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# Editorial

**Volume 16, Issue 1 - 2022. Dr Ann Moir-Bussy**

Welcome to our first issue of the Australian Counselling Research Journal for 2022. We are slightly later than usual. Mainly because of the ongoing pandemic and flu outbreaks.

This issue has focused on five diverse areas covering multicultural counselling, climate-informed practice, social support for counsellors recovering from substance abuse, communication with End-of-Life persons and families, and male-friendly therapy and masculinity.

Competency in multicultural counselling is essential in Australia, where such huge diversity exists. Gonzales, Popis, Smith and Antezana from Murdoch University present a comprehensive research study with Australian Counsellors and psychologists, examining their perceived multicultural counselling competency. The study confirmed that the counsellors' experience influenced multicultural competence levels. In addition, those from a multicultural background and who spoke more than one language outperformed those from a single cultural background.

Beel, Brownlow, Jeffries and Preez provide results of their research into male-friendly therapy and masculinity after interviewing 15 Australian male-friendly therapists in a qualitative study. The themes that emerged from the counsellors' interviews highlighted their underpinning beliefs about how they perceived men, their issues and their social context. The authors would like to see more dialogue between masculinity researchers, educators and therapists to ensure that the varying fields are informed by each other.

Counsellors are known to support those who experience substance abuse. Still, research has not often explored the challenges for recovering counsellors working in substance abuse treatment agencies, including the risk of relapse and burnout. Azahah Abu Hassan Shaari explores recovering counsellors' challenges and social support in Substance-Abuse-Treatment Agencies in New York. His research sheds light on the heavy demands placed on these counsellors and the support needed to improve the quality of mental health and oversell wellbeing among those working in addiction treatment.

The effects of climate change are at the forefront of world leaders' policies, and research has begun on the impacts of climate change on the mental health of individuals. Katrina Wong interviewed eight climate involved mental health therapists using semi-structured interviews to examine some of the significant themes their clients experience because of climate change. These ranged from trauma and grief and anxiety, disempowerment and disconnection, empowerment through values-based collective action and systemic engagement as a profession. This research is enlightening and well worth reading.

The final paper in this issue explores barriers to effective communication about end-of-life issues with families of terminally ill members. Katarina Linder researched the literature regarding End-of-Life, noting that attitudes toward death and dying often left the sick member without positive discussions and support. She feels that more research is needed to understand the reasons behind the general lack of communication and to find ways to give more support to families and their loved ones.

**Editors**

**Dr Ann Moir-Bussy**
Adjunct Associate Professor – Charles Darwin University
**Tarquam McKenna**
Professor Emeritus – Victoria University, Melbourne

We hope that readers, researchers, and practitioners find this issue will provide powerful insights into their counselling and psychotherapy work and practice.

The second issue will be ready in November, and we encourage readers, practitioners, and researchers to submit manuscripts for review. We welcome students' research, and in particular, we look for more Indigenous research that will enable counselling and psychotherapy to be more relevant and appropriate to those in their communities needing healing.

Dr Ann Moir-Bussy
Editor

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**Volume 16, Issue 1 - 2022. Dr Ann Moir-Bussy**

# Perceived Multicultural Counselling Competencies Amongst Australian Counsellors and Psychologists

**Hugo M. Gonzales, Briarna Popis, Phoebe Smith, Gaston Antezana**

With 1 in 4 Australians being born overseas, awareness, knowledge, and skills are needed when working with these multicultural clients. This mixed methods study investigated the perceived multicultural counselling competency of Australian Counsellors and Psychologists. This study has confirmed multicultural counselling competencies are essential for counsellors and psychologists working with multicultural clients. Participants (N=81) completed an online survey and (N=7) in-depth interviews. Results indicate significant relationships between multicultural identification and increased multicultural awareness and knowledge, along with themes of Person-Centred, Training, Knowledge, Awareness, and Culture as more than Ethnicity. This study confirmed that multicultural competence levels are influenced by experience and multicultural counsellors who spoke more than one language performed better than those who spoke one. Significant effects were also found with those counsellors born outside Australia obtaining higher scores on the Awareness subscale. Similarly, those from a multicultural family background outperformed those from a bicultural background, and those from multicultural backgrounds also outperformed those from single culture background. As a limitation to this study, the sample size for the survey was rather small which limits the generalisation of these results.

**Keywords:** *Multicultural counselling, Perceived multicultural competence, competency, multicultural identification, multicultural awareness*

## Introduction

Australia is one of the most diverse countries in the world, both culturally and linguistically, with close to 400 languages spoken across the nation (Australian Bureau of Statistics, 2010). According to the Australian Bureau of Statistics (2020) in 2019, there were more than 7.5 million migrants living in the country, and 29.7% of the population was born overseas. With a growing and diverse population, and an increase in the awareness and prevalence of mental health disorders, now more than ever is the need for mental health professionals to be multiculturally competent (Sue, Zane, Hall, & Berger, 2009).

This research will discuss the perceived level of multicultural counselling competencies amongst Australian psychologists and counsellors. Multicultural counselling competence can be identified as the awareness of a person's own personal beliefs, attitudes, and values, the awareness and knowledge of the worldview of multiculturally diverse people, and culturally relevant skills (Sue, Zane, Nagayama Hall, & Berger, 2009). Despite Australia's diversity and multicultural counselling competencies being deemed a "necessary skill", there is a lack of research in this area that has been conducted in Australia, as most of it is focussed on the USA (Sehgal et al., 2011; Matthews, Barden, & Sherrell, 2018). One of the few studies conducted in Australia by Tan and Denson (2019) focuses on bilingualism and multilingualism in psychologists, however this fails to account for all Australian counsellors and psychologists. This research study aims to address a gap in the literature and provide more awareness on the topic of multicultural counselling competencies, and what training is needed to improve levels of competencies.

The main research questions of this study include:

1. How competent do counsellors and psychologists in Australia perceive they are in a multicultural counselling setting?
2. What further training could be implemented to ensure counsellors and psychologists perceive themselves to be competent in multicultural counselling?
3. How has the training (or lack of) impacted the therapeutic alliance for counsellors and psychologists?

Corresponding Author: Dr Hugo M Gonzales

Email: hugonzales@copecentre.org

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## Literature Review

Australia is known for its multiculturalism, with multiculturalism being defined as a value system which emphasises accepting different cultural backgrounds and behaviours and supporting the existence of these differences (Arasaratnam, 2014; Birrell, 1995; Dolce, 1973).

A multicultural society is a vast diversity of people with differing thoughts, beliefs, attitudes, behaviours, values, and perceptions of the world. For the individuals who decide to leave their country of origin and move to Australia, often there are a variety of difficulties they may encompass, for example language barriers, lack of social support, financial struggles and potentially experiences of racism (Chiang & Yang, 2008; Collins & Reid, 2012; Gonzales, 2010; Kosny, Santos, & Reid, 2017; Liamputton, 2006).

What accompanies the potential difficulties migrants and immigrants may face is an increased risk of developing a mental health disorder due to factors such a lack of social support, isolation, and racism (Cho & Haslam, 2010; Oppedal, Røysamb, & Sam, 2004; Pumariega, Rothe, & Pumariega, 2005). Some studies have even highlighted higher suicide rates of immigrants in Australia compared to the general Australian population (Forte et al., 2018; Kliewer & Ward, 1988). A study by Minas et al. (2013) outlined the low rates of mental health services accessed by immigrants and refugee communities in Australia. There are a variety of reasons why these rates are low, however current literature suggests it is due to a lack of accessibility. Studies have outlined the barriers that culturally diverse people experience when attempting to access mental health support which include factors such as language barriers and effective communication, and lack of translators and interpreters (Davidson et al., 2004; Youseef & Deane, 2006; Wohler & Dantas, 2017). Principe (2015) reports a lack of cultural sensitivities in health services, and in contexts such as mental health services, multicultural competencies is essential when working with culturally diverse individuals who may be survivors of trauma, and persecution. To bridge the gap amongst accessibility issues in immigrants seeking mental health support, healthcare workers have been encouraged to increase their level of multicultural competency (Mollah, Antoniades, Lafeer, & Brijnath, 2018).

Over recent years there has been discussion amongst professionals over the importance and need for multiculturally competent mental health professionals (Sue, Zane, Hall, & Berger, 2009). Research conducted in the USA, for example, has outlined the increased risks immigrants have to developing a mental health disorder, such as depression, with increased exposure to their new culture (Herman et al., 2004). Dudgeon, Milroy, & Walker (2014) highlighted the need for mental health professionals to access training as a means of developing a level of multicultural counselling competency.

Multicultural counselling competency has been described as an ongoing and continuous process that a professional strives towards, rather than a destination to be reached (Diller, 2018; Tomlinson-Clarke, 2013). Literature indicates that the current processes adopted for multicultural counselling training are not sufficient enough in assisting professionals in the growth process towards developing improved cultural competency (Tomlinson-Clarke, 2013). It has been suggested by Chao (2013) that training in multicultural counselling should be adapted depending on the ethnic backgrounds of the trainees. Research that has been conducted on multicultural counselling competencies in the USA has suggested that to develop multicultural competencies, the therapist must first develop self-awareness (Ratts, Singh, Nassar-Mcmillan, Butler, & McCullough, 2016). Developing self-awareness is said to be a lifelong process and will help a therapist understand the attitudes, beliefs, and values of multicultural clients (Ratts et al., 2016 Wilkinson, 2011). Roysircar (2004) claims that developing self-awareness is integral to effective multicultural counselling.

The aim of this research is to explore the relationship between counsellors' and psychologists' multicultural counselling competencies, and various demographic variables such as bilingualism and multiculturalism. The purpose was to understand and explore the beliefs and attitudes that Australian counsellors and psychologists have alongside the knowledge of their worldview when working in a multicultural counselling setting. This research intended to address gaps that existed in the literature on multicultural counselling competencies in Australia, and to develop an increased awareness on the importance of multicultural counselling in Australia, and how vital the perceived and actual levels of multicultural counselling competence is for clinicians.

## Method

### Research Design

The study was conducted using a fixed mixed-methods design, to gather complimentary data that was comprehensive enough in helping to understand the complex topic being researched (Johnson, Onwuegbuzie, & Turner, 2007). Combining the strengths of the quantitative approaches with in-depth qualitative data allowed comparison, contrast, validation and expansion of the data (Creswell & Clark, 2017). The triangulation convergent model allowed researchers to collect quantitative and qualitative data concurrently, analyse data separately and converge the results during interpretation (Creswell & Clark, 2017).

A survey based on the Multicultural Counselling Inventory (MCI) (Sodowsky, Taffe, Gutkin, & Wise, 1994) and the Marlow-Crowne Social Desirability Scale Short Form (MCSDS) (Reynolds, 1982) was created to research participant's perceived competencies in multicultural counselling.

The survey was a self-report survey which included the 40-items from the MCI and 10-items from the MCSDS. The Multicultural Counselling Inventory is designed to assess the competencies of counsellors and psychologists working with multiculturally diverse clients (Arthur & Januszkowski, 2001). The MCI contains four subscales – multicultural awareness (10 items), multicultural counselling knowledge (11 items), multicultural counselling relationship (8 items), and multicultural counselling skills (11 items) (Green et al., 2005). The questions were answered on a Likert scale from very inaccurate through to very accurate, where 1 indicates low multicultural counselling competency through to 4 which indicates high levels of multicultural counselling competency. Questions include "I perceive that my race causes clients to mistrust me", for example, to which participants may answer on a 4-point likert scale from very inaccurate (4 points) to very accurate (1 point).

The Marlow-Crowne Social Desirability Scale (Short Form) is a 10-item scale asking participant's true or false questions such as "I like to gossip at times" (Reynolds, 1982). The aim of

the scale is to control for the tendency of participants to respond in a socially desirable way, and to eliminate social desirability bias (Andrews & Meyer, 2003). Social desirability occurs due to participants choosing responses which they think will be viewed favourably by others rather than choosing responses which reflect their true thoughts and feelings (Grimm, 2010).

## Participants and Recruitment

Participants were registered with a counselling or psychological body in Australia and were recruited through purposive sampling. 81 participants (*N*= 38 Counsellors, *N*= 43 Psychologists) completed the survey, and 7 participants (*N*=3 Counsellors, *N*= 2 Psychologists, *N*=2 Provisional Psychologists) completed in-depth interviews.

The inclusion criteria of participants for this study included Counsellors and Psychologists living and working in Australia who are registered with a psychological or counselling governing body. The exclusion criteria included anyone that was not a counsellor or psychologist living and working in Australia and was not registered with a relevant governing body.

Participants were recruited from the Psychotherapy and Counselling Federation of Australia (PACFA) and the Australian Counselling Association (ACA) online directory and were contacted via email. A Google search was also used to find Counselling and Psychology organisations across Australia in all five major cities to ensure the sample was equally spread across the country. LinkedIn was also used to recruit participants, with additional snowball sampling. Approximately 350 emails were sent to Counselling and Psychology services across Australia found through a Google search. Approximately 400 contacts from the PACFA and ACA website were emailed and invited to participate. Recruitment was partially funded by the research study's supervisor.

## Materials

In this research study the Multicultural Counselling Inventory (MCI) and the Marlowe-Crowne Social Desirability Scale Short Form were used to form the basis of the online survey which was conducted through Qualtrics. The survey data was analysed using SPSS (version 23), and the in-depth interviews were conducted via Zoom. Otter was used to audio record and transcribe the in-depth interviews, and NVivo was used to analyse the qualitative data. Information letters and consent forms were also sent to participants.

## Procedure

Participants were invited to complete our online survey conducted on Qualtrics, alongside participating in in-depth interviews conducted on Zoom. The in-depth interviews were semi-structured with 9 open-ended questions used as a guide to gather information on the experiences of the participants. Interview participants were asked to sign a consent form before participating. The in-depth interviews were audio recorded and transcribed using Otter. The recordings were then listened to, and the transcribing was edited to ensure accuracy of verbatim. The survey data was analysed using SPSS (version 23 for Mac). A step-by-step thematic analysis was conducted using NVivo Software (version 12 for Mac) to find overarching themes and search for trends and patterns in the data (Vaismoradi, Jones, Turunen, & Snelgrove, 2016). A thematic map of the final themes and subthemes are shown in *Figure 1.*

## Ethical Considerations

Due to the nature of working with human subjects, considerations and precautions were taken to ensure the safety and wellbeing of participants. The identities of the survey participants were kept anonymous, and the in-depth interview participants were de-identified and kept confidential. To maintain confidentiality, the audio recordings, interview transcriptions, and survey results were removed from the researchers computers and were stored securely on Cloudstor (a password protected software) where they will remain safely stored for 5 years before being destroyed, as per the regulations of the Murdoch University Human Ethics Department. Participants were informed of the nature of the study before consenting to participate, and were given the option to withdraw from the study at any point without any limitations or consequences. In the unlikely event that the study were to cause distress to participants, contacts for relevant support services were provided.

## Trustworthiness

To ensure the validity and rigour of the research, the 4 criterions of trustworthiness in qualitative research were met – credibility, transferability, dependability, and confirmability (Korstjens & Moser, 2017). Triangulation was implemented through using multiple researchers to conduct the research and analyse the data. Transferability was ensured through purposive sampling, and dependability and confirmability were maintained through the researchers keeping a reflective research journal and audit trail throughout the research process (Borg, 2001; Korstjens & Moser, 2017; Ortlipp, 2008; Tuckett, 2005). The researchers also analysed the data separately to ensure trustworthiness, and an independent third party reviewed the data to eliminate any researcher bias (Norris, 1997).

There are multiple versions of multicultural counselling competence scales, however the most established and reputable is the Multicultural Counselling Inventory developed by Sodowsky, Taffe, Gutkin, and Wise (1994) (Pope-Davis & Nielson, 1996). Multiple studies have assessed the construct validity of the MCI, and have noted consistent levels of acceptable internal consistency through conducting a Cronbach's alpha test (Constantine & Ladney, 2000; Pope-Davis & Ottavi, 1994; Sodowsky, 1996; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998; Worthington, Mobley, Franks, & Tan, 2000). The MCI has a moderate degree of validity and a moderate-high degree of internal consistency and test-retest reliability (Ponterotto & Potere, 2003). The MCSDS (Short Form) has a .66 moderate reliability, and a satisfactory internal consistency and reliability (Ray, 1984).

# Findings and Results

## Quantitative Results

The sample size of the survey was *N*=83 and descriptive statistics indicated that the mean age of participants was *N*=47.3 years old.

There was a diverse range of cultural and ethnic identities amongst the participants including Australian, Aboriginal Australian, North American, African American, Bosnian, British, Bulgarian, Celtic, Chinese, Danish, Greek, Indian, Irish, Italian, Latin American, Malaysian, New Zealander (European descent), Scottish, South African, Sri Lankan, Turkish, and Welsh.

A number of statistical analyses were run using SPSS to analyse the survey data. Independent samples t-tests conducted to assess a difference between means for gender conformity, found no significant differences across all MCI subscales. Similarly, t-tests conducted to determine a difference between education level (undergraduate or postgraduate level) found no statistically significant differences across all MCI subscales.

Independent samples t-tests testing for a difference between means on MCI subscales for number of languages spoken (grouped into one and more than one) found a significant effect on the Awareness subscale, $t(79)=-3.21$, $p<.05$, specifically that those who spoke more than one language performed better than those who spoke one.

An independent samples T-test was conducted to test for differences between the means of participants' country of birth and their scores on the MCI subscales. Significant effects were found, with those born outside Australia obtaining higher scores on the Awareness subscale, $t(79) = -2.21$, $p<.05$.

Upon running independent samples T-tests for ethnicity (divided into Western and Non-Western origin), it was found that participants of non-Western origin outperformed their Western counterparts on the Awareness subscale, $t(79) = 3.761$, $p < .001$.

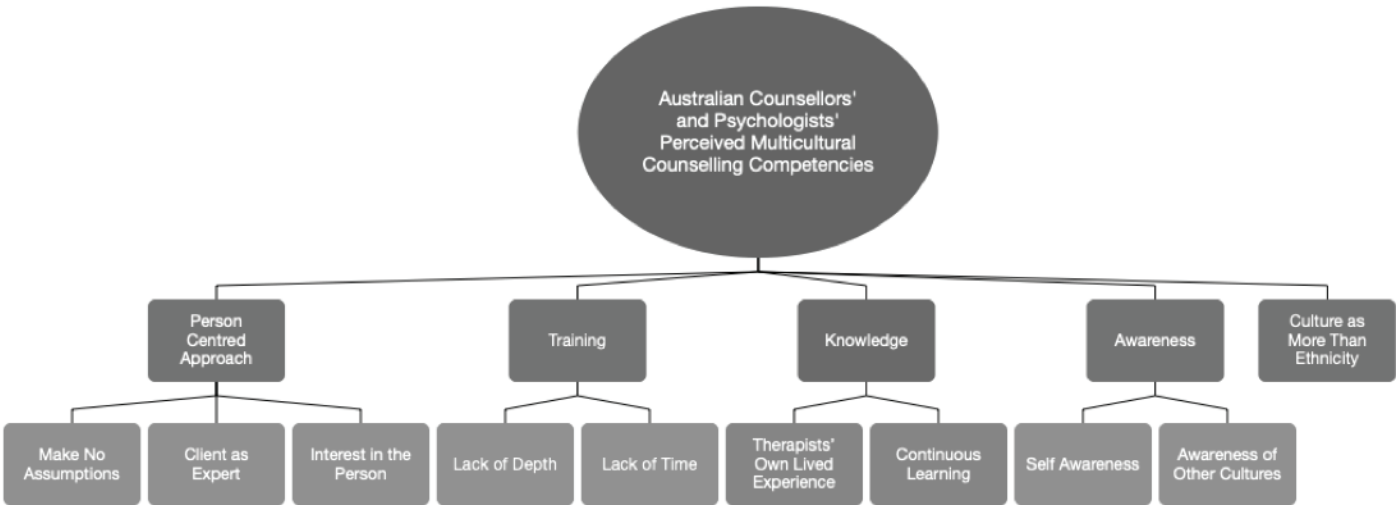
A one-way ANOVA was conducted to test for differences between multicultural, bicultural, or single-culture family backgrounds. A significant effect was found on performance on the Awareness subscale, $F(2,78) =13.14$, $p < .001$. A Tukey post-hoc test revealed that those from a multicultural family background outperformed those from a bi-cultural background, $t(78) = -2.62$, $p <.05$. Those from multicultural backgrounds also outperformed those from single culture background, $t(78) = 5.00$, $p < .001$.

A one-way ANOVA was conducted to test for differences between the means for age of participants on their performance on the MCI subscales. It was found that there was a significant effect on the Relationship subscale between different ages, $F(2,39.4)=3.70$, $p<.05$. Post-hoc Games-Howell testing revealed that those in the 60-80 age range outperformed those in the 20-40 range, $t(40.7)=-2.65$, $p<.05$. However, the ANOVA also found that the Social Desirability Scale scores were also significantly different between groups, $F(2,41.9)=10.6$, $p<.001$. Post hoc Games-Howell tests revealed that 60-80 year olds scored higher on the Social Desirability Scale than 20-40 year olds, $t(35.9)=-4.62$, $p<.001$ and than 40-60 year olds, $t(31.7)=-3.28$, $p<.05$. This indicates that the significant differences between Age means and Relationship subscale are no longer valid.

## Qualitative Results

In-depth interviews were conducted with seven participants - six female participants and one male participant. Three participants were counsellors and four were psychologists. Participants were asked a series of open-ended questions to gather their experiences as mental health professionals (counsellors and psychologists) working with multicultural clients, and their perceived level of competencies. Themes and sub-themes were identified from the data (see Fi).

*Figure 2:* Thematic Map Outlining Themes and Sub-Themes




**Theme 1:** Person-centred

Therapists try to work with multicultural clients in a person-centred manner including making no assumptions, seeing the client as the expert in their own lives and having a genuine curiosity and interest in the individual.

**Sub-theme:** No assumptions

A frequent theme which emerged during the in-depth interviews was that of not making assumptions about clients and people in general. A majority of participants discussed the importance of not making assumptions about clients based on their physical presentation or ethnic background. The topic of stereotyping was mentioned frequently amongst the participants, with the general consensus that they make an effort to not stereotype people, and to have an open mind and "polite curiosity" when getting to know a person before making any assumptions. "You can't ever assume anything about anyone ever until you actually get to know them and that's across the board" (Participant 6).

**Sub-theme:** The client is the expert

A frequent topic that was discussed was the importance of remembering that a client is the expert in their own lives, no matter the amount of knowledge the therapist may have about their client's culture. Two participants highlighted this well - "Your clients have the expertise in their lives and in their organisation.",

"..not going into any situation thinking you're the expert".

**Sub-theme:** Take an interest in the individual

This sub-theme is related to a therapist taking an interest in the client as a person, rather than as someone who is multicultural and has a diverse background. Participants expressed the need to have an interest in the person as an individual. By having curiosity towards the client as an individual it allows for a deeper understanding. Participants spoke repeatedly about having an open-mind and being curious about getting to know the client and asking them about their cultural background and letting them tell you their experience - "It's more being really interested in the person that you're counselling." (Participant 6).

**Theme 2:** Training:

The topic of training in multicultural counselling was a frequently discussed topic amongst all participants in the in-depth interviews. Most participants reported receiving a lack of training in both their tertiary studies as well as in their workplaces – "In terms of other multicultural training... fairly limited" (Participant 1). When asked if they would like to see universities and workplaces provide more training specifically on multicultural counselling one person replied, "Oh yes, a thousand times yes, I think you can always benefit from more training." (Participant 7)

**Sub-theme:** Lack of depth

Alongside many participants reporting the lack of training they have received in multicultural counselling, the lack of depth of the training they did receive was mentioned also. Participants discussed the "token" aspect to having a 2-day training on multicultural counselling every year or two, and how they felt it was not enough. "I feel like a lot of the training I've done, particularly in workplaces, has been quite token" (Participant 1). One participant demonstrated an awareness of multicultural clients by outlining the relationship between a lack of depth of training and a client potentially feeling misunderstood by the therapist - "I knew that there was no nuance to it. It was just kind of like, well yes, but I can't imagine that that would make an Indigenous person feel like you actually got them and got who they were." (Participant 3).

**Sub-theme:** Lack of time

The lack of time was a factor that was discussed as a barrier to receiving sufficient multicultural counselling training in both education settings and workplaces. Participants discussed the practicalities of time constraints in workplaces (both in the public and private sector) scheduling in clients, supervision, as well as other mandated professional development too. "I think if we were given more time... it would be nice sometimes to have that extra time to learn and to research and understand where people are coming from but sometimes that's hard in a pragmatic sense" (Participant 1).

**Theme 3:** Knowledge

When knowledge of multicultural counselling was discussed, it was separated into two sections – the therapist's knowledge based on their own lived experience from being born overseas or living overseas, and knowledge acquired from training.

**Sub-theme:** Therapist's own lived experience

A majority of the participants interviewed spoke about their knowledge and awareness of other cultures as a result of the travelling they have done and living overseas for a period of time. The participants who had more lived experience both with other cultures and multicultural clients, reported feeling more comfortable working with multicultural clients and felt they had a sufficient level of knowledge, but that there was always more to learn – "I'm from Hong Kong… It has been a multicultural kind of place… I moved to Australia three years ago and I also did an exchange in London. So for me.. I've been quite comfortable working with people from different backgrounds" (Participant 7).

**Sub-theme:** Continuous learning

Participants discussed their desire for learning more about other cultures to better understand their multicultural clients. They described multicultural training as something that is ongoing and needs to be continuously worked on as a learning journey rather than a destination – "...but there's always more to learn.. like I don't feel like I'm an expert on anyone no not at all and never will be" (Participant 1), "I feel like I'm still learning every single day" (Participant 5).

**Theme 4:** Awareness

Awareness was an important theme that was discussed in the in-depth interviews – the importance of both self-awareness and also awareness of other cultures and their beliefs, values, and attitudes and how they may differ from our own.

**Sub-theme:** Self-awareness

Participants discussed self-awareness in relation to working with multicultural clients and being aware of their own personal beliefs, culture background, and how that may align when working with diverse clients. As many of the interview participants identified as Caucasian Australian, many of them spoke about the importance of a therapist being aware of their own privilege, as not having awareness and sensitivity of the privilege they have can result in negative emotions for both the therapist and the minority client – "I try to be very aware of my privilege... I recognise that I can navigate the world a lot more easily and freely than perhaps my clients can" (Participant 1).

**Sub-theme:** Awareness of other cultures

Awareness of other cultures related to self-awareness of the therapist and being aware of your own level of knowledge towards other cultures – "...in the mainstream mental health system you have to be aware that the language you use can be completely meaningless to the person. You can't assume that someone knows what you mean by depression... a lot of cultures think you only go to counselling if you're crazy." (Participant 6). Different cultures come with different norms, ways of being, language nuances and relational processes. Therapists discussed this awareness as important in understanding the client and creating a strong therapeutic space.

**Theme 5:** Culture as more than ethnicity

During discussion of multiculturalism and working in a multicultural context, respondents discussed culture in a variety of aspects. Respondents discussed their own cultural background in terms of parents' heritage and ethnicity, their religious background, cities and countries lived in, gender norms and differences within and outside ethnic backgrounds, sports culture, and different groups such as special needs and disability in a cultural aspect. "And I think that the same applies to people with special needs and disabilities, that diversity is not just religion, it is not just ethnicity" (Participant 2). "I remember meeting a person who was of Aboriginal heritage who was transitioning from male to female. And her perspective on what that was like would not be the same even if her sibling did it."

## Discussion

As demonstrated in the results and findings, multicultural counselling competencies are essential for counsellors and psychologists working with multicultural clients (Anuar, Rozubi,

& Abdullah, 1992). Multicultural Counselling Competencies are suggested to positively influence the therapeutic relationship (Arthur & Januszkowski, 2001). The findings from the Multicultural Counselling Inventory were somewhat similar with findings that have been reported in previous literature. In the in-depth interviews, therapists who had more experience working with multicultural clients reported feeling more competent when working with multicultural clients. This aligns with research by Berger, Zane, and Hwang (2014) who reported similar results in their study analysing multicultural counselling competencies amongst mental health clinicians in the USA.

The theme of 'Person-Centred'' that resulted from the in-depth interviews was a new theme in terms of qualitative data, as currently there is no literature which outlines similar results. Lago (2011) outlined the idea of a person-centred approach when working with culturally diverse clients and minority groups, and how the core conditions of Carl Roger's person-centred approach are not sufficient enough in a multicultural setting. Lago suggested for therapists to develop self-awareness of their own cultural background, and attitudes and beliefs towards others in order to improve awareness, knowledge and skills in multicultural competency. This aligns with another theme discovered in this research, "awareness" with the sub-themes "self-awareness" and "awareness of other cultures''. This theme aligns with Minami (2008), who found that in order to develop multicultural counselling competence, developing self-awareness is imperative.

The lack of training the participants reported in both their university and tertiary education settings and their workplaces is consistent with the current literature. Constantine (2001) and Calisch (2003) wrote about the lack of multicultural counselling training in tertiary counselling courses. For counsellors who have experienced multicultural training, the lack of depth in the training was reported also. This view is reflected in current literature which argues that current training in multiculturalism and multicultural counselling is not sufficient enough as the complexities of this area are often oversimplified (Dickson & Jepsen, 2007; Tomlinson-Clarke, 2013). Many participants spoke about seeking out their own multicultural training if they were not provided any in their education or workplace or were not satisfied with the level of training they received. This aligns with research by Ratts et al. (2016) which outlined the innate curiosity therapists tend to have to learn about others and their proactivity at seeking out their own professional development.

Results from Independent samples T-tests indicated that the more languages spoken, coming from a multicultural family background, being of non-Western nationality and being born outside Australia were variables which obtained higher scores on the Awareness subscale of the MCI. Through ANOVA, it was also found that those from bicultural and multicultural family backgrounds outperformed those from single-culture backgrounds on the Awareness subscale. Results from ANOVA indicated that participants of a higher age (and hence experience in their field) performed better on the Relationship subscale. However, as older participants also significantly scored higher on the Social Desirability Scale, the finding that they outperformed younger participants on the Relationship subscale may be a reflection of social desirability bias.

These results are supported by findings of American researchers Constantine and Ladany (2000) who also conducted a self-report multicultural counselling competence study and controlled for social desirability. As there is a lack of research investigating multicultural counselling competencies of counsellors and psychologists in Australia, it is difficult to compare these results. Potentially in the future, if this study is replicated and expanded upon with a much larger sample size, there may be a greater significance across more of the MCI subscales.

## Limitations and Future Research

There are some limitations in this study that need to be acknowledged when considering future research. Firstly, the sample size of the survey was rather small for a quantitative study and did not reach the necessary numbers for a proper power analysis. This could be expanded upon in future research by an increased time limit for conducting the study to ensure a larger sample size of participants is recruited. The small sample size could potentially be explained due to the length of the survey which could have impacted the drop-out rate and response rate of participants. The COVID-19 pandemic affected our recruitment process as many counsellors and psychologists across the country were time-poor due to an increased demand for mental health services. There was a potential bias which may have impacted participant responses, as the participants who chose to participate in the study may have had an interest in multicultural counselling and so may respond in a particular way. We may not have heard the perspective of individuals who were not inherently interested in this topic or who do not think multicultural counselling is important or valuable or perceive themselves to be competent in this area.

This study is a starting point for multicultural counselling research and needs to be expanded upon. More research needs to be completed on a larger quantitative scale to truly encompass the competencies of all Australian counsellors and psychologists and should preferably include people who are not interested in the multicultural domain.

Future research should focus on therapists' perceived MCC with multicultural client outcomes to see if perceptions are accurate and could incorporate the therapeutic techniques and theories the therapists use. Longitudinal studies could be conducted with regards to multicultural training and experiences to discover effective ways to increase MCC.

# Conclusion

A mixed-methods design was used to investigate the perceived multicultural counselling competencies amongst Australian Counsellors and Psychologists. The multicultural counselling survey controlled for social desirability and demonstrated participants' levels of multicultural counselling competencies based on four subscales – multicultural awareness, multicultural counselling knowledge, multicultural counselling relationship, and multicultural counselling skills (Green et al., 2005). Statistical analysis highlighted the significant relationship between the number of languages spoken by a counsellor or psychologist and their level of multicultural awareness, and a therapist's multicultural background demonstrating high reported levels of multicultural knowledge.

Thematic analysis highlighted five main themes – person-centred, training, knowledge, awareness, and culture as more than ethnicity. The lack of training counsellors and psychologists have received in their studies and workplaces was highlighted, and the ongoing training that needs to be undertaken in order to enhance multicultural counselling competence. The

training, knowledge, and awareness themes were found to be consistent with the current literature available. It needs to be taken into account that most of the literature is based in the USA, however. It is hoped that research in this area will be expanded upon further, with a focus on Australian Counsellors and Psychologists, so that further training and education can be implemented to ensure these professionals perceive themselves to be sufficiently competent working in this particular field. Professional training in Multicultural Counselling has become more critical since Australia is perceived as a multicultural society.

Data Availability Statement: The data that support the findings of this study are available on request from the corresponding author [HMG]. The data are not publicly available due to restrictions e.g., their containing information that could compromise the privacy of research participants.

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# Show no weakness: Male-friendly counsellors' descriptions of men.

**Nathan Beel, Charlotte Brownlow, Carla Jeffries, Jan du Preez**

Male-friendly therapy and the theorising of men and masculinity have gradually developed and become visible over the last forty years. However, courses on this topic remain rare in professional training programs. Despite the lack of available training, some therapists advertise as specialists in working with men and presumably, have a more vital awareness of gender issues than general therapists. However, little is known about these therapists, what they understand about men, and potentially, what they might offer the research community. Given this, this research seeks to explore how contemporary Australian men's therapists currently perceive men and their issues. Based on interviews of 15 Australian male-friendly therapists, this qualitative study developed two themes and seven subthemes. The paper recommended greater dialogue between masculinity researchers, educators, and therapists to ensure that practice and academic theorising mutually inform each other.

Show no weakness: Male-friendly counsellors' descriptions of men.

As a social group, men have an over-representation in imprisonment (ABS, 2019), violent behaviour (ABS, 2020c), suicide (ABS, 2020b), substance abuse (ABS, 2018), and sexual abuse perpetration (ABS, 2020a). Although their mental health needs are similar to women's, they have lower rates of help-seeking (Addis & Mahalik, 2003) and mental health service usage (Burgess et al., 2009; Vessey & Howard, 1993). Male-friendly counselling is an inclusive phrase for gender-sensitive treatment designed or adapted for men. Various authors on male-friendly therapy (see, for example, Brooks, 2010; Englar-Carlson et al., 2014; O'Neil, 2015; Pollack, 2005) position male distress as intrinsically linked to damaging gendered socialisation processes and subsequent commitment to problematic traditional masculine norms. Understanding masculine norms, both dominant (and more marginalised) and the associated strains become central to therapists developing strategies to gain rapport, reduce resistance, conceptualise distress, and guide the selection of interventions.

The earliest seminal list of traditional masculine norms comes from David and Brannon (1976), who described and critiqued what they framed as four archetypal rules of manhood in the United States. Men must avoid appearing feminine and be successful, strong, and aggressive (David & Brannon, 1976). More complete descriptions of dominant masculine norms in the United States include emotional stoicism, independence, restricted affection between men and homophobia, work/family conflict, sexism and female subordination, status-seeking and risk-taking (Mahalik et al., 2003; O'Neil, 2015). Pleck (1981) introduced the Gender Role Strain Paradigm (GRSP), shifting the attention to the impacts of adherence or violation of socially ascribed gendered sex roles. Pleck (1981) contended male socialisation processes and the attempt to achieve or rigidly enact traditional masculine norms leads to damage and distress in men and negatively impacts others. These norms become reinforced by society and internalised in men.

Many of the masculine norms identified in the scholarly literature are based on dominant male norms in the United States. Connell (2005) cautioned that there is no single universal masculinity but a diversity of masculine patterns across different groups of men, contexts, and times. The concept of global masculinities recognises that variations of masculine norms exist between international locations and cultures (Connell, 2007). Scholars have provided descriptions for a range of regional masculinities, including Australian (Moore & Crotty, 2007), Chinese (Louie, 2007), Mexican (Gutmann, 2007), and East European masculinities (Mudure, 2007). Male-friendly therapy and masculinity studies should not assume that hegemonic masculine norms identified in one region are sufficient to adequately interpret male dysfunction and distress in another region.

In the past few years, Australia has shown increased interest in addressing the health risk factors associated with men. The Australian Government has developed a National Male Health Policy (Commonwealth of Australia, 2010) that seeks to address a range of health and help-seeking disparities

Corresponding Author: Beel, Nathan
Email: nathan.beel@usq.edu.au

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that impact men and commits to further research and support to work towards solutions. Research efforts have often been targeting help-seeking behaviours (Seidler et al., 2016), how to engage Australian men in treatment (Seidler et al., 2017) and understanding how Australian men's constructions of masculinity impact their health risk and promotion behaviours (Mahalik et al., 2007). This research will focus on the Australian context, which has its hegemonic masculine norms, other less dominant norms, and potential explanations for distress.

While the scholarship in the psychology of men and masculinities has gathered momentum over two decades, the uptake of the teaching of its theoretical concepts and findings has been relatively slow. Delivery of academic or professional training courses relating to the psychology of men outside of the United States has historically been low (Mellinger & Liu, 2006; O'Neil & Renzulli, 2013), and in Australia, it is largely ignored in mental health within the medical curriculum (Seidler et al., 2018).

While researchers/clinicians have contributed richly to the development of theory and practice on men, they may or may not reflect the perspectives of men's therapists outside of the scholarly communities. There is very little available research using male-friendly therapists as informants to contribute to the broader scholarship on men, with only one known published study to date (Beel et al., 2020). This omission potentially relegates current scholarly theorising to be informed from the priorities and theoretical commitments of those within the relatively small group of male-friendly therapy researchers. Robertson (2013) recommended that clinicians be invited to take part in qualitative research to discuss their experiences on topics related to men. Clinicians have proximity to intricate details of men's stories and experiences. Accordingly, therapists may be viewed as professional informants, containing practice wisdom and insight that might benefit the wider scholarly community and stimulate new research. Likewise, therapists also operate from their own gender beliefs (Trepal et al., 2008) and are vulnerable to hold stereotyped views that can prejudice their assessment of clients depending on their alignment with non-traditional gender role behaviour (Robertson & Fitzgerald, 1990). Male-friendly counselling texts highlight therapists have also been immersed in gender socialisation (Brooks, 1998) and recommend therapists do their own gender reflection on their attitudes and beliefs about men and masculinity (Englar-Carlson et al., 2010). Therapists will vary in their own attitudes, beliefs, and biases associated with gender (Mahalik et al., 2012). Men's therapists as research informants therefore bring special insight because of their exposure and interest in men's issues and rich stories, and like their clients, also were raised and socialised in cultures that expose them to gendered experiences, roles, norms, and values.

With the relative absence of evidence of formal training in the psychology of men outside the U.S. and sparse research on those who specialise in working with men, this research seeks to explore how contemporary Australian men's therapists currently perceive men and their issues. How do they understand the men they treat and men's challenges in broader society? This study will allow an exploration of male-friendly practitioner discourses, what they are currently emphasising, and how they make sense of men in society and therapy.

## Methods

Ethics approval to conduct the research was gained from the University of Southern Queensland Human Research Ethics Committee [approval number: H17REA124]. The target participants were professional therapists who advertised as specialising in working with men. A Google search restricted to Australian sites was conducted using the terms 'men' AND 'counselling'. Only those in private practice were selected for inclusion on the assumption that private practitioners might not be constrained to comply with specific frameworks required by some organisations. For instance, Mensline, a national service for those identifying as males, operates from a feminist framework (DV Connect, 2019) and requires its therapists to align with these principles (DV Connect, n.d.). The search was closed after 20 pages of listings due to the repetition of previous listings with no new services identified. Twenty-six therapists were contacted by email and/or phone, and from these, 16 agreed to participate, and 15 completed interviews in June 2017. No compensation for time or expertise was offered to the participants.

The therapists interviewed included counsellors (n=10), social workers (n=2), psychologists (n=3), and a combination of males (n=12) and females (n=3). Two of the 15 had bachelor's degrees, while the remaining had postgraduate qualifications in their respective professions. There are no legal limitations on who or where counselling services can be provided in Australia. Australia has a professional identity of counsellor that is distinct from social workers and psychologists who practice counselling. Hence in this paper, the term 'therapist' is used for all participants. Of the participants, one reported holding a Graduate Certificate in Social Science (Male Family Violence). Therapists were in New South Wales, Queensland, Victoria, and Western Australia. The average experience across therapists working with a specific interest or focus on men was 10.5 years, with a minimum of 2.5 years and a maximum of 20 years.

Data was gathered through individual interviews and formed part of a larger project (Beel et al., 2020). The first author, the interviewer, was a male PhD student, a full-time counselling lecturer, and a part-time counsellor. Participants were provided with written information on the research aims as part of the consent process. The interviews were conducted using a video conference platform, except for one participant interviewed by phone. Each interview was recorded and transcribed verbatim. Interviews ranged from 29 to 82 minutes, with one participant requesting and receiving a second interview.

The semi-structured interview began with general questions about qualifications, professional identity, and the type and format of service offered. The interviewer then asked each participant how they developed an interest in working with men. This was followed by questions about what they have observed about men in their practice, what they thought was important for therapists to know about men, and their recommendations for therapists working with men. The interviewer reflectively listened to assist interviewees in amplifying their answers, and follow-up questions were asked to explore areas of interest to the participants. After transcription, the interviewees were emailed a copy of the transcript to check for accuracy. In this process, one interviewee requested a second interview, whilst none of the others added any corrections or comments.

The research process chosen aligned with thematic analysis (Braun & Clarke, 2006; Terry et al., 2017), underpinned by a critical realist paradigm. The critical realist paradigm recognises that knowledge is constructed from within the participants and the researchers' accounts, yet also affirms that the accounts derived from experiences are based on objective reality (Gorski et al.,

2013). Besides this, the researcher's understanding of these is filtered through each person's own experiences, perceptions, values, and biases. Thus, the researchers aimed to achieve faithfulness in representing the data while recognising subjective 'truths' as the participants viewed and expressed them.

The primary author followed a six-phase guide for thematic analysis (Braun & Clarke, 2006). He familiarised himself with the data by listening to the interviews, reading, and rereading the data to identify codes in relation to the research question. The coding was semantic in that he focused on identifying and describing the surface meaning rather than looking for latent meanings in the scripts. He then searched for potential themes in an iterative process, crosschecking them against the codes and content in the codes. A second researcher read the transcripts and checked the codes and initial themes to ensure congruence with the data. The themes developed were reviewed with a research team of two males and two females until consensus on the final themes was achieved. This aimed to ensure the written narrative in the final report had stronger representational accuracy with codes and topics well supported in the data.

## Findings

The therapists in this study were asked to talk about issues associated with their work with men, what they thought other therapists might need to know about men, and the specific characteristics Australian men display. The questions invited broad generalisations of Australian men as a category. Some therapists answered questions by illustrating their answers with specific issues (e.g., anger) they assisted men with. Others drew attention to men identified with various occupational classes, religious affiliations, sexual orientation, and ethnic cultures and discussed how these identities intersected. While the information below focuses on broader themes represented in their answers, this information should not be interpreted to suggest men are a homogenous group.

The interview data was divided into two major themes, with four subthemes for theme one and three subthemes for theme two. These are listed below in Table 1.

**Table 1**

| Themes | Subtheme |
|---|---|
| Men must perform manhood well | Men must demonstrate capability and strength<br>Men must be prepared to endure hardship<br>Men are reluctant to show vulnerability<br>Men must deprioritise and conceal emotions |
| Men as damaged and devalued | Damaging socialisation experiences<br>Impacts of neglect and damage<br>Devaluation of men |

### Theme 1: Men must perform manhood well

The first theme focuses on the performance of several masculine norms and the resulting strain that this produces for the man. The male-friendly therapists perceived that men, specifically their clients, perceive pressure internally and from loved ones, peers, colleagues, and society to enact their manhood adequately.

> If I can do such stuff, you know I'm generalising now, do stuff then I'm adequate. If I can fix the car, I can mend the bike. I can mow the lawns. I can get the kids up and do whatever to do, and then I'm okay because I'm judged by what I do. (MC-14)

> Boys are definitely shown ways of behaving by other men, by models of adult malehood [sic] that are different around being strong, being self-reliant, learning to cope on your own, and not showing your feelings truly. (MC-11)

These performance requirements can impact men's coping, relating, and sense of responsibility. Men must appear strong, endure hardship, avoid appearing weak, demonstrate adequacy, and deprioritise emotions.

#### Men must demonstrate capability and strength.

A key requirement for the performance of manhood is that men must appear strong and capable. FP-2 noted that "To be a man is to be strong and hold it all together and provide". This requirement includes silently enduring and concealing pain and displaying invulnerability. MP-8 described the invulnerability as "bulletproof men who get hit by bullets and keep running". They must exhibit self-sufficiency, demonstrate endurance despite costs, and consistently perform their duties as providers and workplace performers, irrespective of the personal sacrifices required.

The therapists offer several reasons about why boys and men enact a commitment to be strong. Explanations included modelling from other men, conditioning, and meeting expectations (from other people or various external conditions). These functional expectations require men to provide stability and security to loved ones, society, and the workplace. One therapist personalised his response, linking men's roles with the protector of loved ones and society if needed.

> It's been our role in defending, taking care of, and making sure the family members are safe and available to fight if necessary, whether it's for your family or your country. (MC-11)

A few therapists emphasised that men feel highly motivated to provide for their families financially and must maintain a firm commitment to their income source. According to the Conformity to Masculine Norms Inventory (Mahalik et al., 2003), this would be regarded as the Primacy of Work factor. This commitment to the workplace with a goal of provision was also cited as a source of stress.

> Men are so loyal to their families. They're so afraid of failing their families. They don't want their kids to go hungry. They want the best for them. ..when their children are born, there's a massive shift inside the male psyche… "Oh my God, I'm now a provider, I'm now responsible." (MSW-13)

Some therapists indicated that men have no choice but to adopt toughness to compete and survive, particularly if they perceive inadequate support. They may also have a reluctance to reach out if support is available.

> I would think that out there in the world, …the corporate world, the world of business, it's dog eat dog. It's very competitive. (MC-11)

> I know from what clients have told me… the main thing is that we have a stereotype of the male. He has to cope with everything. He has to be the strong one. He has to manage everything. A lot of men that I see are truck drivers or tradesman and they work horrendous hours. Work cultures have a bullying and bantering aspect behind them and there's nowhere to go and there's no support and they just have to just toughen up and deal with it. (FC-3)

These statements from therapists commonly linked performance pressures with men's vocational work. The motivation for maintaining the performance was from a fear of

failing their families or a desire to accrue material success.

### Men must be prepared to endure hardship

The toughness required of men was not described as a temporary display of strength but appeared to be a requirement of ongoing toughness, involving maintaining strength and performance over time. Therapists believed men feel required to endure to the point of harm, whether the harm is caused by overload, receiving insufficient support, or a combination of the two. This was most notable in relation to their commitment to work. Men believe they must endure workplace conditions, including long hours and strenuous expectations in fulfilling the roles they believe need to be fulfilled as men.

> You have to look at the environment that the man is working in; very often they are extremely unhealthy…. It's terrible for them because a lot of them just go home and they can't cope and they're exhausted. Their self-care is terrible, they don't get enough sleep. This stereotype that the man can just keep going and cope with everything like a machine is just not true. (MC-3)

Part of the toughness requirement is to display endurance and strength without requesting or requiring assistance. Self-reliance was referred to or implied as men attempt to cope with their work and emotional burdens without the aid of others. The therapists believed men felt expectations to show capability associated with provision for the material needs. Some of this related to maintaining a level of status, and some were to meet the obligation to provide for their families and perform well in their work.

### Men are reluctant to show vulnerability

> This whole thing of being tough and strong and self-reliant means that you can't acknowledge your vulnerability. (MC-11)

Therapists described how a component of projecting strength, endurance, and stability for others relied on concealing weakness and emotional vulnerability. Vulnerability was juxtaposed with toughness. Men often believe that they would be stigmatised by others as weak or deficient as men if they disclosed weakness. Maintaining a veneer of coping, avoiding talking about difficulties, or responding with aggression were strategies that were highlighted.

> Probably summed up in a term that I'd call vulnerability is seen as a weakness rather than a strength. (MC-15)
>
> There's a fear factor that they're seen as less or not potent, in their own sense of themselves. So, there's a lot of covering up. There's a lot of armouring themselves... (MC-1)

MP-10 highlighted that younger men will often heavily regulate expression, particularly of emotions and struggles, to ensure they maintain gender role expectations to appear strong.

> It's all the men that still the stereotype that men don't go there, we're not helping to carry a permission to express freely. It's very important to fit in so you don't go outside the norm in terms of peer groups and role models…. (MP-10)

The gender role expectations to conceal vulnerabilities were highlighted by describing the hyper-masculinised environment of a men's prison. FP-2 highlighted the social risks of vulnerability within a prison context, whereby inmates fear consequences of having displayed evidence of revealing vulnerability.

> Sometimes it's when I'm talking about that vulnerability … their fear is sometimes that it will mean that they take that outside the session, and they won't be able to pull it all back together... You cannot walk out the door of a session with the psychologist and show any vulnerability because that's actually dangerous. In prison, it's even more so. You have to be able to hold your shit together, so to speak. (FP-2)

This reticence to disclose vulnerability has a negative impact in terms of help-seeking. The act of reaching out for help can be perceived by men as admitting failure as a man. This can leave them to struggle in isolation with personal problems and insecurities or attempt to cordon off awareness of their concerns through diversionary strategies such as substance abuse, denial, excuse-making, and/or emotional numbing. MP-10 discussed their unsuccessful attempts to deal with their concerns in isolation.

> Don't talk about your uncertainties, hold it in, keep your head low that something will drop in your lap and that'll be the solution and you'll be right. Of course, usually things don't drop in your lap so men can stay in a deficit position for a long time. (MP-10)

To conceal vulnerability and maintain an image of strength, men believe they must refrain from disclosing or displaying more vulnerable feelings and pain.

### Men must deprioritise and conceal emotions

Over two thirds of the therapists highlighted patterns of society actively shaping men to deprioritise their emotions.

> [The] practices of rearing boys. How can I put it? They don't encourage emotional sensitivity, let's put it that way. (MC-11)
>
> I think I find a lot of men don't sit with emotion or they're told that emotion is not okay. (FSW-12)

The therapists described how men learn to restrict both their experience and expression of emotions. They also tend to lack language to describe, articulate, and differentiate emotions, and deaden awareness of emotions to varying degrees, as they tend to prioritise cognitive processing and a non-relational task-oriented focus. Talking about and expressing feelings has not been encouraged, and several therapists highlighted that men often have restricted emotional vocabularies.

> A lot of them can't even express themselves emotionally. They don't have the words. Asking a man sometimes how he feels is very confronting because he may be so shut down and he may not know his emotions. He may not have the words to actually be able to speak that and you have to be able to work with that. (FC-3)

Therapists identified that the inexpression and restricting of emotions is learned from gendered childhood prohibitions, from role modelling of other males, and also actively used as a coping mechanism.

> A lot of men don't express how they feel either because I think when there is trauma, one of the coping mechanism is to shut down. If you shut down your emotional system, then you can be immune from feeling… Not feeling is a protective mechanism. (FC-3)

Anger was an emotion highlighted that many men do experience. In describing how men shut down their emotions, FC-3 highlighted how they default to anger.

> Often, the only thing they know is anger because we all defer to anger. It's easy to express that, it's easy to say, "I'm angry." (FC-3)

Appearances are important. Men may be aware when they are not coping internally, but nonetheless attempt to project the appearance of coping. MP-8 described a client who was given responsibility to take on 'the man of the house' role as a young boy.

> Even if he was extremely upset or frustrated, he would rather cry in his room alone because he needed to be the man. (MP-8)

This theme of *Men must perform manhood* well, could best be summarised by the following quote from MC-11, who mentioned the conditioning of boys to need to be strong, to conceal vulnerability and to not demonstrate vulnerable emotions.

> I would say that there is an unconsciously driven, but strong pattern in the way boys are raised. The classic, "Don't cry, boys don't cry." I don't know that that still applies anymore with children being born now so much because people are better educated, but certainly in my generation and generations following me. It's true that boys have been conditioned into feeling it's not okay to be vulnerable, to have either sadness or grief for that matter, in their lives. You've got to be strong, tough, and self-reliant. (MC-11)

## Theme 2: Men as damaged and devalued

The second theme moved from describing gender norms as noted by therapists, to explanations for the norms and for men's dysfunctions. Most therapists proposed that men in society and as seen in their practice, are damaged from their developmental socialising experiences and face ongoing misunderstanding and discriminatory treatment by society and, at times, therapists. This damage leads men to experience shame, difficulties with intimacy, and the reliance on various psychological defences. The underlying focus of this theme is both the contributors and the negative impacts of men's socialisation experiences.

> I believe it very strongly, that we do raise boys to be tough, to be self-reliant, to not show feelings, to not be intuitive... It's all unconscious, in terms of how people raise their sons. Nevertheless, the impact is, that it is tougher for boys to be able to trust themselves, and to be vulnerable. (MC-11)

### Damaging socialisation experiences

Five therapists highlighted the impact of formative childhood conditions, most notably as influenced by parents, as contributing to problems that men experience. This was through a lack of guiding nurturance, a lack of meaningful connection, or through punishment for violating gender norms.

> It almost comes where there's a bit of theme we're saying we need to recognise the historical influences on people, and not see them as just bad people who have developed bad habits. These are people shaped by a whole range of different forces. (MC-11)

Fathers were described as having a pivotal role in the development of boys, and when this role was not done well, it impacted negatively on the sons, their fathering, and their intimate relationships. "There's sort of some developmental issues almost that a lot of men have—the relationship with their fathers" (MC-1). Fathers who were absent, unavailable, uncommunicative, non-affirming, abusive, failed to provide an adequate guidance or an environment for their sons to develop a secure sense of self. The requirements of fathers to nurture their sons was that they provide a positive role model and that they affirm the child's worth as a person. MC-7, a psychodynamic-oriented therapist, highlighted that parenting that lacked affirmation and guidance contributed to a hidden sense of pervasive shame.

> I think there's a deep sense in a lot of the guys I see, that they're not okay. It's seriously like, they're not just a scratch as a human being, as a man. There's that sense, that parents never nurtured him in the way that they could see their worth. (MC-7)

MC-7 noted much of this came from deficits in his client's emotional development came from their parents, most notably fathers. This shame, for MC-7, was what was behind the reluctance and defensiveness that can be displayed by men in therapy.

Two therapists spoke about mothers also having an impact, with MC-9 indicating the psychological damage caused by mothers is as significant as that caused by fathers but was rarely discussed. For him, when both father and mother failed to provide sufficient affirmation of the son's worth, it created psychological wounds that carried over into adulthood if left unaddressed. MC-11 proposed that when mothers discouraged their sons from displaying vulnerability to help develop toughness that it may lead to problems in their future intimate relationships.

> I think why men have difficulty in their relationships very often compared to that of women is because there's been problems with their mothers as well. Because their mothers put expectations on them to be tough, strong boys so vulnerability is not encouraged. If you can't be vulnerable, you can't be loving truly. Men often have difficulty with intimacy. (MC-11)

Four of the therapists stated that at least some of their male clients had trauma histories. They described a link between trauma experiences, emotional in expression, and various psychological concerns. FC-3 believed early trauma was underpinning many of men's anger problems.

> That's one thing I've learned that we label men as angry, but I think a lot of them are traumatised…. They've grown up in abusive homes, they've been abused themselves. I've had a lot of them, not all of them… but a significant number, more than 50% will have stories of abuses…. Then, the anger just follows them around their whole lives, and I think that depression, anxiety, anger, addictions, they're generally symptoms. (FC-3)

The gendered social conditioning was cited as another reason for damage to men and boys. The socialisation processes not only have the potential to create trauma and developmental delays, but the restrictions imposed on boys about emotional expression reduce their ability to cope sufficiently. The conditioning included inculcating boys with the rules that they must demonstrate toughness, strategies for coping with problems, as well as teaching them to disconnect with or suppress their more vulnerable emotions.

> It's true that boys have been conditioned into feeling it's not okay to be vulnerable, to have either sadness or grief for that matter, in their lives. You've got to be strong, tough, and self-reliant. (MC-11)
>
> I think men, we've been allowed to be emotional beings in to about seven years old and then after that our ego starts to develop, and we're not allowed to show emotional vulnerability. We can't show that so we armour up and we convert and we learn to suppress those painful vulnerable emotion then we convert them into anger or convert anxiety. (MSW-13)

### Impacts of neglect and damage

Due to their upbringing involving socialisation towards toughness, independence, suppressing emotions and weakness, and for some, the impact of trauma, the therapists often linked these with various personal and relational deficits. The male's sense of self-worth appeared linked with satisfactory performance of strength, endurance, toughness and competency; and its counterpart, the hiding of weakness, vulnerability, and emotion.

> Yes, I would say that there's an unconsciously driven, but strong pattern in the way boys are raised. ... It's true that boys have been conditioned into feeling it's not okay to be vulnerable, to have either sadness or grief for that matter, in their lives.

You've got to be strong, tough, and self-reliant. (MC-11)

This accompanies a sense of fear, defectiveness, and shame, particularly the exposure of the vulnerability or flaws to others, so therapists reported men would often attempt to conceal them. According to MC-14, the experience of vulnerability for many men may be accompanied by intense undesirable internal emotional reactions. The evoking of vulnerability in therapy may activate a powerful sense of fear and shame.

> I think most men are terrified of stepping into that space of being vulnerable. …. Shame is telling us that we're inadequate. Shame is telling us that we're useless, we're poor providers, we can't do anything right, we get everything wrong. But shame is not telling us that at all. All that shame is telling us is at mid-moment I may have done something wrong. But *it reminds us of all those things that we think we should be as a male.* (MC-14, emphasis added)

A number of therapists talked about a reservoir of pain, often unconscious, that boys and men carry but do not feel willing, sufficient trust, or permission to experience and disclose. Some therapists related this to trauma, while others to socialisation experiences that required emotional suppression and may have humiliated boys who showed more vulnerable emotions.

> There's been really much discourse around the deeper, "I'm hurting. I'm vulnerable here. I hate vulnerability. I can't show anxiety. I've never been allowed to show anxiety in a football field because I would have been crucified." (MSW-13)
>
> I think we often lose sight of the little boy in men. Sometimes it's about accessing that really painful space that the little boy has had to struggle with. … It's about tapping into that real space where very few people will go to or allow others to access for them. (MC-1)

**Devaluation of men**

Almost all the therapists believed society negatively discriminated against boys and men, but in different ways. Some gave examples from upbringing, socialisation, from society from therapy and from within intimate relationships.

The most common concern was that men and boys had been damaged because of a lack of attention to their needs and the marginalisation of the male feelings and voice. MC-6 highlighted that men were trained to conform to the expectation of others and, as part of this conformity, were required to shut out their own emotional experience. Men were trained to self-stigmatise, tune out, and repress their own emotions from a young age as part of their male socialisation, thus losing touch with their own internal senses and voice within. In addition to this, Anna implied there may be a disinterest towards the needs of men:

> I think a lot of people [work] with women in counselling and men are often seen as the problem and I think … men have just as many worries and feelings and problems as women do…. Often when they're coming to counselling it's really the first time they're sitting with someone who actually really is interested in hearing…. (FP-2)
>
> … I think it's a little bit difficult because it goes into the political thing. Because when it will look like we have a voice, we can understand to be a man, then we get crucified, if they don't understand what we mean. (MC-14)

Society itself was portrayed by some therapists as being tilted to support women and discriminate against men. Different therapists identified different examples to help emphasise this perception. MC-11 talked about male victims of domestic or sexual violence as being ignored, men's aggression only held as culpable, and that society can treat fathers as dispensable in the family unit. MC-1 and MC-4 both spoke about training that emphasised gender in relation to female perspectives only. MC-4 highlighted that: "…when I first started in my journey as a counsellor, I was actually told … I needed to be less masculine". Later in the interview he said:

> I think sometimes they're disempowered by society because you can't be angry. You can't do this. You can't do that. ... I did some work … where everybody … had to reapply for their jobs. … The thing that really made them angry [was] that they knew that some of the people who would take their jobs would be the … female employees, because if they keep the females that makes their gender ratios equal. (MC-4)

MSW-13 noted that society tended to highlight male faults while neglecting attention to men's needs.

> Nobody ever identifies that for them. There's no, "How are you coping with the, "You're now a provider for another mouth." It's the focus on the mother and the child, which is fair enough, but what's going on for you?... It's all about violence and sexual abuse". (MSW-13)

Both male and female therapists noted that therapists can default responsibility for problems and present the burden of change to the male in the heterosexual relationship, or ignore the man's own needs, perceptions, and feelings. The therapists and the men's partners, for some respondents, may be tempted to oversimplify and stereotype the male rather than work with each person with full dignity and voice. They noted they would attempt to invite female partners to learn to understand the male partner's voice as part of the process rather than defaulting the relational problems to the man.

> Just because he's male and you're a female doesn't make him wrong and you can really get lots of mileage out of just hearing him and affirming as a male and it's okay to be a male. (MC-14)

An exception to most therapists who viewed men in some ways as being discriminated against or having lower access to social support was MC-5, who worked within a pro-feminist domestic violence paradigm and context. For him, the issue was that men's violence arose from their patriarchal privilege, power, and a sense of male entitlement. MC-5 highlighted that he still treated men with value, positive regard, and support, while viewing their justifications and accusations against their partners as attempts to avoid responsibility for their behaviour and misuse of power. Alternatively, for females concerned about their own aggression in the relationship, he helped them see they were not responsible for their aggression, but "that's her way of dealing with what we refer to as a violent relationship". For MC-5, the men were solely responsible for relationship aggression, while for females, he would reframe their aggression as understandable.

## Discussion

The findings from this study show that men's therapists are mindful of masculine norms as also identified in scholarly literature and have theories about how men adopt these norms and why they are distressed. The interviews were conducted in June 2017, before the APA (APA Boys and Men Guidelines Group, 2018) guidelines were released, and near the time of the APS (APS, 2017) guidelines publication date. A minority (n=3) of the participants were psychologists and the APS document was only available to members. To our knowledge,

no other Australian profession-endorsed practice guidelines were available on working with men. The data representing the therapists' views was categorised into three closely interrelated themes; that men must perform manhood well, and have been damaged and devalued. The interviews were categorised into two closely interrelated themes; that men must perform manhood well that described recognised norms associated with traditional masculinity, and that men have been damaged and devalued, mostly in their socialisation experience and also from prejudicial treatment.

The first theme reflects the discourses of men's therapists in how they describe these common characteristics of men. At a general level, theme one builds on current knowledge. Existing literature discusses precarious masculinity, norms of toughness, independence and emotional stoicism, fear of the feminine (or antifemininity), commitment to work, commitment to status and success, reluctance to show vulnerability and to seek help (Addis & Mahalik, 2003; David & Brannon, 1976; O'Neil, 1981; Vandello & Bosson, 2013). All norms, with the exception of fear of the feminine and the status and success norm, were explicitly referred to by the sample of therapists.

The fear of the feminine is represented in the influential GRC ideology as a key motivator for male norms and ideology (O'Neil, 2013). This includes attempts to avoid appearing feminine such as not appearing to be dependent or emotional (Kierski & Blazina, 2009). In this research, fear was not specified as a motivator. However, the subthemes of reluctance to show vulnerability and the concealing of emotions are stereotypically linked with women (David & Brannon, 1976; O'Neil, 1982). Rather than directly appealing to fear of the feminine as a motivator, one maintained a motivator as patriarchal control, another as reflecting natural sex differences, while the remaining therapists focused primarily on the impacts and restrictions of socialisation and the fear of failing to maintain masculine norms.

The second implicit norm represented was seeking status and success. Often, success and status are associated with aspirational competitiveness and can be aligned with egotistic attainment, whereas for this sample, its focus was a fear and avoidance of failure of meeting masculine standards. This may reflect that male-friendly therapists may see men struggling to gain or preserve basic masculine status rather than building additional status.

The narratives of the therapists provide a rich descriptive context of the perceived interplay between men's experiences in family, work, and society; their masculine norms; and presenting them as meaningfully related. For instance, therapists linked emotional inexpressiveness with emotion-shaming messages in children and adulthood. Thus overall, rather than portraying potentially problematic aspects of masculinity as a means for attaining power and control or fearing the feminine, most framed masculine norms as conscious and unconscious attempts to adapt and cope within their social context using the conditioned responses developed in their socialisation. The norms also represented solutions of men to avoid aversive treatment and judgements, and to meet minimum standards for the male role one was required to perform. These more positive interpretations may have been partly due to the interview context about 'male-friendly counsellors' and their therapeutic responsibility to empathically situate themselves with male clients. Adopting negative evaluative positions might undermine empathic alignment.

Discourse on men can sometimes focus on power, control, privilege, entitlement, and status-seeking. Yet the second theme captured a focus on men starting from a position of being damaged, ill-equipped to cope with the damage, unsupported socially, and struggling not to fall into deficit. Therapists spoke of aggression, anger, addiction, depression, relationship issues, and shame as commonly associated with male trauma symptomology, whether it be from abuse, neglect, or the shaping of boys towards toughness and stoicism leading to emotional and relational disconnection and impaired coping strategies. The male socialisation processes have been regarded to be potentially traumatic (Levant, 1995, 2005; Lisak, 2005; Pleck, 1995) for males and that internalisation of some norms of traditional masculinity, such as stoicism, may retard or prevent recovery (Lisak, 2005) or reduce likelihood of achieving optimum mental health. Various authors have suggested that masculine norms of repression of emotions, independence, and concealing of vulnerabilities are part of their coping (Crete & Singh, 2014), and that society's general blindness to male trauma and victimisation (Lisak, 2005) mean that men's trauma often goes unacknowledged and unaddressed.

Therapists talked about the formative experiences that shape masculine norms and contribute to their problems and restricted coping resources. Psychoanalytic and psychodynamic paradigms emphasised the impact of normative male childhood trauma related to parent-child interactions and, most notably, early emotional separation boys experience from their mothers that can negatively shape their psychological development (Addis & Cohane, 2005; Pollack, 1998; Rabinowitz & Cochran, 2002). One impact of this is the adoption of defensive autonomy; the attempt and struggle to demonstrate independence yet still be dependent (Pollack, 1990, 1998). Likewise, the quality of the relationships with fathers has been noted to have profound effects on sons (E. D. Miller, 2013). The 'father wound' refers to damage or neglect of boys' emotional needs by the father, such as not emotionally connecting with the father, not being able to gain the father's approval, or experiencing an overly harsh and demanding father (Levant, 1996). The impact can affect the psychological and emotional development and is often repeated intergenerationally if not resolved (O'Neil & Lujan, 2010).

The concept of shame has been explored for understandings about men and their development. Shame can be understood as a painful feeling of inadequacy and unworthiness (Blum, 2008). In psychoanalytic theory, shame has been suggested as connected to emotionally leaving the mother to be aligned with the father (Osherson & Krugman, 1990). It has also been linked to perceived failures to meet masculine norms both through humiliation from others and self-criticism (Shepard & Rabinowitz, 2013) and often results in attempting to conceal vulnerability (Krugman, 1995). The descriptions of shame provided by the therapists were congruent with writers on male shame.

In this study, two-thirds of the therapists highlighted men faced discrimination, misunderstanding and devaluation from society, and at times, educators, employers, therapists, and female partners, and noted that men did not receive the same degree of social support as women. These comments implicitly and occasionally, explicitly suggested that society, social norms, and some female partners, demonstrate unfair prejudice and treatment towards men that contribute to their distress and problems. While male-friendly counselling literature recognises the potential of bias against males in treatment and assessment (Mahalik et al., 2012), that individual males may be vulnerable

to victimisation (Englar-Carlson, 2014; Monteith et al., 2019), and that minority males experience intersectional oppression (Good et al., 2005), it has largely apportioned responsibility for men's problems on gender socialisation towards rigid adherence to traditional masculinity (Wexler, 2009) within a patriarchal social context that still largely benefits men (APA Boys and Men Guidelines Group, 2018). This position reflects the pro-feminist men's liberation perspective (Flood, 2007) and is "aligned with a strong activist stance of reducing patriarchal power, male dominance, male sexism, and the restructuring of masculinity itself" (Englar-Carlson & Kiselica, 2013, p. 401). An alternative position proposed by a smaller number of available texts, often cited by men's rights activists, list concerns that society disadvantages, discriminates against and scrutinises men in varying degrees; while claiming modern Western societies now show systemic favouritism and support to women and girls (Ashfield, 2011; Benatar, 2012; Farrell, 1993; Hoff Sommers, 2015; Nathanson & Young, 2001). Pro-feminist and men's rights advocates can be highly critical of each other's positions and motivations (for example, see Kimmel, 2010; Nathanson & Young, 2001), and reflect deep ideological differences that influence the perceived reasons they assign for male problems. Taken as an aggregate, the therapists predominantly foregrounded gender norm socialisation and restrictions as the dominant focus, with some therapists perceiving broader social prejudice against men as contributing to their problems.

There were two main gender philosophies of individual therapists evident. As mentioned earlier, most therapists emphasised socialisation as what primarily shaped and impacted men. These therapists emphasised understanding the socialised impacts and gender role stress on men and helping to heal and liberate them from the effects and constraints through a combination of understanding and education. Three male and one female therapist appeared to hold what might be classed as more gender essentialist views (Heyman & Giles, 2006). They endorsed the 'naturalness' of masculinity, identified with their own sense of personal masculinity, while two of the male therapists emphasised a natural masculine essence or energy. These therapists emphasised acceptance and adaptation of treatment for men and might find the psychology of men challenging to their more gender essentialist perspectives. Overall, the therapists in most ways, were more alike than different in emphasising common therapeutic factors (i.e., unconditional acceptance, authenticity etc.) according to their preferred modality and evidenced strong compassion towards men.

Australian therapists practice from a wide range of therapeutic modalities (Bloch-Atefi et al., 2021), so there would be a diversity of thoughts about males. However, the male-friendly therapists' views and interpretations may also reflect sparse opportunities for training in men and masculinity studies in Australia and may echo a range of sources of influence beyond personal experience and the counselling room itself. Australian popular and professional thought has been influenced by the mythopoetic men's movement and bestselling author and psychologist Steve Biddulph (Biddulph, 1995, 2013), who drew from Bly (Bly, 1990; Buchbinder, 2013). The feminist Duluth model for domestic violence (Phillips et al., 2015) has been influential in the domestic violence sphere at a practice and policy level, while academic sociologist Raewyn Connell (Connell, 2005) and proposer of the hegemonic and multiple masculinities theories has had considerable influence in the academic domain. While there was a therapist who espoused a masculine essence theory and another who aligned with the feminist domestic violence model, most appeared to reflect a social learning and gender role stress approach to understanding male distress. Given training in men and masculinities studies in Australia is relatively uncommon within psychology, counselling, and social work, the making sense of men's distress by male-friendly therapists is likely to continue to demonstrate the diversity of interpretations.

## Recommendations

Unsurprisingly, the male-friendly therapists who participated in this study appeared gender-aware, particularly in relation to gendered social norms and impacts experienced by males and evidenced reflectiveness in their gender journeys. The major guidelines for working with males (APA Boys and Men Guidelines Group, 2018; APS, 2017) recommend practitioners develop an understanding of gender socialisation on male mental health. The APS (2017) guidelines also recommend therapists working with males familiar with research literature develop a more informed understanding of the complex and diverse contributors to male experience. While there is a diversity of theories that inform understanding of men's experiences and issues, engagement with key theories and their criticisms (see Edley & Wetherell, 1995) might assist in developing informed gender-sensitive frameworks from which to integrate into practice. Given gender is central to many clients' identities and experiences, training in gender-sensitive treatment should be a part of foundational professional training or be accessed via various forms of ongoing professional development.

For the research community, this study highlights most of these male-friendly therapists interviewed believed men were vulnerable to discrimination at a more pervasive level, in various specific domains. Researchers might inquire about what informs these impressions, how pervasive and accurate are these impressions, and what might these impressions mean for male-friendly counselling education, and therapy with men.

## Limitations

There are several limitations of this paper. The first is that some may view this as a weakness by not taking a firm position in relation to the existing literature. For instance, where therapists vary from currently preferred theoretical positions, is this an indicator of inadequate training, or are current theoretical conceptions too constricted? Although we asked how therapists came to be interested in working with men, we did not inquire about the sources of their understandings of men. Some volunteered their learning came from their gender journey, from clinical experience with men or men's programs, and popular books (for example, Biddulph, 1995). None mentioned higher education courses on men, and none used more technical terminology associated with men's studies (such as Gender Role Strain). Finally, although participants were afforded opportunities to check the accuracy of the verbatim transcripts, they did not review the final themes. Member checking of themes and subthemes may have enhanced confidence in the credibility of the themes (Birt et al., 2016).

## Conclusion

Previous research (Beel et al., 2020) explored what

Australian private practice male-friendly therapists recommended for counselling male clients. This current research articulated their underpinning beliefs and perceptions about how these therapists perceive men, their issues, and the social context they experience. The themes positioned men as burdened, damaged, and unsupported as boys and men, contrasting discourses of men that emphasise their social advantage and privilege. The therapist's own gendered experiences, reflections on their gendered journeys and experiences with men, therapeutic training, interactions with male clients and partners, and observations of society all appeared to have contributed to their understanding of how they viewed men and their problems. The comparative lack of alluding specifically to gender theoretical frameworks by the practitioners may be in part a reflection of the interview format and questions asked; however might also reflect the relative unavailability of such training in educational programs (Mahalik et al., 2012; Mellinger & Liu, 2006) in the therapist's localities and disciplines. While these therapist opinions and perspectives reflect a range of influencing factors across personal, professional, and therapeutic domains, they serve as a starting point to generate discussion between clinicians, researchers, and educators.

## Bio

**Dr Nathan Beel** is a Senior Lecturer (Counselling), and the Counselling Discipline Lead at the University of Southern Queensland.

**Professor Charlotte Brownlow** is the Associate Dean (Graduate Research School) at the University of Southern Queensland.

**Dr Carla Jeffries** is a Senior Lecturer (Psychology) at the University of Southern Queensland.

**Dr Jan du Preez** is a Senior Lecturer (Psychology) at the University of Southern Queensland.

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# An Exploration of Challenges and Social Support Among Recovering Counsellors in Substance-Abuse-Treatment Agencies in New York, USA

**Azahah Abu Hassan Shaari**

This qualitative study explored the challenges and social support of 18 recovering counsellors working in substance-abuse-treatment agencies in New York, USA. Results highlighted heavy workloads, countertransference, and witnessing clients' resistance to quitting using drugs as complex challenges in their roles as counsellors. Findings also revealed that participants regularly attended peer-support 12-step meetings, saw personal therapists, and talked with supportive coworkers to sustain their own recoveries while providing counselling services to substance-abuse clients. In the context of high turnover and burnout among counsellors working in the substance-abuse-treatment workforce, an understanding of challenges and strategies to seek support will improve their mental-health quality and overall wellness.

**Keywords:** *Counselors, New York, recovery, social support, substance abuse.*

## Introduction

Substance abuse has been recognised as a chronic disease and the leading cause of high mortality and morbidity rates in the United States. Approximately 10% of the general American population have lifetime struggles with substance use disorder (SUD), and more than 23 million adults in the United States struggle with problematic substance abuse (Ignaszewski, 2020). Substance abuse has long resulted in deleterious consequences on people's physical health, psychological well-being, and overall quality of life. In 2020, drug overdose deaths in the United States rose nearly 30% to 93,000, accounting for more deaths than car crashes, gun violence, or the AIDS epidemic (Katz & Sanger-Katz, 2021).

Substance-abuse-treatment agencies play crucial roles in combating substance abuse's societal and health impacts. In 2020, an estimated 14,500 specialised substance-abuse-treatment facilities will provide counselling, behavioural therapy, medication, case management, and other types of services to people suffering from substance abuse (National Institute of Drug Abuse, 2020). In 2019, there were approximately 319,400 counsellors working in substance-abuse-treatment agencies. It is projected that workers in this position will increase to 398,400 by 2029 (Bureau of Labor Statistics, 2021). Recovery from substance abuse is a unique characteristic of many counsellors working in substance-abuse-treatment agencies (Baverly, 2020; Nielson, 2016; Simons et al., 2017). Fialk (2018) estimated that approximately 60% to 70% of people in recovery from substance abuse work as counsellors in addiction-treatment agencies. Despite these high percentages, there are still limited studies that have examined the challenges and social-support systems of this population.

Currently, existing studies regarding counsellors in recovery from substance abuse focus more on topics such as relapse and overcommitment to work (Eddie et al., 2019; Greene, 2014; Greene et al., 2019; Jones et al., 2009; O'Sullivan et al., 2015; Shannon, 2017), and risk for experiencing countertransference when working with substance-abuse clients (Knight, 2015; Reamer, 2020). At the same time, previous research also has shown that many recovering counsellors in addiction-treatment agencies were reluctant to attend support groups and were averse to recovery-focused supervision due to concerns that their participation would diminish their credibility as counsellors (Dingle et al., 2015; Warren et al., 2011). Unfortunately, most of the studies are quantitative and conceptual in nature. Consequently, this study seeks to explore recovering counsellors' insights into the challenges they face while working in the addiction treatment field. It also seeks to explore their social-support networks to sustain their own recoveries from substance abuse while providing counselling services to current substance-abuse patients at addiction-treatment agencies.

Corresponding Author: Azahah Abu Hassan Shaari
Email: azahah.ah@umk.edu.my

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Specifically, this study seeks to fulfil these two specific research aims:

1. Explore recovering counsellors' perceptions about challenges they face while working as counsellors in the substance-abuse-treatment field.
2. Understand the social support that recovering counsellors use to sustain their own recoveries while providing counselling services to substance-abuse clients.

# Literature Review

## Challenges for Substance-Abuse Counselors

This section examines previous research on the challenges for recovering counsellors working in substance-abuse-treatment agencies, including the risks of relapse and burnout.

### Risk of Relapse.

Previous research has discovered a link between burnout and relapse (Baldwin-White, 2016; Doukas & Cullen, 2010; Oser et al., 2013) among those who are in recovery from substance abuse working as counsellors. Baldwin-White (2016) and Doukas and Cullen (2010) reported that overinvolvement with work and clients, discontinuation of seeking support, and emotional exhaustion are factors that predict relapse among recovering counsellors working in substance-abuse treatment. In addition to these factors, studies also have found that relapse contributes to health degradation and loss of credibility and intention to work, and it often leads to loss of employment (Doukas & Cullen, 2010; Greene, 2014; Greene et al., 2014). Furthermore, coworkers and clients who were directly involved experienced feelings of betrayal and deterioration of trust once they discovered the relapses of recovering counsellors (Doukas & Cullen, 2010; Eddie et al., 2019). A study by Jones et al. (2009) that surveyed 1,239 counsellors found that 38% of them experienced a relapse. A more recent study by Greene et al. (2019) of 265 counsellors found the percentage of counsellors who relapse was 14.7%. Despite the decrease in relapse percentage among recovering counsellors, there are still very limited peer-reviewed articles that discuss relapse among recovering counsellors (Greene et al., 2019).

### Countertransference.

According to Hartmann (2018), countertransference can be defined as a counsellor's thoughts, feelings, and attitudes toward a client's characteristics or situation based on similar life experiences between the counsellor and client. Countertransference negatively impacted the therapeutic-counselling process because recovering counsellors became more confrontational and failed to address the deeper core issues of substance abuse experienced by their own clients (Davis, 2013; Fialk, 2018; Gallagher, 2010; Kaplan, 2005). Furthermore, Ham (2009) found that counsellors' countertransference resulted in them viewing their clients either as outcasts or as manipulative people, which eventually led to the premature cessation of addiction treatment or client withdrawal. In some cases, countertransference was developed during an informal interaction or exchange between recovering counsellors and their clients outside their agencies (Adams & Warren, 2010; Knight, 2019; Reamer, 2020).

Studies from Greene (2014) and Shannon (2017) further described that recovering substance-abuse counsellors may establish informal relationships with their clients while attending peer support group meetings (known as 12-step groups outside the agencies). Additionally, when a recovering substance-abuse counsellor decides to disclose their recovery status to their clients, this potentially can result in a conflicted clinical relationship (Woehler et al., 2021). Most studies on countertransference found it to be problematic. However, practising effective management strategies, such as counsellors' monitoring the self-awareness and seeking supervision, are crucial to address any negative outcomes of countertransference, including overconcern, punitive issues, and loss of boundaries (Rácz et al., 2015; Rothrauff-Laschober et al., 2013; Woehler et al., 2021).

### Burnout.

Studies also have identified burnout as another significant challenge among substance-abuse counsellors. On the one hand, a few studies have examined factors that lead to burnout among substance-abuse counsellors, including heavy or demanding workloads (Beitel et al., 2018; Gutierrez et al., 2019; Landrum et al., 2012; Schmidt et al., 2013; Wardle & Mayorga, 2016), work with clients from the criminal justice system who lack the readiness to change (Manuel et al., 2017; Perkins & Sprang, 2013), and societal stigmas toward the counselling profession that view helping substance-abuse clients as impossible (Baverly, 2020; Vandewalle et al., 2018). Furthermore, a study by Oser et al. (2013) found that inadequate pay and excessive working hours were other factors that contributed to burnout among substance-abuse counsellors. Subsequent studies concluded that burnout among counsellors had affected job dissatisfaction, lowered job productivity, decreased organisational commitment, and increased turnover intentions (Eby & Rothrauff-Laschober, 2012; Wardle & Mayorga, 2016; Young, 2015). Eby and Rothrauff-Laschober's (2012) longitudinal study reported that the average annual turnover rates in 27 geographically dispersed addiction-treatment facilities were 33.2% and 23.4%, respectively, for counsellors and clinical supervisors. In a more current study by Hatch-Mailette et al. (2019), the turnover rates of substance-abuse counsellors within two years were found to range from 33% to 74%.

## Social Support for Counselors Working in the SUD Field

Given the potentially negative or stressful experiences that increase the vulnerability of counsellors in recovery from substance abuse, it is vital to examine the social support that contributes to building resilience among recovering counsellors.

### Attending 12-Step Meetings.

Many qualitative studies have explored active engagement with 12-step peer-support-group meetings among people in recovery from substance abuse (12Step.org, n.d., 12 Steps of Alcoholic Anonymous). Studies show that 12-step peer groups provide platforms for members to share their stories and enhance their sense of belonging while decreasing the feeling of isolation often experienced by people in recovery from substance abuse (DeLucia et al., 2015; Hofer et al., 2018; Lange-Altman et al., 2017). Regular attendance of 12-step meetings provided counsellors with a safe place to share firsthand experiences and resources and a way to sustain recovery (Myrick & Del Vecchio, 2016; O'Sullivan et al., 2015). Moreover, Lange-Altman et al. (2017) reported the importance of belief in a higher power and

spiritual components in 12-step programs, both of which were identified by members as powerful and sources of strength for them to continue their recovery journeys.

**Seeing Personal Therapists.**

Meeting with a personal therapist was reported as a significant help-seeking practice that provided counsellors with the ability to discuss concerns related to both personal growth (Sackett & Lawson, 2016; Simionato & Simpson, 2018) and professional growth to build a more therapeutic relationship with clients (Von Haenisch, 2011), to overcome disappointment, and to manage the stresses of meeting with abusive or unhelpful clients (Kumari, 2011; Sim et al., 2016). Personal therapy provides an opportunity for counsellors' self-reflection, professional learning, training, and the creation of healthy boundaries between themselves and work (Rizq & Target, 2008). Despite their potential effectiveness, most counsellors with SUD problems were reluctant to seek support because of the stigma attached to substance abuse and the risk of losing licensure or employment (Miller & Fewell, 2002; Warren et al., 2011).

**Support From Colleagues.**

Another facet related to social support is support from colleagues. Studies by Landrum et al. (2012) and Winning et al. (2018) surveyed counsellors in an outpatient drug-treatment program and reported that good rapport and knowledge sharing among colleagues increased productivity in working with their clients. Brooks and Matthews's (2000) and Coaston's (2017) studies of counsellors' self-care practices—including self-acceptance, a loving attitude, and wisdom for wellness—were correlated with better spiritual well-being.

In summation, previous studies have underscored challenges, such as the risks of relapse and burnout, and examined countertransference relationships between substance-abuse counsellors and their clients. Studies also have emphasised the importance of support mechanisms, such as participating in peer-support 12-step meetings and seeking personal therapy, to cope with the complexity of their recoveries and provision of their counselling services. However, most studies have been quantitative and conceptual in nature, with limited qualitative studies integrating both challenges and social support for recovering counsellors working in addiction-treatment agencies.

## Theoretical Framework

This study used the conservation of resources (COR) theory. The COR theory was developed by Hobfoll in 1989 to understand the emotional experience of individuals and aligns with the research objectives of this study: to explore the challenges as well as social support mechanisms of recovering counsellors working in addiction-treatment agencies. The COR theory identifies four types of resources: conditions, personal characteristics, objects, and energy that will affect the overall individual's well-being. Conditions are types of resources that are valuable, sought after, and treasured by an individual, for example, tenure or seniority (Hobfoll, 2001). Since conditions are valued, they will buffer against or reduce individuals' stress levels. Personal characteristics include having a healthy self-esteem and being open-minded and optimistic, which will equip the individual with better coping skills when dealing with stressful situations. Objects also are resources valued by the individual due to their physical attributions or status. Finally, energies are valuable resources that can be exchanged for other resources, such as time, money, and knowledge. In relation to this study, the object is to work as a substance-abuse counsellor. The conditions refer to an ability to recover from substance abuse. Personal characteristics refer to recovering counsellors' recovery statuses, and energies comprise the knowledge related to the complexity of substance abuse, withdrawal, and relapse.

## Methodology

### Study Design

This study employs a qualitative research design based on two reasons. First, a qualitative research design provides participants with the opportunity to share their stories and express their voices (Creswell, 2007). Secondly, Marshall and Rossman (2010) described that the exploratory nature of qualitative methods allows the researcher to capture participants' thoughts and gain a deeper perspective of participants' interpretations, which aligns well with the goal of this study (to shed light on the challenges and social support while providing services to SUD clients). Further, a narrative inquiry research methodology was adopted in this study. The narrative inquiry is an appropriate methodology for this study because it allows and enables a rich, deep, and intimate study of individuals' experiences over time and within context (Josselson & Lieblich, 2003). Secondly, a narrative inquiry provided an optimal method of understanding the lived experiences that recovering counsellors were telling in such a way that participants could interpret and make meaning of their own stories (Kaushik & Walsh, 2019) as recovering counsellors working in addiction-treatment agencies.

### Study Respondents

A combination of purposive and snowball sampling techniques was used to recruit participants from a nonprofit organisation in New York. A purposive sampling strategy was used to recruit participants from an addiction-treatment agency in Long Island, New York. Upon the data collection, I approached the agency's director and explained the purpose of the study. The director agreed to participate and wrote formal permission for me to collect data at the addiction-treatment agency. Furthermore, I disseminated flyers during the agency's monthly meetings, and interested individuals then contacted me directly via email or phone. During this initial contact through phone and email, I screened potential participants to ensure they met the inclusion criteria. Another strategy to recruit participants was through snowball sampling, in which respondents who completed the interview were requested to refer other potential individuals who had an interest in participating in the study.

### Respondent Inclusion Criteria

The sample of this study consists of people in recovery from substance abuse who are currently employed full time in addiction-treatment agencies. The specific selection criteria of the respondents were as follows:

1. Provide weekly counselling services to substance-abuse clients.
2. Have been in substance-abuse recovery for at least two years before working as a counsellor.

A counsellor who had a relapse within a month before the interview was excluded from the sample

## Respondents' Backgrounds

The final sample consisted of 18 recovering substance-abuse counsellors working in addiction-treatment agencies in the state of New York, providing counselling services to substance-abuse clients. In this study, 10 (55%) participants identified themselves as Caucasian, six (33%) as African American, one (6%) as Hispanic, and one (6%) as Native American. In addition, 12 participants were male (67%), and six (33%) were female. Participants' ages ranged from 35 to 66, with a mean of 53.6 years. Most (89%) reported being in recovery from substance abuse for more than 10 years and never having experienced a relapse (Table 1). Sixty-seven per cent had been working in the addiction treatment field for more than 10 years. All 18 recovering counsellors except one had attended 12-step meetings, and 13 reported that they still attended the meetings. Nine of 18 participants were working in outpatient treatment centres, seven in inpatient rehabilitation centres, and two in peer-run counselling centres.

**Table 1**

*Demographic profile of participants*

| No | Pseudonym | Length of recovery (years) | Years of counselling (years) |
|---|---|---|---|
| 1 | Sigmund | 35 | 10 |
| 2 | Randy | 38 | 36 |
| 3 | Ray | 13 | 8 |
| 4 | Lari | 15 | 14 |
| 5 | Jack | 25 | 6 |
| 6 | Jay | 33 | 32 |
| 7 | Jerry | 13 | 12 |
| 8 | John | 28 | 20 |
| 9 | Hailey | 31 | 28 |
| 10 | Lorri | 22 | 20 |
| 11 | Mitch | 3 | 2 |
| 12 | Ben | 24 | 18 |
| 13 | Jasmine | 5 | 3 |
| 14 | Mose | 13 | 13 |
| 15 | Darlene | 12 | 6 |
| 16 | Ruth | 28 | 25 |
| 17 | Tim | 24 | 22 |
| 18 | Carol | 20 | 16 |

## Data Collection

Data for this study were collected using one in-depth semistructured face-to-face interview with each participant. Before the interview, each respondent was asked to complete a short sociodemographic and background questionnaire. There were 18 interviews, and on average, they lasted approximately 72 minutes, the longest being approximately 88 minutes. As is the norm in qualitative research, the sample size in this study was decided by saturation (i.e., when the participant interviews were no longer generating new information, such as new themes and subthemes) (Padgett, 2008).

## Data-Analysis Procedure

All recorded interviews carefully were transcribed verbatim and analysed by the researcher. Each interview transcript was analysed based on Fraser's (2004) guideline for analysing personal stories in narrative research. First, I listened and relistened to the audio-recorded interviews to avoid producing "overintellectualising" personal stories and to think critically about the stories. Secondly, I transcribed the audio-recorded interviews to categorise the transcribed information into themes or patterns and organise them into coherent categories. Finally, all the similar and different themes that emerged from the data were combined to create in-depth stories about recovering counsellors' shared experiences.

## Rigour and Trustworthiness

To ensure the rigour and trustworthiness of the data, credibility, transferability, and confirmability were maintained throughout the study (Nowell & Albrecht, 2019). The credibility of the data will be maintained by using two techniques. First, member checking was used to minimise my own bias. After the interview, I contacted all 18 participants to ask whether they agreed to review the final subthemes and themes. Of 18, 10 agreed to participate and asked me to email the final themes and preliminary data. All 10 participants agreed with the final themes, and no further revisions and comments were received from participants. Secondly, I used peer review or debriefing with peers that had experiences in the field of substance abuse to guard against researchers' bias (Creswell, 2007, p. 208). For the peer-review process, I presented the emerging subthemes and themes to two counsellors working in the addiction treatment field, and no further revisions were suggested by either reviewer.

Transferability refers to the applicability of findings to other contexts (Nowell & Albrecht, 2019). This was maintained using a triangulation of methods during the data collection: (a) an audio recorder to capture laughter, sighs, and sarcasm-aural aspects of the interview, and (b) the author's field notes, which helped the author to process the full immersion into the data-collection experience (i.e., how to address interviewees' concerns). Triangulation will generate a solid description of the underlying phenomena (Padgett, 2016). To assist in reflexivity, I used an epoche that allowed me to account for my own bias, experiences, and interference in the interviews and data analysis (Marshall & Rossman, 2011).

## Ethical Considerations

This study was reviewed and approved by the researcher's university's Institutional Review Board (IRB). Participants reviewed, signed a written consent form, and discussed the objectives and scope of the study, including voluntary participation and the participants' rights to discontinue and/or withdraw from the study at any time without penalty. None of the participants withdrew from the study.

# Results

The results highlighted many challenges experienced

by recovering substance-abuse counsellors, including managing heavy workloads and dealing with countertransference and clients' resistance toward SUD treatment. For participants in the current study, seeking social support by regularly attending 12-step meetings, having personal therapists of their own, and talking with supportive coworkers are crucial components to support their own recoveries while providing effective counselling services for those seeking substance-abuse treatment.

## Theme 1: Challenges While Working in the Addiction-Treatment Field

The results highlighted addressing countertransference, heavy workloads, and clients' resistance as complex challenges in their counselling work in addiction-treatment agencies.

### Countertransference.

All participants clearly shared that their recovery status provided them with insights into addiction. At the same time, it also created a risk for participants to develop countertransference in managing their role as counsellors, in which they tend to insert themselves into situations instead of highlighting client needs. One participant describes this risk:

*I previously thought that working in the field would get me sober. I was trying to get from the field rather than give to the field. And all of [the] other recovering counsellors could be in danger of that. They think working in the field is going make them important and feel good about themselves. Guess what? It won't.*

### Heavy Workloads.

A significant challenge identified by many was the heavy workload. Most participants reported that, due to an acute shortage of counsellors, they ended up with a caseload of 35–40 clients per week at any given point in time, which severely curtailed the amount of time spent with their clients:

*I have somebody from 9 to 9:45, and then I would go to group from 10 to 11, and 11 to 12 is my next client, and from 12 to 1 is another client. I have lunch at 1 and come back at 1:45 because I have intakes at 2, and then at 3 o'clock, I would have another one until 4. So the time is not there at work because there are too many things going on.*

Additionally, the heavy workload toll forced participants to work longer hours, including until midnight and on weekends. Consequently, this affected their ability to provide comprehensive counselling services to clients. Some reflected on their colleagues' decisions to eventually quit the field of substance-abuse treatment.

### Witnessing Clients' Resistance to Change.

Another challenge that many respondents described is witnessing clients' resistance to initiating the change process toward recovery, especially among mandated clients. To some degree, participants reported being blamed by their own clients for not helping them, as participants explained below:

*People are here because they're mandated by parole, mandated by the court. They don't want to be here, so they resist, and their mentality is really different. They're not open to change. And they blame you, and it's a lot that you have to deal with.*

Participants also shared that, being a person in recovery, witnessing clients' reluctance could be unbearable and difficult, especially when it led to fatal overdoses:

*Overdosed and died or, you know, to see, like, a lot of the hardships that occur…those are difficult. And that's…that is… obvious. The other part is, for me, being in recovery, to know the result of something or to see something coming down the road because you've experienced it and not be able to convince them [to change].*

## Theme 2: Social Support to Sustain Counselors' Own Recovery

Findings revealed that participants actively sought support by attending 12-step meetings, meeting with personal therapists, and talking with supportive colleagues to sustain their own recoveries.

### Attending 12-Step Meetings.

Participants' narratives revealed that actively seeking support from recovery networks, such as 12-step programs, was an effective strategy that helped them to sustain their recoveries while working as substance-abuse counsellors. According to many respondents, regular attendance at 12-step meetings provided them with an opportunity to socialise with others who were in recovery and be privy to new and different perspectives:

*Everyone should get some help. And I got that from 12-step meetings. I have been in recovery for 25 years, and I still have a sponsor. My sponsor has about 16 years, which is less than my sober time. But he got different perspectives; he's Buddhist and has some interesting thoughts that are different from mine. So when we meet, I benefit because he got a different way of thinking.*

Another benefit of attending 12-step meetings for many participants was an opportunity to gain knowledge that they could apply while working with clients in the addiction treatment field, including ways to set up healthy expectations for others:

*I learned from the 12-step meetings not to put expectations on others. I learned that my boss is not always going to be right and that I am not always going to be right. It's not a battle that I will fight and win. So I apply the step that I've learned from the 12-step meetings in order to stay in the recovery, stay sane at my work, and for me, not become one of the relapse statistics.*

Attending 12-step meetings equipped the counsellors with a strategy to manage their negative thoughts and feelings, accept mistakes, and improve their self-confidence, eventually enabling them to work effectively with their clients.

### Meeting With Therapists.

Respondents in this study shared that meeting regularly with a personal therapist was an important strategy to sustain their long-term recovery. Specifically, participants reported the use of a personal therapist was helpful in discussing and processing the traumatising and triggering stories of their clients and in exploring and healing their own traumas. One participant shared:

*Even after 12 years, I still meet with a therapist to discuss some stuff that still [is] bothering me during the counselling sessions. Last week, when I read one of my client's charts and all of the things that she had been through, it was like reading about my own life. I had a hard time at first. I was like, How am I going to talk with her and get her through this when I can't even swallow right now? It almost traumatised me. So I met with my therapist, and she provided me with ways to handle it.*

### Talking to Supportive Coworkers.

Participants explained the platform offered by colleagues to share their clients' struggles and traumatic experiences and the impacts that it had on them as recovering addiction counsellors. For many, coworkers were an important

source of support when trying to cope with complex situations. As one participant described:

*I have enough coworkers here to support me, and I am always brainstorming with them. Just now, before you came in, I told her, "He [the client] was lying to me again. He [the client] didn't tell me the truth." And she [the coworker] told me, "He's active; he's using. Of course, he's going to lie to you because he did not want his counsellor to know." It's just as simple as that. So I have a good relationship with my coworkers, and we support each other when we need to.*

Findings revealed that despite experiencing various challenges—specifically, experiencing countertransference, heavy workloads, and clients' resistance as challenges they faced while working in the addiction treatment field. Actively seeking support from various media, including attending peer-support 12-step meetings and seeing therapists, was identified as a key factor in sustaining their recoveries while providing services to SUD clients.

## Discussion

The results highlighted dealing with countertransference, managing heavy workloads, and witnessing clients' resistance to quit using drugs as complex challenges for substance-abuse counsellors in recovery. On the one hand, their recovery status provided the counsellors in this study with insights regarding the complexity of addiction, such as difficulties in sustaining recovery and relapse, similar to studies from Pietkiewicz and Skowrońska-Włoch (2017) and Simons et al. (2017). On the other hand, their history of substance abuse imposed on the recovering counsellors the risk of developing a sense of countertransference with their substance-abuse clients. As a result, recovering substance-abuse counsellors tend to become confrontational toward themselves and their clients, similar to studies by Davis (2013), Gallagher (2010), and Fialk (2018), which reported that countertransference negatively influenced counselling-treatment outcomes, including early termination and the development of unclear boundaries between recovering counsellors and their clients.

Furthermore, managing heavy workloads was identified as another significant challenge for recovering substance-abuse counsellors in this current study, consistent with research by Beitel et al. (2018), Gutierrez et al. (2019), and Wardle and Mayorga (2016). Additionally, witnessing clients' resistance to stop using drugs, which led to multiple relapses, presented further challenges for recovering substance-abuse counsellors in this study. Similarly, Manuel et al. (2017) reported that working with clients from the criminal justice system who lacked the readiness to change posed significant challenges among counsellors and staff members working in the addiction treatment field. Perkins and Sprang (2013) also found that individuals' involuntary decisions to enter drug treatment were associated with a higher risk of recidivism and a lower chance of recovery.

Despite the counsellors' experiences with multiple challenges, the findings also revealed that actively seeking support ultimately provides recovering substance abuse counsellors with a better opportunity to manage the complex processes of their personal recoveries while working with their clients. Most participants also shared that actively attending 12-step peer-support meetings is an effective way for people in recovery from substance abuse to sustain their recovery. This is similar to studies from Lange-Altman et al. (2017) and Myrick and Del Vecchio (2016), which reported 12-step group members' willingness to share their recovery experiences with others as successful in decreasing the isolation often experienced by people in recovery.

The results in this study also highlighted the extensive benefits of seeing therapists as a strategy for recovering counsellors to sustain long-term recovery. These findings were congruent with another study from Sackett and Lawson (2016), which also found that those who had been exposed to the benefits of addiction-counselling treatment were likely to continue using the services, including those in recovery and working as counsellors in the same field. This finding was aligned with research from Edwards (2018) and McMahon (2018), which suggested that healthcare service providers should be mandated to meet with therapists as a self-care practice and to increase their professional and personal development.

Findings from the current study also reaffirmed the vital roles played by supportive coworkers, as documented by prior research, in helping recovering counsellors sustain their own recoveries (Mullen et al., 2017; Nielson, 2016). A positive social connection at the workplace and the social support received from coworkers served as principal factors in reducing counsellors' burnout (Litam et al., 2021).

### Implications Subsection (Practice and Research)

This study's findings have implications for practice and research in the substance-abuse-treatment field. Organisational demands—specifically, heavy workloads—posed risks for burnout for the majority of participants in this study. A combination of intensive addiction-treatment services, including counselling and medication dispensing for substance-abuse clients (e.g., methadone) will, in the opinion of the researcher, enhance the ability of substance-abuse treatment practitioners to provide integrated patient care without overreliance on only one service (e.g., counselling) and therefore will likely reduce counsellors' heavy workloads.

The study results also point to the importance of seeking support from outside therapists and coworkers. This has other practice implications: establishing training-on-trainers (TOT) to identify red flags when coworkers are in distress and developing a buddy system for checking up may help practitioners to achieve wellness, especially if they receive support from coworkers in the same field and agencies. Regarding the education implication, the findings from this study report utilisation of, and active engagement with, a peer recovery-support group: 12-step meetings, as part of the continuity of care and sustenance of recovery. Introducing the topic of peer-support programs, including 12-step meetings, into colleges' counselling-education syllabi creates an awareness of its philosophy, along with other evidence-based practices (EBPs), such as cognitive-behavioural therapy, motivational interviewing, and group therapy.

### Theoretical Implications

The COR theory posited that recovering counsellors who are actively seeking and retaining resources would overcome workplace challenges. Furthermore, the COR theory was supported by respondents' decisions to actively foster their resources by seeking therapy to protect them from the risk of relapse. At the same time, talking with supportive coworkers was

perceived as a resource for them to cope with clients' resistance to quitting using drugs. In this current study, recovering counsellors shared the resources they must build and protect: 12-step meetings, meetings with therapists, and talking with supportive coworkers enabled them to cope with stressful situations in the workplace, which include countertransference, heavy workloads, and witnessing clients' resistance to change.

## Directions for Future Research

This qualitative research presents several possibilities for future explorations in both qualitative and quantitative studies. Future quantitative research must measure and explore the associations between challenges and social support with significant variables, including work motivation and intention to remain working in the field as counsellors. Future studies related to burnout among those working in the addiction-treatment field—specifically, factors that cause it and ways to address it—are needed to improve the quality of overall well-being and life among substance-abuse counsellors. Furthermore, studies should be conducted regarding best practices for the operational management of substance-abuse-treatment agencies related to staff recruitment and retention, staff scheduling, and service hours to address heavy workloads among counsellors. Qualitative studies to understand the importance of providing social support through the lenses of coworkers and therapists on recovering counsellors' well-being and sustained recovery will be enlightening, as the current study highlights the importance of support in the workplace, including from coworkers. Additionally, future research should focus on training supervisors and coworkers to support their coworkers more effectively, benefiting the organisation and the field in general.

## Limitations

Some limitations of this study, however, are worth noting. Because all recovering counsellors in the addiction-treatment field were from the southeast region of New York, the ability to apply the findings of the study to other geographical areas also was limited. The purposive sample recruited for this study largely comprised recovering addiction counsellors with over 10 years of experience in the addiction treatment field. Furthermore, the mean age of participants in this study is 53.5 years old, with ages ranging from 35 to 66 years old. Hence, the study may not reflect the views or experiences of those who have entered the field more recently and counsellors who are younger. Respondents work in diverse treatment settings. Half (9/18) work in outpatient settings, and the remaining work in inpatient (7/18), and peer-run clinics (2/18), making the findings' generality limited to these types of treatment settings. Since study participants are limited to counsellors actively involved in 12-step meetings (13/18), the ability to apply the study's findings to other recovering counsellors who do not attend 12-step groups was limited.

## Conclusion

An estimated 60% to 70% of people in recovery from substance abuse work as counsellors in the addiction-treatment field, making recovery status an important topic to be explored (Baverly, 2020; Rácz et al., 2015). This study explored insights into the challenges and social-support systems among recovering substance-abuse counsellors working in addiction-treatment agencies. Among the challenges for recovering counsellors working in this field were handling heavy workloads and witnessing clients resistant to change. Garnering social support from peer recovery-support groups (i.e., 12-step meetings) and seeking mental-health counselling, however, proved beneficial and provided the opportunity to balance counsellors' work and personal lives. Ultimately, this support enabled recovering counsellors to sustain their own recoveries while providing counselling services to clients. In the context of high turnover and burnout among substance-abuse counsellors (Hatch-Mailette et al., 2019), an understanding of challenges and strategies to seek support will improve the quality of mental health and overall wellness among those working in addiction treatment.

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# Towards Climate-Informed Practice: Insights from Climate-Aware Mental Health Practitioners

**Katrina Wong**

Climate change has been described as the greatest threat to global human health of our time. However, there is a lack of qualitative research exploring how people are experiencing climate-related mental health distress, how mental health practitioners are responding, and the broader role of the mental health sector in addressing climate change. This research aimed to address these gaps by interviewing eight climate-aware mental health practitioners. Rich data was collected through semi-structured interviews and analysed through thematic analysis. Four main themes emerged: (1) Climate change experienced as anxiety, grief, and trauma; (2) Disempowerment and disconnection; (3) Empowerment through values-based collective action; and, (4) Systemic engagement as a profession. These findings provide qualitative insights into how people are experiencing climate-related mental health distress, and highlights the importance of connection, collective action, and systemic responses. These findings may contribute towards the development of climate-informed practice, paramount given the escalating impacts of climate change.

**Keywords:** *climate change, mental health, eco-anxiety, climate related mental health distress, climate-aware mental health practitioners, thematic analysis, climate-informed practice.*

Climate change and its increasingly devastating impacts are being felt by communities globally; the Intergovernmental Panel for Climate Change (IPCC) reports that the heatwaves, cyclones, and other human-influenced natural disasters attributable to climate change are set to worsen significantly, and will continue to affect marginalised communities first and worst (Arias et al., 2021; Zhai et al., 2018). As the world hurtles towards climate crisis, many feel that international governments are failing to act with requisite haste, gravity, and co-operation (United Nations Climate Change Conference, 2021). Mental health professions are now beginning to document the mental health burden associated with climate change (Clayton et al., 2017). The Black Summer bushfires which raged across Australia over the summer of 2019-2020 brought this issue to domestic shores (Zhang et al., 2020), highlighting the current lack of climate-appropriate responses and the urgency with which mental health professions must develop these (Commonwealth Scientific and Industrial Research Organisation [CSIRO], 2020).

This research aims to turn the spotlight on how climate change is impacting mental health and wellbeing, through the perspective of climate-aware mental health practitioners. Just as one might consult trauma therapists for issues relating to trauma, climate-aware mental health practitioners were chosen for this research due to their experience in the intersection between climate change and mental health. This research further aims to explore how these practitioners are responding to climate-related mental health presentations, and their view on the growing role of the mental health sector in addressing climate change more broadly.

## Literature Review

### Climate Change as a Direct Threat

The most well-established area of the literature is on the direct psychological impact of events such as natural disasters and extreme weather events; for example, increased incidences of PTSD, depression, and elevated alcohol use in communities affected by the Black Saturday fires in Australia (Bryant et al., 2014), and an increase in mental health symptoms in rural

Corresponding Authors: Katrina Wong
Email: katrina.wong.sl@gmail.com

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Australia during prolonged periods of droughts (Obrien, Berry, Coleman & Hanigan, 2014; Berry et al., 2011). The challenge for this field of research is 'connecting the dots' between these discrete research outcomes, climate change, and mental health (Reser, Morrissey & Ellul, 2011). Rickards, Neale and Kearnes (2017) argue that in the Australian context, this challenge is systemically compounded by governmental manoeuvres such as the defunding of CSIRO climate research, frustrating efforts to link natural disasters and extreme weather events with climate change.

Establishing the link between climate change and climate-related events such as floods and droughts is crucial to this area of research, so that empirical research on discrete issues can increasingly be viewed under a more holistic, climate-informed lens (Clayton et al., 2017). There have been several publications which integrate existing literature, and posit that the extreme weather events, natural disasters, and displacement associated with climate change are likely to increase people's vulnerability to grief and loss, post-traumatic stress, anxiety, and depression (Clayton et al. 2017; Doherty & Clayton, 2011; Hayes et al., 2018; Obradovich et al., 2018). Furthermore, marginalised groups with lower recovery capital (for example, Indigenous peoples, elderly, climate change refugees, and outdoor labourers and farmers) will be disproportionally affected both materially and psychologically by climate change, as peoples' homes and livelihoods are increasingly impacted by climate change (Clayton et al., 2017; Weissbecker & Czinez, 2011; Zhai et al., 2018). However, these reviews are not of empirical field research (Reser, Morrisey & Ellul, 2011), and commonly note the need for more empirical research on the intersection of climate change and mental health specifically (Clayton et al., 2017; Hayes et al., 2018).

## Climate Change as an Existential Threat

For those without direct experience of climate impacts, climate change may be experienced primarily as a vicarious and existential threat (Hayes et al., 2018). One way of establishing a direct link between climate change and mental health is to ask people expressly, and there have been several surveys conducted to this end.

Whilst Australians in rural and coastal areas are increasingly exposed to the direct impacts of climate change, most Australians are still relatively sheltered from impacts such as bushfires and coastal erosion (Fritze et al., 2008). However, several surveys have been conducted which demonstrate increasing concern about climate change amongst the general Australian public. For example, the Australia Institute's annual Climate of the Nation survey polled 2626 voters and found that 75% of Australians were concerned about climate change, with 82% concerned that climate change will result in more natural disaster and species extinction (Quicke, 2021). These results are supported by other comprehensive Australian surveys that not only demonstrate increasing concern, but also demonstrate strong support for government interventions and policies related to the mitigation of climate change (Kassam & Léser, 2021; Ipsos, 2019). These statistics lend weight to Gifford's (2011) postulation that people do not have to be directly impacted by climate change to experience climate-related mental health distress and concern.

Whilst these surveys are important in substantiating climate-related concerns amongst the Australian public, qualitative research on the impacts of climate change on mental health is limited. A seminal work by Albrecht et al. (2005) introduced the concept of 'solastalgia', or a sense of loss and longing for an environment that once was. This research involved community interviews with those impacted by mining and long-term drought in the Hunter Valley region in Australia (n = 50), and described emotional distress caused by a landscape forever changed by mining and drought. McManus, Albrecht, and Graham (2014) conducted further qualitative work in this area and described 'solastalgia' and 'eco-anxiety' as 'psychoterratic' symptoms: mental health symptoms related specifically to a changing environment and climate. Whilst these studies describe how people are experiencing climate-related mental health distress, there is still a significant lack of qualitative research in this area.

## Therapeutic Implications of Climate Change

Despite the potential for hopelessness, anxiety, and despair, the "wicked problem" of climate change has also given rise to climate activism and engagement (Hayes et al., 2018). This suggests that while the magnitude of climate change can be paralysing, for some the task of tackling climate change has an activating effect. Existing literature supports the idea that post-traumatic growth and strengthened resilience can occur after natural disasters (Lowe, Manove & Rhodes, 2013; Ramsay & Manderson, 2011). In a 20-month longitudinal and quantitative study, people who had experienced the effects of extreme flooding in Poland (n = 285), Kaniasty (2012) found that social support and altruistic engagement immediately following the floods were associated with greater psychological well-being among participants. This supports the results of similar studies on hurricane-exposed youths (Banks & Weem, 2014), which suggests that social and community engagement are both empowering and protective following climate-related events.

In a fundamental step towards the development of mental health strategies for climate-relate mental health concerns, Ojala (2010, 2012) published several qualitative research papers characterising the different forms of coping mechanisms present in young people regarding climate change. Ojala identified three forms of coping utilised by participants: problem-focused, emotion-focused, and meaning-focused coping (2012). While she views problem-focused and emotion-focused coping as necessary and valid responses to climate change, she recommends that educators of young people encourage meaning-focused coping strategies such as positive reappraisal and existential hope. This stems from her findings that young people who engage in meaning-focused coping tended to balance psychological well-being and pro-environmental activity (Ojala, 2012).

In an integrative review, Fritze et al. (2008) acknowledged the difficulty in recommending therapeutic interventions specific to climate-related mental health concerns, namely because of the myriad ways these may present in the therapeutic space (for example, grief, anxiety, trauma). Fritze et al. posit, however, that the promotion of hope is fundamental in empowering individuals into action against climate change, as well as building communities which are more emotionally resilient to the despair that climate change may cause. Furthermore, it is important to note that there are cultural differences in the expression and experience of mental health, and therefore there are differences in help-seeking behaviours and appropriate treatment of mental

health distress (Gopalkrishnan, 2018).

Despite the literature described above, there is still little known about how mental health practitioners might respond to climate-related mental health distress.

## The Broader Role of Mental Health Professions in Addressing Climate Change

Organisations such as the American Psychological Association (APA) and the Australian Psychological Society (APS) have begun strategizing for a future wherein more people are seeking mental health support for climate-related issues (Clayton et al., 2017; Burke, 2017). The APA publication (Clayton et al., 2017) provides general recommendations on how to treat individuals and advises on how to engage communities. Many of their recommendations (such as training people in the community, developing post-disaster plans with the community, and increasing cooperation and social cohesion) are targeted at disaster-related mental health support (Clayton et al. 2017). The APS similarly suggests connecting with personal values and with nature itself, encourages community engagement and a collective mindset in addressing climate-related mental health distress, and cross-references many of the same articles as the APA guidelines (Burke, 2017). Psychology for a Safe Climate have developed professional development for the sector which will enable practitioners to better respond to climate-related mental health distress, in the hopes of developing a network of Climate-Aware Practitioners (Psychology for a Safe Climate, 2022). In a systematic review, Berry et al., (2018) furthers the discussion by proposing a systems-level approach to understanding climate change and mental health and emphasise the importance of acknowledging societal level context and constraints (for example, the influence of governments and big business). They posit that while individuals have a degree of personal control and responsibility to act, mental health in the context of climate change requires a "whole person, whole community, whole of life, whole of planet" approach, and note that political will on climate change is an indicator of mental well-being in this context (Berry et al., 2018).

## Research Gaps

There is a lack of qualitative research in exploring experiences of climate-related mental health distress, and less so on how mental health practitioners are responding to these presentations. While valuable, current recommendations are not informed by in-depth research with mental health practitioners who have encountered climate-related mental health distress in their work.

## Research Aims

This research aims to make a small contribution towards the above gaps, by exploring emerging climate-related mental health distress and its treatment through the qualitative perspectives of climate-aware mental health practitioners. This research aims to gain insights specifically from practitioners who may already practice with a climate-informed lens, as they are well-positioned to provide rich perspectives and contributions to the field. This research also aims to provide a more human, practical perspective to the climate-focused mental health guidelines that are emerging. These aims were explored through three main research questions: (1) How is climate-related mental health distress presenting in therapeutic spaces?; (2) How are mental health practitioners responding to this? and; (3) How do participants view the broader role of the mental health sector in addressing climate change? It is hoped that the findings will provide practitioners more considered pathways on how to approach climate change in session, as well as bring into consideration the broader role that the sector might play in addressing climate-related issues and presentations.

# Method

## Study Design

This study was a cross-sectional exploratory study. Qualitative methodology was chosen for this research, as a constructivist-interpretivist approach is best suited for addressing the current research questions and context. Interpretivism views realities as local and constructed, and "depend on the individuals and groups holding them", while constructivism focuses on "meanings people bring to situations and behaviour" (Punch, 2014, p. 17). Qualitative research recognises reflexivity and acknowledges the influence of researcher experience and values on the interpretation of the data (Vossler & Moller, 2015). Vossler and Moller (2015) further state that qualitative research is well-suited to asking exploratory questions, which are asked especially when a research area is new. This research study is necessarily exploratory, as climate-related distress is a nascent field of mental health research. Qualitative methodology also allows for a semi-structured interview method and thematic analysis of the data (Braun & Clarke, 2006). Both semi-structured interviews and thematic analysis were chosen for this research given its exploratory nature. This research was submitted to and approved by the Australian College of Applied Psychology/Navitas College of Public Safety and Navitas Professional Institute Human Research Ethics Committee (NPI HREC) (approval number 564210220).

## Participants

This research is being conducted as part of a Master of Counselling and Psychotherapy; however, the researcher chose to widen the research scope to include a range of mental health professions as broader perspectives may be valuable in addressing an issue of this magnitude, and may broaden the generalisability of these findings across mental health fields. Inclusion criteria for this research required that participants were mental health practitioners who considered themselves to be involved in the climate/environmental justice, and who have encountered clients presenting with climate change anxiety and distress. Eight participants (n = 8) met these criteria and agreed to participate in this research, with the ages ranging between 25 and 55. Three were clinical psychologists, three were counsellors, one a psychotherapist and the remaining participant worked in mental health research. The level of climate involvement and clinical experience varied between participants.

## Materials

A semi-structured interview schedule with ten open

ended questions was used to explore this research question. Semi-structured interviews enable the researcher to collect a broad range of rich data and allows for the exploration of spontaneous ideas and themes which may also steer the direction of the research (Braun & Clarke, 2006). Research aims were explored with the questions such as, "How is climate-related mental health distress presenting in session?". The complete interview schedule can be viewed at Appendix 1. Interviews lasted 60 minutes, recorded through the online program Zoom, and transcribed by the researcher through online/computer programs Wreally and Microsoft Word.

## Procedure

### Data Collection

Purposive sampling is a non-random form of sampling in which the researcher sets out to find a group of people who are well-informed on the research subject (Etikan et al., 2016). Given that the inclusion criteria for this research study was quite specific, purposive sampling was used for this research study. The researcher digitally distributed a flyer detailing inclusion/exclusion criteria (as stated above), research design, and researcher contact details through social media amongst environmental/mental health groups. Participants self-selected by emailing the researcher. Participants were able to withdraw consent at any point and were sent their transcripts for member checking. Member checking is a process by which qualitative research can improve credibility (Morrow, 2005). Two participants requested that small sections be redacted from their transcripts to protect the identities of their clients, however this did not impact on the data analysis process.

### Data analysis

All interviews were transcribed by the researcher by watching the audio-visual recordings, and the audio files were also listened to again during the analysis process. The data was analysed using Braun and Clarke's (2006) thematic analysis process which comprised of six phases: the researcher became familiarised with the data, generated initial codes, searched for themes, reviewed themes, defined themes, and finally, produced this report. An inductive approach was chosen for the research, allowing for themes to be generated from the "bottom-up", rather than generating themes to fit pre-existing theories (Braun & Clarke, 2006). This process was recursive, with the researcher re-reading transcripts and reconceptualising mind-maps until final themes and subthemes were formulated in a way that highlighted participant voices. Thematic analysis allows for researcher immersion in the data, and beyond the organisation of data, analysis often goes further into the interpretation of these themes.

### Data storage

All recordings were conducted and stored on a password protected computer only accessible by the researcher; audio-visual files were also password protected. The data was treated in accordance with the Australian College of Applied Psychology/Navitas College of Public Safety and NPI HREC data storage policy. Participants were informed of measures to protect confidentiality prior to signing informed consent forms.

## Positionality Statement

This research is being undertaken due to researcher interest in the intersection between climate change and mental health, as both a novice counsellor and a climate activist. This research was conducted as part of the Master of Counselling and Psychotherapy, which the researcher completed 2020. The researcher has also engaged in climate activism by participating in various climate justice groups over the last three years.

Bracketing is a process wherein researchers are asked to set aside their preconceived notions and prior knowledge about a research topic as a way of ensuring validity and accurately describing participant responses (Chan et al., 2013). However, Chan et al. (2013) observe that the scope and methods of bracketing are ill-defined and dependent on the various phenomenological approaches under which the research is being conducted. Given the researcher's embeddedness in both mental health and climate activism contexts, a hermeneutic approach was an intuitive and common-sense approach for this research study. A hermeneutic research tradition acknowledges that researchers exist within a context, and that while efforts to bracket preconceived notions during the research are necessary, it is arguably impossible for researchers to completely detach from their previous experiences, knowledge, and perspectives, particularly when the researcher holds "insider" positionality (Neubauer et al., 2019; Chavez, 2008). This approach asks that researchers acknowledge their preconceived notions around the topic, engage in ongoing reflexivity throughout the research process, and overt any potential biases or presuppositions where possible. As such, the researcher engaged in reflexive journaling as a means of encouraging further self-awareness and reflexivity, particularly on the experience of bracketing and potential bias. Reflexive journaling encourages both methodological rigour and critical self-reflection which can impact the research process as it is happening (Ortlipp, 2008). The researcher also engaged in regular supervision.

# Results

Four main themes were identified across participant responses, along with fourteen subthemes.

## Climate Change Experienced as Anxiety, Trauma, and Grief

All participants spoke about climate change as being felt as anxiety, trauma, and/or grief, either as a direct result of climate-related disasters or as an impending disaster and anticipatory loss of future. This theme consists of two subthemes: *direct impacts*, and *existential and impending*, both of which are defined below. As Participant 3 stated, "Because climate crisis is just an existential trauma for everybody. And it will become an actual trauma for everybody." (3, 502-503).

### Direct Impacts

Half of the participants described either living in and/or working with communities that are already very affected by climate-related impacts. Participant 1 noted:

> The smoke has meant that … the Elders have, you know, all of the health problems we know that go with trauma and with being part of an oppressed group. So like, it's killing them. Climate change is killing them. They can't breathe. They literally cannot breathe. (1, 122-123)

### Existential and Impending

All participants described emotional responses to

climate change as an anxiety over impending trauma, or grief over potential futures. Participant 6 offered this metaphor:

> It's sort of like you've been diagnosed with a fatal illness - in some ways, if you want to conceptualise what it would be most like. Because … people are at the point where... it is irreversible, probably at this point… And how do you process that? (6, 270-273)

Participant 8 described the impact this has on mental health:

> I would say the summer just gone, people were terrified in Kinglake. We could so easily have had another major fire, as there were major fires all up in the east coast ... You know, that was just constantly raising people's arousal levels and anxiety and fear, and you know, the memory that was stored in their cells … Yeah, you're going to get that [trauma] happening every summer. (8, 305-310)

### Disempowerment and Disconnection

All participants spoke of themes of disempowerment and disconnection in relation to climate change, which appear to be perpetuated in a top-down manner. This theme is comprised of 3 subthemes: *systemic disempowerment, community disconnect, and the burden of perceived responsibility and powerlessness.* These will be expanded below. Participant 8 summarised this theme:

> We know that when we don't have power, people tend to turn on one another and they don't hold power collectively. And then the worst thing they do is then turn on themselves … they individualise and it becomes shame, which is super toxic. (8, 544-548)

### Systemic Disempowerment

All participants spoke about the difficulties of treating individuals within a system that places the burden of responsibility for addressing climate change on communities and individuals. Participant 5 observed the link between the lack of systemic leadership on climate change and community disconnect around climate change:

> We have a Prime Minister who literally rips away the laws and things to support it, and denies it [climate change] essentially. And so it would be quite a confusing time for people if they were like, oh I'm really worried about this … because they'd go back into the real world and they'd talk about it, and people would be like … 'We don't care about that in this country. (5, 288-293)

### Community Disconnect

Many participants noted divisions in communities about climate change owing to the disconnect between the reality of climate crisis and systemic responses. Participant 7 captured this feeling of disjuncture, which was echoed by other participants in relation to both youth and adult clients:

> It's where it gets hard for the kids too, I think. Because they do know that there are many people out there who ... go by 'ignorance is bliss'. So it is that conflict of interest, like do I speak up and get shut down and it was all worth nothing and my anxiety is going to fall over into a heap again, or am I going to keep pushing? (7, 421-425).

### Powerlessness in the Face of Perceived Individual Responsibility

All participants noted a sense of individual burden and powerlessness in addressing climate change, both in their clients and in themselves. Participant 5 observed:

> I was speaking with a lot of clients, who - they would just call up crying, and really, really panicked … kids who are 8, 9 years old … You've got these young people who are concerned about having a future and concerned about what happens when they grow up … And so they're just left with this overwhelm, and not knowing how to shift it or how to empower themselves. (5, 76-87)

### Empowerment through Connection

All participants spoke of the importance of connection in empowerment. There are four subthemes within this theme: *acknowledging underlying connectedness, connecting with self: safety and self-compassion, empowerment through values-based collective action, building community resilience.* Participant 8 summarised this theme as:

> How we turn to one another, not turn on one another… We need to be constituted much less as a neoliberal hero individual and much more as someone who's part of a web of connections - an ecological, cultural, and social web of connections. (8, 330-333)

### Acknowledging Underlying Connectedness

All participants reflected on the larger connectedness between the self, others, and the natural world, and this appeared to underline most of their practices. Participant 1 noted:

> They [First Nations people] get climate change much more deeply and much more viscerally than I do… I was like, can you explain to me the link between, as an Aboriginal woman, the link between yourself and the earth, like what is that relationship. And she's like it's not a relationship, we are the same. The earth and my personhood, we are the same being. So when the earth hurts, I hurt. (1, 303-310)

### Connecting with Self: Safety and Self-Compassion

Most participants commented on the lack of real or perceived safety felt by clients and noted that to overcome emotional overwhelm and engage in action, clients needed to feel a basic sense of safety, connection, and self-compassion within and towards themselves. Participant 2 reflected:

> So how do we - in a world which is unsafe in terms of the … collapse of multiple ecosystems - how do we create that safety for someone to actually feel engaged enough to make those changes in the first place? Changes in terms of wishing to engage in any kind of climate action. (2, 385-388)

Participant 3 described the importance of self-compassion in engaging in reconnecting with values and engaging in action:

> And we… invited her to see that [self-reproach] as a signal that she was not in complete alignment. But then, self-compassion, self-compassion, self-compassion. Because that kind of self-reproach is toxic … It only helps as like a kickstarter, to motivate us to do something. (3, 364-371)

### Empowerment through Values-Based Collective Action

Most participants noted that hope and mental well-being was derived from action and engagement, and that this was particularly prominent with collective rather than individual action. Participant 1 provided this summary:

> The way through eco-anxiety is action. And it's belonging and creating a community that fosters a sense of belonging. And that fosters self-efficacy, you know. … You get hope by taking action. Not only do you feel better, but it has an actual ripple effect in the world. (1, 95-98)

Participant 6 provided an example of this amongst youths:

> They all talk about how upset they are about it, and then they rally for change. And each of them gets a little bit of control

back. … they go and help someone on a farm who needs their fences redone, they go and attend the climate change rallies - not on their own, they take a friend with them … the faster they engage in … things that they would previously do around climate change, the quicker their anxiety is amended. (6, 278-284)

### Building Community Resilience

Most participants observed the importance of building and empowering community in response to climate change and its mental health impacts. As Participant 1 stated: *"And that's where the way forward comes from, doesn't it. Just, community. Just keep building community, keep healing together, keep joining in the circles."* (1, 754-755).

Half of the participants noted how deep listening and non-violent communication can help build resiliency in the communities at the front line of climate action. Participant 7 posited, "I would want to get non-violent communication training for all of the activists and really working on enabling better communication. And just ... oiling the cogs … making sure that everything's running smoothly." (7, 462-466).

## Theme 4. Systemic Engagement as a Profession

Almost all participants felt that mental health professions had a larger role in addressing climate change than treating individual symptomology. This theme has five subthemes: *learning from resilient communities, mutuality and access to services, communicating informative effectively and accessibly, advocacy, being courageous and engaging imperfectly.* These are addressed below.

### Learning from Resilient Communities

Half the participants noted that learning is multidirectional, and that a wealth of knowledge that is pertinent to mental health fields exists within communities that are already resilient. Participant 1:

Community is crucial to our existence and Western society has lost a huge amount of the skills and the knowledge about that, so First Nations people have just, despite everything, have kept alive the importance of community … so it's like, these are the people to join up with, these are the people who know how to survive atrocity and disaster and climate change. (1, 761-768)

### Mutuality and Access to Services

All participants identified a need for more accessible mental health support and training for activists, clients, and for practitioners themselves, with half emphasising the importance of mutuality between these groups. More than half of the participants had either facilitated or participated in free (or close to free) skills-sharing/space-holding groups. Participant 8 noted:

One of the challenges and opportunities is … to not hold a professional boundary around something that you own because you've been privileged enough to have some professional education ... How do we democratise that … so that more and more people can respond well to people in crisis, emotional crisis and existential crisis as well as things that are exacerbated by trauma and oppression and violence. (8, 133-140)

### Communicating Information Effectively and Accessibly

Half the participants commented on the inaccessibility of information to the public, and how this may impact attitudes and actions relating to climate change. Participant 4 discussed the implications of ineffective communication:

The psychology of behavioural change is very important, so we need to do a better job at getting people on board. So I think, on a big level, psychologists can help change the messages … People feel, probably overwhelmed by climate change, "I can't do anything, it's too big", so changing the narrative so it's like, we can all do something actually. (4, 269-272).

Participant 1 noted:

Knowledge is often hidden behind paywalls, and is often written in language that is totally, totally inaccessible to the majority of people, and we take pride in how clever we are in our words. But yeah, that just means that people can't understand what you're saying. (1, 410-412)

### Advocacy

Half the participants spoke about how mental health practitioners could use professional privilege to speak up about climate change. Participant 4 observed the changing dynamics within mental health professions around advocacy:

I think that's shifting a bit and people [practitioners] are like, no, we probably should stand up for social justice as well. We need to actually stand up for what's right and speak up more and not be neutral… So I think we have a huge part to play in climate change issues and getting people on board. (4, 262-265)

### Being Courageous and Engaging Imperfectly

This subtheme was discussed by all participants in relation to their own experience, not just as practitioners but as humans experiencing the threats from climate change. From a practitioner perspective, participant 1 described the challenges voiced by some participants about addressing the rise of climate-related mental health concerns within existing mental health frameworks:

You've got to take risk. We are in uncharted territory here as far as climate change goes. The colonial structures that support patriarchy, that support racism, that support climate destruction ... we need to be creative and remember that we're part of these systems. (1, 722-728)

Participant 3 reflected on how their process and journey likely mirrored a universal process, and similar sentiments were shared by almost all participants:

So active hope to me is that we do what we can, even without knowing the outcome. ... who knows whether we'll be successful in anything that's happening, but my goodness we're going to try. And we don't want to feel bad that we're not doing enough, we just want to try. (3, 415-423)

Further participant excerpts on all main themes and subthemes may also be viewed at Appendix 2.

# Discussion

The nascent research area on climate-related mental health distress, treatment, and broader systemic response is unique in that it responds to a real threat facing all of humanity - practitioners and clients alike. As such, more research around the mental health sector's response to climate change is urgently needed. This study sought the perspectives of climate-aware mental health practitioners as they are well placed to describe and provide insights into what is happening "on the ground", having experienced the intersection between climate change and mental health both personally and professionally. The three research questions were: (1) How is climate-related mental health distress presenting in therapeutic spaces?; (2) How are

mental health practitioners responding to this? and; (3) How did participants view the broader role of the mental health sector in addressing climate change?.

Previous papers proposed that there would be a wide variety of emotional responses to climate change, and that these would increase as the impacts of the climate crisis are directly felt by communities (Arias et al., 2021; Zhai et al., 2018; Doherty & Clayton, 2011). This was supported by the findings of this research, as most participants reported client mental health distress due to the major fires over the summer of 2019-2020. In addition to the mental health burden likely attributable to these direct events, the results of this research are also supportive of literature positing that the impact of climate change is also indirect – experienced as an impending, existential, psychological threat (e.g. Doherty & Clayton, 2011). Specifically, participants described how their clients presented with anxiety and worry, depression and despair, grief and mourning, unconscious defences, numbness and apathy, and vicarious psychological trauma. Most prevalent was anxiety, grief, and trauma. The prominence of trauma relating to client presentations was a unique and interesting finding, as it was not only mentioned overtly as post-traumatic stress responses following Black Saturday and the 2019-2020 bushfires, but also in more subtle themes of powerlessness, personal responsibility, shame, and guilt. The themes of disempowerment and disconnection from self and community were universally reported by participants regarding their clients' climate-related mental health distress. A unique finding of this study is the influence of systemic disempowerment on community disconnection, and the implications this has on the powerlessness, personal responsibility, shame, and guilt reportedly experienced by participants' clients. While not expressly about trauma, these are common characteristics and outcomes of traumatising situations (Herman, 2015), and further research on how the general trauma literature may be extrapolated to those experiencing climate-mental health distress would be valuable.

Regarding how mental health practitioners were responding to climate-related mental health distress as it presented in therapeutic spaces, participants had different preferred modalities and interventions. Furthermore, as participants practice with a client-centred lens, they often used a range and combination of interventions to suit the variety of presentations and client needs. As such, this research was not able to validate any specific interventions as being particularly prominent or effective in relation to treating climate-related mental health distress. Nonetheless, this finding is consistent with observations by Fritze et al., (2008) that therapeutic approaches to treating climate-related mental health presentations will likely vary greatly due to the variety of presentations themselves, as well as being influenced by clinician training and affiliation towards different orientations. Although stemming from a broad range of professional backgrounds and therapeutic orientations, all participants referred to an underlying connectedness between themselves, others, and the world, and this informed the way they framed the treatment of climate-related mental health distress. By fostering a deeper connection with self, others, and the world, and further encouraging values-based actions, participants in this study were arguably encouraging meaning-focused coping through their various preferred modalities and interventions. Meaning-focused coping was found by Ojala (2012) to balance pro-environmental activity and psychological well-being.

Again, of interest was the prevalence of trauma in participant responses. For some practitioners, explicit trauma counselling was necessary due to the impacts of the 2019-2020 Black Summer bushfires. Participants reported encouraging empowerment through values-based collective action, and actions which build community resilience (see Appendix 2), which supports reports that community engagement and social support are protective following natural and climate-related disasters, and indeed may lead to post-traumatic growth (Clayton et al., 2017; Kaniasty, 2012; Banks & Weem, 2014; Ramsay & Manderson, 2011). On a more subtle level, however, fostering safety and self-compassion, encouraging values-based engagement, and increasing connection to self, others, and the world were universally reported by practitioners, regardless of their chosen modalities, as clients commonly felt a sense of personal responsibility, guilt, shame, and powerlessness. Although not explicitly trauma-related, these ways of framing treatment are commensurate with the general trauma literature, which emphasises connection and empowerment (Herman, 2015). More enquiry on therapist orientation and whether this was an artefact of timing following the Black Summer bushfires would be appropriate in further research on this area.

Hayes et al. (2018) had several recommendations for climate change adaptation on a systemic level, which included improving access and funding to mental health care, climate change adaptation/resilience planning in the mental health system, community-based interventions, and special training for care providers and first responders. The results of this study echo these recommendations, with many participants already participating or facilitating skills-sharing groups and proactively seeking out climate-related training. Many participants noted that further training and upskilling was needed in this area, for practitioners themselves as well as those in the community. The subtheme of mutuality as a parallel function in increasing access to services was an unexpected finding. Clayton et al. (2017) suggested building community resilience by training people within the community to respond to crises. The participants of the current research study took this a step further by acknowledging the wealth of knowledge that already exists within resilient communities (particularly First Nations communities) and that learning can be multidirectional, with mental health practitioners being the recipients of knowledge as well as the purveyors.

Most participants acknowledged systemic contributions to the climate crisis (particularly on a governmental level) and the privilege afforded to them as professionals, and saw a role for the profession as a group to advocate for more systemic change. This is supportive of the notion posited by Van Lange, Joireman, and Milinski (2018) that mental health professionals are well placed as "advisors" and "mediators" to not only speak out as a profession, but also upwards to wider systems and governments, representing those they are supporting. Hope is described by Ojala (2012) and Fritze et al. (2008) as being fundamental in maintaining engagement. The theme of being courageous and engaging imperfectly speaks to the way participants viewed hope and engagement on a multitude of levels - for their clients, the general public, as a sector, and for themselves as humans and practitioners.

## Limitations

Two major limitations were noted for this research, both relating to the generalisability of findings. Whilst not a research question in itself, participants noted that the demographics

of people seeking therapy for climate-related distress were predominantly activists, young people, and people who had been directly impacted by the Black Summer bushfires of 2019-2020. Therefore, the findings for the first research question regarding climate-related mental health presentations may have limited generalisability to general populations that do not belong to these demographics. Furthermore, research interviews for this study were conducted between March and July 2020, following the Black Summer bushfires that raged across Australia over the summer of 2019-2020. The prominence of trauma may have been a consequence of the collective trauma experienced by participants and their clients due to the devastation of these bushfires. The research period also coincided with the emergence of COVID-19 globally, and therefore cannot be discounted as a contributor to the prominence of trauma in these results.

### Recommendations and Implications

Recommended future directions for research include focused research studies on each of the three research questions. The findings of this research imply that on an individual level, the specifics of a modality are of less importance than fostering a sense of safety and connection towards the goals of empowerment and collective engagement and action. The generalisability of the general trauma literature to climate-related mental health distress (particularly in the context of systemic disempowerment) would be an interesting area for further research, and increasingly pertinent should global leaders continue to respond to climate in ways that many consider to be inadequate (Berry et al. 2018; UNFCC, 2021).

The implications of these findings are that while treating individual mental health is important, larger issues which impact mental health (such as change climate), and the urgency with which society must address climate change necessitates that mental health professions consider a wider system response, multidirectional learning, and action. Further research on the ethics and practice of engaging systematically (and the implications this has on the personal, political, and professional domains for practitioners) is recommended not only in response to climate change, but for social justice issues more broadly. These findings may be of interest to mental health practitioners in search of more informed pathways on addressing climate change as it presents in therapeutic spaces, and on responding to climate change more broadly as a sector. Furthermore, given that systemic engagement was a major theme, these findings may also be useful to mental health organisations such as the APS, Psychotherapy and Counselling Federation Australia (PACFA), Australian Counselling Association (ACA), and Australia Association of Social Workers (ASW) when considering their own positions and actions on climate change, and may assist in creating publications for dissemination among their members.

## Conclusion

The intersection between climate change and mental health is a new field of both therapy and research. More research is needed as demand for climate-related mental health support is expected to grow as climate-related impacts increase in frequency (Arias et al., 2021). This research study adds a qualitative perspective to the direct and indirect climate-related mental health distress felt by the Australian public, hopes to provide a human voice to the statistics and guidelines that currently predominate the literature. This study also posits that in addressing climate change in therapeutic spaces and more broadly, it is necessary to move beyond the individual; to increase connection with self, others, and the world, engage in community and collective action; and finally, to acknowledge systemic influence and advocate upwards. It is hoped that these findings will go some way towards improving climate-literacy in the mental health sector, and subsequently towards developing climate-informed practice.

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## Appendix 1

### Interview Schedule

1. Could you tell me a bit about yourself?
   a. How about your counselling and psychotherapy practice?
   b. How about your involvement with climate action?
2. How has climate change anxiety, distress, or other mental health concerns presented in session?
   a. Are there any particular presentations or issues that you are noticing more of?
3. How have you addressed this?
   a. Is there a particular framework you like to use?
   b. Are there any interventions or types of support that you have found particularly helpful?
4. Have you read any guidelines around addressing climate change and mental health?
   a. How have you interpreted these?
   b. Have you integrated this into your practice?
5. How do you view the broader role of counselling and psychotherapy in addressing climate change?
   a. Has your view on this shifted over time?
   b. What are your views on addressing climate change in session in general?
6. Is there anything else you would like to add?

## Appendix 2

*Themes, subthemes, and examples of corresponding participant excerpts further to those above*

| Theme | Sub-theme | Subtheme Description | Participant Excerpts |
|---|---|---|---|
| Climate Change Experienced as Anxiety, Trauma and Grief | Existential and Impending | Participants described anxiety, existential trauma and future-related grief | "The other stuff was sort of like that grief, for the environment and the more vulnerable people who would be affected. Also … for her future? She's very studious, she was like, 'Should I even finish, what's the point. I can't see myself having children in this situation.' Yeah, so kind of grieving what she would probably lose, if things don't change drastically." "But that has to be in there and I feel like, if we *are* experiencing this whole ecosystem potential disaster as a form of trauma, or like an impending trauma, then it has to come from a place of creating safety." |
| | Direct Impacts | Participants described being personally affected, living in areas, or supporting communities directly impacted by climate-related disasters | "But I guess for us, climate change is really real. Because we're seeing it everywhere. Where Tallangatta is situated, we're about 40 kms south of the Victorian/NSW borders? So, Corryong fires, we're about 40 kms from that." "But I'm not literally out there, it's post. So it's either going to be PTSD or anxiety, depending on you know, how close that person originally was with their view of climate change? And of course, the second was how close they actually were to losing their life. … The two kids whose houses were lost, it was indeed trauma counselling." |

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| Disempowerment and Disconnection | Systemic Disempowerment | Participants observed that political and organisational structures individualise responsibility, causing disconnection and disempowerment among individuals | "There's stuff we can't control and things we can, and having really awful governments in power in our biggest, big leading countries is *not* helping. Like, finally... I think Australians as a culture are so like, 'She'll be right, mate'. But now we're actually kind of going, 'Oh, maybe it won't. Maybe this is not going so well, maybe we *should* do something."<br>"If you're looking at systemic interventions then you're looking at organisations, you're looking at families, you're looking at neighbourhoods, households.<br>So I feel like that's one of the areas in which counselling and psychology is quite reductionistic - it atomizes people as separate individuals as if we don't have umbilical cords, as if we don't have a history of association and being influenced by all manner of people *and* species *and* landscapes." |
| | Community Disconnect | Participants described situations where individuals lose a sense of safety in the community | "So the key to survival is community right - so in your activist community you are held and you are supported. But often then, there's that disjunction with like - your mother doesn't approve, really strongly doesn't approve the fact that you got arrested - and you've got to choose between getting arrested again and having a relationship with your mother. So there's that continuum of the ways in which you are not supported by the other people in your life, and like, they kind of let me call that a sense of shame, that when we risk being expelled from a community because we've violated those values."<br>"We've got a - a couple of kids are now actively speaking about it. Again, being a small community there's that stigma around touching difficult subjects. And climate change, for one of them... you know, cows - the things that produce the most methane - everyone produces them in our area. … They've almost not spoken about their personal feelings about climate change because it's been clouded by that financial stressor that their families have had." |
| | The Burden of Perceived Individual Responsibility and Powerlessness | Participants described the personal burden felt by their clients and themselves | "Yeah because psychology is often very self-focused, and I think there's harm in that, especially when it comes to climate anxiety, I think it's dangerous that self-focus."<br>"There's definitely anxiety, there's definitely grief. I think there's a lot of anger as well... even shame, guilt, especially older people, I think. I've heard them talk a little bit more about feeling that sense of responsibility and maybe they could've done a little bit more."<br>"So right there from a therapeutic standpoint, you've got self-criticism. So self-reproach isn't helpful, apart from a signifier of "I'm out of step with my values with something I want to be like" or "I'm not aligned with my values"<br>"Yeah, this was kind of part of the process for me as well. So I had felt guilty like I hadn't really been doing … I'm not much of an activist, like just in my personality, I'm more kind of timid."<br>"When the fires came through, it was anxiety |

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| | | | about just sheer lack of control. With climate change and everything, so many things are *out* of your control." |
| Empowerment through Connection | Acknowledging Underlying Connectedness | An understanding of the interconnectedness of self, others, and the world appeared to be underline participant practices | "It was a regenerative thing and a lot of what was involved in "The Work that Reconnects" was *sharing* our experience with climate change, our grief. But then also connecting with ideas like, deep time. So, remembering that we are alive here today because of our ancestors, and even before that, going down to mammals and fish and single celled organisms. Such a long line of survivors. And when you have that perspective, it changes the way that you see climate change, and that comes from Joanna Macy's work."<br>"And [Spell of the Sensuous] is more about how we interact with our senses, and how we as white people, have been… removed from the land so much. And kind of tending it and farming it and kind of making it so unnatural that we actually become really removed from it ourselves … And it was talking about how that's a form of trauma as well and how that's been going on for so many years, that this is why we're so disconnected from our senses."<br>"So much of it is habitual and trauma-influenced, and you don't know, maybe they [people with opposing views] are a lot more connected to you than our common humanity here?"<br>"And I think what really pisses me off is when people... [ignore] the reality of the situation where the people who are going to get hurt the most are probably low socio-economic, um, people of colour, other countries that are less well developed. … I feel like we can get through, but we also have - in my eyes - we have to take a look at who we're actually working for, and what's happening in terms of everybody." |
| | | | "I'm moving more to body-based sort of stuff. So, I guess, using mindfulness to try to help people connect with their body, connect with the emotions coming up, make sense of it."<br>"And I think compassion-focused therapy, self compassion - I did a little bit of that as well, with the first client, just with the distress... So sort of... fully being in the water, fully burnt out, just kind of overwhelmed with the issues - versus kind of standing on the side of the river and still giving herself care through it… giving herself that self-care, compassion for her distress, so she could still be engaged and not be burnt out." |
| | Connecting with Self: Safety and Self-Compassion | Participants noted that safety and self-compassion were important in reconnecting clients with their values and engaging in action | |
| | Vaues-Based Collective Action | Once clients had established motivation, participants noted that participating in values-based collective actions further empowered their clients | "And especially for those kids who went and built the fences, not only were they helping the environment, but also getting that community connectedness. Because they were rebuilding their own towns, things that were close to home for them."<br>"They all talk about how upset they are about it, and then they rally for change. And each of them gets a little bit of control back. … they go and help someone on a farm who needs their fences |

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| | | | redone, they go and attend the climate change rallies - not on their own, they take a friend with them. I see, the faster they engage in regaining control over the things that they would previously do around climate change, the quicker their anxiety is amended."<br>"[Louise Hays] just mentioned that she'd done this webinar on coping with climate change distress using the DNA-v model… I guess that's actually the most clinical thing I've seen... accepting the distress and emotions, but taking values-directed actions to do what you can. Very in line with the APS but I guess in an ACT model instead of a CBT model." |
| | Building Community Resilience | Participants noted that building community resilience will be increasingly important in a changing climate | "So what [Dr Les Spencer]'s doing is looking at how do we prepare collectives to be able to adapt to profound levels of trauma and change."<br>"We kind of co-create practices around - I mean it's all about inter-generational trauma and inter-generational resilience, right? That's what we're doing. So yeah, it's created by community and, you know, I use a lot more, kind of, liberation psychology, narrative therapy... I use whatever justifies it to funding bodies basically but before that it's relationship, it's yarning."<br>"And what we're interested in is the generalisable community resilience, how do you do that preventable, up stream, generalisable community resilience. … So rather than specific preparedness, we say that it's better to create generalisable resilience that means people can adapt to all sorts of different crises, because we believe that concurrent crises are going to be the nature of reality."<br>"Alright, how can you apply regaining control of yourself, to regaining control of your environment. The one thing I've suggested that a lot of the kids do is rebuild the fences. You know, go and be a part of the community." |
| Systemic Engagement as a Profession | Learning from Communities | Acknowledging the wisdom of and learning from resilient communities | "And I would say, by far and away the best tool - like if you were to ask me, having gone through Black Saturday - I would be looking at deploying, if I were a counsellor or psychologist, it would be emotional CPR - teaching people how to listen to one another. The Indigenous people call it Dadirri, so it's less about intervention, and more about deep listening… deep listening and truth-telling."<br>"This is where the learning is. It's the people whose lives are more chaotic. It's the people who have already had to adapt. … So these are the people who are on the edge and they are the ones who have to be creative and do the hard work. They are the ones who have to work together to survive and thrive. So this is where the really interesting work is happening. It's not in research, it's not in departments of psychology or psychotherapy or clinical counselling. It's real people encountering challenges and where they've been marginalized" |

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| | Mutuality and Access to Services | Participants described the need for better service access for climate-related mental health concerns, which may mean moving beyond professional boundaries | "So these are the people involved with blockades and so forth, one of the things they've identified then is the need for more psychologists to support them, like bulk-billed or free… Someone needs to stick their hand up to identify and create a database of psychologists, and you know, professionals, mental health professionals, who will appropriately support activists, and who will do that either free or will just bulk-bill or just find ways to overcome the obstacles for activists who are not going to go to a GP and get a mental health care plan to do this."<br>"But you know, we marketed that [regenerative retreat] to activists and it was very, very cheap. It was just, pay for your camping and bring along food." |
| | Communicating Information Effectively and Accessibly | Participants noted that information is not being communicated clearly or accessibly, both within or beyond mental health professions | "And I think, being able to explain complex ideas very simply to people is also really missing at the moment, and I think a lot of people just don't really understand some of these complex ideas."<br>"How do we engage more broadly mental health professionals with these issues of justice and structural injustice? And so one of the things that emerged then was like a publication - so if we can create a publication that helps mental health professionals engage with these issues and think about them, which hopefully then prompts them to some kind of action, whatever that may be." |
| | Advocacy | Participants discussed using professional privilege to speak up and speak out | "And also I can use the skills I've got to try and speak up, so... like being a Climate Media Centre spokesperson, I can do that. ... So that's the stuff that isn't so much *directly* supporting *them*, it's trying to have my small, very small and limited bits of influence on the structures, you know trying to tackle the structures that keep us all trapped in climate change." |
| | Being Courageous and Doing it Imperfectly | Participants described their own journeys | "Like this period of time, if we're going to get through it, if we're going to lead our species through climate change and ecological collapse and everything else that's going to go with it, we're going to have to be profoundly courageous. So, really what we'll be requiring of our counsellors, our psychologists, and our psychotherapists, is how we're going to demonstrate both compassion and courage." |

# The barriers to effective communication about death in families with a terminally ill family member?

**Katarina Linder**

When a person is given a terminal illness diagnosis, it can change their sense of identity and their relationships with their family members or caregivers. Improved communication with the terminally ill person regarding end-of-life can assist them and the family to adjust to their new reality and achieve a better quality of life prior to death. Improved communication about end of life (EOL) by medical staff to patients and their families has shown to have reduced rates of patients' feeling isolated, as well as families experiencing depression and complicated grief. Despite the positive benefits for terminally ill people and their families, EOL discussions are often not conducted by medical staff effectively or early in the dying process. The literature regarding EOL discussions show three main barriers: i) medical attitudes towards death impacts the EOL conversations with families and terminally ill people; ii) delays in communicating poor prognoses and EOL options by medical staff; and iii) caregiver attitudes. Support programs have been shown to be beneficial in reducing caregiver stress; training and support programs in EOL discussions may be of benefit as well. Further research is required to understand the relationship between medical staff discussions that take place and whether these lead to an improvement in communication within families with the terminally ill person.

## Introduction

"In the past, most people died at home surrounded by their loved ones, and although inevitable, death was perceived as an integral part of life" (Braun, Gordon and Uziely, 2010, p. E43).

In modern times, the trend has been for the process of dying and death to be in the medical sphere where the medical aspects of dying become a higher priority than the personal and spiritual aspects for the terminally ill person. There is a move in society for death and dying to be more welcomed in the home, but this seems to be in its infancy. At this time in Western history, death is still an event that is to be avoided so that people who have a terminal illness may also feel isolated from their family and society. Death literacy in the form of End-of-Life (EOL) discussions have become an area that medical staff are now increasingly expected to engage in with families and patients. However, it is also noted that broadly, EOL discussions are not done well for adults or for children and there are many barriers that stops these important discussions taking place (Ulrich, Mooney-Doyle and Grady, 2018, p. 15). An EOL discussion should have at its core the wishes of the person who is dying and be able to support communication between the terminally ill person and their family (Nguyen, 2012, p. 17).

The care of terminally ill persons in the medical sphere poses an ethical dilemma for medical staff, as their focus is on improving health outcomes (Peters et al, 2013, p. 19). In their quest to extend life, effective communication about EOL and death may be negatively impacted (Menzies, Menzies and Iverach, 2018, p. 186). Medical staff who have a positive attitude towards death are more likely to provide effective EOL care for patients; whereas, if they hold negative attitudes, the EOL care will be affected negatively (Peters et al, 2013, p. 19; Menzies, Menzies and Iverach, 2018, p. 186). There have been many studies done in ICUs where family conferenc es have been one strategy used for medical staff to engage in EOL discussions with families and this has assisted families in understanding the prognosis of their terminally ill family member (Fisher and Ridley, 2012, p. 81). Support programs for caregivers has also been shown to ease their overall stress experience. The literature regarding EOL discussions show three main barriers: i) medical attitudes towards death impacts the EOL conversations with families and terminally ill people; ii) delays in communicating poor prognoses

Corresponding Author: Katarina Linder
Email: katarinalinder@live.com.au

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and EOL options by medical staff; and iii) caregiver attitudes.

## Methods

This review assesses the available literature regarding the barriers to effective communication about death in families with a terminally ill family member. These discussions are known as End-of-Life (EOL) conversations. The search strategy for research articles on this topic was conducted through the UNE Library website and Google Scholar. The primary phrases used in the searches were "barriers for families to talk about death"; "communicating about end of life" and "caregiver characteristics and end of life". Further articles were located using the recommended list of articles to the right of the screen (in UNE library searches) and using the reference list of suitable articles. The research studies selected were published from 2009 until present. Several studies have been completed in Intensive Care Units (ICUs) where the terminally person is often unconscious, but they were selected as they still represent the barriers of effective EOL discussions between medical staff and families or caregivers.

## Results

The three major barriers identified in the reviewed studies were: i) medical attitudes towards death impacts the end-of-life conversations with families and terminally ill people; ii) delays in communicating poor prognoses and EOL options by medical staff; and iii) caregiver attitudes.

### Barrier 1 - Medical attitudes towards death impacts the end-of-life conversations with families and terminally ill people

Wright et al. (2008) conducted a study of 332 terminally ill people and their individual carers to determine whether end-of-life (EOL) discussions reduced the aggressiveness of medical procedures received in the last week of life. Various scales and questionnaires were used to record mental health, culture, social demographic, quality of life, comorbid medical conditions of the patients and their caregivers. Overall, 37% of patients (123 people) are recorded as having EOL discussions with their doctor and caregivers were also followed up after 6 months of the person's death. Not only were EOL discussions shown to reduce the number of aggressive medical treatments, but the patient's quality of life also increased as well. For caregivers, it was shown that any aggressive medical treatments were at higher risk of their developing a major depressive disorder. The study also showed a direct correlation between the patient's quality of life prior to death and the caregiver's ability to adjust to life 6 months post death. The results show that there was no evidence of higher levels of emotional distress or psychological issues by doctors having an EOL discussion with the patients and their caregivers. The authors recommend a further study that records the EOL conversations to assess a baseline standard of EOL discussions. The authors support the development of training programs to enhance communication skills that have an emotional component for EOL discussions.

Granek et al (2017), conducted a study with 79 oncologists to assess the association between an oncologist's secondary traumatic stress (STS) and compassion satisfaction (CS) and their approach and avoidant communication about EOL with their patients. A Professional Quality of Life Scale and Communication about EOL survey were used in the study. The results show that lower STS and higher CS scores were linked to a more nuanced approach communication strategies and that the oncologist was more likely to have an EOL discussion with the patient. Higher STS scores was associated with higher avoidant communication strategies leading to less likelihood of an EOL discussion taking place. The conclusions made by the authors were that emotional factors (such as STS and CS) need to be considered for medical staff for EOL discussions to occur with terminally ill people.

Braun, Gordon and Uziely (2010) conducted a study of 147 nurses in Israel that were routinely exposed to death in the course of their work. Their attitudes towards death and the bearing this had on their care of a dying person was scored using three questionnaires: 1/ The Frommelt Attitude Toward Care of the Dying Scale (30 scaled responses measuring nurses' attitudes toward the dying patient and their family); 2/ The Death Attitude Profile-Revised Scale (32 scaled responses measuring fear of death, death avoidance, and types of death acceptance); and 3/ a demographic questionnaire. The study found a direct association between a nurse's personal view regarding death and their care of the dying person. The nurse may display a positive attitude toward the dying person and their family but if they have a fear of death may use avoidance techniques, so that the issues around death and dying are not considered. This could be viewed as the nurse's own coping mechanism but is not helpful for the patient or the family when being confronted with death and dying. The authors recommend that training and support programs include a nurses' culture and religion be considered as they are an important aspect in the development of views about death.

### Barrier 2 - Delays or lack in communicating poor prognoses and EOL options by medical staff to families of the terminally ill

Gutierrez (2013) conducted a small qualitative study in one 22 bed adult Intensive Care Unit in America. The unit had an average of 10 deaths per month occurring primarily after a medical event (74% of patients) and ventilation had been withdrawn. Ten medical doctors (noted as critical care physicians and fellows) and 20 family members participated in the study. One researcher used observation techniques including medical and verbal information, body language, people involved in the discussion and the setting. The information was collected over a ten-month period. The patient's prognosis regarding their death was placed into the following five categories – imminent death, inevitable death, recovery is highly unlikely, death is probable, and death is unknown. To ascertain patterns in the observed communication, fixed and non-fixed time markers were used. For example, a fixed time marker was 24 hours after a patient was admitted to ICU and again after a 2-week period since admission. A significant change in a patient's prognosis would be a non-fixed time marker. The 2-week fixed time marker was the accepted point at which communication with families was focussed on EOL treatment if the prognosis was poor. The study found that medical staff relied on empirical information (medical data) and intuition to formulate a view of the patient's prognosis, but the doctors would delay an EOL discussion until the empirical evidence supported their intuition. The study found that family

members were requesting information about the patient's prognosis earlier than the doctor was usually willing to provide the information. The study highlights the tension within the uncertainty of prognosis and the doctor wanting certainty before engaging in an EOL discussion with the family. The conclusion of the study is that discussion regarding a prognostic outcome is separate from the decision-making discussions about EOL, so that the family will have time to process the ramifications of the empirical medical evidence. The recommendation for research is that it is expanded across more ICUs to see whether the trend is across the board and to determine whether the 2-week fixed time marker is still an appropriate period, given the rapid changes in the medical field. Despite the small scale of the research, the abundance of information from the collection of qualitative data is broad and captures the nuances of the competing interests of doctors, patients, and their families.

Ibañez-Masero et al. (2019) used a qualitative style approach to researching the views of 123 caregivers of terminally ill persons, as to their view about the information communicated to them about their person's end of life period. Caregiver groups and individuals were interviewed across eighteen health care settings. The questions that were asked in the questionnaire gave an insight into the different areas where information is withheld and the impact of that on the quality of care experienced by the terminally ill person and their families. They acknowledge the importance and value of family and patients receiving clear communication with the relevant information (and that it is their right to have this information), but that this does not always occur for all people. The negative impacts of poor communication and emotional support are patient isolation and complicated grief for caregivers. A higher level of satisfaction was reported by patients and caregivers when honest and open discussions were held about EOL. It can be inferred from this study that the quality of information clearly communicated has a direct effect on the ability of caregivers to communicate with their terminally ill loved one.

Krawczyk and Gallagher (2016) conducted a study with 90 relatives of person's who had died 4-6 months previously. The After-Death Bereaved Family Member interview was used for the questionnaire and was conducted over the phone focussing the last 48 hours of the terminally ill person's life. The results showed that 50% of relatives were satisfied with the level of communication about EOL with 43% in this category reporting that they were kept informed about their relative's condition; and 45% of relatives wanted more information about the person dying and what to expect. The study highlighted certain themes that relatives experienced during the last 48 hours –

1. "Lack of awareness that the person was sick enough to die
2. Lack of communication about possible prognosis
3. Dissonance between probable outcome of care and ongoing treatments
4. Inappropriate use of euphemisms
5. False provision of hope
6. Suspicion of malfeasance" (Krawczyk and Gallagher, 2016, p. 4-5).

The authors recognise that a limitation of the study was the different cultural norms, especially regarding the doctor's role in EOL processes. The study highlights the need for medical staff to have EOL discussions with relatives and that not doing so may not be providing them with enough information for informed consent and they have limited understanding of what is occurring for their family member.

Lind, Lorem, Nortvedt, and Hevrøy (2011) conducted a qualitative study with 27 relatives of ICU patients 3–12 months after the patient's death. The results show that relatives felt that medical staff were unavailable to communicate with them and often adopted a 'wait and see' approach that left them with little understanding of the patient's prognosis; this often led families to a false hope of recovery. The relatives also reported that if an EOL discussion was held after the 'wait and see' period, it came too abruptly, and they did not have adequate time to adjust to the new information. Also, EOL decisions were made regarding clinical aspects of care, often leaving relatives out of the decision-making process. For the relatives where EOL discussions were held early, they reported better relationships with medical staff, and they felt part of the EOL decisions. The study concludes that the 'wait and see' approach is "an ineffective and ambiguous communication strategy" (Lind, Lorem, Nortvedt, and Hevrøy, 2011, p. 1147).

Periyakoil, Neri, and Kraemer (2015) conducted a mixed method study using a one-time online questionnaire with 1040 multi-speciality medical doctors in two different hospitals. Their focus was to explore the main barriers for doctors in discussing EOL with patients and their relatives. The results show that only 8 doctors did not report any barriers to having EOL discussions and 85.7% of doctors found these discussions to be very challenging. The main barriers that were highlighted related to cultural issues, whether they were language, religious or values-based differences. Health literacy was also reported to be a barrier that led to a lack of understanding of medical terms and relatives having unrealistic expectations of recovery. The authors highlight the need for doctors to receive training doctors in conducting culturally appropriate EOL discussions especially for the social minority groups.

## Barrier 3 – Care giver characteristics

Bachner and Carmel (2009) used a questionnaire to assess the level of communication about illness and death as perceived by 236 caregivers (unpaid) of a terminally ill persons in the last 3 months of their life. The questionnaire consisted of six statements, and each had a 5-point scale response that the caregiver could choose. The caregivers' characteristics were measured by a self-reporting scale covered their demographic, education, religiosity, education, sense of coherence, optimism, mastery, self-efficacy, fear of death and dying, emotional exhaustion, depression and length of time being the caregiver. The overall results show that caregiver communication with the terminally ill person was low, and they avoided discussing EOL issues. A higher self-efficacy score related to an increased score for communication, while higher scores of exhaustion and depression led to less communication about EOL. A limitation of this study is the caregivers recall, given the time after the death of the terminally ill person. The authors recommend support programs for caregivers to improve coping capacity.

Shin et al (2015) assessed 990 patient and caregiver 'dyads' using paired questionnaires scoring preferences regarding disclosure of terminal status and family involvement in the disclosure process. Medical information and sociodemographic information were also included in the study. The results show a poor concordance between the terminally ill person's wishes and their families regarding the terminally ill person's terminal status, family involvement in the disclosure process and EOL choices. Of the terminally ill persons in the study, 56.1% agreed

that the medical doctor should inform them first of their diagnosis. Interestingly, families tended to want the medical doctor to inform them first and then only inform the terminally ill person if they agreed to do so. The only area in which there was a clearer agreement, was the preference for palliative care over more aggressive life extending treatments. A limitation of the study was the use of hypothetical questions and the differing types and stages of illness. The authors highlighted the need for effective EOL communication between medical staff, terminally ill persons, and their families and that it is the medical staff that should lead these discussions.

Lee, Yiin, and Chao (2016) tested 81 cancer patients (who had been given a prognosis of death within 3 months) and their caregivers where 40 caregivers were given support intervention at least three times in a two-week period until the patient's death. Information about the caregiver's self-efficacy including subjective and objective stressors that they were experiencing. Varying tools were used to measure subjective and objective burden including heart rates. In the group receiving support, the caregiver's self-efficacy increased in comparison to the control group thereby reducing their overall stress. The identification of caregiver stress early on was highlighted as important for both the patient and caregiver. The main limitation was that it was not a randomised control study, and it was conducted in one hospital only.

## Conclusion

The studies show the importance of EOL discussions with families and terminally ill persons and that these discussions have a more positive effect if had earlier than later in the dying process. Due to death and dying occurring predominately in a medical care setting, it is currently the medical staff that hold the duty of care for these EOL discussions to take place. There are many interacting barriers, however, that stop these conversations taking place effectively, so that the wishes of the terminally ill persons are known, and the family have a basis for full understanding of the prognosis and process of death and dying. Further research is clearly indicated to understand the positive impact an effective EOL conversation in care settings outside of ICUs including the person's home. Studies looking at the effectiveness of training and support programs incorporating cultural aspects of caregiving would also be beneficial for medical staff and families or caregivers of the terminally ill. Further research should be conducted to understand the relationship between medical staff communicating EOL information with terminally ill people and their families and if this communication has a positive or negative effect on communication within the family caring for a terminally ill person. Caregiver stress and the relationship between the level of stress and the level of effective communication is another element to be explored as this would have an impact on the quality of EOL discussions between terminally ill people and their families.

## Bio

Katarina Linder recently completed her Master of Counselling from University of New England and is interested in cross cultural counselling, in particular, with First Nations people. She is currently working in the Northern Territory after relocating from New South Wales.

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