding environment within which the therapeutic relationship has the potential to grow. It is to this environment that the practitioner brings the 'essence' of themselves, and a sense of 'reverie', self-presence. In this environment Geller's process of presence builds the 'present relationship': A dynamic relationship between self and other, a 'moment of meeting' which holds the potential for full and transformative presence (Stern, 2004).

Tavernier's (2006, p. 152) conceptual analysis of presence continues the view of presence as both 'a quality and an intervention', an amalgam of behaviours and interpersonal aspects. Tavernier, however, outlines the specific interpersonal characteristics required for a 'present relationship'. These characteristics included the ability to build 'trust, intimacy, and safety', be patient-centred, and intentionally attend to and with the client, while recognising the influence of the encounter on both themselves and the client. The highest levels of presence required specific 'knowledge and skills', 'a conducive and supportive environment', and an 'awareness of self' (p. 154).

In contrast to the dichotomy of views suggested by Smith (2001) above, Finfgeld-Connett's (2006, p. 710) meta-synthesis emphasised that presence is a fluid 'process' that should be adapted to the context. Finfgeld-Connett indicates that presence requires 'holistically focused' 'interpersonal sensitivity' where the practitioner adapts to and with the client in the here and now and.., in an 'intimate way', that requires 'engaged availability, affectionate touching and attending to personal needs'. At its deepest this is a presence that influences both client and practitioner.

In a move that re-emphasises the interpersonal end of the dichotomy, Iseminger et al. (2009) maintain that presence is a core aspect of the 'art of nursing'. Presence in this context involves interpersonal relationship skills and transcendent practices that are more difficult to operationalise and more relevant to the experiential aspects of practice. Iseminger et al. (p. 448) stressed the impotence of the "art of nursing (presence)" and how it contrasted with those who emphasised the 'science of nursing' and its empirical, objective methodologies (Turpin, 2014). Iseminger et al. considered presence not as an object to be dosed out, but as a 'transformative, healing, relationship' in which a 'greater appreciation of the subjective experience' of an other can be developed (p. 457). The art of nursing develops from the practitioner's ability to be open, flexible, supportive, and aligned with an other's goals. Their skills in developing self-awareness, 'empathic appreciation, respectful listening', facilitate their capacity to 'embrace another's situation' (p. 456) and ultimately be transformatively present.

Reid (2009), in her discussion of the art of practice, also emphasised the importance of interpersonal skills and self-presence in exploring 'mindful presence' with Occupational Therapy. Reid acknowledges the importance of 'being with' the client, as many of the authors mentioned above have recognised, however, she suggests that it is necessary to be more than just 'with' the client, presence requires mindfulness. To be mindfully present, the practitioner has to put their 'knowledge and skills into action while at the same time observing themselves in action', in the here and now (p. 186). This view of presence highlights the importance of self-awareness, and the acquisition and timely application of knowledge, critical thinking, and reflection.

In somewhat of a shift in thinking, McMahon and Christopher's (2011), developed a model which Iseminger et al. might suggest is based within the science of practice. The 'mid-range theory of nursing presence' model was designed to assist in teaching presence as a 'relational skill' (p. 71) and emphasises the empirical, objective view of presence. The aim was to assist practitioners in determining the appropriate 'dose' of presence a client may need (p. 73). McMahon and Christopher's preferring the term dose rather than level as presence is seen as an 'intervention' rather than a way of being. The model centres on five interacting elements: the practitioner, the client, the relationship, the environment, and the practitioner's actions.

Two features of the mid-range theory of nursing presence model are generally not emphasised in the other discussion explored above. The model is one of the few to include 'non-presence' (*absence*) (McMahon & Christopher, p. 77). McMahon and Christopher also highlighted the importance of conscious action where the practitioner takes a moment to reflect and 'contemplate' the appropriate course of action, the 'nurse pause' (p. 79). While not mentioning mindfulness their description of the nurse pause is consistent with Reid's (2009) emphasis on the need for mindful presence, to pause and 'reflect [on the] chosen way of being'' (McMahon & Christopher, p. 79). This ability to pause and reflect brings the practitioners into the here and now, helping them focus and make informed decisions.

In a similar vein to McMahon and Christopher, Taylor (Gorenberg & Taylor, 2014; Taylor, 2008) developed the Intentional Relationship Model (IRM) to help occupational therapy practitioners develop positive therapeutic relationships. This model also emphasised the practitioner, the client, interpersonal engagement, within a specific therapeutic context. Taylor indicates that to engage in a therapeutic relationship, the practitioner needs to have a range of interpersonal traits which closely match those traits identified within Self, Partial and Full presence. These traits include; openness, respect, caring, patience, flexibility, empathy, and an awareness of themselves, their style, and the way they interact with clients. The application of these traits, in context, are skills that Taylor suggests exemplify the 'professional', 'quiet presence' of an expert practitioner (2008, pp. 268, 40).

In their more recent summaries of the literature, Bright (2012) and Bozdoğan et al.'s (2016) description of presence embodies most aspects of the fields model we presented above and discussed within the literature. Their discussions accentuate the amalgam of ideas and the flowing nature of presence. Bright for example argues that therapeutic change requires the practitioner to be self-present, consciously engaging with an *other* 'at a level that goes beyond technical expertise and addresses the issue of human suffering' (p. 94). She highlighted the difference between presence as an action, a 'way of doing' where the *other* is acted upon, and presence as a 'way of being'

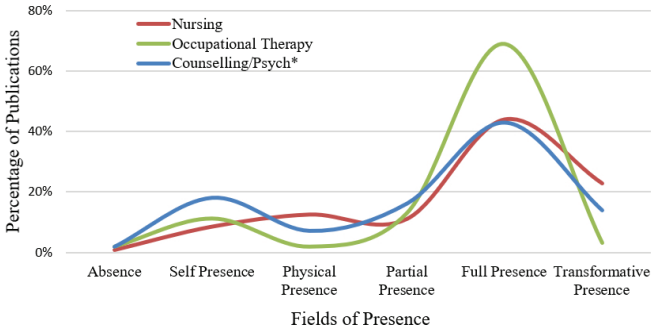
mindfully in a subject to subject relationship (p. 15). The process of building presence assists the practitioner and client to 'evolve' and transform, shifting from 'chaos to order' (p. 94). Bozdoğan et al. (p. 97) comment that presence involves a practitioner 'doing for' and 'being with', but also has the potential for them to interact 'with each other mentally, bodily, and spiritually'. Bright and Bozdoğan et al. imply that presence at the doing level involves self and physical presence with the practitioner utilising a range of behavioural, physical and cognitive skills to work upon and for the client. Being with, on the other hand, encompasses the inter/intrapersonal or affective aspects, partial and full presence. Interactions that evolve to include all aspects of body, mind and spirit build the level of presence that has the potential for transformation.

The importance of mindfulness in developing presence has been mentioned previously, and its prominence appears to have increased in recent times (see Brito, 2014; Geller & Greenberg, 2012; Pollak et al., 2016). Brito suggests that a critical strategy for improving presence is through teaching and learning mindful practices. Geller and Greenberg suggest that mindfulness has its origins in the 'Pali term *satipatthana*' which translates to 'attention or awareness' and 'keeping present'. They indicate that presence and mindfulness are distinct in two ways; mindfulness is a 'technique' that can improve presence, while presence can be achieved via 'mindfulness practice' (p. 181). Geller and Greenberg also comment that mindfulness practices are 'an approach for the individual' (p. 181), and useful in developing self-presence. Pollak et al. (2016, p. 29), however, define mindfulness more widely and suggest that 'in many ways mindfulness and presence are synonymous'. The mindful presence they describe is an awareness of the here and now, together with a sense of openness, attention and attunement to an *other*; representing self, partial and full presence. Bien (2010, p. 43) supports this view, indicating that mindfully acting *with* and *for* others is imbedded in mindful presence which has 'transformative value' and involves deep listening, intentionality, a desire to 'be fully present' .

5. Discussion

The discussions above indicate that the model of presence discussed here represents a useful tool to explore the notion of presence across disciplinary boundaries. Fig 2. summarises, in graphic form, the number of times each field of presence was discussed within the literature. Three patterns emerged and highlighted the usefulness of the model, bringing to attention not only the similarities but also the differences in the emphasis placed on the fields of presence by each profession. The diagram suggests that Occupational Therapy and Counselling/Psychotherapy/Psychology share a similar pattern across the first three fields; absence, self-presence, and physical presence. Counselling/Psychotherapy/Psychology and Occupational Therapy initially have a higher focus on Self Presence than the Nursing literature, which places greater emphasis on the importance of physical presence. In the middle fields, all professional groups share a similar focus on partial presence. The right side of Fig 2. suggests that Nursing and Counselling/Psychotherapy/Psychology follow a similar flow, moving from partial presence to full and then transformative presence. Occupational Therapy, however, has a focus on full presence rather than transformative presence.

Fig. 2: Relative % of each Professions' Publications discussing each Field of Presence



This third pattern to emerge highlights the differences between the professional groups. At the deeper fields of presence, Occupational Therapy focuses on full presence, almost to the exclusion of transformative presence. While Nursing and Counselling/Psychotherapy/Psychology publications emphasise both full and transformative presence, it is perhaps not surprising to see the emphasis placed by Nursing on physical presence (13%) compared to the other two groups. However, we were curious to observe that while Occupational Therapists also undertake physical roles within medical settings, only 2% of the occupational therapy literature focussed on physical presence.

6. Conclusion

This paper explored the development and application of a model of presence – The Fields of Presence (Fig 1.) that extends the concept and which we believe is useful for, and resonates with, each of the relationship-based professions examined. The fields of presence model proposed here would be a valuable mechanism to explore further the differences in how each profession uses and emphasises presence in their practice. Areas for further exploration also include understanding the facilitators and barriers to moving through the fields of presence.

Seven hundred seventy-seven documents related to presence were investigated. Collectively they revealed that although presence has been explored and discussed in different ways across the disciplines, there is agreement that presence is an important element in developing professional therapeutic relationships within each professional. We suggest that presence evolves out of absence, shifting to an object to object relationship and on towards a subject to subject relationship with an ever-increasing connection. The deepest fields of presence occur from the development of a relationship that is greater than the participants, a relationship that involves transformative presence and which profoundly influences the outcome for both practitioner and client. The core view across all professional groups is that presence is a powerful internal and external relationship, dependent on the practitioner and the client's ability to be in the here and now, acting *with* each other.

Authors' Contributions

AH developed the article within the context of their PhD thesis and completed the literature review and subsequent data analysis. The model presented here was created by AH.

AM-B was the principal supervisor for AH's PhD thesis and provided input and advice on the development of this article.

Competing Interests

The authors declare that they have no competing interests.

Bio

Dr Alec Hamilton is a school and private practice-based psychologist with over 30 years of experience supporting teachers, parents and students. Alec believes that the most critical factor in teaching and counselling is the relationships people make with each other and the stories they build together. He has spent a significant part of his working life assisting people to build positive relationships, relationships that promote growth and development. When individuals are provided with opportunities to grow, they can realise their potential as powerfully competent people who live positive and rewarding lives. Alec has also taught in education and counselling programs at Deakin University, The University of Alberta, Canada and The University of the Sunshine Coast.

Footnotes

[1]Psychology, Counselling, and Psychotherapy were combined as many of the same articles were found in the search results.

[2]In the paper, the term 'relationship' will be used to represent the type of relationship developed within the professions and which is often described as a 'therapeutic relationship'.

[3]Osterman and Shwartz-Barcott (1996) use both 'transcendent' and 'transformative' interchangeably: 'Whether one calls this caring communion, spiritual transcendence, or transcendent present, …presence …is an essential ingredient in the transformation'. To our minds 'transformation' more accurately captures this field of presence within relationship-based disciplines.

[4]The searches based on 'Health Science' produced no articles that were not included in the professional groups represented and the term was dropped from the analysis.

References

Benner, P., Tanner, C., & Chesla, C. (1998). *Expertise in nursing practice: Caring, clinical judgment, and ethics.* Springer. http://public.eblib.com/choice/publicfullrecord.aspx?p=423245

Bien, T. (2010). The four immeasurable minds: Preparing to be present in psychotherapy. In S. F. Hick & T. Bien (Eds.), *Mindfulness and the therapeutic relationship.* (pp. 37–54). Guilford Press; cat00097a.

Binswanger, L. (1994). The case of Ellen West. In R. [Rollo] May, E. Angel, & H. F. Ellenberger (Eds.), *Existence* (pp. 214–236). Jason Aronson.

Bozdogan Yesilot, S., & Oz, F. (2016). Nursing presence: A theoretical overview. *Journal of Psychiatric Nursing, 7*(2), 94–99. https://doi.org/10.5505/phd.2016.96967

Bright, A. (2012). *Presence in nursing practice: A critical hermeneutic analysis* [Doctoral dissertation, University of San Francisco]. repository.usfca.edu/cgi/viewcontent.cgi?article=1043&context=diss

Brito, G. (2014). Rethinking mindfulness in the therapeutic relationship. *Mindfulness, 5*(4), 351–359. https://doi.org/10.1007/s12671-012-0186-2

Buber, M. (2002). *Between man and man* (R. G. Smith, Trans.). Routledge. (Original work published 1947)

Bugental, J. F. T. (1978). *Psychotherapy and process: The fundamentals of an existential-humanistic approach.* Addison Wesley Pub Co Inc.

Carman, T. (1995). Heidegger's concept of presence. *Inquiry, 38*(4), 431–453. https://doi.org/10.1080/00201749508602399

Doona, M. E., Chase, S. K., & Haggerty, L. A. (1999). Nursing presence: As real as a milky way bar. *Journal of Holistic Nursing, 17*(1), 54–70. https://doi.org/10.1177/089801019901700105

Finfgeld-Connett, D. (2006). Meta-synthesis of presence in nursing. *Journal of Advanced Nursing, 55*(6), 708–714. https://doi.org/10.1111/j.1365-2648.2006.03961.x

Frank, J. D. (1958). Therapeutic use of self. *American Journal of Occupational Therapy, 12*(4 (2)), 215–225.

Frank, J. D. (1961). *Persuasion and healing: A comparative study of psychotherapy.* Johns Hopkins Press.

Freire, P. (2014). *Pedagogy of the oppressed* (30th anniversary ed.). Continuum. (Original work published 1970)

Gadotti, M., Torres, C. A., & Milton, J. (1994). *Reading Paulo Freire: His life and work.* State University of New York Press.

Geller, S. M. (2001). *Therapists' presence: The development of a model and a measure* [Doctoral dissertation, York University (Canada)]. http://search.proquest.com.ezproxy-b.deakin.edu.au/docview/304730351/abstract/89B817E3D794B4EPQ/1

Geller, S. M. (2017). *A practical guide for cultivating therapeutic presence.* American Psychological Association. https://doi.org/10.1037/0000025-000

Geller, S. M., & Greenberg, L. S. (2012). Buddhist mindfulness: A way of enhancing therapeutic presence. In S. M. Geller & L. S. Greenberg, *Therapeutic presence: A mindful approach to effective therapy.* (pp. 179–205). American Psychological Association. https://doi.org/10.1037/13485-010

Ghaemi, S. N. (2001). Rediscovering Existential Psychotherapy: The Contribution of Ludwig Binswanger. *American Journal of Psychotherapy, 55*(1), 51–64. https://doi.org/10.1176/appi.psychotherapy.2001.55.1.51

Godkin, J. (2001). Healing presence. *Journal of Holistic Nursing, 19*(1), 5–21. https://doi.org/10.1177/089801010101900102

Gordon, H. (2001). *The Heidegger-Buber controversy: The status of the I-Thou.* Greenwood Publishing Group.

Gorenberg, M. D., & Taylor, R. (2014). The intentional relationship model: A framework for teaching therapeutic use of self. *OT Practice, 19*(17), CE1–CE6.

Hamilton, A. I. (2019). *Australian higher education counselling educators' conceptualisation of presence within the context of their teaching* [PhD Thesis, University of the Sunshine Coast]. https://research.usc.edu.au/vital/access/manager/Repository/usc:29056?exact=sm_creator:%22Hamilton,+Alexander%22

Heidegger, M. (2001). *Being and time: A translation of Sein und Zeit* (J. Macquarrie & E. Robinson, Trans.). Blackwell Publishing.

https://pdf.yt/d/6-meFnHxBTAbkLAv (Original work published 1927)

Hycner, R. (1993). *Between person and person: Toward a dialogical psychotherapy.* Gestalt Journal Press.

Iseminger, K., Levitt, F., & Kirk, L. (2009). Healing during existential moments: The "art" of nursing presence. *Nursing Clinics of North America, 44*(4), 447–459. https://doi.org/10.1016/j.cnur.2009.07.001

Kaufmann, W. (2013). I and you a prologue. In M. Buber (Ed.), & W. Kaufmann (Trans.), *I and thou* (pp. 10–59). Penguin.

Kierkegaard, S. (2004). *Either/or: A fragment of life* (V. Eremita, Ed.; A. Hannay, Trans.; 1843). Penguin Books Limited. (Original work published 1843)

Krug, O. T. (2009). James Bugental and Irvin Yalom: Two masters of existential therapy cultivate presence in the therapeutic encounter. *Journal of Humanistic Psychology, 49*(3), 329–354. https://doi.org/10.1177/0022167809334001

Lanyado, M. (2004). *The presence of the therapist: Treating childhood trauma.* Brunner-Routledge. https://doi.org/10.4324/9780203507520

Luborsky, L., Rosenthal, R., Diguer, L., Andrusyna, T. P., Berman, J. S., Levitt, J. T., Seligman, D. A., & Krause, E. D. (2002). The dodo bird verdict is alive and well—Mostly. *Clinical Psychology: Science and Practice, 9*(1), 2–12. https://doi.org/10.1093/clipsy.9.1.2

Major, C. H., & Savin-Baden, M. (2011). Integration of qualitative evidence: Towards construction of academic knowledge in social science and professional fields. *Qualitative Research, 11*(6), 645–663. https://doi.org/10.1177/1468794111413367

Marcel, G. (1950). *The mystery of being* (G. S. Fraser, Trans.). London: Harvill Press. http://archive.org/details/themysteryofbein00marcuoft

McMahon, M. A., & Christopher, K. A. (2011). Toward a mid-range theory of nursing presence. *Nursing Forum, 46*(2), 71–82. https://doi.org/10.1111/j.1744-6198.2011.00215.x

McManus, D. (2012). *Heidegger and the measure of truth.* Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199694877.001.0001

Mead, G. H. (1932). *The philosophy of the present.* Open Court Publishing Company. https://archive.org/details/philosophyofthep032111mbp

Miller, S. D., Hubble, M. A., Chow, D. L., & Seidel, J. A. (2013). The outcome of psychotherapy: Yesterday, today, and tomorrow. *Psychotherapy, 50*(1), 88–97. https://doi.org/10.1037/a0031097

O'Donohue, J. (2011). *Anam Cara: Spiritual wisdom from the Celtic world.* Random House.

Osterman, P., & Schwartz-Barcott, D. (1996). Presence: Four ways of being there. *Nursing Forum, 31*(2), 23–30. https://doi.org/10.1111/j.1744-6198.1996.tb00490.x

Osterman, P., Schwartz-Barcott, D., & Asselin, M. E. (2010). An exploratory study of nurses' presence in daily care on an oncology unit. *Nursing Forum, 45*(3), 197–205. https://doi.org/10.1111/j.1744-6198.2010.00181.x

Oxford English Dictionary. (2018). Field. In Oxford English Dictionary. Oxford University Press. https://en.oxforddictionaries.com/definition/field

Paul, L. A. (2015). Precis of transformative experience. *Philosophy and Phenomenological Research, 91*(3), 760–765. https://doi.org/10.1111/phpr.12249

Peplau, H. E. (1952). *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing.* Springer Publishing Company. https://archive.org/stream/interpersonalrel00pepl#page/36/mode/2up/search/presence

Pollak, S. M., Pedulla, T., & Siegel, R. D. (2016). *Sitting together: Essential skills for mindfulness-based psychotherapy.* Guilford Publications.

Reid, D. (2009). Capturing presence moments: The art of mindful practice in occupational therapy. *Canadian Journal of Occupational Therapy, 76*(3), 180–188. https://doi.org/10.1177/000841740907600307

Ricoeur, P. (1992). *Oneself as another.* University of Chicago Press.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6*(3), 412–415. https://doi.org/10.1111/j.1939-0025.1936.tb05248.x

Schofield, M. J. (2008). Special issue: Australian counselling and psychotherapy research. *Counselling and Psychotherapy Research, 8*(1), 1–3. https://doi.org/10.1080/14733140801945105

Smith, T. D. (2001). The concept of nursing presence: State of the science. *Scholarly Inquiry for Nursing Practice, 15*(4), 299–322; discussion 323-327.

Sokolowski, R. (1980). The issue of presence. *Journal of Philosophy, 77*(10), 631–643. https://doi.org/10.5840/jphil1980771027

Stern, D. N. (2004). *The present moment in psychotherapy and everyday life.* W.W. Norton.

Tavernier, S. S. (2006). An evidence-based conceptual analysis of presence. *Holistic Nursing Practice, 20*(3), 152–156. https://doi.org/10.1097/00004650-200605000-00010

Taylor, R. (2008). *The intentional relationship: Outpatient therapy and use of self.* F.A. Davis.

Tisdell, E. J. (2012). Themes and variations of transformational learning—Interdisciplinary perspectives on forms that transform. In E. W. Taylor & P. Cranton (Eds.), *The handbook of transformative learning: Theory, research, and practice* (pp. 21–36). John Wiley & Sons.

Turpin, R. L. (2014). State of the science of nursing presence revisited: Knowledge for preserving nursing presence capability. *International Journal for Human Caring, 18*(4), 14–29. https://doi.org/10.20467/1091-5710-18.4.14

Vaillot, M. C. (1962). *Commitment to nursing: A philosophic investigation.* Lippincott.

Welwood, J. (2000). Reflection and presence. In T. Hart, P. L. Nelson, & K. Puhakka (Eds.), *Transpersonal knowing: Exploring the horizon of consciousness* (pp. 85–112). SUNY Press.

In Defense of anger: A misunderstood relationship

Jo Christmas*

Whilst anger is a universal emotion that counsellors are likely to feel on occasions within their practice, a counsellor's experience of anger is rarely thought of as an important and valuable resource. This article explores a student counsellors personal and professional relationship with anger, how she 'did' anger and what it made possible for both herself and within her practice.

Keywords: *Anger, compassion, love, presence, Mastery, healing.*

"Imagine that the anger you were feeling is a pathway that leads you back to what's important. Where does it take you and what does it show you?" (Roffman, 2004).

In western culture, anger is often described in negative terms (Cox et al., 2004). Even when acknowledged as standard, the psychological language generally states or infers that it needs to be controlled and managed, suggesting danger or potential for adverse effects. Whilst anger has been described as an emotion, anger is often used interchangeably with assertion, aggression, and even violence (Chemaly, 2018). For clarity and the purposes of this paper, my definition of anger is an emotion, which I recognize as an activated, embodied feeling.

My experience as a student counsellor led me to wonder whether anger could be beneficial and even act as a resource within my counselling practice. Some researchers have suggested that rather than anger causing harm, it is the judgement of anger that causes anger ignorance (Reynolds, 2019) which hinders our ability to utilise it effectively and constructively. Supporting individuals to develop anger competence could allow it to become a vital resource. The term anger competence is defined as developing anger awareness, distinguishing between anger, assertion and aggression, and the deliberate and constructive expression of anger (Cox et al., 2004; Chemaly, 2018).

Roffman (2004) suggested that anger acts as a signal of emotional importance and often relates to values, needs, inequity and breached boundaries, providing critical information for counsellors to be aware of within their practice. With so many potential benefits, I wondered why an intimate relationship with anger felt so at odds with the concept of being a counsellor? A few researchers suggested that clients benefit from gaining support from counsellors who developed and modelled anger competence (Cox et al., 2004; Chemaly, 2018). I wondered what anger competence would mean for me as a counsellor, what it would look like, how I might 'do' anger and what it might make possible within my practice? As I pondered these questions, I was forced to acknowledge that I might be anger incompetent. Whilst I had an intellectual awareness of what it might mean, I wanted to ground my learnings in the experience and context that would allow me a deeper understanding, that I might apply and use to develop my practice. The following study explores what anger competence means to me as a counsellor, how I 'do' anger, how anger might be helpful in my practice and what it makes possible?

Some background

I had spent the final year of studying a Masters in Counselling, both captivated and challenged by anger. It started innocently enough with me becoming curious about anger whilst working within the area of Domestic Violence (DV). It was curiosity that led me on a mysterious tour to discover a rich inner world I hadn't been aware of.

The Masters I was studying had introduced me to social constructionism, which familiarised me with the idea that world views are shaped by social constructs and subsequently got me noticing and challenging assumptions that I had previously accepted to be truths. It made me conscious of things I hadn't considered deeply before, such as power, social systems,

Corresponding Author: Jo Christmas
Email: jochristmas17@gmail.com
Jo Christmas has recently completed a Masters in Counselling. She has BSc Hons in Psychology and a background in nursing, where she worked in areas such as Palliative care, HIV & AIDS and Occupational Health. She acknowledges that self-awareness, presence and well as changes in thinking and perception have been transformational in creating more peace in her life and enjoys exploring this with others.

Australian Counselling Research Journal ISSN1832-1135

language, meaning-making and the potential to limit and expand possibilities with our beliefs, thinking, language and meaning-making. These discoveries have offered me a more expansive view of myself, others, 'problems' and opportunities.

Also, as part of the Master's programme, I had clinical experience with a team of three other students and a supervisor where I was either a primary counsellor or part of a reflecting team. The team was an essential part of exploring anger, offering observations, asking questions to debrief and witnessing my journey. I had also been working as a volunteer counsellor with women and children who had experienced DV and was lucky enough to have regular external supervision, internal supervision and debriefing, which also supported the process of reflection. Whilst I rarely think to identify myself as a white western woman, I believe it is important to acknowledge that I am looking through that lens. The following paper is a reflexive account of my intimate experiences as a western woman who has been immersed in a western cultural world view all of my life, becoming curious about my assumption that anger is a negative and potentially harmful emotion.

I have used an auto-ethnographic method to share my journey with you. Auto-ethnography is an emerging qualitative research method based on postmodern philosophy that is more commonly used in anthropology, sociology and education (Anderson, 2006; Ellis et al., 2000; Etherington, 2004; McIlveen, 2008; Reed-Danahay, 1997). It is a form of critical inquiry, embedded in both the theory and practice of the researcher-practitioner (McIlveen, 2008) who uses self-reflection and writing to explore personal experience, connecting their story for more comprehensive social, cultural and political meanings and understandings. To explore my relationship with anger, I used personal and professional experience, journals, intentional reflexive positioning and multiple modes of supervision and debriefing to explore what it means to embrace and use anger as a tool and resource for myself personally, and within my practice. To do this, I needed to suspend my structural notion that anger needs to be controlled and managed and the cognitive approach I often used when addressing anger. Instead, I choose to invite it more fully into my world; feel it, observe how it showed up, acknowledge it to myself, colleagues and sometimes clients, listen to what it had to say, value its contribution and find ways to deliberately express anger and take action, that I hoped would be in service to both myself and clients. I review my experience of personally and professionally feeling, owning, acknowledging and exploring anger and challenging dominant discourses surrounding it whilst living and working within a system that often holds the idea that anger is harmful, needs to be controlled and managed as a truth.

This inquiry focuses on my unique and personal experience as a student counsellor connecting with participants within the counselling programme that I was part of and community settings. It offers my reflection of how anger might be used as a valuable tool and resource for counsellors in service to themselves and clients. I've decided to write in the first person to acknowledge my presence. Whilst other forms of research often attempt to limit the researcher's influence as much as possible to gain an objective conclusion, I hope that sharing my personal and very subjective experience will offer rich and detailed data that will act as stimulus material for you to consider and use in whichever way will be meaningful and valuable for you. You'll also notice I've offered lots of context of what invited me to explore anger, prompted my thinking, decisions and how I came to certain conclusions because I wanted to ground it in lived experience and offer a representation of my process and experience, to allow you to connect with what captured your attention, consider your position, reflect on what was important to you, develop your meanings and consider the implications for your practice. I only hope that I can adequately convey a little of what I have experienced with the inevitable constraints of using language. I hope you also might allow yourself to suspend what you already know about anger and see what anger may come to mean for you.

Our Story

My relationship with anger started most surprisingly. Anger and I were not friends. In fact, I tried to keep my distance as much as possible. Although anger demanded my attention at times, it was never welcome. To be honest, I tried not to focus too much on anger and wasn't interested in creating a relationship with anger. I had become so proficient and skilled at sidestepping anger that I often wasn't aware of when it was present. As I endeavoured to maintain a healthy distance between us, the anger felt external to me and whilst it forced its way into my consciousness at times, I quickly dealt with it so that I could be the person I wanted to be in the world, which was most certainly NOT angry. In all honesty, I was far more interested in forging a relationship with love and compassion and anger felt separate and actually in opposition to them; as if anger might pull me in and away from who I wanted to be, but anger surprised me, and rather than being separate, it led me closer to both love and compassion. This is when our story begins…

Working as a volunteer counsellor with women and children who had experienced DV and the adverse effects of anger being used as a form of control and domination was a consistent theme and risk to consider. Whilst anger was often present in the stories I was hearing, it was generally related to the person who had used violence. Clients rarely spoke directly about anger being present for them, and if they did, it was fleeting, and the focus was quickly diverted. As they shared their experiences, I couldn't help but feel that anger might be an understandable response to what I was hearing and wondered why it was absent? Anxiety, sadness, depression, hopelessness was often present, so why not anger? I started to wonder whether there could be such a thing as a deficiency in anger? On occasions, clients and I would deconstruct emotions like anxiety in the session. I was always surprised at the wisdom that presented itself. Clients would often leave the room excited about what they had discovered. I started to wonder whether anger might actually hold similar knowledge and even act as a resource at times.

To understand more about anger and potential benefits, I began to read through research and broader texts. I often get this unsettled feeling when something doesn't make sense, and I could feel its presence, but I wasn't sure what it was about. Cognitively, I understood anger as an emotion, and so why did it need to be managed or controlled? Weren't emotions just information? So maybe there was more to anger, and I wondered what anger meant to me? As I read more, I realised that the term anger was often used interchangeably with responses to anger, such as assertion, aggression, control (Chemaly, 2018) and even violence which seemed to solidify angers position as a negative emotion that needed to be controlled or managed, but wasn't an emotion separate from an action? Finally, I read about the importance of distinguishing between the emotion of anger and

the related activities (Cox et al., 2004; Chemaly, 2018), and I felt a calmness in my body that came with a deeper awareness that made sense. This helped me crystallise that anger showed up as an uncomfortable, activated, embodied feeling. As I came to this clarity, somehow anger seemed less frightening, and I pondered whether my discomfort with anger was more to do with what I had made anger mean, rather than the experience itself?

As I examined the data, I became much more aware of the gendered, socio, cultural and political bias that had significantly influenced anger was perceived, expressed and responded to within western culture. Many studies showed how gender roles and social messages were internalised at such a young age and to such an extent (Bayet et al., 2015; Chemaly, 2018; Thomas et al., 2009), that individuals and especially women were often completely unaware of how these hidden messages may have impacted their experience and expression of anger (Chemaly, 2018; Cox et al., 2004). Research also highlighted various other manifestations of anger: crying, self-silencing, eating, anxiety, depression, and somatic symptoms (Thomas et al., 2009). However, Cox (2004) suggested these were more likely to be covert emotional ways to escape anger awareness. I pondered, had a fear of anger infiltrated us to such an extent?

The research suggested that those that diverted their anger experienced higher anxiety and other pathologies (Kopper et al., 1996; Maji et al., 2018; Munhall, 1993; Van Velsor et al., 2001). As I read more, I became aware of the pervasive implicit and explicit messages that suggested the expression of anger may threaten relationships, lead to social rejection and distress (Hatch et al., 2001; Cox et al., 2004), which often resulted in individuals ignoring their discomfort and prioritise the needs and feelings of others over their own.

I could feel a tightness in my body. Had we been programmed so much that we would ignore anger at all costs, even when it may harm us to do so?

Another author shared that anger always occurs in context or relationship to something (Roffman, 2004)

Yes, what about context? In the majority of papers, I had read about anger, authors rarely discussed context. Wasn't it normal to be angry sometimes?

I started to see that as anger is always experienced in a relationship to something or somebody and without the richness of relational context, it is easy to vilify anger which at the same time prevents it from sharing its wisdom and benefit. Whilst I understood why many might have concerns that anger could be used to control and dominate, I could also see how the demonisation of anger and ignorance of the context in which it occurs could also suppress, manipulate and control.

"This is fucked"

Chemaly (2018) had asserted, *"if someone does not consider why you are angry or why anger is your approach to a specific event or problem, they are almost certainly part of the problem".* As I felt that tight embodied activation, I became more aware that whilst I may process anger on a cognitive level, I had rarely allowed myself to fully experience it. And as I became aware of how little I knew about anger, I acknowledged that I was very much part of this system. I often didn't seek context when I was angry. I just made myself wrong. I noticed with this new understanding of context, I felt more justified in being angry, and the activated feeling never seemed to be far away. It was like a beast that had been unleashed.

"Finally, some sanity."

I discovered a couple of rare studies related to sexual abuse that acknowledged anger as a valid and appropriate response to experience (Apolinsky et al., 1991; Simmons, 1994), but did it take sexual abuse to make anger a valid response? Wasn't anger valid when any values or boundaries had been breached or when needs were unmet? The authors identified anger as an essential tool in the healing process (Cox et al., 2004). Even more interestingly, perhaps, they suggested that the benefit was more related to directly accessing the genuine response of anger rather than assigning responsibility.

I smirked, "I must be healed", I thought. Then quickly returned to the irony that whilst being able to access and respond to anger was healing, we were often discouraged from feeling and expressing anger.

"Surely this suggested that anger is more likely to be a solution rather than a problem".

"This is so fucked up."

It was becoming more straightforward and easier for me to notice the activated, visceral response I often experienced. However, at times I might have used softer terms such as irritation or frustration to identify it. The more I thought about the effects of anger having been pathologised, the gendered inequity, the systems that supported this and the consequences it had on women and the broader community, the more activation I felt in my body. I could see how these messages had impacted me, members of my family, clients and colleagues, and wondered if I ignored and suppressed anger because I was scared that it would damage a relationship or that I would be rejected? I felt a sinking and almost calm feeling present in my body that said, yes.

I thought about what was absent but implicit in angers voice. Roffman (2004) had said simply, "something important is occurring," I thought about how many times I had inadvertently pushed past values, boundaries and what was important to me, how I had treated myself and what I had lost as a result. As I sat with the feeling, I considered all the incredible people I had connected with over the years who had put caring for others ahead of their own needs, all those who had ignored what was important to them and didn't feel able to claim their right to be and feel authentically in the world. I wondered whether anger would have helped them notice that, as it had me?

I wondered how it was possible to even change your relationship with anger and other emotions such as anxiety, sadness, depression, without fully engaging with them? That activated feeling seemed to be a constant companion as I thought about our western systems supposedly in place to create safety and well-being, yet pathologised emotions such as anger, anxiety, depression and sadness, inviting the individuals to feel wrong for feeling how they were feeling. As I considered this further, I was reminded of some of the tactics I had heard being used in DV, where clients had been ignored or punished for attempting to create boundaries and then made wrong for feeling angry or unhappy about it. It seemed to me that the pervasive belief that anger was wrong discouraged resiliency, respectful relationships, equity and compassion, rather than supporting it. I was furious.

I guess you can't 'un-know' something because I noticed that these new awarenesses remained active within me and would often ignite that increasingly common embodied feeling that let me know something significant was occurring. I did not want to be part of the charade and primed the team that I intended to really 'do' anger deliberately. They took every

opportunity to allow me to be and reflect on my experience and relationship with anger.

"Maybe you should call yourself the angry therapist?" a colleague teased. "Maybe I should", I smiled as I heard the others giggle in the room. I knew he had a point.

But as I naturally responded with a smile, I felt a different type of feeling in my body and heard that internal voice saying,

"Oh no, they think I'm angry", " I hope I'm not upsetting them", "are they trying to let me know nicely that I need to tone things down" "I hate feeling like this".

I couldn't help but wonder what the impacts might be of rejecting these social norms as a woman and counsellor; how might this impact my identity, relationships and practice?

I took a breath. I would never get to know if I opted out.

"If anger had a voice, what would it say?" one team member asked.

"This is bullshit, having a philosophy that talks about the importance of respectful relationships and then not respecting where someone is at".

I admitted sheepishly to the team halfway through the year, "I just feel like I'm always angry at the moment". They smiled.

Compassion Fatigue

I took part in a professional development workshop with some colleagues where the trainer mentioned 'Empathy puts people at higher risk for compassion fatigue and burnout."

We all shouted, *" I've got that".*

I started to wonder whether the intense focus on empathy and compassion, together with the idea that anger was damaging to relationships, might invite counsellors to suppress 'negative emotions' such as anger which may have alerted them to self-care needs and instead prioritise the needs and feelings of others over their own. And whether this subsequently increased their risk of compassion fatigue?

"Maybe I had a point about a deficiency in anger?"

Germer et al. (2015) had posed the question, how can someone offer genuine compassion to others if they are unable to care for themselves compassionately? *I thought I provided genuine compassion, but I was beginning to wonder what did self-compassion even look like in practical terms?*

Kolts (2019) shares that Compassion begins with the courage to face the things that make us uncomfortable and what makes us most scared about ourselves. For me, I think it was anger.

Neff et al. (2003;2014) described the practice of self-compassion as being open to one's own emotions and suffering without avoiding or disconnecting from them and healing oneself with kindness. As I thought about the activated feeling that often appeared when I made myself wrong for feeling angry, it suddenly occurred that maybe anger was an invitation for compassion and that anger and compassion co-exist (Peters, 2015).

Serra (2014) describes anger as a warrior, wise and protective, constantly monitoring all of your edges with tireless diligence and never doubts the depths of your worth.

"I think I might be falling a little in love with anger", I mused.

I also learnt that self-compassion acted as a buffer against burnout (Barnard et al., 2011), and counsellors who better met self-care needs were more likely to set appropriate boundaries and less likely to use clients to meet their own personal or professional needs (Neilson, 1988). I had noticed that being more aware of anger had allowed me to be more aware of my positioning and agendas.

Vignettes

In the following section, I will present some de-identified vignettes to illustrate my experiences with anger as a counsellor. The vignettes provide a brief context drawn from my extensive auto-ethnographic diary of reflections and learnings from debriefings and supervision.

Vignette 1: My admission of anger

I had the pleasure of being a primary therapist for a client over about six months. Initially, she had identified with feeling depressed and hopeless. However, more recently, she had been able to increase her working hours and identified with feeling capable and powerful to change her world. In this session, the client talked about how her workplace was demanding she have a mandatory flu vaccination despite having health issues that she felt would make it detrimental. As she spoke of feeling hopeless, I could feel the activation within and felt pulled to give advice. Still, as I concentrated on my breath, I became aware that my issue of systemic abuse of power was one trigger and my wish for things to be different for her another. Rather than following my agenda, I was able to reposition myself. I smiled and acknowledged, "I notice that I'm feeling angry at the moment". "Yes," she said, and I noticed her sink into herself. I imagine that my acknowledgement validated what she was feeling in some way, although she did not use the term anger. Interestingly though, her energy changed, and she seemed to shift her perspective from the situation being personal to a systemic issue which enabled her to consider some other possibilities that she identified as helpful.

Vignette 2: How I do anger

Whilst being part of the reflecting team and listening to a client recounting her experience of how she had tried to say no to her partner, which he would ignore and when she tried to reinforce her position, he had said, *"yeah, I'm a really bad boyfriend", "you're always attacking me".* The anger I felt got my attention and offered clarity. I recognised this as a common tactic I had heard from clients who had experienced DV that seemed to distract from addressing the issue at hand, often leaving the client feeling wrong, confused and disempowered to create change.

As I breathed to calm my nervous system, I was able to formulate a question,

"I wonder how it would be possible to reinforce a boundary when attempts to assert a position are received as an attack?

As I shared the activation I had felt, the team asked me how I was able to formulate a question when I was triggered, and I realised that I did have a process to "do anger", which I shared with them.

"I concentrated on my breathe and deliberately increased the exhale. It helps me to create a space between the trigger and a response to gain clarity and perspective.

I realised that I had always used my breathing to calm my nervous system without really being conscious of it before. As I shared my process with them, I realised that this was how I "did" anger

Vignette 3: Ode to Anger

One author had suggested that non-expression of anger allows individuals to go in profoundly and truly feel anger. Whilst this seemed counter-intuitive to me, when I practised non-expression, I was able to fully feel and acknowledge anger in a deep way which created a feeling of the most incredible gratitude and appreciation for it. This is an extract from my journal.

Anger, I'm so sorry for how I have treated you. I can see that whatever is said about you, you are really love. In actual fact, I've never been loved like this before, so I didn't recognise you. You have always put my needs first, consistently trying to get my attention and remind me what was important to me, even when I was prepared to look the other way, and despite my treatment of you, you've never given up on me. You've continually stood by me and always have my best interests at heart in a way that no one else does, not even me. You're not silenced by inconvenient times or because it's 'inappropriate' or awkward. You're not prepared to ignore transgressions towards me, even when I try to minimise them. Anger, you have put me before anyone or anything, and I know I can trust you like no one else.

Conclusion

Whilst, I have felt vulnerable about sharing my intimate experience of anger, I have also found the whole process liberating as it allowed me to experience and represent my own personal truth, rather than being at the effect of the colonised views of western culture. Developing a closer relationship with anger allowed me to feel more whole, compassionate, adaptable and capable within myself as well as within my practice. It has helped me to notice and challenge binaries, has highlighted values and perceived threats, it has invited me to reflect and question my position and expand my consciousness around broader themes such as compassion, empathy, safety. It also invited me to be present to and listen and connect more compassionately to myself and others. It reminded me that intellectual knowledge is limiting without being grounded in experience and that social constructs such as anger aren't real. I recognised that by remaining connected and curious, I get to create more insight and freedom surrounding who I currently am and who I or others wish to become. More than anything, though, I was moved by the experience of anger being witnessed, accepted and valued as a part of me. It was profound and strengthening in a way that words are unable to convey, and I want to make that experience available to others.

I also want to be transparent and acknowledge that in an attempt to create some cohesion in the stories I've told you, I have left out some things which may give the impression of a more linear and logical approach, but in truth, it was anything but. Much of what I have described happened concurrently, I had numerous and spontaneous 'aha' moments in the most unlikely times and places; data was messy, often didn't make sense and felt generally chaotic. I've also tried to focus on my reflections and experience whilst offering enough context to scaffold understanding but also to preserve the privacy and confidentiality of those I was working with. Also, in becoming captivated by anger, I had to be careful not to seek it out in sessions and choose to focus on myself instead, rather than clients.

Peters (2015) offered that the true master's view is deeply emotional in nature and involves getting close enough to ourselves to see what's happening, be honest about it and care for ourselves and others to the best of our ability. My broader hope is that as counsellors, we provide for ourselves and others the opportunity to engage in a 'mastery' approach; create supportive communities that are open to and supportive of engaging in an intimate relationship with emotions, that will challenge the dominant discourses and limiting constructs, whilst holding space, offering witness and to model and support emotional competence from a master's perspective.

References

Apolinsky, S.R., Wilcoxon, S.A. (1991). Adult Survivors of childhood sexual victimisation: A group procedure for women. Family Therapy. 18,37-45.

Barnard, L.K., Curry, J.F., (2011). Self Compassion: Conceptualisations, correlates and interventions. Review of General Psychology. 15, 280-303.

Bayet,L., Pascalis, O., Quin, P.C., Lee, K., Gentaz. E., Tanaka, J.W., (2015). Angry facial expressions bias gender categorisation in children and adults: behavioural and computational evidence. DOI: 10.3389/fpsyg.2015.00346

Chemaly, S., (2018). Rage Becomes Her: The Power of Women's Anger. London. Simon & Schuster.

Coaston, S.C. (2017). Self-care through Self-compassion: A balm for burnout. The Professional Counsellor. 7, (3), 285-297.

Cox, D.L., Van Velsor, P., Hulgus, J.F. (2004). Who me angry? Patterns of angry diversion in women. Health Care for Women International, 25, 872-893.

Ellis, C., Bochner, A.P., (2000). Autoethnography, personal, narrative reflexivity: Researcher as subject. DOI:http://dx.doi.org/10.4135/9781446286463.

Ellis, C., Adams, T.E., Bochner, A.P., (2011). Autoethnography: An overview. Forum: Qualitative Social Research, 12 (1), http://doi.org/10.17169/fqs-12.1.1589.

Etherington, K. (2004). Becoming a Reflexive researcher: Using Our Selves in research. London: Jessica Kingsley Publishers.

Germer, C.K., Neff, K.D. (2015). Cultivating self-compassion in trauma survivors. In Mindfulness-orientated interventions for trauma: Integrating contemplative practices. New York, Guilford Press.

Hatch, H., Forgays, D.K. (2001). A comparison of older adolescents and adult females' responses to anger-provoking situations. Adolescence. 38, 557-570.

Kolts, R. (2019) Anger, compassion and what it means to be strong. TEDxOlympia.

Kopper, B. A. (1996). Gender, gender identity, rape myth acceptance, and time of initial resistance on the perception of acquaintance rape blame and avoidability. Sex Roles 34, 81–93. DOI: 10.1007/BF01544797

Mali, S., Dixit, S. (2018). Self Silencing and Women's Health: A review. International Journal of Social Psychiatry. DOI: 10.1177/0020764018814271

McIlveen, P. (2008). Autoethnography as a method for reflexive research and practice in vocational psychology. Australian Journal of Career Development. 17, (2), 13-19.

Munhall, P. (1993). Woman's anger and its meaning: A

phenomenological perspective. Health Care for Women International.14, 481-491

Neff, K.D. (2003). Self-Compassion: An alternative conceptualisation of a healthy attitude towards oneself. Self and Identity. 2, 85-101.

Neff, K.D., Zotigen, A.P. (2014). Self-Compassion, well-being and happiness. Psychologie in Osterreich, 2, (3), 114-119. Retrieved from http://self-compassion.org/wp-content/uploads/publications/Neff&Costigan.pdf

Peters, J. (2015) The Spirituality of Anger. https://spiritualityhealth.com/blogs/pathfinding-yoga-and-mindfulness/2015/12/23/julie-peters-spirituality-ange

Reed-Danahay, D.E. (1997). Auto-ethnography: Rewriting the self and the social. Oxford: Berg

Reynolds, M. (2019). How to use Anger as a force for good. TEDxAtlanta.

Roffman, A.E. (2004). Is anger a thing to be managed? Psychotherapy, Theory, Research, Practice, Training. 41, (2), 161-171.

Simonds, S.L. (1994). Bridging the silence: Nonverbal modalities in the treatment of adult survivors of childhood sexual abuse. New York: Norton

Serra, D. (2014). Your Anger is Sacred. www.dawnserra.com/your-anger-sacred

Thomas, S.T., Gonzalez-Prendes, A.A. (2009), Powerless, Anger and Stress found in African American Women: Implications for Physical and Emotional Health. Health Care for Women International. 30, 93-113.

Van Velsor, P., Cox, D.L. (2001). Anger as a vehicle in the treatment of women who are survivors: Reattributing responsibility and accessing personal power. Professional Psychology: Research and Practice. 32, (6), 618-625.

Demographics, Personality Traits & Satisfaction amongst altruistic surrogates who carry for strangers

Sam G Everingham & Katrina Hale

This study describes demographic and surrogacy-related characteristics, personality traits & satisfaction levels amongst thirty surrogates who carried for previously unknown intended parents in Australia or New Zealand.

Surrogates commonly carried for heterosexual (63%) and gay (43%) singles or couples. Over a quarter had used their own eggs. A significant proportion (40%) were located in regional or remote locations. Many (44%) had engaged in more than one arrangement. Nearly three in ten (29%) arrangements were rated as negative experiences. A significant proportion (20%) carried as single women or for intended parents at a distance, yet there was no correlation with higher journey dis-satisfaction amongst these groups. NEO-PI3 personality profiles demonstrated a wide mix of personality types. Altruism scores were the same as population norms.

The results suggest that surrogates who carry for previously unknown parties are a vulnerable group who may require significantly more support from professionals and intended parents.

Domestic surrogacy arrangements between previously unknown parties have seen a dramatic rise in Australasia; however little is understood about the types of agreements or surrogate demographics and satisfaction levels with the arrangement.

Results showed such surrogates are no more altruistic than the general population, are commonly in regional locations, sometimes single, and often carrying for intended parents at a distance. For many, the experience does not meet expectations. Despite this, it was common to carry for multiple recipients.

The results suggest that Australasian altruistic surrogates who carry for previously unknown parties are a vulnerable group who may require significantly more support from professionals and intended parents.

Background

Annual births via altruistic gestational surrogacy in the Australian context have seen a five-fold increase in the last eight years (Newman et al. 2020; Macaldowie et al. 2012). Yet, there remains a dearth of studies on the demographics, satisfaction, and personality profiles of Australasian surrogates and a particular absence of data on surrogates who carried for recipients who they had not previously known.

No psychological screening or post-approval healthcare professional oversight of Australian surrogacy arrangements is provided. Research in this sector has previously raised concerns that surrogates may be inadequately emotionally prepared for the surrogacy process (Purewal et al., 2012). Some regret their decision to become a surrogate. Dissatisfaction may increase as contact with intended parents diminishes post-birth.

In the altruistic surrogacy context, research in the U.K. and Israel has shown that non-monetary expectations compensate for the lack of financial reward. Such surrogates are prepared to give up family and personal time in exchange for a new and lasting friendship. They want to be part of a trusted kinship network, involving a genuine relationship, based on mutual trust and appreciation (Teman, 2010; Campbell, 2012). They believe that their intended parents will be equally helpful in return. If this does not occur, dis-satisfaction may be more likely.

A European study found that 70 per cent of surrogates had a desire to be repeat surrogates because of their satisfactory experience (Lorenceau et al., 2015). A UK study of 34 surrogates found six per cent were dissatisfied with the experience (Javda et al. 2003). In Canada, in an analysis of 266 current and past arrangements involving Canadian surrogates carrying for previously unknown intended parents, most (78%) had the support of a surrogacy agency. In 12% of arrangements, surrogates rated their satisfaction as neutral or relatively low (Yee

Corresponding Authors: Sam G Everingham & Katrina Hale
Email: sam@stethoscopemr.com.au

Australian Counselling Research Journal ISSN1832-1135

et al., 2019). However, Yee & colleagues found dis-satisfaction to be correlated with surrogates carrying for foreign intended parents. Hence a hypothesis we considered was whether there was a correlation between surrogates carrying at a distance from their intended parents and subsequent satisfaction with the arrangement.

Professionally managed surrogacy programs in the U.S. typically use psychological screening instruments in addition to clinical interviews to assess suitability (Lorenceau et al., 2015; Fuchs, & Berenson 2016). Australia utilizes such tools only to screen for psychopathology. In the U.S. context, the Minnesota Multiphasic Personality Inventory (MMPI) is widespread. Braverman & Corson's 1992 study showed surrogates tended to be the dominant partner in the relationship, were motivated by a wish to help, enjoyed being pregnant, showed narcissistic needs, and expressed a desire for secondary financial gain (Braverman & Corson 1992).

A study of 43 prospective U.S. surrogates administered the MMPI-2 concluded that this population made an effort to appear free of misgivings or undesirable features and tried to portray themselves in a positive light. The same study showed surrogates to be more outspoken than average females, with higher self-esteem and lower levels of anxiety and depression. They scored significantly higher on ego strength, social obligation and duties, and contained hostility, relative to the normative group (Pizitz et al. 2013).

Research with European surrogates utilized the Interpersonal Reactivity Index (empathy index), the Hospital Anxiety and Depressions Scale, and the MC20, a social desirability scale. It showed surrogates to be less anxious and depressed than normative samples while their empathy indexes were similar to normative samples, sometimes higher (Lorenceau et al., 2015).

Some studies have reported instead on surrogate traits using the Personality Assessment Inventory (PAI). A retrospective review of Australian surrogates who were nearly all (95%) relatives or friends of their intended parents showed most had PAI scores in the normal ranges, indicating they were psychologically healthy and well-functioning (Montrone et al., 2020).

While the PAI is the default psychopathology screening tool amongst Australian surrogates, it is possible that the NEO-PI3 may be more appropriate because it is not only shorter but more focussed on personality style and functioning in normal populations.

The NEO Personality Inventory-3 is the third iteration of a personality inventory first used in 1978 with adult men and women without overt psychopathology (McCrae et al 2005). It measures five key factors: neuroticism, extraversion; openness; agreeableness and conscientiousness. In addition, it gives insights into the six facets which define each domain. It has 240 items answered on a five-point Likert scale. A study of U.S. surrogates using the NEO PI-R showed significantly higher scores on extraversion, excitement-seeking and positive emotions, fantasy, and altruism and markedly lower on conscientiousness, order, dutifulness, and achievement striving (Kleinpeter & Hohman, 2000).

Aims & Objectives

Amongst surrogates who carried for previously unknown commissioning parents in Australia or New Zealand, this study aimed to describe demographic and surrogacy-related characteristics as well as personality traits & satisfaction with the relationship. The study was also designed to provide benchmark data on NEO-PI3 personality attributes amongst surrogates versus population norms and to assess the utility of this instrument in the Australian surrogacy context.

Research Design

Ethics approval was granted by the University of Wollongong. Participants needed to have agreed to carry for an intended parent(s)who were not previously known to them; entered into a surrogacy agreement and birthed a child sometime in the past seven years; to be resident in Australia or New Zealand when they carried; and be aged over 18 years.

Subjects were recruited through a mix of email and social media invitations to Australian and New Zealand surrogates, through co-operation with non-profit and community organizations as well as peer support social media groups. Community organizations promoted the research via social media advertising and by emailing a one-page information letter to all surrogates on their databases.

To reduce a potential source of sampling bias, the methodology also tapped into offline recruitment of surrogates. A possible bias was the exclusion of surrogates who had engaged in an arrangement with intended parents but were not successful.

The inclusion of both gestational and traditional surrogates in the selection criteria was not considered to be a significant confounder, given past research has shown that there are no significant differences in outcomes for these two types of surrogates (Imrie & Jadva 2014).

Recruitment and fieldwork took place with 30 surrogates in August and September 2018 via computer-based video interviews of 40 -70 minutes duration. Considering an average of 48 Australian or New Zealand surrogates gave birth via gestational surrogacy each year over the 2012-2018 period, and the majority of these are for family members or friends, the sample size of n=30 provided a robust representation of the total number who carried for previously unknown intended parents (Newman et al. 2020; Macaldowie et al. 2012).

The outcome of each research participant's completed surrogacy arrangement(s) was coded as 'positive' or 'negative' based on whether they had experienced significant conflict in their relationship with the intended parent(s); whether they felt positive or negative about the experience and whether they maintained a positive relationship with their intended parents.

As well as a depth interview, participants were invited to complete the NEO-PI3 online in their own time. Those who only partially completed or did not complete it were excluded from this part of the analysis. We used algorithms already developed to interpret test results. Subjects were provided with a quantitative summary of their scores where requested.

Quantitative variables were coded and reported as means or percentages of the total sample. Comparison of mean scores between populations used p values at the 0.05 significance level. Between-group correlations with satisfaction used the Chi-squared statistic with the Yates correction for continuity and a one-sided t-test.

Results

Participant Characteristics

Of those thirty surrogates who took part in qualitative interviews, their mean age at the time of the interview was 36.6 years. The majority of recruited participants lived in NSW (n=9), Victoria (n=8), or Queensland (n=7). Surrogates in Tasmania and ACT were also represented. Three participants were residents in New Zealand. A significant proportion (20%) carried as a single woman, without the support of a partner. While the majority resided in metropolitan settings (60%), a significant proportion were in regional (37%) or remote (3%) locations. On average, participants had delivered their most recent infant via surrogacy 20 months prior to the interview (range 0 -80 months).

Table One summarises participant characteristics

Table One: Surrogate Sample Characteristics

Age at Interview	
28 – 32 years	23%
33 – 37 years	27%
38 – 42 years	43%
43 - 45 years	7%
Mean age	36.6
Relationship Status	
Partnered	80%
Single	20%
Type of Arrangements	
Gestational Surrogacy	73%
Traditional surrogacy	7%
Gestational & traditional	20%
Carried for	
Heterosexual recipients	63%
Gay recipients	43%
Location	
Metropolitan	60%
Regional	37%
Remote	3%
Distance from Recipients[1]	
<2 hours (local)	43%
>3 hours (long distance	57%
Previously an egg donor	37%
The overall experience of the first surrogacy journey	
Poor	27%
Good	73%

Twenty of the total sample chose to complete the online NEO-PI instrument. Reasons for non-completion were not gathered, but this was an optional component.

Surrogacy Experience

A sizable proportion (37%) had come to surrogacy after being an egg donor. Fifty-six per cent (17/30) had commenced just one surrogacy arrangement, eight had commenced two arrangements, four had the experience of three arrangements, and one had engaged in six surrogacy journeys.

Over a quarter had engaged in traditional surrogacy, and a minority (7%) had the experience of both traditional and gestational surrogacy. Participants were more likely to have carried for heterosexual intended parents (63%), although nearly half (43%) had carried for a gay single or couple. Participants were more likely to have engaged with intended parents over three hours of travel away (57%).

Of 41 arrangements rated, 69% were rated as a positive experience. However, 29% (n=12) of arrangements were rated as distinctly negative experiences associated with significant trauma, stress, and negative emotions. There was no significant correlation between satisfaction with the surrogacy arrangement and carrying for intended parents at a distance ($X2 = 1.73$, $p=0.05$).

Personality Data

As shown in Table Two, of the 20 surrogates who completed the NEO-PI3 instrument, the only key personality factor on which they scored significantly higher than the population average was on the facet' values' ($\mu=61.5$, $p=0.03$).

Table Two: Mean Scores on Five Key Factors & Individual Facets

	Means	SD	Z
Neuroticism	46.95	9.7	-0.31
Anxiety	42.60	8.2	-0.90
Angry Hostility	47.65	7.9	-0.30
Depression	47.20	10.4	-0.27
Self-consciousness	50.45	9.6	0.05
Impulsiveness	48.15	8.4	-0.22
Vulnerability	44.55	9.5	-0.57
Extraversion	50.60	11.2	0.05
Warmth	50.40	9.0	0.04
Gregariousness	45.10	11.5	-0.43
Assertiveness	52.80	11.9	0.23
Activity	51.20	10.6	0.11
Excitement Seeking	52.80	12.2	0.23
Positive Emotions	54.35	9.6	0.45
Openness	55.95	10.5	0.57
Fantasy	51.05	10.3	0.10
Aesthetics	49.45	11.4	-0.05
Feelings	53.30	9.2	0.36
Actions	53.00	12.0	0.25
Ideas	55.10	12.1	0.42
Values[2]	61.50	6.2	1.85
Agreeableness	52.00	7.3	0.27
Trust	53.50	7.4	0.47
Straightforwardness	53.20	9.5	0.34
Altruism	52.90	8.1	0.36
Compliance	47.45	7.8	-0.33
Modesty	56.90	7.9	0.87
Tender-mindedness	55.80	9.1	0.64
Conscientiousness	51.50	8.9	0.17
Competence	54.30	8.7	0.50

Order	49.05	8.3	-0.11
Dutifulness	51.50	7.7	0.19
Achievement Striving	56.45	8.0	0.81
Self-Discipline	50.95	8.6	0.11
Deliberation	49.10	11.0	-0.08

Plotting openness vs agreeableness showed almost half (n=9) could be classified as progressives. In regard to the style of character, our sample was more often well-intentioned (n=8) – defined as giving, sympathetic, and genuinely concerned about others. Just 15% (3/20) had character styles placing them in the 'effective altruist' quadrant.

In regard to the style of interests, our sample was more often Creative Interactors (n=9). Looking at the style of defence, surrogates could most often be classified as hypersensitive (n=7) or adaptive (n=7). There was no correlation between hypersensitivity and journey dis-satisfaction, but most surrogates who had adaptive personalities (87%) were satisfied with their surrogacy arrangement.

Concerning anger control, surrogates were more often classified as timid (n=6) or easygoing (n=7). These personality types were not correlated with differences in satisfaction with their surrogacy arrangement.

Discussion

The mean age of surrogates in our study (37 years) was very similar to that reported by Montrone et al. (2020) and suggests that Australian and New Zealand women do not come to surrogacy until after completing their own families. Recent studies of surrogates in the U.S. and Canada have shown significantly lower mean ages (Fuchs & Berenson, 2016; Pizitz et al., 2013; Van den Akker, 2003) though in the U.K. altruistic context, mean ages at which surrogates carry a child are similar to Australia (Javda et al. 2003; Pizitz et al., 2013).

A significant proportion of surrogates carried as single women and for intended parents at a distance, yet there was no correlation with higher dis-satisfaction for these groups, suggesting that single surrogates and those at a distance can have the appropriate support networks to support their journeys. A recent review of Canadian surrogates showed a similar proportion were single, separated, or divorced (Yee et al. 2019).

The NEO-3 personality profiles of altruistic surrogates in our study demonstrated a broad mix of personality types. Interestingly, mean scores on altruism were the same as population norms. However, a differentiating feature of Australian and New Zealand surrogates who carry for strangers is the importance they place on values. Such women are prepared to re-examine their social, political, and religious values, to accept others' beliefs, ideas, and behaviours.

For many, there was a sizable delay between their surrogacy arrangement, concluding and taking part in the research. Subjective measures of satisfaction with the relationship amongst surrogates are likely to have been tempered with time.

Although the U.S. surrogate NEO-PI3 scores were measured before their surrogacy arrangement, such scores tend to be stable over time. Hence comparing these two population's scores is appropriate. The pattern of Australasian NEO-3 profiles was very different from those of U.S. compensated surrogates (Kleinpeter & Hohman, 2000) who were significantly more likely to be day-dreamers, altruists, excitement-seeking, joyful and high-spirited. None of these traits was reflected in our sample. It is likely that the ability to advertise for and financially compensate U.S. surrogates attracts an entirely different type of woman than seen in the altruistic context.

A 'progressive' personality type was common. Such women have a thoughtful approach to social problems, are willing to try new solutions, have faith in human nature, and are confident society can be improved through education, innovation, and co-operation. Altruistic surrogates were also often Creative Interactors - women whose interests revolve around the new and different, who like to share their discoveries with others. Such personality types enjoy public speaking and teaching, fit in well to discussion groups and enjoy meeting people from different backgrounds. The high proportion of Creative Interactors may in part be a product of sampling bias by relying mainly (though not exclusively) on recruitment of surrogates who maintained an active online profile.

Altruistic surrogates tended to be either hypersensitive or adaptive. Those with hypersensitive personalities vividly imagine possible misfortune and sometimes have odd and eccentric ideas. In the independent surrogacy setting, this personality type may lead to increased stress for both surrogates and intended parents. Adaptive types are keenly aware of conflict, stress or threat, but use these situations to stimulate creative adaptations. Such a personality type is likely to be protective in the surrogacy context.

We saw a split between Timid and easy-going surrogates. Timid individuals are heavily conflicted over anger. Yet, they are reluctant to express anger because they do not want to offend others. Agreeable individuals are slow to anger and also unwilling to show anger if it does arise. They would prefer to forgive and forget and try to work toward common ground in resolving disputes. The disinclination to express anger may be a positive aspect of their involvement in intimate surrogacy relationships.

A limiting factor in interpreting personality type trends was the smaller sample size which limited the power of the study.

The high proportion of repeat altruistic surrogates in our sample is of considerable interest. Yee and colleagues' (2019) survey of Canadian surrogates found that an even higher proportion had engaged in multiple arrangements (78%).

Despite over a quarter of Canadian surrogates reporting a weak or absent connection to their intended parents, their dissatisfaction was less than half that reported in our study. However, over a quarter of Canadian surrogates consciously chose to carry for foreign singles or couples, which suggests a lower expectation of an ongoing friendship.

The lack of professional support in the Australasian environment may lead surrogates who are outside kinship networks to depend more on relationships with their intended parents. Higher dissatisfaction may be related to intended parents being unable or unwilling to invest in the close relationship sought by the surrogate.

Our study provides insight into the range of demographic and personality types who engage as altruistic surrogates for strangers and the kinds of intended parents they carry for. It may be generalizable to other environments where surrogates can match and work independently with intended parents, such as the UK, Canada, and the USA.

Given this study failed to demonstrate any correlation between surrogate dis-satisfaction and surrogate personality or

circumstantial factors, further quantitative research should be conducted to examine possible reasons for dissatisfaction. Only with such insights can altruistic surrogate expectations be better managed and protected.

Bio

Sam Everingham BSc, MA, MPH has twenty five years experience as a social & healthcare research professional. He is on the board of the charity Surrogacy Australia and has co-authored prior research studies on Australian attitudes to surrogacy, as well as Australians use of domestic and cross border arrangements. His research has been published in the Medical Journal of Australia, The ANZ Journal of Obstetrics and Gynaecology, Reproductive Biomedicine Online & the Australian Institute of Family Studies

Katrina Hale is a Sydney-based ANZICA-registered Psychologist and Infertility Counsellor with over 20 years counselling experience. She is passionate about supporting altruistic surrogacy arrangements and works closely in screening and supporting all parties. She has supporting dozens of Australian surrogates as well as gay and heterosexual intended parents prior to and during surrogacy arrangements.

Footnotes

[1]Based on their first arrangement if they had carried more than once

[2]P<0.05 (one-sided)

References

Braverman, A.M. & Corson, S.L. (1992). Characteristics of Participants in a Gestational Carrier Program, *Journal of Assisted Reproduction & Genetics, 9*(4), 353-357. https://doi.org/10.1007/BF01203959

Campbell, A. (2012). Law's Suppositions About Surrogacy Against the Backdrop of Social Science. *Ottawa L Rev 43*(1) 29. CanLIIDocs 81, https://canlii.ca/t/28d0

Fuchs, E.L. & Berenson, A.B. (2016) Screening of gestational carriers in the United States. *Fertility and Sterility 106*(6) 1496–1502. https://doi.org/10.1016/j.fertnstert.2016.07.1111

Imrie, S. & Jadva, V. (2014) The long-term experiences of surrogates: relationships and contact with surrogacy families in genetic and gestational surrogacy arrangements. *Reproductive BioMedicine Online, 29*(4), 424-435. https://doi.org/10.1016/j.rbmo.2014.06.004

Javda, V., Murray, C., Lycett, E., MacCallum, F. & Golombok, S. (2003) Surrogacy; the experiences of surrogate mothers, *Human Reproduction, 18*(10) 2196-2204. https://doi.org/10.1093/humrep/deg397

Kleinpeter, C.H., & Hohman, M.M. (2000) Surrogate motherhood: personality traits and satisfaction with service providers. *Psychological Reports 87*(3) 957-970 https://doi.org/10.2466/pr0.2000.87.3.957

Lorenceau, E.S. Mazzucca, L., Tisseron, S., & Pizitz, T,D. (2015) A cross-cultural study on surrogate mother's empathy and maternal–foetal attachment. *Women Birth, 28*, 154-159 http://dx.doi.org/10.1016/j.wombi.2014.11.006

Macaldowie, A., Wang, Y.A., Chambers, G.M. & Sullivan, E.A. (2012) Assisted reproductive technology in Australia and New Zealand 2010. Assisted reproduction technology series no. 16. Cat. no. PER 55. Canberra: AIHW. https://npesu.unsw.edu.au/surveillance/assisted-reproductive-technology-australia-new-zealand-2010

McCrae, R.R., Costa, P.T. & Martin, T.A. (2005). The NEO–P.I. –3: A More Readable Revised NEO Personality Inventory, Journal of Personality Assessment. *Journal of Personality Assessment. 84*(3), 261–270. https://doi.org/10.1207/s15327752jpa8403_05

Montrone, M., Sherman. K.A., Avery, J., Rodino, I.S. (2020) A comparison of sociodemographic and psychological characteristics among intended parents, surrogates, and partners involved in Australian altruistic surrogacy arrangements. *Fertility and Sterility, 113*(3), 642-652 https://doi.org/10.1016/j.fertnstert.2019.10.035

Newman, J.E., Fitzgerald, O., Paul, R.C., Chambers, G.M. (2020). Assisted reproductive technology in Australia and New Zealand 2018. Sydney: NPESU University of New South Wales Sydney. https://npesu.unsw.edu.au/surveillance/assisted-reproductive-technology-australia-and-new-zealand-2018

Purewal, S., Crawshaw, M. & van den Akker O. (2012) Completing the surrogate motherhood process: Parental order reporters' attitudes towards surrogacy arrangements, role ambiguity and role conflict. *Human Fertility 15*(2), 94–99.

Pizitz, T.D., McCullaugh, J., Rabin, A. (2013) Do women who choose to become surrogate mothers have different psychological profiles compared to a normative female sample? *Women Birth; 26*(1) 15–20. https://doi.org/10.1016/j.wombi.2012.06.003

Teman, E. (2010) Birthing a mother: The surrogate body and the pregnant self. London: University of California Press.

Van den Akker, O. (2003) Genetic and gestational surrogate mothers' experience of surrogacy. *Journal of Reproductive and Infant Psychology, 21*(2) 145–161. https://doi.org/10.1080/0264683031000124091

Yee, S., Goodman, C.V. & Librarch, C.L. (2019) Determinants of gestational surrogates' satisfaction in relation to the characteristics of surrogacy cases. *Reproductive Biomedicine Online, 39* (2) 249-261. https://doi.org/10.1016/j.rbmo.2019.04.001

Yee, S. & Librarch. C.L. (2019) Analysis of gestational surrogates' birthing experiences and relationships with intended parents during pregnancy and post□birth. *Birth. 46* 628–637. https ://doi.org/10.1111/birt.12450

Beyond Multicultural Competency: Pluralistic Multicultural Orientation Treatment (PMCOT)

Daryl Mahon

The present conceptual paper offers a model of multicultural treatment that seeks to learn from the client their important cultural identities, values and beliefs. Pluralistic Multicultural Orientation Treatment (PMCOT) extends the multicultural competency framework by integrating four independent but interconnected interventions to create a conceptual model. The multicultural perspective has been discussed within the literature for many decades; however, evidence is mixed as to its overall effectiveness. This conceptual paper reviews effective components of multicultural practice and effective methods for working with diversity in general and assimilates them into this conceptual model. Multicultural orientation, illness myth, pluralistic therapy and feedback informed treatment provide the key processes of PMCOT and its commitment to learn from clients, not about clients, their important cultural identities as they present in the therapy relationship. A discussion provides both strengths and limitations to this model and explores areas for possible further research.

Keywords: *Multicultural, competency, orientation, pluralistic, PMCOT*

Introduction

Research within counselling and psychotherapy is generally conducted within the Western world. Sue et al. (1992) suggest that therapy is, therefore, more suitable to this dominant culture and may not be congruent with other ethnic or racial groups, beliefs or values. At the same time, other researchers such as Frank and Frank (1993), and Wampold (2007), argue that counselling and psychotherapy are culturally encapsulated healing processes specific to particular cultural contexts.

Consequently, and supported by an ever-growing body of evidence (Davies et al., 2018; Owen et al., 2014; Owen et al., 2016; Wampold, 2015; Benish et al., 2011), addressing cultural experiences in therapy can help improve psychotherapeutic outcomes. While the broader field of psychology and the therapy field specifically have been attempting to address these gaps within the research, there is still a relative dearth of evidence as to how using a cultural competency framework impacts client outcomes and treatment outcome has shown heterogeneity in effect sizes (Huey et al., 2014; Tao et al., 2015). Thus, the present conceptual paper seeks to provide a model based on current evidence of what works in this area. Drawing on four individual but interconnected concepts, two of which are multicultural specific, namely, multicultural orientation and illness myth. In addition to two transtheoretical interventions, pluralistic counselling and feedback informed treatment, the author presents Pluralistic Multicultural Orientation Treatment (PMCOT).

PMCOT is presented here as building on the multicultural competency model through integration of independent and interconnected, and overlapping interventions from the extant literature. I present the conceptual model in a linear format illustrating how it can be used during the initial assessment, throughout the therapy process, and in monitoring the process of therapy by paying attention to the therapeutic alliance in a multicultural manner. Importantly, and at the heart of this conceptual model, is the idea that each of the four components of PMCOT is used to learn from our clients their important cultural values, beliefs and identities, and how these can inform therapeutic responsiveness from practitioners. While the four components are presented as a linear concept for ease of understanding their application, there is a great deal of overlap in their use during therapy.

Multicultural approach

Concerns have consistently been noted within the extant literature regarding the extent to which diversity has been included in research trials of evidence-based therapies

Corresponding Author: Daryl Mahon
Email: outcomesmatter1@gmail.com
Affiliations: Outcomes Matter, Wicklow, Ireland
Address: Wicklow, Ireland
Funding: No funding or conflicts

Australian Counselling Research Journal ISSN1832-1135

and the extent to which these therapies are actually effective for those from diverse ethnic and racial population (Huey and Polo, 2008; Huey et al., 2014; Miranda et al., 2005; Sue et al., 2009). Disparities in mental healthcare treatment have been consistently identified within racial and ethnic minority groups, and studies have documented that many practitioners have better outcomes with White clients (Drinane et al., 2016; Hayes et al., 2015; Imel et al., 2011). This, of course, led to calls to research and make treatment more applicable and effective to this population.

However, although researchers have attempted to respond to these issues, overall, the evidence has been mixed as to the effectiveness. Indeed, some research studies have demonstrated that cultural tailoring can sometimes diminish the impact of general practice (Huey et al., 2014). At the same time, the multicultural and diversity literature has noted different methods of responding to these issues. While the multicultural competency approach has seemed to garner the most attention, there are questions concerning its applicability and effectiveness in general (Huey et al., 2014).

According to Hook et al. (2016), there have been high rates of racial-ethnic microaggressions in therapy, with as many as 53% to 81% of clients who have reported experiencing an experience of at least one microaggression. Clients who perceive racial-ethnic microaggressions from therapists have reported lower therapeutic alliances and diminished therapy outcomes (Owen et al., 2018).

In addition to this, differentiated models calling for different ways of addressing diversity have been added to the literature; this could be one of the issues impacting on establishing overall efficacy. Adaptations to treatment models, attitudes and processes have all been identified as effective components of multicultural treatment. However, limitations have been noted for each of these areas. Again, definitions for multicultural responsiveness have been defined differently, further adding burdens to addressing research questions. However, meta-analysis does provide some strong evidence overall, and it is this evidence that informs the present conceptual model, PMCOT.

Prominent multicultural studies

Smith et al. (2010), in a meta-analysis of 65 quasi/experimental studies, found that culturally adopted treatments had a medium effect size of (d=0.46), with treatments adopting metaphors/symbols that match the clients cultural worldview and treatments to specific ethnocultural identities being more effective. However, for the author, this may only be a fruitful approach for those working with specific demographics. Practitioners would have to learn an insurmountable amount of treatment approaches with specificity to work with the variety of multicultural identities who attend routine practices. At the same time, many of the studies in this meta-analysis did not test direct comparison; thus, caveats apply.

Similarly, Griner and Smith's (2006) meta-analysis found that treatment adapted to specific cultural identities was as much as four times as effective (d=0.45), and matching clients to therapists who speak their own language were up to twice as effective.

In their meta-analysis, Benish et al. (2011) found that culturally adapted psychotherapy for race/ethnicity is more effective than un-adapted (d=0.32) compared against bona fide therapies. Adaptation of the illness myth was the sole moderator of superior outcomes via culturally adapted psychotherapy. The smaller effect size, when analysed against the above Smith study, may be accounted for by the direct comparison studies and provides us with more reliable findings.

Huey et al. (2014, p.1), in their Annual Review of Clinical Psychology, posit that "support for cultural competence as a useful supplement to standard treatment remains equivocal at best". However, they do note the findings from the above Benish et al. (2011) study and the adaptation of the illness myth and its link to common relational factors, and note some of the findings from the Smith et al. (2010) meta-analysis, specifically, matching worldview, metaphors and symbols. The illness myth adaptation would seem to be congruent with the general psychotherapy outcome variance literature, that suggests building expectancy, hope and providing a rationale for treatment outcome/ credibility produces superior outcomes (Duncan et al., 2011; Constinano et al., 2018; Constinano et al., 2018; Frank and Frank, 1969; Wampold, 2015; Wampold and Imel, 2015). For these empirical reasons, illness myth (discussed later) is incorporated into the present conceptual model.

Tao et al. (2015) meta-analysis of multicultural competency examined MC and its correlation with several processes and clinical outcomes. Specifically, MC was correlated with process measures (r =.075) and clinical outcomes (r =0.29). In addition, there was a strong correlation between general counselling competencies and satisfaction with therapy.

The analysis in this study suggests that client ratings of practitioners' MC account for approximately 37% of the variance in the therapeutic alliance, 52% of the variance in client satisfaction, 38% of the variance in general competency, and 34% of the variance in session depth. Thus, Tao et al. (2015, p.344) suggest that 'therapist MC should be considered an important empirically supported therapeutic relational factor', with a variance of approximately 8.4% on outcomes. Based on this evidence, the PMCOT model incorporates informed feedback treatment (alliance and outcome measures) and the pluralistic approach with a focus on preference accommodation (satisfaction) into the model (discussed later). In addition, both can be considered trans-theoretical general competencies.

The most recent secondary analysis within the multicultural domain is a narrative review by (Davies et al., 2018.). This review examined the evidence for the multicultural orientation (MCO) (Owens et al., 2015), with individual studies within the narrative review providing evidence for correlations between one of the three aspects of MCO (discussed later) and outcomes. Due to the strong emerging evidence for the multicultural orientation approach and it's process/attitude orientation, it is incorporated into the present conceptual model. The MCO provides a lens in which the practitioner considers how their own cultural conditioning interacts with the clients and the healing potential and barriers that may come from these interactions; in addition to providing a general direction on how to go about broaching cultural markers as they present in the session, that is, the process (Davies et al., 2018; Owen et al., 2014).

Multicultural competencies

The multicultural competency movement can be considered the fourth force in psychotherapy, following on from the psychodynamic, behavioural and humanistic traditions

(Pederson, 2002). The competency movement has gained increasing attention since the 1980s across settings such as psychiatry, psychology, therapy and social work. Multicultural Competency (MCC) proposes that it is possible to learn to work with diverse client populations across cultures, identities and treatment paradigms by adopting treatment to specific cultural identities.

The MCC approach stipulates three broad ideas; (1) that there are a set of competencies that can impact client outcomes and can be acquired by therapists through a standardised training regime. (2) competency in these skills can be assessed and identified in the therapist; (3) the competencies are a standard characteristic across client populations.

However, there is little support for the position that multicultural competencies are a stable characteristic of the practitioner, as studies have not illustrated adequate convergence across ratings of the same practitioner (Owen et al., 2011), or that competencies are strongly linked to outcomes. This is not surprising when we contextualise it within the general outcome research in counselling. That is, the correlation between therapist competency and client outcomes is weak, with less than 1% of the variance in therapy outcomes accounted for by competency (Wampold, 2015; Wampold and Imel, 2017; Webb et al., 2010).

Thus, employing another competency framework for cultural counselling may not be the most effective method to improve client outcomes. Instead, a 'way of being ' (Owen et al., 2016) in sessions is proposed, which would be more aligned to the factors set out in evidence-based relationships (Norcross & Lambert 2001; Norcross & Wampold, 2018; Norcross & Wampold, 2019) and outlined within my rationale for the PMCOT model.

The model of cultural competency most often cited and recognised is the person-based model (Chu et al., 2016). The person-based model proposes three components, namely, self-awareness of one's own cultural background and how this impacts practice; knowledge about the worldview and culture of those from diverse cultural backgrounds; and learning skills in culturally appropriate treatment interventions (Sue et al., 1982; 1992; 2013). Often referred to as the tripartite model (Chu et al., 2016), of multicultural knowledge, skills and attitude, or KSA (Watkins et al., 2019). Perhaps reflecting the wider discourse in psychotherapy, Watkins et al. (2019) argue that the knowledge and skills components have received more attention, with the attitudinal aspect lagging. However, Ratts and Pederson (2014) and Ratts et al. (2016) would suggest that it is the attitude component that provides the KSA with its foundation and successful implementation. As Gonsalvez and Crowe (2014, p.22) argue, "the 'big' competencies with deep impact are attitude-value attributes."

Pluralism

The pluralistic approach is a collaborative philosophy and practice rooted in humanistic and person-centred values. Its fundamental proposition is that each client is unique, and therefore may need different things from therapy (Cooper & McLeod, 2000). This idea and flexibility converge nicely with the illness myth, which itself can be considered cultural pluralism. That is, clients may have different culturally specific ideas of how the treatment should work and what type of approaches and methods will be helpful. One way the pluralistic approach can help with mitigating some of these issues is through preference accommodation. Swift et al. (2018) demonstrate in their meta-analysis that preference accommodation is associated with superior client outcomes and reduced early attrition, both of which have been shown to disproportionately impact clients of diversity. Cooper and Norcross (2016) provide the Cooper Norcross Inventory of Preference to help incorporate important issues into treatment, such as style of therapy, format, and focus. There is also a question relating to client preference towards their therapist across demographics of diversity. While not a cultural specific inventory, it does provide a good starting point to begin incorporating important client preferences in general, which can be explored under a cultural lens also

The cultural implications of research, treatment and our understanding of therapy also need to be carefully considered, lest they are not congruent with the clients' experience of their emotional problems. While this is important for all people, it comes into a sharper focus when we consider diversity. For example, the Western worlds diagnostic system of pathologising, is certainly not consistent with all cultures. Our research and training have taught us to re-cast other people's experiences in terms of our own culturally situated symbolic system. Thus, the pluralistic concept has been incorporated into this conceptual model as a starting point for addressing cultural preferences. It may be used during the assessment phase or before the first therapy session occurs, thus, orientating practitioners to important cultural markers that are identified and can be followed up with other multicultural interventions, for example, the idea of using the illness myth.

Illness Myth

Articulated previously, one of the methods of successful culturally informed psychotherapy was documented in the Benish et al. (2011) meta-analysis through the illness myth. As far back as 1962, Wrenn described psychotherapy as culturally encapsulated, calling for more cultural diversity in the delivery of treatment. Frank and Frank (1963) and Wampold (2007) suggest that an important aspect of universal healing is the cultural explanation and a set of healing rituals provided to the clients, which are embedded within a cultural context. "What is important to the sufferer is not the scientific validity or falsifiability of the illness explanation but rather the congruence of the explanation with the client's cultural beliefs about the illness" (Benish et al., 2011, p.281).

The adaptation of illness myth would seem to be especially important in providing a rationale that is consistent with the clients cultural understanding, beliefs about symptoms, aetiology, how the issues will evolve, and opinions on acceptable treatment approaches. Considering the impact that incorporating the illness myth has on outcomes (Benish et al., 2011) and its attitudinal/process orientation, we find that it is a good fit and evidence base for PMCOT. The illness myth can be used throughout therapy; however, we see the benefit in its use during the assessment phase, and it can be used in conjunction with preference accommodation, especially when multicultural needs have been initially identified through administering the Cooper-Norcross Inventory of Preferences. As such, it is a starting point where the practitioner can learn from the client their important cultural identities, how they view their presenting issues, and what, if any, ideas they have regarding treatment within a cultural context. At the same time, we need multicultural practices that can be used in the moment. Owen et al. (2018) discuss multicultural orientation as a way to achieve this.

Multicultural orientation

For Watkins et al. (2019), the Multicultural Orientation (MCO) can be viewed "as a process-oriented, attitudes-additive perspective to the MCC KSA framework". MCO is used to operationalise the process-oriented perspective and as a complement to the attitudes component of the KSA framework; and the multicultural competency approach in general (Davies et al., 2018). The MCO approach is made up of three interconnected and interdependent ideas; cultural humility, cultural opportunity and cultural comfort. "The cultural worldviews, values, and beliefs of the client and the therapist interact and influence one another to co-create a relational experience that is in the spirit of healing." (Davis et al., 2018, p. 90).

Culturally humble therapists seek out markers for cultural opportunities to enquire into clients identities that arise in session. These culturally humble therapists seek to find cultural comfort in these interactions while engaging differential client cultural identities. While cultural humility seems to be the foundation of this orientation, Watkins et al. (2019) suggest that on its own, it may not be enough to improve outcomes.

Cultural humility can be considered a virtuous component of the MCO approach. Increasingly, those across disciplines within the mental health domains have come to understand humility as an alternative and/or complementary language to the competency approach (Foronda et al., 2016; Davies et al., 2018). Humility is conceptualised as consisting of both intrapersonal and interpersonal components. That is, a level of self-awareness regarding the view a practitioner holds of themselves and their limitations; and the extent to which one is other orientated rather than being consumed with Self and their superiority over others.

We can therefore extrapolate that cultural humility as a subdomain of humility is the extent to which a practitioner can hold an interpersonal position with a client that is curious about their cultural identity; or as Hook et al. (2013, p.354) articulate, "the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client."

Importantly, cultural humility goes beyond the traditional position of 'not knowing' adopted by practitioners and actively seeks to learn from clients their cultural identities. If cultural humility is the motivational factor for practitioners who want to find out about others important identities, then cultural opportunity and cultural comfort can be considered the in-session behaviours when these markers are identified and need to be broached. Said another way, through cultural humility, practitioners identify important cultural markers as they present in the session and broach the subject using cultural opportunities and cultural comfort.

Owen et al. (2016) describe cultural opportunities as those points in a session where important cultural beliefs, values and identities present and can be explored by both practitioner and client. At the same time, cultural opportunities are always present, and therapists should feel that they can broach these issues if they feel that there will be therapeutic value in situations where cultural opportunities may not be manifest. Davies et al. (2018) suggest doing this gently and authentically and without big transitions or forcing the issue. Hence, practitioners who practice cultural humility and opportunity will have a certain level of ease with engaging in these practices, that is, cultural comfort.

Cultural comfort explains the level of ease that practitioners experience before, during and after conversations with clients about their cultural identities (Owen et al., 2017). While cultural comfort would be needed to navigate the complex interpersonal dynamics that occur in session, cultural discomfort may be a good indication that something has been triggered and needs attending to; as such, Davies et al. (2018) use the language of cultural transference and counter-transference. Viewed under this lens, feelings of cultural discomfort may precede cultural humility and would seem important for practitioners to identify as they may impede therapeutic progress.

The current evidence for MCO in therapy is emerging as strong across a number of studies (Davies et al., 2018; Hook et al., 2013; 2016; Owen et al., 2014; 2015; 2016). Owen et al. (2018) found that clients who experienced microaggressions from their therapists experience worse therapeutic alliances and worse therapy outcomes. At the same time, Owen et al. (2018) found that therapists ability to identify 1 of 3 microaggressions in simulated sessions was 38% to 52%. Hook et al. (2016) demonstrated that for clients who experienced microaggressions, cultural humility predicted the number and impact of this aggression after controlling for general multicultural competencies, indicating the added value of humility.

In a retrospective study, Owen et al. (2016) examined therapist cultural humility and missed opportunities. Findings suggest that clients who rated their therapist as culturally humble had better therapy outcomes, while those who rated their therapist as having missed opportunities to discuss their cultural identity (cultural opportunity) reported worse outcomes. Again, Owen et al. (2014), in a study focused on religious, cultural identities, reported that therapists who were more culturally humble with religious clients had better outcomes.

It's not surprising that multicultural orientations seem to be mediated by the therapeutic alliance. Hook et al. (2013, study 1) found that cultural humility was correlated with the alliance. In a second study, Hook et al. (2013, study 2) demonstrated that cultural humility correlated with the alliance and client outcomes. In a third study, Hook et al. (2013, study 3) found that cultural humility mediates the alliance and client outcomes. Taken together, these seven empirical studies demonstrated positive client outcomes, and thus, the MCO is incorporated into the present conceptual model. However, as illustrated previously, it is not just the MCO that has demonstrated effectiveness; other cultural processes are also impactful and need consideration.

Feedback Informed Treatment (FIT)

One of the most cited rationales for clinicians incorporating multicultural competencies into therapy is how poorly clinicians attend to ethnic and other minorities (Huey et al., 2014) and the disparities within mental health outcomes for these populations. However, individual clinician experiences and opinion may not be congruent with the literature. For example, several studies during the last 30 years (e.g. Allison et al., 1996; Hansen et al., 2006; Holcomb-McCoy & Myers 1999; Lopez & Hernandez, 1986; Maxie et al., 2006) of predominantly White therapists illustrates that between 72-91% of clinicians perceive themselves as practising multicultural competencies to some extent. For the author, it is difficult to reconcile these statistics. While Benish (2010) suggests that this may be reflective of a certain level of cultural competency as a norm, another way to view these statistics could be through the lens of cognitive bias

on the part of practitioners.

The less knowledge, expertise and self-awareness one has about a field of practice; the more likely one is to overestimate their degree of knowledge in that area (Kruger & Dunning, 1999). So, having less expertise working with an area of diversity might make it harder for one to see one's limitations in that area. This bias, combined with self-enhancement dispositions, may make it difficult for practitioners to perceive and take responsibility for their limitations (Davis et al., 2018). Indeed, Fuertes et al. (2006) and Dillion et al. (2016) found that counsellor's self-assessment of their multicultural competencies was found to exceed that of their client's assessment. This may not be overly surprising considering the previously cited Owen (2018) study on therapists ability to spot microaggressions as they happen in session.

At the same time, the general psychotherapy literature informs us that clinicians tend to overestimate their rates of client improvement and underestimate their rates of client deterioration (Chow et al., 2014; Walfish et al., 2012). Thus, in the studies cited above, clinicians may be overestimating their abilities and or use of cultural competencies. One method to help practitioners improve these issues is by tracking their progress, outcome and process of care with standardised measures. Coupled with the previous research attesting to the power of the alliance in multicultural therapy, feedback approaches would seem to be indicated as helpful tools.

FIT is an evidence-based trans-theoretical approach for improving the outcome and process of behavioural healthcare. It involves using two ultra-brief measures at every session to solicit feedback from clients on the therapeutic alliance and outcome of care and using the information provided to adapt the therapists approach in real-time to meet these needs. FIT uses the Outcome Rating Scale (ORS) to solicit feedback on how the client is responding to treatment, that is, the benefit they are getting from therapy. The Session Rating Scale (SRS) is used to assess the therapeutic alliance.

Both measures are reliable and valid tools, and meta-analysis has demonstrated that their use to improve therapy outcomes by helping to identify those not benefiting from care; at risk of early termination, and those actively deteriorating while in care (Brattland et al., 2018; Lambert et al., 2018); all of which make up a significant percentage of clients in routine practice.

Specifically, the SRS can be used to keep track of the therapeutic alliance in general, but also within a culturally informed manner. As the measure tracks the extent to which clients are satisfied with the bond between themselves and the practitioners, the goals and topics discussed, and the methods and approach used. In doing so, practitioners may also garner a clearer picture of their multicultural abilities and align their process orientation more towards the individual diversity, and intersectionality's that their clients present with, reducing possible self-effectiveness bias. At the same time, previously cited studies have suggested that therapists may be unaware of microaggressions that occur in session; thus, tracking the alliance with a structured measure at the end of each session may be one way to identify and attend to cultural ruptures in real-time.

Considering that all of the empirical studies discussed previously indicated that multicultural outcomes were mediated through the alliance, it makes sense that we explicitly attend to this when working with diversity. Indeed, in their meta-analysis, Tao et al. (2015) suggest that clients perceptions of their therapist's multicultural competency account for 37% of the variability in the therapeutic alliance. While FIT has a specific meaning regarding feedback, all the concepts discussed previously seek feedback from clients in some manner, and it is this attitude of learning from the client that is at the heart of PMCOT.

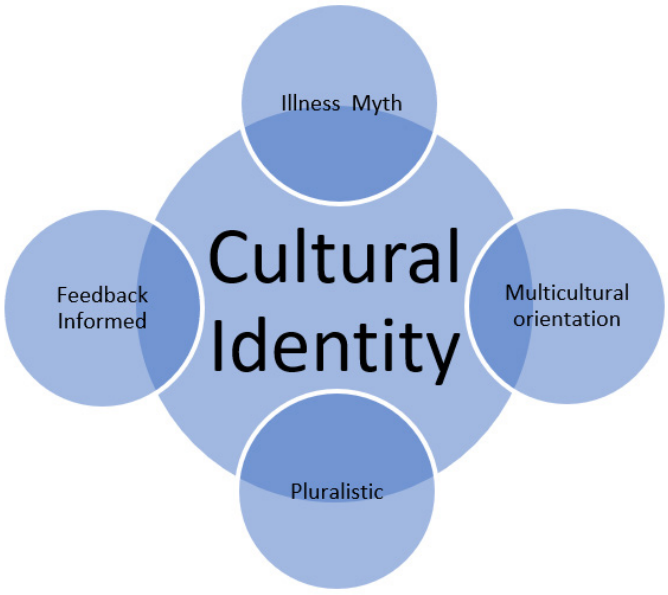
Implications for practitioners

Learning about others culture can be quite difficult, not least because what we learn may not be representative of the wider population, re-stereotyping may occur, and outliers are always present. While adapting to specific ethnocultural populations is one way of providing multicultural support, it is beyond the scope of any practitioner to learn about all cultures and their intersectionality's. It is just not feasible to learn about others important beliefs, values and cultural identities from a book chapter.

Therefore, an approach that can be utilised with differential cultures and their intersectionality would certainly be more feasible for the average practitioner. Huey et al. (2014), in their *Annual Review of Clinical Psychology*, note that approaches to multicultural therapy that has high training needs, complex protocols and substantial costs that further narrow their applicability to specific demographics are unlikely to be adapted and maintained by clinicians.

In response to this, PMCOT (Figure. 1) aims to offer a brief, uncomplicated multicultural model that can be used with diverse, multicultural populations and intersectionality, and be assimilated into current practices with relative ease and without competency protocols which account for little in the way of variance in change generally.

Figure.1



Discussion

Since multicultural competency presented on the horizon over 50 years ago, the idea of multicultural practice has been embraced at different levels by different disciplines and practitioners. Yet, the research literature is often ambivalent on its conceptualisation and effectiveness as it relates to diversity and the outcomes associated with care. At the same time, multicultural competency has scant evidence to support its consistent effectiveness. Inconsistencies have been demonstrated in the literature, with different studies having different outcomes and

practitioners not being consistent with its use as rated by clients

The present paper contributes to the extant literature in several ways. Firstly, it responds to Huey et al. (2014) call for a multicultural approach that is not overly complicated with excessive training regimes, competency-based protocols, and financial burdens. Secondly, it adds to the current body of knowledge in the multicultural arena by moving beyond the multicultural competency approach, adding a phased approach that can be used to identify and learn about clients multicultural identities. At the same time, PMCOT distils concepts already within the literature that have meta-analysis support for their individual effectiveness in multicultural domains and related practices.

Thirdly, one of the strengths of PMCOT is that it incorporates the evidence of multicultural factors that have shown to be effective and offers a mechanism to track and monitor whether these interventions are being helpful in the naturalistic setting. In light of the PMCOT process orientation, these tracking systems may be especially important for outcomes and the author hypotheses that it could be these aspects that give PMCOT predictive validity over some of its individual components. Finally, the use of measures of the alliance and outcome of care can assist practitioners in maintaining focus with multicultural issues that are important to clients; to repair ruptures in the alliance that may be caused by microaggressions, lack of cultural humility, or missed cultural opportunities.

The limitations of the present paper are concerned with the lack of primary data to understand if PMCOT is actually effective in clinical practice. Given that it is based on the most recent research trials, we can be confident that some aspects of the model will likely provide for effective multicultural therapy. However, the extent to which this would be more or less effective is unknown in the absence of primary data. Thus, future research may wish to study PMCOT within a clinical environment with primary data. In order to establish relative efficacy, a RCT with established active controls would need to be considered. The MCO model or the illness myth method would both individually be considered active controls and would provide data regarding the extent to which PMCOT may add value beyond these individual components. Furthermore, a dismantling study that removes different components of PMCOT is another possible methodology that may be considered, or indeed a relative effectiveness study with the multicultural competency approach.

Conclusion

This conceptual paper sought to address the gaps in multicultural practice by providing a model of multicultural therapy that will add to the existing literature in a meaningful way. Thus, PMCOT is a process-based model drawing on research from a meta-analysis in the multicultural domain and meta-analysis in other components of therapy that have demonstrated effectiveness. PMCOT adds to the competency skills and knowledge-based components by addressing the attitude and processes needed by effective multicultural practitioners. In doing so, PMCOT has at its heart a commitment to learn from the client and not about the client. This is demonstrated by the PMCOT model having in each component a feedback mechanism that seeks to understand the client's experience of an important cultural issue, their impact on their experience in therapy, and the outcomes associated with quality care. Thus, practitioners may wish to consider this model as a valid addition to their multicultural practices.

References

Allison, K. W., Echemendia, R. J., Crawford, I., & Robinson, W. L. (1996). Predicting cultural competence: Implications for practice and training. *Professional Psychology: Research and Practice, 27*(4), 386–393. https://doi-org.jproxy.nuim.ie/10.1037/0735-7028.27.4.386

Brattland, H., Koksvik, J. M., Burkeland, O., Gråwe, R. W., Klöckner, C., Linaker, O. M., Ryum, T., Wampold, B., Lara-Cabrera, M. L., & Iversen, V. C. (2018). The effects of routine outcome monitoring (ROM) on therapy outcomes in the course of an implementation process: A randomised clinical trial. *Journal of Counseling Psychology, 65*(5), 641–652. https://doi.org/10.1037/cou0000286

Hansen, N. D., Randazzo, K. V., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., Burke, C., Kershner-Rice, K., & Norvig, G. (2006). Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Professional Psychology: Research and Practice, 37*(1), 66–74. https://doi-org.jproxy.nuim.ie/10.1037/0735-7028.37.1.66

Cooper, M., Norcross, J. C., Raymond-Barker, B., & Hogan, T. P. (2019). Psychotherapy preferences of laypersons and mental health professionals: Whose therapy is it? *Psychotherapy*, 56(2), 205–216

Cooper, M., & Norcross, J. C. (2016). A brief, multidimensional measure of clients' therapy preferences: The Cooper-Norcross Inventory of Preferences (C-NIP). *International Journal of Clinical and Health Psychology, 16*(1), 87–98. https://doi.org/10.1016/j.ijchp.2015.08.003

Constantino, M. J., Coyne, A. E., Boswell, J. F., Iles, B. R., & Vîslă, A. (2018). A meta-analysis of the association between patients' early perception of treatment credibility and their posttreatment outcomes. *Psychotherapy (Chicago, Ill.), 55*(4), 486–495.

Constantino, M. J., Vîslă, A., Coyne, A. E., & Boswell, J. F. (2018). A meta-analysis of the association between patients' early treatment outcome expectation and their posttreatment outcomes. *Psychotherapy, 55*(4), 473–485.

Chu, J., Leino, A., Pflum, S., & Sue, S. (2016). A model for the theoretical basis of cultural competency to guide psychotherapy. *Professional Psychology: Research and Practice, 47*, 18-29.

Sue, D.W., Arredondo, P. and McDavis R.J. (1992), Multicultural Counseling Competencies and Standards: A Call to the Profession. *Journal of Counseling & Development,* 70: 477-486. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x

Sue, D.W, Sue S, (2013). *Counseling the Culturally Diverse: Theory and Practice,* 6th ed. John Wiley

Davis, D. E., DeBlaere, C., Owen, J., Hook, J. N., Rivera, D. P., Choe, E., Placeres, V. (2018). The multicultural orientation framework: A narrative review. *Psychotherapy, 55*(1), 89-100. http://dx.doi.org/10.1037/pst0000160

Dillon, F. R., Odera, L., Fons-Scheyd, A., Sheu, H.-B., Ebersole, R. C., & Spanierman, L. B. (2016). A dyadic study of multicultural counseling competence. *Journal of Counseling Psychology, 63*(1), 57–66. https://doi.org/10.1037/cou0000118

Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: A study of therapy dyads. *Psychotherapy*, 43, 480 – 490. http://dx.doi.org/ 10.1037/0033-3204.43.4.480

Holcomb-McCoy, C.C. and Myers, J.E. (1999), Multicultural competence and counselor training: A national survey. *Journal of Counseling & Development,* 77: 294-302. https://doi-org.jproxy.nuim.ie/10.1002/j.1556-6676.1999.tb02452.x

López S, Hernandez P. (1986).How culture is considered in evaluations of psychopathology. *J Nerv Ment Dis.* 174(10):598-606. PMID: 3760850.

Lambert, M. J., Whipple, J. L., & Kleinstäuber, M. (2018). Collecting and delivering progress feedback: A meta-analysis of routine outcome monitoring. *Psychotherapy, 55*(4), 520–537. https://doi.org/10.1037/pst0000167

Maxie, A. C., Arnold, D. H., & Stephenson, M. (2006). Do therapists address ethnic and racial differences in cross-cultural psychotherapy? *Psychotherapy: Theory, Research, Practice, Training, 43*(1), 85–98. https://doi-org.jproxy.nuim.ie/10.1037/0033-3204.43.1.85

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: a direct-comparison meta-analysis. *Journal of counseling psychology, 58*(3), 279–289. https://doi.org/10.1037/a0023626

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparison study of psychotherapy.* John Hopkins University Press.

Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing,* 27,210–217. http://dx.doi.org/10.1177/1043659615592677

Hayes, J. A., Owen, J., & Bieschke, K. J. (2015). Therapist differences in symptom change with racial/ethnic minority clients.*Psychotherapy*, 52, 308–314. http://dx.doi.org/10.1037/a0037957

Drinane, J. M., Owen, J., & Kopta, M. (2016). Racial/ethnic disparities in psychotherapy: Does the outcome matter? *Testing, Psychometrics, Methodology in Applied Psychology,* 23, 531–544.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 531–548. https://doi.org/10.1037/0033-3204.43.4.531

Gonsalvez CJ, Crowe TP, (2014).Evaluation of psychology practitioner competence in clinical supervision. *Am J Psychother;* 68:177–193

Pedersen, P. B. (2002). The making of a culturally competent Counselor. *Online Readings in Psychology and Culture, 10*(3). https://doi.org/10.9707/2307-0919.1093

Imel, Z. E., Baldwin, S., Atkins, D. C., Owen, J., Baardseth, T., & Wampold, B. E. (2011). Racial/ethnic disparities in therapist effectiveness: A conceptualization and initial study of cultural competence. *Journal of Counseling Psychology,* 58, 290–298. http://dx.doi.org/10 .1037/a0023284

Kim, B. S. K., & Atkinson, D. R. (2002). Asian American client adherence to Asian cultural values, counselor expression of cultural values, counselor ethnicity, and career counseling process. *Journal of Counseling Psychology,* 49, 3-13.

Owen, J., Jordan, T., Turner, D., Davis, D., Hook, J., & Leach, M. (2014). Therapists' multicultural orientation: Cultural humility, spiritual/religious identity, and therapy outcomes. *Journal of Psychology and Theology, 42,* 91-99.

Owen, J., Tao, K., Drinane, J., Hook, J., Davis, D., & Foo Kune, N. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice, 47, 30-37.*

Hook J.N., Davis D., Owen J., & DeBlaere, C. (2017). Cultural humility: Engaging diverse identities in therapy: *American Psychological Association.*

Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology,* 63, 269–277. http://dx .doi.org/10.1037/cou0000114

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O.(2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology,* 60, 353–366. http://dx.doi .org/10.1037/a0032595

Owen, J. (2013). Early career perspectives on psychotherapy research and practice: Psychotherapist effects, multicultural orientation, and couple interventions. *Psychotherapy*, 50, 496–502. http://dx.doi.org/10.1037/a0034617

Owen, J.J., Tao, K., Leach, M.M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy*, 48, 274–282. http://dx.doi.org/10.1037/a0022065

Owen, J., Tao, K. W., Drinane, J. M., Hook, J. N., Davis, D. E., & Kune, N. F. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *ProfessionalPsychology:ResearchandPractice,*47,30–37. http://dx.doi.org/10.1037/pro0000046

Norcross, J. C., & Lambert, M. J. (2011). Evidence-based therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (p. 3–21). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199737208.003.0001

Norcross, J. C., & Wampold, B. E. (2018). A new therapy for each patient: Evidence-based relationships and responsiveness. *Journal of clinical psychology, 74*(11), 1889–1906. https://doi.org/10.1002/jclp.2267

Norcross, J. C., & Wampold, B. E. (2019). Relationships and responsiveness in the psychological treatment of trauma: The tragedy of the APA Clinical Practice Guideline. *Psychotherapy, 56*(3), 391–399. https://doi.org/10.1037/pst0000228

Ratts MJ, Pedersen P, (2014).Counseling for multiculturalism and social justice: Integration, theory, and application, 4th ed. , *American Counseling Association*

Ratts MJ, Singh AA, Nassar-McMillan S, Butler, S.K. and McCullough, J.R.

(2016). Multicultural and social justice counselling competencies: Guidelines for the counseling profession. *J Multicult Couns Devel 44:28–48*

Swift, J. K., Callahan, J. L., Cooper, M., & Parkin, S. R. (2018). The impact of accommodating client preference in psychotherapy: A

meta-analysis. *Journal of Clinical Psychology, 74*(11), 1924–1937
Smith, T.B., Rodríguez, M.D. and Bernal, G. (2011), Culture. *J.Clin.Psychol.,*67:166-175. https://doi.org/10.1002/jclp.20757
Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counseling Psychology, 62*(3), 337–350. https://doi.org/10.1037/cou0000086
Wampold, B.E. (2015), How important are the common factors in psychotherapy? An update. *World Psychiatry,* 14: 270-277. https://doi.org/10.1002/wps.20238
Wampold, B. E., & Imel, Z. E. (2015). *Counseling and psychotherapy .The great psychotherapy debate: The evidence for what makes psychotherapy work (2nd ed.).* Routledge/Taylor & Francis Group.
Webb, C. A., DeRubeis, R. J., & Barber, J. P. (2010). Therapist adherence/ competence and treatment outcome: A meta-analytic review. *Journal of Consulting and Clinical Psychology,* 78, 200–211. http://dx.doi.org/10 .1037/a0018912
Watkins, C. E., Jr, Hook, J. N., Owen, J., DeBlaere, C., Davis, D. E., & Van Tongeren, D. R. (2019). Multicultural orientation in psychotherapy supervision: Cultural humility, cultural comfort, and cultural opportunities. *American journal of psychotherapy, 72*(2), 38–46.

Exploring the Feasibility and Acceptability of BRiTA's Individual and Online delivery

Nazanin Ahangari[1] Nigar G. Khawaja[1] & Dragos Ileana[2]

Building Resilience in Transcultural Australians (BRiTA) is a strength-based preventative program that facilitates the acculturation and resilience of migrants. This study explored the feasibility and acceptability of delivering the BRiTA program to culturally and linguistically diverse adults in an individual setting via an online platform, Zoom. Four adults participated in four weekly sessions of BRiTA in either English or Persian. Participants completed pre-and post-questionnaires assessing acculturation, resilience, and psychological well-being. They also provided feedback after every session and at the end of the program. Thematic analysis was used to interpret the qualitative data. A reliable change index was used to investigate pre-to-post change quantitatively. Findings supported the feasibility and acceptability of delivering BRiTA in an individual setting via Zoom and highlighted the strength and utility of the program. Participants demonstrated varying levels of change in acculturation, resilience, and psychological well-being. BRiTA's individual delivery via Zoom, implications and future research directions are discussed.

Keywords: *Acculturation, BRiTA Futures, Culture, Diversity, Prevention, Resilience.*

The cultural diversity in Australia has increased exponentially. Seven and a half million immigrants constituting 30% of the overall population, call Australia home (Australian Bureau of Statistics, 2019). These individuals are from almost 200 different ethnically and linguistically diverse groups (Department of Immigration and Border Protection, 2015). The Cultural and Linguistically Diverse (CALD) population in Australia refers to individuals, who themselves or their parents were born overseas, identify with a culture different from the mainstream, and speak a language that is different from English (Khawaja et al., 2013). The CALD population is composed of immigrants who enter Australia as immigrant or refugees and mostly settle well and contribute to Australian society.

Nonetheless, some CALD immigrants (term used in this paper to represent immigrants and refugees) experience acculturative stress, impacting their mental health and well-being (Driscoll & Torres, 2013). These mental health concerns get exacerbated if the CALD immigrants do not possess adaptive and non-avoidant coping strategies and personal resilience (Lumley et al., 2018). Therefore, there is a consensus to use preventative programs to enhance CALD adults' and children's acculturative experience and promote their well-being in the early stages of their journey (Frounfelker et al., 2020).

Acculturation and Acculturative Stress

All those who migrate to another country undergo an acculturation process unique to each person (Lee et al., 2020). It involves the newly arrived individuals going through psychological (behavioural, emotional, and cognitive) and cultural changes when exposed to the host and other cultural groups (Berry, 2005). Although most of the CALD immigrants adapt and acculturate well, around 15% of this population in Australia experience acculturative stress. Studies indicate that if acculturative stress exceeds their psychosocial resources to cope, their mental health becomes compromised (Minas et al., 2013; Silva et al., 2017) and can lead to the development of mental health difficulties such as Post-traumatic Stress Disorder (PTSD), anxiety and depression (Kartal & Kiropoulos, 2016; Spallek et al., 2015).

Corresponding Authors: Professor Nigar Gohar Khawaja[1], Nazanin Ahangari[1], Dragos Ileana[2].
School of Psychology & Counselling[1], Faculty of Health
Queensland University of Technology
O Block B wing, Rm 525
Ring Rd, Kelvin Grove, Qld 4059
Phone: 61 7 3138 4540
Fax: 61 7 3138 0486
Queensland Transcultural Mental Health Centre[2]
Running Head: BRiTA

Australian Counselling Research Journal ISSN1832-1135

Risk and Protective Factors

A set of risk factors exacerbate immigrants' acculturative stress due to language barrier (71%), separation from friends and family (43%), worries associated with families in their country of origin (57%), and being extraordinarily young or older (Alizadeh-Khoei et al., 2011; Ngwena, 2014). Other risk factors are structural and cultural barriers (Agrawal & Venkatesh, 2016). Structural barriers can be limited access to healthcare, psychosocial challenges, and financial limitations. In contrast, cultural barriers are composed of a lack of culturally sensitive services and interpreters, perceived discrimination, absence of materials in one's native language, and lack of knowledge about the hosting country (Disney & McPherson, 2020).

Nonetheless, some studies indicate that CALD immigrants are mentally and physically healthier than the host population and possess higher levels of resilience in response to their life stressors, which is a protective factor in their acculturation journey (Kennedy et al., 2015). Resilience is a dynamic multidimensional phenomenon resulting from interactions between social, neurological, and personality traits (Reich et al., 2010). Resilience can help CALD immigrants bounce back and overcome their challenging experiences and respond effectively and adaptively to stress (Hosseini et al. 2017). Considering that acculturative stress can result in some immigrants developing mental health difficulties, it is crucial to assist them through preventative interventions. To conceptualise such programs for CALD immigrants, their risk and protective factors must be acknowledged (Mitchelson et al., 2010).

Preventative Programs

Preventative programs are formulated to foster individuals' protective factors, thus delaying and reducing the potential for individuals to experience mental health difficulties (Amodeo et al., 2004). These programs enhance the protective factors, minimise risk factors, and reduce the future costs of providing secondary care interventions for difficulties that may become severe (Close et al., 2016). The same principles can be extended to the challenges that CALD immigrants experience through the process of settlement. Preventative programs focus on promoting CALD immigrants' and refugees' experiences of acculturation and resilience and lead to prolonged benefits for the individual and the society (Ehsan et al., 2020; Wu et al., 2018).

One of the evidence-based preventative group programs for CALD immigrants in Australia is Building Resilience in Transcultural Australians (BRiTA) (Mitchelson et al., 2010; Queensland Transcultural Mental Health Centre [QTMHC], 2010). BRiTA is an eight-module program developed in Australia by the Queensland Transcultural Mental Health Centre (QTMHC) to foster protective factors and minimise the effects of the risk factors in adults, adolescents, and children from CALD immigrant backgrounds (Lemerle & Prasad-Ildes, 2004). Further, this program uses a strength-focused approach and Cognitive Behavioural Theory principles to foster well-being, identify risk and protective factors, and increase self-reflection on cultural identity and the process of acculturation (Mitchelson et al., 2010; QTMHC, 2010). BRiTA attempts to reduce experiences of acculturative stress by fostering their resilience. Research indicates that CALD adults and adolescents who attend BRiTA experience enhancing their psychological well-being, resilience, and acculturation experiences (Khawaja & Ramirez, 2019). The eight modules (see Table one) can be delivered over eight weeks or in other flexible formats, such as four weeks or in a 2-day intensive workshop, to increase immigrants' accessibility to the program (Khawaja & Ramirez, in press).

Online Delivery

Most of the preventative programs offered to CALD individuals have been face-to-face. Nonetheless, online platforms are associated with easier accessibility of mental health services required and higher levels of self-disclosure, engagement, and activity within sessions (Feijt et al., 2020). In online sessions, clinicians found the experience of rapport building and progress to be homogenous to face-to-face delivery (Acierno et al., 2017). It is important to note that a qualitative study reported Zoom to be more beneficial for participants than the traditional method using face-to-face, telephone, or other platforms due to its ease of use, encryption, and cost-effectiveness (Archibald et al., 2019; O'Mahony et al., 2012). In particular, CALD immigrants and refugees reported online delivery as a beneficial method of accessing the support they require through a confidential platform (O'Mahony et al., 2012). Moreover, Choi et al. (2012) reported that delivering an internet-based intervention for CALD individuals can reduce the acuteness of their depressive symptoms when juxtaposed to the group receiving no intervention.

Group and Individual Delivery

Preventative programs are primarily delivered in face-to-face group-based settings, associated with experiencing "healing" through normalisation from hearing other individuals' narration of their difficulties within groups (Stige & Binder, 2017). According to the randomised controlled trial by Holgersen et al. (2020), group delivery is cost-effective, enhances an individual's psychosocial functioning, and reduces PTSD symptoms. Nonetheless, Strauss et al. (2015) found that nearly 75% of the participants experienced individual delivery as more beneficial than group delivery. Chouliara et al. (2020) reported that the perceived fear and experienced threat of receiving judgement from group members tend to prevent individuals from disclosing details of their experiences, making individual delivery more preferred. Moreover, allocating individuals to homogenous groups where they feel culturally and linguistically comfortable can be associated with long periods of being on a waitlist (Leiderman, 2020). Furthermore, problem-solving language barriers and involving interpreters can be facilitated more easily in individual settings (Jaeger et al., 2019).

Feasibility and Acceptability

As Australia faces an increase in the CALD population through humanitarian and non-humanitarian migration and becomes more culturally and linguistically diverse, a need for providing suitable and culturally competent services becomes of high importance for CALD populations (Geerlings et al., 2018; Kayrouz et al., 2017). Despite the documented benefits of the BRiTA program being successfully delivered in a face-to-face group setting, there is scarce evidence on other methods of providing this preventative program. Feasibility and acceptability

studies play a role in determining whether an intervention or program is fit for further testing and whether it would be acceptable to the target population and sustainable (Bowen et al., 2009). It is critical to examine the demand for the intervention and whether it can be delivered without any constraints as planned (Bowen et al., 2009). Thus, feasibility and acceptability studies tend to be the first step in evaluating a new intervention and set the scene for further pilot and effectiveness studies (Orsmond & Cohn, 2015).

Aims of the Study

The study aimed to assess the feasibility and acceptability of delivering BRiTA in an individual setting via Zoom. It examined whether the individual delivery via Zoom produced a Reliable Change (RC) in acculturation, resilience, and psychological well-being across participants, pre-to-post delivery. It was hypothesised that BRiTA's individual and online delivery would be acceptable and feasible and would predict changes across participants' acculturation, resilience, and psychological well-being over time. Qualitative data explored the participants' experiences and how the program could be further refined.

Methods

Design

Qualitative and quantitative methods were used (Creswell & Clark, 2017). The qualitative component explored the participant's experiences, which was deemed an essential element in studying the feasibility and acceptability of delivering the BRiTA program in a novel method (Yardley et al., 2015). Quantitative methods examined changes as a result of the program.

Participants

Four adults (one male and three females) residents of South-East Queensland participated in the study. Their age ranged from 22 to 55 (M = 36.25, SD = 14.86). Their stay in Australia ranged from 1.5 to 4.5 years (M = 2.75, SD = 1.32). One participant was married, while the others were single. Two participants had children. One participant was from Africa, while others were from the Middle East. One participant was a student, and one was a business operator. Two were professionals. Three were university graduates, and one had completed high school. All participants demonstrated adequate proficiency in English.

Measures

Demographic Form

A form collected data on participants' demographics such as gender, age, language spoken at home, religious and educational background, the reason for leaving their home country, number of years residing in Australia, occupation, marital status, visa, and financial situation.

Adult Acculturation and Resilience Scale (AARS)

AARS (Khawaja et al., 2014) measured the acculturation processes of CALD immigrants to Australia and was developed with the Australian CALD population. It consisted of three subscales: resilience (14 items), acculturation (11 items), and spirituality (five items). Participants scored on a Likert Scale of one (do not agree) to four (always agree) to items such as "I can find many ways to solve a problem". Total overall scores range from 30 to 120, where high scores reflect elevated levels of resilience concerning settling in a new country, acculturation and adaptation in Australia, and spirituality. AARS is effective with CALD individuals, has a good Cronbach Alpha value of .90, good test-retest reliability (.86), and divergent validity (Khawaja et al., 2014).

The Connor Davidson Resilience Scale (CD-RISC)

CD-RISC (Campbell-Sills & Stein, 2007) was utilised to investigate general resilience. It is an abbreviated version of the CD-RISC-25 which focuses on dimensions of resilience. It is composed of 10-items such as, "I tend to bounce back after illness or hardship", which the participants responded to on a Likert scale of zero (not true at all) to four (true nearly all of the time), with total scores ranging from zero to 40, with higher scores indicating higher levels of resilience (Connor & Davidson, 2003). CD-RISC is a unidimensional measure of resilience that has been validated across different countries, has a Cronbach's Alpha of .91, demonstrates good test-retest reliability, convergent and construct validity, and is successfully used cross-culturally (Coates et al., 2013; Notario-Pacheco et al., 2011).

Patient Health Questionnaire-2 (PHQ-2)

PHQ-2 (Kroenke et al., 2003) was administered to screen the participants' psychological well-being. This questionnaire is the shorter version of PHQ-9 and is composed of 2 items, such as "Feeling down, depressed, or hopeless", which participants scored on a zero (not at all) to three (nearly every day) Likert scale. Overall scores are the sum of both items and ranged from zero to six. The lower score indicates an absence of depression and a presence of well-being. This scale is used as a screener for depression and participants' psychological well-being. PHQ-2 has a robust internal consistency, as demonstrated by .7. Cronbach's Alpha value and good construct validity cross-culturally (Dadfar et al., 2019; Scoppetta et al., 2020).

Qualitative Prompts

The authors developed a semi-structured 6-item checklist that explored the participants' experiences of attending the program, what they found beneficial from the program and what they think could be improved (e.g. "What did you find helpful about today's session?")

Procedure

Ethical clearance and health and safety were obtained from the Health Department and the respective university. The QTHMC staff disseminated the information about the study among their consumers. Those who expressed an interest were recruited and informed about the study. Feasibility and acceptability studies do not require large sample sizes as they are not aimed at carrying out null hypothesis testing (Tickle-Degnen, 2013). Therefore, four participants were recruited. To determine participants' suitability for the study, the first and third author interviewed the participants via Zoom. Those CALD immigrants who met the inclusion criteria and not the exclusion criteria (serious mental health issues, such as Substance abuse, psychoses and suicidality) were recruited. Written informed

consents were obtained, and these suitable participants were informed of confidentiality and their ability to withdraw consent at any time. Participants completed the pre-delivery questionnaires and subsequently attended the eight modules of BRiTA (Table one) over four weeks in an individualised format on Zoom. The duration of each session was 120 minutes and was delivered in English or Persian by the first author. At the end of each session, participants completed the battery (excluding the demographic form) and responded to the first author's queries about the content and delivery of the sessions. Within a week after completing the program, participants attended another semi-structured telephone interview with the second author to provide feedback on their experience of attending the program, intending to reduce the interpretation bias. The first author kept a reflexive journal record of every session and met with the other authors every week to discuss potential process issues. Participants were debriefed upon the end of the program. The qualitative data were transcribed and prepared for the analysis.

Table 1

BRiTA Future's session details.		
Week	**Eight Modules**	**Rationale**
One	• Healthier and BRiTA Futures	Establishing foundations for the program and introducing the concept of risk factors, protective factors, and well-being.
	• A different and common journey: The migratory process	Increasing participant's awareness of the different stages of migration and associated emotions.
Two	• Building a new society: The meeting of cultures	Expand the understanding of culture and cultural identity as part of the acculturation process.
	• Challenges and strengths to bounce back: Resiliency	Increasing knowledge on resilience and coping strategies to manage adverse situations related to immigration and AS.
Three	• Weaving links: Social connectedness	Increase knowledge of social connectedness and its importance.
	• Communication: Steps to a better dialogue	To review ways of communicating and practicing cross-cultural communication.
Four	• Family: Evolving roles	Impact of immigration on the roles of men, women, and parents.
	• Intergeneration: Challenges for all	Increase awareness of participant's interpersonal challenges and acculturation across generations.

Data Analysis

Qualitative

The qualitative data obtained after every session and at the end of the program were analysed utilising Braun and Clarke's (2006) six steps of conducting a thematic analysis. The first author familiarised herself with the data, ensuring a continuous and prolonged engagement with the data while recording personal reflections, generating codes, organising and conceptualising themes, reviewing themes, defining themes, and producing the analysis (Braun & Clarke, 2006). The trustworthiness criteria by Lincoln and Guba (1985) and Nowell et al. (2017) were followed. To achieve credibility, the study ensured triangulation in qualitative data collection (e.g. internal and external interviews, reflexive journal, observations), had prolonged engagement with the participants for five to eight weeks, consistent recording of observations, reflections, and sharing the interpretations with participants, as well as regular consultations with the second author (Lincoln & Guba, 1985; Nowell et al., 2017). Transferability was achieved by providing a "thick description". Dependability was ensured by utilising the code-re-code strategy and triangulation (analyst and data collection). Confirmability was attained by having an audit trail of keeping the original data, preparing transcripts, keeping a reflexive journal (containing author's external dialogues, objective observations, internal affective experiences as a researcher, and their values), and referencing participants so their quotes could be traced back to the interviews. Following all of the steps outlined by Braun and Clark (2006), the first and second author identified a number of primary and secondary themes.

Reflexivity

All authors were from CALD backgrounds. The authors actively reflected on their own experiences of acculturation and how being a bilingual (fluent in English and other languages) international student or migrants from the Middle East, South Asia, and Eastern European background could influence the interpretation of the data. Thus, the first author kept a reflexive journal about their experiences and interpretation of the data. Moreover, prolonged proximity to the data was maintained, the code-re-code strategy and analyst triangulation were utilised, to minimise the potential bias in interpreting the qualitative data by the author.

Quantitative

The participants' pre- and post-responses to the acculturation, resilience, and psychological well-being measures were used to examine reliable change (Guhn et al., 2014). Reliable Change Index (RCI) was calculated using Jacobson and Truax's (1991) four steps of calculating the RCI, as seen in Table 2. The total pre- and post-scores were then compared to existing normative data.

Table 2

Outlining the RCI approach to calculating clinical change pre-to-post delivery		
Step	**Step**	**Formula**
One	Calculating Standard Error of Measurement	SEM = s$\sqrt{1-rxx}$
Two	Calculating Standard difference between pre-and-post scores	SDIFF = $\sqrt{2}$(SEM 2)

Three	Calculating the difference scores between pre-to-post measurements	Diff = xt1 -xt2
Four	Calculating the clinical change using the RCI index formula	RC= xt1 -xt2 /SDIFF

Note: RCI = Reliable Change Index.

Results

Qualitative Findings

Table 3

Identified primary and secondary themes through thematic analysis.		
Theme	**Primary**	**Secondary**
One	Acceptability of BRiTA's individual delivery	• Confidentiality and provision of a safe space in an individualised setting. • The importance of keeping a balance between individual and group delivery. • The organisation of the program and potential modifications.
Two	Feasibility of BRiTA's delivery	• Attendance in the comfort of my home via Zoom, individually.
Three	BRiTA fostering reflection, normalisation, and processing	

Acceptability of BRiTA's Individual Delivery through Zoom

Confidentiality and Provision of a Safe Space in an Individualised Setting

Participants supported the individualised and online delivery of the sessions via Zoom. This delivery method was found to be acceptable as it enabled participants to understand the program's content through flexible means and in a safe space. Being in a safe space enabled them to reflect on and share their personal experiences, which allowed a higher level of engagement with the program's content and strengthened their understanding of acculturation and adaptation to the Australian cultures. For instance, participant one stated, "some cultures are concerned about their image which makes them not share the things they feel. In individual setting, there is less judgement". Further, this mode of one-on-one delivery eliminated the fear of judgement by other community members. It reduced the perceived possibility of breaching confidentiality, which is often a concern in group settings. For example, participant four shared "individual (setting) may be good. Trust may be built easier." This may have indicated that the non-judgemental safe space and established trust allowed participants to explore and process their experiences of acculturation at a deeper and more personal level. Thus, it was evident that individualised and online delivery of BRiTA was an acceptable delivery method across all participants.

The Importance of Keeping a Balance Between Individual and Group Delivery

Despite strongly supporting the individualised delivery of BRiTA, all participants recognised the value of delivering this program in a group setting. They saw the value in amalgamating individual and group delivery by emphasising that certain activities and contents could be better understood within a group setting. It would foster social connectedness and facilitate normalisation and externalisation of acculturation stress. There was a consensus that modules focused on the evolving roles of families and acculturation are best suited for a group setting. Participant three shared, "people could get support and encouragement and understand that it's normal to feel like this", and participant two corroborated this comment by stating, "the program could work in a small group version of four people, to be able to learn from each other, therapeutically". Likewise, participant four emphasised the importance of fostering hope in group settings "group allows getting opinions from different people, having different experiences, and get to know more people and hear different stories which may give hope". A combination of group and individual format was recognised as valuable.

The Organisation of the Program and Potential Modifications

All participants reported that the BRiTA program's sessions covered the content gradually in a meaningful manner. According to participant one, "the sessions have good orders, it goes slowly and doesn't jump over topics which is good". Thus, emphasising the importance of gradual exposure to the content covered in the program. Participants suggested that BRiTA's content can be adapted in future to suit the needs of an individual's specific cultural background and status of voluntary or involuntary immigration. For instance, participant one reported, "the content can be modified to match the person's current lifelike, I have a job, I have been here for a number of years, single, no kids". Similarly, participant two reported that "different versions of the program would be good, for example, specifically for refugees". Therefore, it was suggested that content could be modified or components could be selected consistent with the participant's stage in their journey of acculturation and background.

Feasibility of BRiTA's Delivery

Attendance and Accessibility in the Comfort of My Home via Zoom

Participants attended all sessions. Zoom increased the accessibility to the program by enhancing the participants' ability to participate in the program after work hours or between domestic and work commitments. It also saved financial resources by limiting travel costs and time. For instance, participant one highlighted these merits by stating, "my work and life are busy, so attending the session online reduces the movement time between appointments". Similarly, participant four emphasised the importance of having online delivery when having multiple commitments "Zoom is better for very busy people. To be honest, I don't think I could come for five weeks if it was in person". Also, all participants reported that online delivery through Zoom did not impact the author's level of connection and rapport building.

Participant three stated, "I feel comfortable with Zoom and the two-way communication", indicating that individual and online delivery via Zoom did not impact the quality of the relationship that the facilitators often establish in a one-to-one setting.

BRiTA Fostering Reflection, Normalisation, and Processing

All participants found the experience of attending the program positive, beneficial, and therapeutic. The content of the program helped them understand their journey of acculturation. The information provided enabled them to incorporate new learnings and skills into life outside of sessions, which was deemed therapeutic for their well-being. Participant two reported, "the program was a good journey of reflecting over the past, and I could relate to the stages discussed in the program like the honeymoon period and acculturation". Moreover, participant four acknowledged that the experiences explored in the BRiTA program were a common experience for immigrants - "the experience is something that I have gone through, and it was good to learn about it". Participants also reported reflecting on their cultural identity and values outside of sessions. For instance, participant two reported, "I was thinking of what you said in the session last week. It made me feel better because I tried to accept my feelings and turn it into a positive experience". According to participant one, "it was good to reflect on my culture and what is good/bad about my culture", thus highlighting the therapeutic values of the BRiTA program.

Acculturation

As shown in Table 4, AARS pre-delivery scores for all participants were above the normative mean score (M = 88.57) for CALD individuals within Australia (Khawaja et al., 2014). Participant two demonstrated a significant RC post-delivery (RCI = -2.42 > 1.96). Participant three (RCI = 1.77 < 1.96) and four (RCI = 1.13 < 1.96) experienced a decline in their acculturation score, which did not meet the threshold for an RC (Table 5). As seen in Table 4 and 5, participant one exhibited a minimal change in their acculturation scores which was not an RC over time (RCI = -.32 < 1.96).

Resilience

As illustrated in Table four, all participants' levels of resilience were above the normative mean (M = 32.0) range (Chamberlain et al., 2016). As seen in Table five, participant one (RCI = .15 < 1.96) and two (RCI = -.61 < 1.96) experienced an incline in their scores of resilience. However, they did not meet the threshold for RC. Participants three (RCI = .45 < 1.96) and four (RCI = .61 <1.96) both experienced a decline in their resilience score, which did not meet the threshold for an RC.

Psychological Well-being

According to Table 4, all participant's pre-and post-scores were below the level of community mean for the psychological well-being scale (M = 2.1), indicating higher levels of well-being (Boyle et al., 2011). As seen in Table 5, an RC in participant one's psychological well-being was found (RCI = 3.12 > 1.96). Participant two experienced a decline in their score post-delivery. However, this change did not meet the threshold for an RC (RCI = 1.56 < 1.96). According to Table 5, participant three (RCI = .0 < 1.96) and four (RCI = .0 < 1.96) did not demonstrate a RC pre and post-delivery of the program.

Table 4

Acculturation, Resilience and Well-being (pre and post-delivery scores.)			
Participants	**Acculturation**	**Resilience**	**Well-being**
1	100(102)	37(38)	2(0)
2	89(104)	34(38)	1(0)
3	114(103)	36(33)	0(0)
4	112(105)	40(36)	0(0)

Note: Post-delivery scores are in the paratheses.

Table 5

Reliable Change in AARS, CD-RISC, and PHQ-2 for participants through RCI.				
Participants	**AARS**	**CD-RISC**	**PHQ-2**	**RCI**
A	-.32	.15	3.12*	PHQ-2 Improved
B	2.42*	.61	1.56	AARS Improved
C	1.77	.45	.0	No change
D	1.13	.61	.0	No change

Note: * RCI>1.96 indicating a Reliable Change.

Discussion

A combination of qualitative and quantitative methods examined the acceptability and feasibility of the BRiTA program when used in an individual setting via an encrypted and confidential platform, Zoom. Qualitative findings supported the feasibility of this delivery method as the program was delivered as planned previously without any constraints. Qualitative findings supported the acceptability of this delivery method through having a consistent level of attendance, no dropouts, and high levels of engagement. However, not all participants experienced a reliable change in their experiences of acculturation, levels of resilience, nor psychological well-being, pre-to-post delivery. Overall, the study supported the implementation of a preventative program to enhance the acculturation and resilience of CALD immigrants.

Individual Delivery Via Zoom

Feasibility

The findings indicated that the BRiTA program could be delivered in an individualised and online setting without significant challenges. The format of delivery helped maintain attendance and prevented dropouts. Consistent with previous research (Archibald et al., 2019; O'Mahony et al., 2012), online delivery was associated with better ease of access and cost-effectiveness in CALD adults and ran without significant complications. Congruent with previous research conducted by Acierno et al. (2017), rapport building and the quality of the therapeutic relationship on an online platform was as effective as that observed in face-to-face delivery format. Participants did not identify barriers towards the delivery of the program via Zoom for

either rapport building and therapeutic alliance.

Acceptability

The qualitative data obtained indicated that participants found the experience of attending the BRiTA program individually and online beneficial and therapeutic. Protected space within their home environments, where they could attend the program via Zoom, was valued. Consistent with the previous research (Chouliara et al., 2020), delivery in an individualised setting provided participants with a safe space to express their thoughts, and explore and process their cultural strength, without the fear of receiving judgement for expressing potential weaknesses in the presence of individuals from their community. Interestingly, consistent with Türk et al.'s (2019) findings, participants recognised the benefits of group format and recommended mixing individual and group delivery formats. Further, participants emphasised the need for the BRiTA program's content to be refined to suit the needs of a CALD consumer's background. This may indicate that the program's acceptability could be further enhanced if there is an amalgam of individual and group delivery, with a greater focus on the individual's particular background.

Acculturation, Resilience, and Psychological Well-Being

The quantitative data revealed mixed results. Scores of two participants improved, while those of the other two decreased. Nonetheless, all participants possessed higher levels of acculturation, resilience, and psychological well-being when compared to the community sample at both the baseline and post-delivery of the program.

The increases in the scores reflected better acculturation and adaptation to the Australian culture, which supports the content in BRiTA's modules and its impacts on enhancing individuals' protective factors. These findings were congruent to previous research indicating that the delivery of BRiTA enhances participants' experience of acculturation and resilience (Khawaja & Ramirez, 2019; Mitchelson et al., 2010). Moreover, the demonstrated improvement in half of the participants may also indicate that they had been engaging in more positive and adaptive coping strategies introduced by the BRiTA program's modules. Further, they were also utilising their cultural and personal strengths and building positive relationships with other individuals (Khawaja & Ramirez, 2019). These improvements were potential indicators of adapting further to the Australian culture after attending the BRiTA program.

It is suggested that the lack of demonstrated improvement in the other half of the participants' scores may not have been correlated to the delivery of the program. For instance, some participants had been in Australia for more than two years, experienced financial stability, had an adequate level of education and security in their life, and were potentially acculturated with good personal resources. Thus, the participants may have learnt and adopted some of the concepts introduced in the program through their journey of acculturation. As a result, the lack of improvement was due to them already possessing high levels of acculturation and resilience, regardless of their attendance of the program. Further, participants' age may also be a predicting factor. The youngest and the oldest participant demonstrated a lack of improvement in their scores, indicating that they may have been exposed to more psychosocial stressors congruent with past research (Alizadeh-Khoei et al., 2011).

Implications

This study had theoretical and practical implications for the literature. Firstly, the study highlights the significance of the preventative intervention. The data indicated that BRITA could be utilised with newly arrived immigrants to enhance their psychological well-being. Further, the combination of qualitative and quantitative data provided different sources of information on CALD adults' experiences of attending the individual and online delivery of BRiTA. Moreover, this study provided preliminary evidence for the feasibility and acceptability of delivering BRiTA to CALD immigrants in an individual and online setting as a new delivery method that could improve the accessibility and attendance of CALD immigrants to the preventative help that they need within the community. The program was also offered to one participant in her native language, Persian, which suggests that individual delivery, online, in a language other than English is also feasible and acceptable. Moreover, suggestions provided by participants indicate that individual delivery can be combined with group delivery if required by facilitators in the future. The program also helped consolidate and normalise CALD immigrants' challenges and experiences of acculturation, which positively impacted their well-being.

Limitations and Future Directions

This study exhibited a few limitations. The study's participants were already highly acculturated and high functioning individuals and may represent a subsection of CALD immigrants. Moreover, the sample size was not equally balanced across genders. Therefore results should be taken with caution. Future studies should recruit a diversity of gender group of CALD immigrants from different communities. The sample was recruited only in Queensland. Future studies should expand to other states at a national level. This study only measured RC pre-to-post treatment without any follow-ups. Studies in the future can employ a longitudinal design to continue with follow-ups six months and 12 months after the provision of the program to assess whether the changes persist, as acculturation is a dynamic construct. The study lacked a comparison group of delivering in an individual setting via Zoom and face-to-face. Therefore, future studies may deliver the program in an individual setting face-to-face to further the literature. The participants all had an adequate level of English proficiency.

Nonetheless, their levels of fluency were different, impacting their interpretation and understanding of the questions. Future studies would benefit future studies to use translations of the questionnaires to prevent any potential language barriers. Lastly, as this was a preliminary feasibility and acceptability study, future research should focus on recruiting a larger sample size to replicate this study, followed by conducting more rigorous studies to evaluate the effectiveness of this method of delivery for a preventive program such as BRiTA.

Conclusion

The preliminary findings support the feasibility and acceptability of delivering BRiTA in an individual setting via Zoom.

It opens further options of accessing preventative programs in a range of settings. BRITA has emerged as a promising program to promote CALD immigrants' psychological well-being and integration into Australian society.

Conflict of Interest

There are no conflicts of interest.

Ethical Standards

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

Acknowledgements

The authors would like to thank Queensland Transcultural Mental Health Centre staff for their support with the execution of the program and the participant for their participation.

References

Acierno, R., Knapp, R., Tuerk, P., Gilmore, A. K., Lejuez, C., Ruggiero, K., Muzzy, W., Egede, L., Hernandez-Tejada, M., A., Foa, E. B. (2017). A non-inferiority trial of Prolonged Exposure for post-traumatic stress disorder: In person versus home-based telehealth. *Behaviour Research and Therapy, 89*(1), 57–65. https://doi.org/10.1016/j. brat.2016.11.009

Agrawal, P., & Venkatesh, A. K. (2016). Refugee resettlement patterns and state-level health care insurance access in the United States. *American Journal of Public Health, 106*(4), 662–663. https://doi.org/10.2105/AJPH.2015.303017

Alizadeh-Khoei, M., Mathews, R. M., & Hossain, S. Z. (2011). The role of acculturation in health status and utilisation of health services among the Iranian elderly in metropolitan Sydney. *Journal of Cross-Cultural Gerontology, 26*(4), 397-405. https://doi.org/ 10.1007/s10823-011-9152-z

Amodeo, M., Peou, S., Grigg-Saito, D., Berke, H., Pin-Riebe, S., & Jones, L. K. (2004). Providing culturally specific substance abuse services in refugee and immigrant communities: Lessons from a Cambodian treatment and demonstration project. J*ournal of Social Work Practice in the Addictions, 4*(3), 23-46. https://doi.org/10.1300/J160v04n03_03

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using Zoom videoconferencing for qualitative data collection: perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods, 18(1),* 1-8. https://doi.org/10.1177/1609406919874596

Australian Bureau of Statistics [ABS]. (2019). *Migration, Australia, 2018–19.* Australian Bureau of Statistics. Retrieved from https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3412.0Main+Features12018-19?OpenDocument

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations, 29*(6), 697–712. https://doi.org/10.1016/j.ijintrel.2005.07.013

Bowen, D. J., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., Weiner, D., Bakken, S., Kaplan, C. P.,Squires, L., Fabrizio, C., & Fernandez, M. (2009). How we design feasibility studies. *American Journal of Preventive Medicine, 36*(5), 452-457. https://doi.org/10.1016/j.amepre.2009.02.002

Boyle, L. L., Richardson, T. M., He, H., Xia, Y., Tu, X., Boustani, M., & Conwell, Y. (2011). How do the phq-2, the phq-9 perform in aging services clients with cognitive impairment?. *International Journal of Geriatric Psychiatry, 26*(9), 952-960. https://doi.org/10.1002/gps.2632

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Campbell-Sills, L., & Stein, M. B. (2007). Psychometric analysis and refinement of the Connor-Davidson Resilience Scale (CD-RISC): Validation of a 10-item measure of resilience. *Journal of Traumatic Stress, 20,* 1019 –1028. https://doi.org/10.1002/jts.20271

Chamberlain, D., Williams, A., Stanley, D., Mellor, P., Cross, W., & Siegloff, L. (2016). Dispositional mindfulness and employment status as predictors of resilience in third year nursing students: A quantitative study. *Nursing Open, 3*(4), 212-221. https://doi.org/10.1002/nop2.56

Choi, I., Zou, J., Titov, N., Dear, B. F., Li, S., Johnston, L., Andrews, G., & Hunt, C. (2012). Culturally attuned Internet treatment for depression amongst Chinese Australians: A randomised controlled trial. *Journal of Affective Disorders, 136*(3), 459-468. https://doi.org/10.1016/j.jad.2011.11.003

Chouliara, Z., Karatzias, T., Gullone, A., Ferguson, S., Cosgrove, K., & Burke Draucker, C. (2020). Therapeutic change in group therapy for interpersonal trauma: A relational framework for research and clinical practice. *Journal of Interpersonal Violence, 35*(15-16), 2897-2916. https://doi.org/10.1177/0886260517696860

Close, C., Kouvonen, A., Bosqui, T., Patel, K., O'Reilly, D., & Donnelly, M. (2016). The mental health and well-being of first-generation migrants: A systematic-narrative review of reviews. *Globalisation and Health, 12*(1), 1-13. https://doi.org/10.1186/s12992-016-0187-3

Coates, E. E., Phares, V., & Dedrick, R. F. (2013). Psychometric properties of the Connor-Davidson Resilience Scale 10 among low-income, African American men. *Psychological Assessment, 25*(4), 1349-1354. https://doi.org/10.1037/a0033434

Connor, K. M., & Davidson, J. R. T. (2003). Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety, 18*(1), 76 – 82. https://doi.org./10.1002/da.10113

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research.* Sage publications.

Dadfar, M., Salabifard, S., Dadfar, T., Roudbari, M., & Moneni Safarabad, N. (2019). Validation of the Patient Health Questionnaire-2 with Iranian students. *Mental Health, Religion & Culture, 22*(10), 1048-1056. https://doi.org/10.1080/13674676.2019.1699042

Department of Immigration and Border Protection (2015). *Migration programme statistics.* Australian Government. Retrieved from http://www.immi.gov.au/ media/statistics/pdf/report-migration-programme-2013–14.pdf

Disney, L., & McPherson, J. (2020). Understanding Refugee Mental Health and Employment Issues: Implications for Social Work Practice. *Journal of Social Work in the Global Community, 5*(1), 19-30. https://doi.org/10.5590/JSWGC.2020.05.1.02

Driscoll, M. W., & Torres, L. (2013). Acculturative stress and Latino depression: The mediating role of behavioral and cognitive resources. *Cultural Diversity and Ethnic Minority Psychology, 19*(4), 373-382. https://doi.org/10.1037/a0032821

Ehsan, A., Bolano, D., Guillaume-Boeckle, S., & Spini, D. (2020). Reducing loneliness in older adults: looking at locals and migrants in a Swiss case study. *European Journal of Ageing,* 1-12. https://doi.org/10.1007/s10433-020-00577-4

Feijt, M., de Kort, Y., Bongers, I., Bierbooms, J., Westerink, J., & IJsselsteijn, W. (2020). Mental Health Care Goes Online: Practitioners' Experiences of Providing Mental Health Care During the COVID-19 Pandemic. *Cyberpsychology, Behavior, and Social Networking, 00,* 1-8. https://doi.org/10.1089/cyber.2020.0370

Frounfelker, R. L., Miconi, D., Farrar, J., Brooks, M. A., Rousseau, C., & Betancourt, T. S. (2020). Mental Health of Refugee Children and Youth: Epidemiology, Interventions, and Future Directions. *Annual Review of Public Health, 41*(1), 159-176. https://doi.org/10.1146/annurev-publhealth-040119-094230

Geerlings, L. R., Thompson, C. L., Bouma, R., & Hawkins, R. (2018). Cultural competence in clinical psychology training: A qualitative investigation of student and academic experiences. *Australian Psychologist, 53*(2), 161-170. https://doi.org/10.1111/ap.12291

Guhn M., Forer B., & Zumbo B.D. (2014) Reliable Change Index. In: Michalos A.C. (Eds.) *Encyclopedia of Quality of Life and Well-Being Research.* Springer.

Holgersen, K. H., Brønstad, I., Jensen, M., Brattland, H., Reitan, S. K., Hassel, A. M., Arentz, M., Lara-Cabrera, M., & Skjervold, A. E. (2020). A combined individual and group-based stabilisation and skill training intervention versus treatment as usual for patients with long lasting posttraumatic reactions receiving outpatient treatment in specialised mental health care–a study protocol for a randomised controlled trial. *Trials, 21*(1), 432-445. https://doi.org/10.1186/s13063-020-04297-z

Hosseini, A., Kakuma, R., Ghazinour, M., Davern, M., Evans, W. P., & Minas, H. (2017). Migration experience, resilience and depression: A study of Iranian immigrants living in Australia. *International Journal of Culture and Mental Health, 10*(1), 108-120. https://doi.org/10.1080/17542863.2016.1270977

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12–19. https://doi.org/10.1037/0022-006X.59.1.12

Jaeger, F. N., Pellaud, N., Laville, B., & Klauser, P. (2019). The migration-related language barrier and professional interpreter use in primary health care in Switzerland. *BMC Health Services Research, 19*(1), 429-439. https://doi.org/10.1186/s12913-019-4164-4

Kartal, D., & Kiropoulos, L. (2016). Effects of acculturative stress on PTSD, depressive, and anxiety symptoms among refugees resettled in Australia and Austria. *European Journal of Psychotraumatology, 7*(1), 28711-28723. https://doi.org/10.3402/ejpt.v7.28711

Kayrouz, R., Senediak, C. I., & Laube, R. (2017). Building a bridge: A case report on communicating mental-health diagnoses to patients of a culturally and linguistically diverse background. *Australasian Psychiatry, 25*(5), 478–480. https://doi.org/10.1177/1039856217726685

Kennedy, S., Kidd, M. P., McDonald, J. T., & Biddle, N. (2015). The healthy immigrant effect: patterns and evidence from four countries. *Journal of International Migration and Integration, 16*(2), 317-332. https://doi.org/10.1007/s12134-014-0340-x

Khawaja, N. G., & Ramirez, E. (2019). Building resilience in transcultural adolescents: An evaluation of a group program. *Journal of Child and Family Studies, 28*(11), 2977-2987. https://doi.org/10.1007/s10826-019-01473-x

Khawaja, N. G., & Ramirez, E. (in press). Building resilience in transcultural adults: An evaluation of a group program. *Australian Psychologists*

Khawaja, N. G., McCarthy, R., Braddock, V., & Dunne, M. (2013). Characteristics of culturally and linguistically diverse mental health clients. *Advances in Mental Health, 11*(2), 172–187. https://doi.org/10. 5172/jamh.2013.11.2.172

Khawaja, N. G., Moisuc, O., & Ramirez, E. (2014). Developing an acculturation and resilience scale for use with culturally and linguistically diverse populations. *Australian Psychologist, 49*(3), 171-180. https://doi.org/10.1111/ap.12052

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. *Medical Care, 41*(11), 1284-1292. https://doi.org/10.1097/01.MLR.0000093487.78664.3C

Lee, R. M., Titzmann, P. F., & Jugert, P. (2020). Towards a more dynamic perspective on acculturation research In P. F. Titzmann & P. Jugert (Eds.). *Youth in multicultural societies: New directions for future research and interventions* (pp. 74-91). Psychology Press. https://doi.org/10.4324/9781351040266-6

Leiderman, L. M. (2020). Psychodynamic group therapy with hispanic migrants: Interpersonal, relational constructs in treating complex trauma, dissociation, and enactments. *International Journal of Group Psychotherapy, 70*(2), 162-182. https://doi.org/10.1080/00207284.2019.1686704

Lemerle, K. & Prasad-Ildes, R. (2004). *Final report on the development and pilot of the 'BRiTA' Program: Building resilience in transcultural adolescents.* Brisbane: Queensland Transcultural Mental Health Centre.

Lincoln, Y., & Guba, E. G. (1985). Naturalistic inquiry. Newbury Park, CA: Sage.

Lumley, M., Katsikitis, M., & Statham, D. (2018). Depression, anxiety, and acculturative stress among resettled Bhutanese refugees in Australia. *Journal of Cross-Cultural Psychology, 49*(8), 1269-1282. https://doi.org/10.1177/0022022118786458

Minas, H., Kakuma, R., San Too, L., Vayani, H., Orapeleng, S., Prasad-Ildes, R., Turner, G., Procter, N., & Oehm, D. (2013). Mental health research and evaluation in multicultural Australia: developing a culture of inclusion. *International Journal of Mental Health Systems, 7*(1), 23.-48. https://doi.org/10.1186/1752-4458-7-23

Mitchelson, M. R., Erskine, H. E., Ramirez, E., Suleman, F.,

Prasad-Ildes, R., Siskind, D., & Harris, M. (2010). BRiTA Futures: A resilience-building program for children and young people from culturally and linguistically diverse backgrounds–Program description and preliminary findings. *Advances in Mental Health, 9*(3), 243-254. https://doi.org/10.5172/jamh.9.3.243

Ngwena, J. (2014). Black and minority ethnic groups (BME) suicide, admission with suicide or self-harm: An inner-city study. *Journal of Public Health, 22*(2), 155-163. https://doi.org/10.1007/s10389-013-0600-9

Notario-Pacheco, B., Solera-Martínez, M., Serrano-Parra, M. D., Bartolomé-Gutiérrez, R., García-Campayo, J., & Martínez-Vizcaíno, V. (2011). Reliability and validity of the Spanish version of the 10-item Connor-Davidson Resilience Scale (10-item CD-RISC) in young adults. *Health and Quality of Life Outcomes, 9*(1), 63. https://doi.org/10.1186/1477-7525-9-63.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16*(1), 1-13. https://doi.org/10.1177/1609406917733847

O'Mahony J.M., Donnelly T.T., Bouchal S.F. & Este D. (2012) Barriers and facilitators of social supports for immigrants and refugee women coping with postpartum depression. *Advances in Nursing Science, 35*(3), 42–56. https://doi.org/10.1097/ANS.0b013e3182626137

Orsmond, G. I., & Cohn, E. S. (2015). The distinctive features of a feasibility study: Objectives and guiding questions. *OTJR: occupation, participation and health, 35*(3), 169-177. https://doi.org/10.1177/1539449215578649

Queensland Transcultural Mental Health Centre [QTMHC] (2010). *BRiTA Futures Building Resilience in Transcultural Australians Program Report.* Queensland Government: Brisbane. https://metrosouth.health.qld.gov.au/qtmhc/programs-and-services/brita-futures

Reich, J. W., Zautra, A. J., & Hall, J. S. (Eds.). (2010). *Handbook of adult resilience.* Guilford Press.

Scoppetta, O., Cassiani-Miranda, C. A., Arocha-Díaz, K. N., Cabanzo-Arenas, D. F., & Campo-Arias, A. (2020). Validity of the Patient Health Questionnaire-2 (PHQ-2) for the Detection of Depression in Primary Care in Colombia. *Journal of Affective Disorders, 278*(1), 576-582. https://doi.org/10.1016/j.jad.2020.09.096

Silva, N. D., Dillon, F. R., Verdejo, T. R., Sanchez, M., & De La Rosa, M. (2017). Acculturative stress, psychological distress, and religious coping among Latina young adult immigrants. *The Counseling Psychologist, 45*(2), 213-236. https://doi.org/10.1177/0011000017692111

Spallek, J., Reeske, A., Norredam, M., Nielsen, S. S., Lehnhardt, J., & Razum, O. (2015). Suicide among immigrants in Europe - a systematic literature review. *The European Journal of Public Health, 25*(1), 63-71. https://doi.org/10.1093/eurpub/cku121

Stige, S. H., & Binder, P. E. (2017). From painstaking work to a new way of meeting the world—Trauma clients' experiences with skill training in a stabilisation group approach. *Psychotherapy Research, 27*(5), 571-582. https://doi.org/10.1080/10503307.2016.1138335

Strauss, B., Spangenberg, L., Brähler, L., & Bormann, B. (2015). Attitudes towards (psychotherapy) groups: Results of a survey in a representative sample. *International Journal of Group Psychotherapy, 65*(3), 410–430. https://doi.org/10.1521/ijgp_2014_64_001

Tickle-Degnen, L. (2013). Nuts and bolts of conducting feasibility studies. *American Journal of Occupational Therapy, 67*(2), 171-176. https://doi.org/10.5014/ajot.2013.006270

Türk, D. (2019). Combined and parallel individual and group therapy—still a red rag?. *Group Analysis, 52*(3), 313-329. https://doi.org/10.1177/0533316419849503

Wu, Q., Ge, T., Emond, A., Foster, K., Gatt, J. M., Hadfield, K., Mason-Jones, A. J., Reid, S., Theron, L., Ungar, M., & Wouldes, T. A. (2018). Acculturation, resilience, and the mental health of migrant youth: A cross-country comparative study. *Public Health, 162*(1), 63-70. https://doi.org/10.1016/j.puhe.2018.05.006

Yardley, L., Ainsworth, B., Arden-Close, E., & Muller, I. (2015). The person-based approach to enhancing the acceptability and feasibility of interventions. *Pilot and Feasibility Studies, 1*(1), 37-44. https://doi.org/10.1186/s40814-015-0033-z