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Editorial

Volume 17, Issue 1 - 2023. Dr Ann Moir-Bussy

Welcome to the New Year and our first issue. Unfortunately, we did not have enough manuscripts to publish the second issue in 2022. It seems COVID and difficulties for many prevented this creative work. We now have many in the pipeline and we look forward to both issues this year.

Karen Phillip is a Master practitioner in Counselling and Hypnotherapy, and she generously shares her ongoing research. This current article explores her research on a new Anxiety reduction method. We are all aware how anxiety and its ensuing distress has grown rapidly during the COVID pandemic, so this pilot study provides a breakthrough for practitioners wanting to alleviate their clients' distress. It is named as a Rapid Anxiety Reduction Method (RARM). A group of therapists were trained to use this method and the results were promising showing effectiveness in 86% of cases. In addition, there was a 70%-90% reduction in symptoms.

This new technique is a guided imagery method used within hypnotherapy. This article is informative and interesting and supports previous research and writings on the power of transformative imagery to cultivate imagination for healing, change and growth. In her edited book on healing imagery Leslie Davenport (2016) brings together authors who write about imagery for healing including Martin Rossman in *Medical Applications of Guided imagery and Sondra Barrett in New Cancer Imagery-Engaging Cellular Science and Ancient Wisdom*. We invite any of you using or researching this mode to please contribute for future issues.

In our second Article, Kunzang Chophel and his co-authors, research ways in which Mindfulness can build social resilience in people living with HIV and Aids in Bhutan. Kunzang is a doctoral student from Bhutan and studying at Charles Darwin University. The current article is a small research and literature review he conducted a year or so ago. Mindfulness is taught throughout school in Bhutan and in compliance with the country's Gross National Happiness Plan everyone learns to practice mindfulness.

This particular study focusses on the ways in which mindfulness practice can build social resilience and support counselling interventions and overcome the stigma and discrimination that many of those suffering with HIV and AIDs experience. Keep an eye out for future writings from his PH D research.

Dr Judy Boyland shares with us her expert knowledge of supervision in counselling, after years of experience, practice, and study. As current Vice President of the Australian Counselling Association Judith's expertise has guided the ACA supervision Policy and she supports many counsellors with her supervision processes.

In this article Judy looks at the development of professional supervision and then addresses some of the key aspects of participation in the supervisory process, the roles and responsibilities of participants, varying models of engagement and the aspects of supervision that make it worthwhile and useful. If you are contemplating undertaking training in becoming a supervisor, then this article is a "must-read".

Editors

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

The last submission for this issue is from Yvette Carter. Yvette has practiced as a counsellor since the 1980's and has worked throughout Australia. A large part of her work has been undertaken with Indigenous communities in far North Queensland. In living and working in these remote places she discovered that many lacked numeracy and literacy skills and so developed a program to help these adult learners gain these skills. Combined with her counselling skills she discovered that her literacy work gained success when used together.

She submits here a short personal reflection of her experience in teaching literacy and numeracy and combining that with counselling and adds two case studies. They are both simple and heart warming and provide encouragement for all counsellors who are genuinely concerned for their clients' stories and welfare.

WE encourage all our readers to think about sharing your own experiences and research and if you are teaching to please encourage your students to publish their research. African writer, Ben Okri (1997) writes:

To poison a nation, poison its stories. A demoralised nation tells demoralised stories to itself. Beware of the storytellers who are not fully conscious of the importance of their gifts, and who are irresponsible in the application of their art: they could unwittingly help along the psychic destruction of their people" (p. 109).

To me this is a powerful quote, particularly in the light of current world events and the anxiety and despair that so many people around us experience. As counsellors, psychologists, and psychotherapists we have a profound responsibility to bring "stories that can heal profound sickness of spirit' (Okri) and your writing, your creativity your stories shared here can being a reawakened sense of wonder.

I will finish with a quote from a Jane "Nightbirde" Marczewski, who though diagnosed with terminal cancer, sang, and brought happiness to others. She appeared on America's talent show, knowing her time was coming to an end, shared her singing and her composition and then encouraged the audience and us too:

"You can't wait until life isn't hard any more before you decide to be happy".

Dr Ann Moir-Bussy
Editor

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Pilot Study into the Effectiveness of the Rapid Anxiety Reduction Method

Karen Phillip

In this pilot study, we measure the efficacy of using the new rapid anxiety reduction method with those struggling with an anxiety issue who have failed to remove or diminish the issue through various treatments. A group of therapists were trained to use the rapid anxiety reduction method (RARM). The results suggest the RARM to be effective and successful in 86% of cases demonstrating a 70-90% reduction in symptoms, while the remaining 14% displayed a smaller decrease in anxiety symptoms of around 40-50%. We conclude this new imagery method is a handy tool to reduce anxiety symptoms in clients who encounter their anxiety issue within a few days.

Keywords: *anxiety, imagery, visualisation, the velocity of therapy*

Introduction

Anxiety disorders are a prevalent health concern for populations worldwide (Freudenthaler et al., 2017). Anxiety refers to the physical and or mental response to the sensations of feeling under pressure, overwhelmed, or fearful of circumstances that are yet to occur, a negative future projection. It can immobilise the individual, prevent them from living a full life, and significantly damage the sufferer's health (Williams & Poijula, 2016).

Anxiety has been reported as the number one mental health concern in women and second for men (Chambala, 2008). Anxiety has been described as a conscious pattern aimed at planning behaviours for anticipating and avoiding future damage or injury (Porcelli, 2020). While those suffering from anxiety either do not know their symptoms, attend extended psychological or counselling sessions, and often take prescribed medication, anxiety remains a major debilitating issue within the population (Deady et al., 2017; Saarni et al., 2007). Researchers have attempted to enhance psychological and counselling treatments (Shepherd et al., 2012).

The most designated evidence-based psychotherapeutic approach for anxiety is cognitive behavioural therapy (CBT) (Meyerson & Konichezky, 2011). CBT aims to identify and challenge the deficiencies in cognition and information processing to improve functioning (Muller & Roberts, 2005). In a study conducted in 2019 (Fung et al., 2019), subjects showed the existence of a hierarchy ranging from fear to anxiety. Fear was reported as an immediate automatic reaction triggered by survival needs, while anxiety required adequate time to activate behavioural control. Anxiety indicates cognitive evaluation and management of behaviour in facing challenging situations, whereas fear is related to our need for survival from immediate harm (Porcelli, 2020). Anxiety is a cognitive processing issue linked to an activity, affecting decisions and control. Anxiety is considered an internal feeling created by an external fear of something that may never occur, whereas fear is a physical variation triggered by emotion (Porcelli, 2020).

Regardless of the research discussing improved ways to reduce and manage the symptoms and feelings of anxiety, there seems to remain a delay in the speed of obtaining successful treatment results. Psychological counselling and hypnotherapy techniques can often aid clients with successful results. However, the time taken for therapy continues to remain considerably protracted (Ramando et al., 2021).

Contemporary psychological literature often focuses on aspects of disassociation when dealing with anxiety issues. It is often viewed as an interruption in the integrated function of consciousness, perception and a dearth of integration in the individual's conscious thoughts, feelings, and experiences (McCraty et al., 2009). Over many years researchers and therapists have explored various techniques using a combination of CBT and hypnosis to reduce anxiety, with many positive results (Bryant et al., 2005; Phillip, 2021; Ramando et al., 2021). Using the individual's unconscious mind combined with guided imagery using specific positive required outcomes, as advised by the client, the rapid anxiety reduction method (RARM) was developed.

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What is the Rapid Anxiety Reduction Method (RARM)

The rapid anxiety reduction method (RARM) is a guided imagery technique created within the client's mind and guided by the therapist to reduce the anxiety issue of the client. The first part of the RARM involves relaxing the client with a short induction to allow the body to relax and the mind the clear. The client is then asked to create an image and feeling of their anxiety issue, preferably an issue that will occur within the next few days. The issues many clients experienced included flying on a plane, undertaking an exam, having a needle, going to the dentist, public speaking, driving over a bridge, walking in crowds, or walking into a shopping centre. On a subjective unit of distress scale (SUDS), with 1 being a feeling of relaxed confidence and ten being extremely anxious and fearful, all participants had a SUDS of between 7-10+.

The therapist guides the client to imagine the scenario of success, as guided by the therapist before being brought back to full consciousness. The therapist then follows a pre-set dialogue to guide the client to imagine a positive outcome. The therapist guides the client to do this multiple times. Each time imagining the success with more intensity, louder, larger, and more colourful. The client is then asked to imagine their previous anxious issue, and another SUDS is obtained. A much lower SUDS is expected to be reported, and the client feels more relaxed and comfortable facing their imminent experience. The therapist confirms the release of the client's anxiety issue a few days later via a phone call and normally after the client has experienced their anxiety issue. This is to verify that the SUDS remained low after treatment and that the client has experienced their anxious experience comfortably.

The RARM technique began being taught to counsellors, psychologists and others in hypnotherapy and psychotherapy courses. All students were required to undertake practicals within the class, followed by using the RARM technique when undertaking their practical assessments. Students also used the RARM with family members and friends in practical work for assigned tasks.

The RARM technique was taught, used by psychologists, counsellors and hypnotherapists, and then reviewed. A more formal assessment of the methods and outcomes was undertaken to validate the findings. More formal surveys were conducted to obtain relevant data on the effects obtained by therapists using the RARM technique within their therapy practice. A thematic analysis was conducted to determine themes from the participant comments.

Research Rationale

This study will be the first to focus on developing an in-depth understanding of the RARM treatment method. Research to date has focussed on a variety of methods to treat anxiety. However, the RAM method is new and, to date, unresearched. Our research will extend existing research by interviewing therapists with heterogeneous experiences and modalities and apply a specific focus on the reported results of using the RARM modality.

Recruitment

Permission was obtained to report on the treatment and results from the therapists delivering the same session. Permission was also granted from clients treated with RARM for their results and comments to be used in the research, allowing the use of collected data.

Participants who conducted the RARM therapy were registered counsellors, psychologists and hypnotherapists trained in using RARM therapy. They all underwent training in RARM and were provided with a scripted dialogue, so all patients and clients received the same dialogue and instructions. While some participants may have added some of their own words during the client intake, the therapy session delivered was the same therapy script as the training provided. The clients experiencing an anxiety issue consented to use their data within the research. All therapists and clients were deidentified, no names were recorded, and only therapists' pseudonyms were used for research purposes. All clients had previously sought therapy treatment to reduce their feelings of anxiety over their specific issue. The clients attended as their anxiety issues remained problematic.

Data Collection

Thirty-seven therapist participants were involved, reporting on between two and three RARM sessions with clients. All sessions included

- completing a client intake form with notes of the presenting issue,
- recording of client words,
- a SUDS scale to measure the severity of the anxiety both before the session then again after the session, and
- a third rating a few days later on a follow-up telephone call with the client.

Measures were taken pre-and post-treatment using the subjective units of distress (SUDS) scale. SUDS was obtained when the client initially attended the appointment, directly after the treatment and again a few days after they experienced the anxiety issue for which they sought treatment. The participants conducted their sessions following the dialogue provided by the researcher in anticipation of reducing the anxiety their client was experiencing. In total, 80 results were analysed via reports written on the results obtained from the participant therapists.

Data Analysis

The researcher used Thematic Analysis (TA) to record comments made by the therapist participants to determine the results of using the RARM technique. Eighty results were analysed. Thematic analysis (TA) was chosen as the data analysis method due to its flexible approach focused on identifying patterned meaning across a dataset. TA allows for identifying patterns or themes across a dataset without theoretical underpinnings (Braun & Clarke, 2006). The primary goal of thematic analysis is to investigate, identify, and analyse themes within data (Braun & Clarke, 2006). TA is beneficial and widely used due to its flexibility, allowing the researcher transparency regarding the assumptions about the nature of the data. The use of TA requires no development of axial coding or data saturation procedures. TA is flexible and practical in capturing the participant's beliefs, feelings, and experiences (Braun et al., 2020). In clinical research,

it has been used in numerous counselling and psychotherapy studies (McLeod, 2011).

The researcher gathered results and used TA from the narrative written responses of participants where themes were identified from participant responses and responses recorded from their clients. Repeated patterns and emergent thematic categories were the focus. The responses from participants were used to determine the thematic patterns (Clarke, 2019; Terry & Braun, 2016).

The analysis was informed by Braun and Clarke's (2006) six-stage process. The first stage focused on becoming familiar with the data. NVivo (QSR International, 1999) was used to highlight any related quotes and descriptive language. The second stage involved the creation of codes from participant descriptions. During this stage, the participants' responses were re-read, and any coding focused on specific words or responses related to the research's main aim. The third stage involved the identification of the themes that were important to the research aims. The identified themes were subsequently reviewed in the fourth stage. At this stage, four themes were identified and accurately represented the data. The fifth stage involved completing the data by identifying patterned responses before defining and naming the themes identified. The sixth stage involved the writing up of the research.

Findings

The analysis of the participant responses identified four distinct themes concerning the effectiveness of the rapid anxiety reduction method. The four main themes identified were: (a) the speed of improvement, (b) ease of use, (c) empowerment and control, and (d) anxiety desertion.

Comments from the therapist participants were divided into four themes. Theme one was the speed of improvement noted by participants and clients. The clients' SUDS were reduced after the RARM session. Theme two was the ease of use for the therapist and client. Participants advised that the clients were pleased to obtain not only fast results but the ease with which they were obtained seemed to excite them. Theme three identified empowerment and confidence obtained by the client. Participants reported that the comments made by clients were consistent, expressing their feeling of empowerment and control over their past anxiety issue. Theme four was anxiety desertion, where the client's anxiety relatively or entirely disappeared concerning their anxiety issue. The single RARM treatment was all that was required by over 86% of participants' clients to significantly reduce their anxiety issues, enabling them to undertake their experience with renewed confidence and comfort. The results reported from using the RARM were continuously effective when the taught technique was used.

Theme one: Speed of Improvement.

Participants all indicated positive results from using RARM. Many comments were noted in participant responses to show this speed of improvement with clients:

… amazed at how fast the RARM technique works to significantly reduce the feeling of anxiety with my clients (SW).

I now use the RARM for so many anxiety issues; it is effective, fast … (JD).

The RARM therapy is typically executed in one session. While seldom times a second session was required due to secondary gains held by the client if their SUDS was not significantly reduced. If the SUDS remained above a 4, another therapy session was recommended to address and alleviate the issue due to secondary gain.

Participants commented on the speed of using the RARM, saying:

I'm astonished at how fast this session changes clients' thoughts and behaviours (LC).

I almost laugh now when a client calls about their anxiety issue as I know when they come in, they will leave feeling so much better, more in control, and in only one session, they think I am a miracle worker (DG).

Client JM stated: … I felt different, less distressed, more distant from the issue almost immediately (JM).

…this is by far the fastest anxiety remedy I have every used with clients; the speed of change blows me away (KD).

Participants continued comments on the speed of the RARM to improve and reduce their clients' feelings of anxiety were consistent throughout their responses.

Theme 2: Ease of Use

Participants described the RARM session as so easy to use. Participants who were counsellors and psychologists commented that they often used multiple sessions to reduce a client's or patient's anxiety level. They advised that once learning and using the RARM; they felt it was easy for them and their client:

… it was just so easy to use, once you obtain the client issue and their precise words, you can use these within the dialogue script to connect quickly with the client/patient and just have them follow the instructions, it is really easy" (LW).

…as a counsellor I was unsure at first if the RARM would be as good as I had heard from other therapists who had trained in it, so I thought I would give it a go; I actually needed some CPD points. I was stunned, surprised and thrilled at how easy it was to get such a fantastic and positive result (AR).

…it is so easy, simple to use and non-threatening, yet provides fabulous results (MM).

…her SUDS regarding attending the class was a 7 now a 1. My client felt it was the easiest therapy session she had ever attended (JD).

… the ease of use with this RARM treatment is fantastic, you have the dialogue to use, the steps are easy, and it works incredibly well (ST).

Client KW commented: … I have had this rotten anxiety most of my adult life, been to therapy heaps of times to manage it, but wow, it has completely gone. I was relaxed, and my mind did all the work. I feel it was too easy, but it just worked (KW).

Participants trained in the RARM therapy technique emphasised it was one of the fastest learned and easiest used therapies that delivered positive results. The theme of ease of use was consistent with all the therapists trained in using the RARM.

Theme 3: Empowerment and Control

Participants commented that their clients felt empowered and in control again. Participants advised that the clients had indicated the issue of anxiety they were carrying had been debilitating, annoying, and challenging for many years. While in

therapy, we often seek to find the initial sensitising event (ISE) in some of the anxiety cases reported; there was a lack of identified ISE. Some clients advised their issue began or developed without any significant cause. This results in additional confusion and frustration for the client:

My client opened their eyes and smiled, saying how amazing she felt. Her SUDS, originally an 8, was down to a 1; she felt empowered and more in control (MM).

… scared to death of driving over a bridge, any bridge. The client reported no incident or accident on any bridge and had no idea where this horrid fear eventuated. It prevented her from driving, and she wanted to regain control over this anxiety issue. Her SUDS was 10, and after I did the RARM, her SUDS went down to a 2 and she was excited to drive and go over a bridge. I called the client three days later to check in, and she advised she had driven over many bridges, felt in total control, empowered, no fear, and her suds was a minus 100 – so a 0 (HS).

…RARM enables my clients to feel they have regained their control over their anxiety issue (JP).

Client AR stated:

… this feeling of power and control I feel has blown my mind completely. I was hoping to feel less anxious about performing again but now I feel like I want to just sit in front of thousands and perform and sing and have fun, like right now (AR).

Participants agreed their clients felt an almost immediate empowerment and regained control over their issue. The comments about feeling empowered and a new sense of control were consistent with all participants. This was consistent with the follow-up phone call undertaken 3 – 4 days after they had faced their anxious event.

Theme 4: Anxiety Desertion

Participants advised how the RARM positively affected their clients. The disappearance from the anxiety feeling occurred after the session. The anxiety desertion remaining days after the session and after the client had experienced the event they were anxious about undertaking or participating in.

… after doing the RARM exercise my client stated that she could no longer feel anxiety at all and could not even place herself in a situation where she was able to feel anxiety (RA).

… the anxiety, panic or sweatiness my client said he experienced through those regularly anxiety experiences had vanished completely (SW).

Participant ML used the RARM with a client who was petrified of needles and required COVID vaccines for work:

...as soon as she sat down to have the vaccine, she said that all her fears and worries almost completely disappeared. She said a feeling of calm washed over her, which was comforting and reassuring. She was surprised and relieved to feel this way. Her SUDS was a 10+ but had come down to a 0-1 (ML).

Client SP commented:

…I am amazed at how my anxiety just seemed to disappear. I truly tried to find it when I was asked to and thinking about the pending event I was so anxious about, but I couldn't; it was just gone (SP).

The participants were congruent in their comments about anxiety desertion.

Conclusion

The research was conducted only on issues occurring within the next few days. The issues included driving over a bridge, walking past dogs, swimming in the ocean, flying on a commercial flight, having a needle, taking a driving test, giving a presentation to a group of work colleagues, fearing an ultra-sound to check on the development of the baby, and attending a job interview. The issues were varied; the results were homogenous. Not only were clients and participants excited about the ease of use, speed of treatment, and clients stated a feeling of control and empowerment; many also commented that the anxiety had disappeared.

The RARM training consisted of a one-day training event and 4-6 practice sessions before participants were advised to use the RARM on clients or patients. The training never promised any miracles, only a possible reduction in the level of anxiety experienced by the client. Further research on using the rapid anxiety reduction method could be conducted to validate a broader range of anxiety issues with a more significant number of participants reporting. Further, a longitudinal study to investigate the reduced feeling of anxiety over months or years could be undertaken.

Bio

Karen Phillip is a Master practitioner in Counselling and Hypnotherapy. Karen has worked over 20 years as a clinical practitioner in counselling and hypnotherapy. She teaches Psychotherapy and Hypnotherapy in the Australian Hypnotherapy College diploma course. Karen also conducts many Masterclasses for therapists around the world. Karen has been published previously with research in rapport building over the telephone and how counselling and hypnotherapy can work congruently. The recent article is research conducted on a new rapid anxiety reduction method. Karen continues to work in private practice while teaching and researching.

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Mindfulness as a Transformative Intervention for Building Psychosocial Resilience in People Living With HIV/AIDS in Bhutan: A Literature Review

Kunzang Chophel, Kuenga Tenzin & Ann Moir-Bussy

People Living with Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) face many challenges at the individual, interpersonal and neighborhood levels. In Bhutan there is an increasing prevalence of people living with HIV or AIDS. The most notable impact for these individuals with HIV or AIDS in Bhutan is felt at the psychosocial level. These people are susceptible to chronic stress and social stigma. The challenge lies in the accessibility of counselling interventions intended toward elevating their psychosocial resilience. Social stigma and chronic stress are two major adversities that men and women living with HIV/AIDS in Bhutan face on a day-to-day basis. Although, both treatment and counselling are available exclusively under the Bhutanese universal health care system and supported by various stakeholders with intervention programs to enhance their psychosocial resilience, those living with HIV/AIDS in Bhutan still face social stigma and discrimination.

Such discrimination includes being disowned by their families, unemployment, simply because it is a sexually transmitted disease. Despite the prevalence of promiscuity in Bhutanese society, infected people often remain silent for fear of discrimination in an otherwise progressive society. Both the government and media have recognized the need to address social stigma, which hampers treatment and prevention, by educating and counselling the general population. This literature review attempts to explore in depth how mindfulness could be used as a transformative intervention for building psychosocial resilience for those living with HIV/AIDS in Bhutan. The role of socio-cultural and religious factors on the psycho-social resilience of people living with HIV/AIDS is an important area that needs further exploration. The study will attempt to delve deeper into the impact of mindfulness based transformative intervention on the multilevel psychosocial resilience of PLHIV/AIDS in Bhutan.

Keywords: *human immunodeficiency virus, acquired immune deficiency syndrome, people living with HIV, mindfulness, sociocultural, psychosocial resilience, transformative intervention, Bhutan.*

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Background

HIV/AIDS was relatively rare among Bhutan's population but has grown into an issue of national concern since Bhutan's first reported case in 1993 (WHO, 2010). Those living with HIV/AIDS in Bhutan are across all social groups, including government employees, businessmen, farmers, soldiers, monks, sex workers and housewives. There is a steady rise in the number of reported cases since the first detection, and in June 2020 the total number of cases stood at 741 (384 males and 357 females). In June

2022 Bhutan detected 40 new cases. Of those, 19 are males and 21 females. This is the highest number of cases detected in a period of six months. It is a serious public health concern for a small population of about 700,000 people in a country, which prompted increased government efforts to confront the spread of the disease. This was done through mainstreaming Sexually Transmitted Disease (STD) and HIV/AIDS prevention, grassroots education, and the personal involvement of the Bhutanese royal family, namely Her Majesty Queen Mother Ashi Sangay Choden Wangchuk.

Lhak-Sam was the first community network in Bhutan to tackle the disease and was formed in September 2009 by a group of HIV positive people in Thimphu. The group was registered as a civil society organization (CSO) on 26th November 2010. Their main aim is to provide and promote leadership, education, and capacity building to those living with HIV/AIDS and their families. In addition, they wanted to establish linkages with regional and international networks of affected people with HIV/AIDS. The Ministry of Health provided strong encouragement and, Lhak-Sam expanded its group to other districts with a mission to create and promote a strong support system based on solidarity, and social networking. The group encouraged people's participation in addressing and taking collective action towards effective responses to HIV/AIDS and its impact. Currently, Lhak-Sam has 107 members (51 females and 45 males) across the country and an executive committee (comprising of 8 members) has been formed that makes all major decisions for the group. Today, Lhak-Sam works with partner organizations alongside the LGBTQ+ community in Bhutan, drug users and affected children in an attempt to eliminate impacts of HIV and AIDS in the country. Lhak-Sam envisions a society where all those living HIV/AIDS and affected family members can have opportunities for a meaningful livelihood with the illness controlled and its impact eliminated.

Being a Buddhist country, Bhutan's people's way of life, attitude and belief system are highly influenced by Buddhist values of self-determination, mindfulness, compassion, loving-kindness, and detachment. These are deemed to be a potential source of inspiration in building the resilience of those in Bhutan living with HIV/AIDS. The Bhutanese social and religious factors are one of the strong precursors that enhance the psychosocial resilience of those living with HIV/AIDS in its country. The Government philosophy of Gross National Happiness (GNH) on the other hand, is concerned with psychosocial wellbeing as one of its domains of GNH, while it further caters for the needs of mental and emotional wellbeing of the people in general. Mindfulness practice is seen as one of the most effective transformative interventions for people with HIV/AIDS in Bhutan. Through their participation in social and religious festivals, it boosts their social and moral values irrespective of their social situations. Besides that, there are many temples and monasteries around the kingdom, where people practice mindfulness and seek blessings for their physical, mental, and emotional wellbeing, thereby significantly contributing to the building of psychosocial resilience.

The Prevalence of HIV/AIDS in Bhutan

A small country between China in the north and India in the south, Bhutan has a population of approximately 733,700, and of these 53% are male and 48% are female (Tshering, Lhazeen, Wangdi and Tshering, 2016, p. 45). The first HIV case was detected in 1993. By the end of 2016, the Royal Government of Bhutan recorded 515 people living with HIV in the country, of whom have 102 died. This translates into almost 100 married couples losing their spouses and leaving behind about 150 children, without either or both of their parents (Annual progress report, MoH, 2016). Unlike neighbouring countries, the HIV epidemic in Bhutan is of a diffused nature with incidences in all the 20 districts of the country, and it is equally distributed among sexes, age group and occupational backgrounds. The most dominant route of HIV transmission is through unsafe sexual practices with a risk of 90%, while mother to child transmissions and probable IDUs attribute to 8% and 2% respectively. It is worrying that almost 84% of transmissions are occurring among the most active working age group of 24 to 49 years (Annual progress report, MoH, 2016). At the end of 2020 Bhutan recorded on average a new HIV case every week, with the majority aged 25-49 years and the rest over 50 years. The most common form of transmission was unprotected sexual intercourse. Unfortunately, UNAIDS estimates that there are 1100-2700 people living with HIV in Bhutan, a case detection gap of 53%, which means 585 people in the country still do not know their HIV status. Without treatment, it takes 7 to 10 years on average for a person living with HIV to show AIDS defining symptoms (Annual progress report, 2016).

Further to this report the Ministry of Health is also dealing with the COVID 19 pandemic and has implemented the 3T approach (Testing, Treating and Tracking) to mitigate the spread. The Director of Public Health, Dr Karma Lhazeen, noted that the

"pandemic had worsened the challenges faced by people living with HIV, women and girls including female sex workers, men having sex with men, and transgender populations as many lost their source of income and faced difficulty in accessing the health care services".

He added that the same 3T method needed to be used in alerting the population and those living with AIDS that it is possible to lessen the transmission if people are aware and know their condition.Health officials also noted that the stigma and discrimination of victims of HIV/AIDS could be discouraged if it was more widely known that there are now well-proven effective HIV medicines (Kuensel , Dec 1, 2020)

Mindfulness and AIDS

In this paper the authors attempt to explore and understand the phenomenon of mindfulness and its impact as a transformative intervention in building the resilience of those living with HIV/AIDS in Bhutan. The study intends to elucidate how Bhutan's unique sociocultural and religious factors determine the resilience of the people living with HIV/AIDS on three different levels: individual; interpersonal; and communal levels.

The need to review the correlation between the mindfulness intervention and the significant stakeholders is of immense importance. The mindfulness intervention is part of a Buddhist tradition, and it is deemed a valuable pre-requisite for every counsellor, mental health professional, policymaker, lawmaker; politician and others in Bhutan, all of whom play some significant roles in determining how those with HIV/AIDS deal with their chronic stress and other mental disorders related to illness.

Review of the Significant Literature

Despite pre-emptive education and counselling efforts, the number of reported HIV/AIDS cases has climbed since the early 1990s (WHO, 2010). On average 50 new infections occur and about 5 positive individuals die of either AIDS related complications or due to repercussions of social stigma every year in Bhutan (Annual Health Bulletin, 2010). As noted earlier, Lhak-Sam is on a mission to mitigate and prevent new HIV infections by ensuring full access to treatment and care services for those with WHIV/AIDS, thereby reducing their psychological burden (Annual progress report, MoH, 2016). This group faces a wide range of obstacles at individual, interpersonal and neighborhood levels. Dulin, et al., (2018) believe that those living with HIV experience psychological trauma including anxiety, depression, and other mental health issues, such as suicidal ideation, substance abuse of drugs and alcohol, low self-esteem, shame and self-guilt. (Riley & Kalichman, 2015). These authors are of the view that on the interpersonal level HIV related stigma is the most significant challenge and at the neighbourhood level economic deprivation and violence (Dulin, et al., 2018). The degree of anxiety is higher during the diagnosis of HIV infection, which is often reflected through blaming one's partner, expressing anger through violence and self-harm, and gradually resorting to drugs and alcohol (Emlet, Tozay & Raveis, 2010; Riley & Kalichman, 2014). One study confirms the prevalence of higher suicidal ideation and depression in people living with HIV/AIDS during the first few months of anti-retroviral therapy (Mahajan, et al., 2008).

Infection and transmission of HIV in South Asia is linked to multiple factors including political tension, religious restrictions on discussion of sex, lack of awareness of safe sex in rural areas, social stigma, and extremism. These factors limit the accessibility of treatment and control prevention programs to a sizable population (Rodrigo & Rajapakse, 2009). However, this may not be true in Bhutan. It is politically stable since 1907, religious and cultural freedom is well-enunciated in its constitution (The Constitution of the Kingdom of Bhutan, 2008). Research claims that HIV infection and transmission in Bhutan is linked to HIV stigma due to its closely knitted social structure (Khandu, Zwanikken & Wangdi, 2019) and the casual attitude of the general population toward unsafe heterogenous sex (Rodrigo & Rajapakse, 2009). More than 92% of infections are transmitted through sex and more than 70% of the infected live in the capital city (Tshering, Lhazeen, Wangdi & Tshering, 2016).

Social stigma is embedded in the consciousness of many. However, Mahajan et al (2008) note that there are men and women living with disclosed AIDS who are able to benefit and access treatment and support services. With Bhutanese people in contrast, it is their family members and children who are likely to face more discrimination and social rejection (BBS, 2018). The Lhak-Sam Centre in Bhutan initiates lots of community based inspired programs such as access to resources (counselling and health services), LGBTQ forums, leadership empowerment, advocacy, and awareness on HIV/AIDS to support the people living HIV and stop further spreading. This initiative has encouraged people living with HIV/AIDS to disclose their HIV status to and avail themselves of support services.

Stigma is defined as "an attribute that is deeply discrediting" (Goffman, 1963). According to him, stigma taints and discounts a person and leads to a socially spoiled identity and, as a result, the individuals are compelled to view themselves as discredited or undesirable. At the same time, others are encouraged to consider them in the same way. Stigma that is related to HIV/AIDS focuses more on individual perceptions and collective constructions of negative stereotypes, which ultimately enforce discrimination against the stigmatized (Mahajan, et.al., 2008).

Resilience is needed to overcome the debilitating effects of stigma. Resilience has been defined in many ways and, in almost every definition, overcoming adversity is the most prominent theme. Resilience is referred to as an individual personality characteristic (Bonanno, 2004; Connor & Davidson, 2003; Leipold & Greve, 2009; Masten, 2001). Resilience is seen as a successful adaptation to negative life events, trauma, stress, and other forms of risk and as having capacity to cope with significant change (Connor & Davidson, 2003).

In this article we use the perspective of resilience that is drawn from the socioecological model of health. According to Baral, Logie, Glosso, Wirtz, and Beyrer (2013), health is influenced by factors at the individual, interpersonal, neighborhood, and societal/policy levels. HIV related stigma faced by the people living with HIV/AIDS at these multi-levels of health can adversely affect their overall health. To help those with HIV/AIDS to overcome HIV/AIDS related adversities at these many levels, it is important to identify the 'resilience' resources at these levels of health (Dulin et al., 2018). Resilience resources in this study refer to positive psychological, behavioural, and societal adaptation in the face of HIV/AIDS stigma related stress and adversities (Fletcher & Sarkar, 2013). Hence, resilience resources in this context are referred to an individual's capacity combined with families' and communities' resources, which are essential to overcome any serious threats to development and health caused by HIV/AIDS related adversities (Earnshaw et al., 2013).

Adversities associated with HIV/AIDS related stigma have been linked to various damaging health behaviours such as lower HIV medication adherence, poorer clinic attendance, and outcomes including less viral suppression (Hotlzman, Brady & Yehia, 2015; Hays et al., 2000). However, any interventions targeted at reducing the stigma and enhancing the resilient resources is known to increase empathy and altruism towards, as well as reduce, the anxiety and fear of people living with HIV/AIDS (Dulin et al., 2018).

After reviewing several peer-reviewed articles and manuscripts on the HIV/AIDS infection, and its impact, stigma and resilience resources, there is a significant research gap in the field of HIV/AIDS resilience research. Most of the existing research was focused exclusively on individual level resilience and ignored the social context and social systems in which resilience may occur (Dulin, et al., 2019). As noted above, HIV/AIDS and resilience research is one of the least explored areas in Bhutan. It calls for more studies in order to understand the science of people living with HIV/AIDS and their experiences of living with it.

Mindfulness as Transformative Intervention in Developing Resilience for PLWHIV/AIDS

The majority of the Bhutanese population is Buddhist and that has a massive influence on their way of life. Their values of compassion, caring and altruism are mostly inspired by Buddhism. With Gross National Happiness (GNH) as the guiding

philosophy of the people of Bhutan, the country is bonded with unique social, cultural, and religious factors that determine the way people live in general. In times of both tangible and intangible crisis, most people in Bhutan seek refuge in Buddhism as a way to alleviate their psychological pain. In recent times, this practice has received more attention from the Government and scholars at large. Mindfulness practice is widely used amongst scholars and professionals in the Bhutanese context (Dorji, 2005; Thinley, 2012; Rabgay & Kezang, 2018; Chophel, 2020; Tshering, 2021). Mindfulness has been introduced to schools in Bhutan in order to help students improve their concentration, to be in the present moment and to deal with stresses of their day-to-day life (Thinley, 2012) According to Canadian psychologist Scott Dr. Bishop (2021), mindfulness allows the participants to step back from thoughts and feelings during stressful situations rather than engaging in anxious worry or other negative thinking patterns that might otherwise escalate a cycle of stress reactivity and contribute to heightened emotional distress.

Mindfulness has strong roots in the socio-cultural fabric of Bhutan. It is practiced under the guiding principles of GNH covering a wider range of the psychosocial domain of the society. It is often seen practiced in hospitals, schools, rehabilitation centers and other social services and provides centers, such as Lhak-Sam, using intervention strategies to enhance the wellbeing of the people affected with social and psychological issues. It is also well practiced as a transformative strategy in developing the resilience of people living with HIV/AIDS in Bhutan through provision of mindfulness coaching, retreats and workshops by many of the professionals and religious scholars.

As noted earlier in this paper, psychological stress is prevalent among individuals with HIV, many of whom face poverty, discrimination, homophobia and stigma (Howland et al., 2000). Mindfulness-based stress reduction (MBSR), developed by Jon Kabat Zinn is one approach that has shown promise as an intervention for patients facing other medical conditions for the reduction of disease progression, psychological distress and maladaptive behaviours (Riley, K. E., & Kalichman, S, 2014). Stress, along with negative affective states, such as anxiety and depression, can affect biological processes and behavioural patterns and so advance diseases and symptoms (Cohen et al., 2007). Of particular concern for people living with HIV, research has found that interpersonal stressors, such as bereavement and stigma, impact the intensity of HIV disease (Goforth, Lowery, Cutson, Kenedi, & Cohen, 2009; Mahajan et al., 2008). Stress has been shown to have a direct influence on disease progression, and an indirect influence on disease progression through maladaptive behaviours, as well as adverse effects on the quality of life (QOL; Hays et al., 2000).

Although social stigma is the biggest barrier that people living with HIV face, many people today accept those infected as a result of a timely advocacy and awareness campaign run by the Ministry of Health and NGOs at different social levels. Mindfulness retreats are a common trend in counselling intervention services provided to people living with HIV/AIDS in Bhutan. With temples and monasteries widespread over the kingdom of Bhutan, those living with HIV have maximum access to mindfulness retreats as part of the treatment plan. In addition, when they accept the harsh reality of the social stigma. their attendance at religious rituals plays a significant role in building their resilience.,

Additionally, stress may hinder one's ability to access adaptive social support, which in turn can impede effective coping strategies, responses to stigma and treatment adherence (Antoni, 2010). Stress is also related to maladaptive coping strategies, including substance use, which have been linked to disease progression. For example, the use of denial coping at the time of an HIV diagnosis predicts greater impairments in immune status functioning over time (Antoni, Goldstein, Laperriere, Fletcher, & Schneiderman, 1995). According to Vedhara and Irwin (2005), psychological stress is one of the major factors influencing treatment access, medication adherence and HIV diseases progression. Mindfulness based interventions help people living with HIV/AIDS to be in control of their emotions through acceptance, through decrease of emotional reactivity and the increase of positive reappraisal (Holzel et al., 2011). One study indicates that mindfulness helps people suffering from chronic disease to slow down and be realistic in evaluating the prognosis, which helps them to identify different aspects of the disease that require action and those that should be embraced (Brown, Ryan, & Creswell, 2007; Carlson, 2012).

MBSR interventions are typically standardised and manualised and include mindfulness meditation training programs developed for treating populations with high levels of stress (Kabat-Zinn, 1982). MBSR intervention programmes typically consist of eight weekly training sessions on mindfulness through group discussions and guided mindfulness meditation, as well as homework and a day-long retreat around week number seven. In more recent studies, MBSR, MBCT and other mindfulness and meditation-based treatments have been found effective in treating anxiety, depression, psychosis, addiction and other physical symptoms as well (Shaheen, Lakhan & Kerry. 2013). In their literature review, they state that mindfulness-based therapy has been useful in treating the symptoms of somatization disorders. However, this is a fairly new model of treatment that still requires more studies to confirm its efficacy to be used in the general population.

Praissman and Sharon (2008) in their literature review stated that mindfulness-based interventions were therapeutic for health care providers. They were of the opinion that health care providers who practice mindfulness have enhanced interactions with their patients. This similar idea has been adopted in Bhutan in recent time, and its efficacy needs further exploration.

There are several potential reasons that suggest MBSR could benefit people living with HIV. Brown and Vanable (2008) suggest that focusing on somatic states as a result of MBSR may explain the amelioration of chronic pain (Cioffi, 1991; Leventhal, Brown, Shacham, & Engquist, 1979; Suls & Fletcher, 1985). Emotional regulation is another potential mechanism through which distress may be decreased (e.g., Carlson, 2012; Feldman, Hayes, Kumar, Greeson, & Laurenceau, 2007). For example, Holzel et al. (2011) shows that mindfulness-based interventions, such as MBSR and mindfulness meditation, are related to emotional regulation in the form of acceptance, decreased emotional reactivity and positive reappraisal. Past reviews regarding the efficacy of MBSR for chronic diseases have noted promising intervention effects, with one broad review across multiple health conditions noting some initial support for the utility of MBSR for people living with HIV infection (Carlson, 2012). However, we did not find robust and conclusive studies on the efficacy of mindfulness-based interventions for people living with HIV/AIDS (Yang, Hui. Liu & Zhang, 2015). They were of the view that since MBSR and MBT were effective in relieving chronic pain, lowering blood pressure, improving psychological

health, people living with HIV/AIDS could also benefit especially in managing their mental health related issues like anxiety and depression.

Conclusion

As noted throughout, there is a lack of study of the phenomenon of HIV/AIDS infection in Bhutan, with special attention on the adversity which people face, and the resilience required on the part of those experiencing HIV/AIDS. However, the Royal Government of Bhutan, religious organizations, multilateral agencies, business communities, and armed forces, donors, volunteers, individuals and the community members and HIV positive networks partners render invaluable support for HIV/AIDS victims in Bhutan. This enables these people to handle their situation more confidently and meaningfully in a more conducive Bhutanese environment. With the support of the stakeholders, the voices of the those with HIV/AIDS are being heard more clearly and enabling the raising of quality of life for these people of Bhutan. The respect and support from partners and stakeholders from Lhak-Sam have given strength and confidence for those with HIV/AIDS and they are moving forward selflessly and tirelessly towards halting and reversing HIV and mitigating its impact in the country and the region. The members and staff of Lhak-Sam passionate hard work and their willingness and drive to learn have caused their support to grow for those living with PLHIV/AIDS. This same momentum needs to continue to overcome all the other challenges and enhance the psychosocial resilience of the PLHIV/AIDS in Bhutan.

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Making the most of supervision

Judith R Boyland

‘Making the most of supervision’ explores a brief history of the development of professional supervision before addressing key aspects of participation in the supervisory process, roles and responsibilities of participants, models of engagement, and what makes for good supervision.

Introduction

Supervision is a process familiar to all practitioners who work in the field of allied health and to a wide range of professionals who work across diverse fields of human service. So, where did it all begin?

According to Watkins (2013), Freud is typically credited with having initiated the possibility of supervisory practice by way of three events. These are recorded as being (1) consultations with Breuer practitioners about their patients’ hysterical symptomatology, during the 1890s; (2) the holding of weekly theoretical and case discussion meetings in his home beginning in 1902 (Davies, 2020); and (3) the tutoring, or “supervising”, of the father of a little boy, about how best to work with his son, referred to as “Little Hans”, who was experiencing a host of psychological problems.

Freud’s Wednesday night discussion meetings have come to be thought of as the “informal” beginnings of supervision, whereas his work with Little Hans’ father has been considered the more “formal” beginning of supervision. Although Freud did never articulate an actual theory of supervision, he still tends to be thought of as our “first supervisor” – a somewhat contentious issue with those who would give this title to Josef Breuer who was a mentor to the young Sigmund Freud and who helped him to set up his medical practice (Davies, 2020).

Breuer is perhaps best known for his work with a patient, pseudonym “Anna”, who was suffering from paralysis of her limbs, reduction in conscious awareness due to a state of anaesthesias brought on by pain reducing medication, and disturbances of vision and speech. Breuer observed that her symptoms reduced or disappeared after she described them to him, and it is said that Anna humorously called this procedure *chimney sweeping* and coined the term of *the talking cure* for this process of talking about what was happening for her. Laying the groundwork for psychoanalysis, Breuer later referred to this therapeutic practice as the *cathartic method* (Gay, 1988, p. 65).

Moving forward into the twentieth century and opening on February 16, 1920, the Berlin Poliklinik was the first clinic in the world to offer free psychoanalysis and came to be the model for future institutes. It was the first establishment to use psychoanalysis as a treatment and to establish a tripartite training model of psychoanalytic education to prepare and ‘supervise’ future psychoanalytic practitioners.

The man said to be ‘its heart and soul’ was Max Eitingon. Under Eitingon’s guidance, that preparation of practitioners involved three crucial components...

- Seminars – didactics focused on grounding in theory and conceptualization of that theory into practice;
- Training analysis where each student engaged in personal experience of psychoanalysis; and
- Supervised practical work.

That model was to become known as *The Berlin Model,* or *The Eitingon-Freud Model.* The basic ideas that underlie the model – know your theory, know yourself, and know your practice through supervision – continue to be widely accepted as being of integral importance in any work that not only engages psychoanalytic processes, but is also related to any field of allied health work (Watkins, 2013).

PROFESSIONAL SUPERVISION – WHAT IS IT?

Since its inception, supervision for the allied health professional has attracted a diverse range of definition, highlighting the clinical, personal experience, and teaching/learning aspects of the supervisory process. Stoltenberg and Delworth (1987: 34) focus on the clinical aspect when they define supervision as “an intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person”. For Lane and Herriot (1990:10) it is “a therapeutic process focusing on the intra- and interpersonal dynamics of the counsellor and their relationship with clients, colleagues, professional supervisors, and significant others”; and for Marais-Styndom (1999), ‘support and learning’ is highlighted with reference to

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… a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance public protection and safety in complex situations.

Moving forward, Falender and Shafranske (2010:3) expand focus on the teaching/learning alliance where engagement is around "a distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process". 2010 also sees the introduction of the notion of 'reflective practice' when Davys and Beddoe refer to a forum for reflection and learning by way of an interactive dialogue between at least two people, one of whom is a supervisor. This dialogue shapes a process of review, reflection, critique, and replenishment for professional practitioners.

What is becoming evident, is that supervision is a professional activity in which practitioners are engaged throughout the duration of their careers, regardless of experience or qualification. The participants are accountable to professional standards and defined competencies and to organisational policy and procedures. However, not until 2003 is the concept of business issues considered as an integral element for discussion in professional supervision. This development was initroduced by Armstrong and subsequently tweaked to the current wording as featured in Armstrong, 2018. Armstrong's definition enunciates supervision as . . .

… "the process whereby a professional can discuss . . .

(1) personal issues (where appropriate and impacting on work),

(2) professional/clinical issues,

(3) business issues, and

(4) industry/work-related issues

with a qualified professional supervisor, who is usually more experienced than the supervisee, in order to identify and resolve professional concerns and emotional issues, and help the supervisee to evolve professionally in a positive manner." (Armstrong, 2018[2003]:5).

KEY FUNCTIONS OF PROFESSIONAL SUPERVISION

Reflecting on the collective nature of the notions put forth in defining 'supervision', it could be perceived as a forum for reviewing practice alongside policies and procedures and the ethical and practice guidelines and standards of the industry. Attention is focused on accountability for client outcomes while assisting the counsellor to clarify role and responsibilities within and across practice context. Thus, it might be ascertained that the key functions of professional supervision are Educational, Relational, and Developmental. These three functions of supervision are not discrete: but overlap, interplay, and complement.

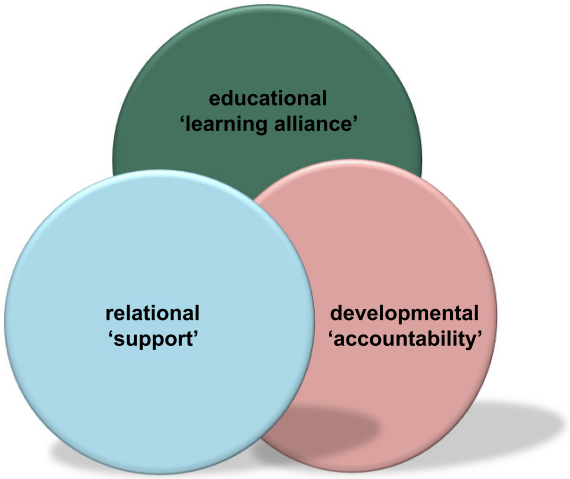

Figure 1 – The key functions of professional supervision

The aim of supervisory education is to inform a better understanding of the client, the Self, and the therapeutic process. The focus of learning is the knowledge embraced by theories, values, and perspectives that can be applied to enhance the quality and outcomes of practice. While attention is on developing practice-based knowledge, understanding, and skills that will improve the competence and the confidence of the counsellor, it is the learning alliance between supervisor and supervisee that is integral to any educational activity.

The quality of the supervisory relationship is an important ingredient in the success of supervision. There needs to be a degree of warmth, trust, authenticity, and respect between supervisor and supervisee; recognising the personal impact counselling practice can have on the practitioner as well as exploring how one's personal space and emotional state can impact best practice outcomes. Strategies to deal with self-care are identified along with encouragement and validation. Working through personal-professional presenting issues as may be relevant and appropriate is one aspect of self-care, as is supporting the supervisee in recognising when external professional assistance may be needed in processing personal issues.

Incorporating the creative, direct, and solution-oriented approach of Milton Erickson to all things related to therapeutic intervention, developmental supervision is centered around the notion of what O'Hanlon (2000) defines in therapeutic intervention as moving from 'liabilities' to 'possibilities' through the practice of doing one thing different. The process is facilitated through exploration and critical reflection and as supervisor and supervisee collaboratively reflect on processes and procedures in practice, attention is focused back to guiding principles as defined in policy, ethics, and scope of practice documents.

WHY SUPERVISION

As an industry expectation, practitioners engage in professional supervision because of the need to meet requirements for industry specific registration, to meet requirement for membership with a professional association, or to comply with requirements within an organisational structure – for example, as might apply for clergy and pastoral personnel working across a religious diocese/archdiocese.

As point of example, the code of ethics and practice for Australian Counselling Association Inc. (ACA) references the need for supervision as defined in articles 4.12.(a)i and 4.12.(a) ii...

> 4.12 "Competence".
> 4.12. (a) i Counsellors must have achieved a level of competence before commencing counselling and must maintain continuing professional development as well as regular and ongoing supervision.
> 4.12.(a) ii Counsellors must actively monitor their own competence through counselling supervision and be willing to consider any views expressed by their clients and by other counsellors
> (Australian Counselling Association, 2022. p.14)

Also stated in *Clinical Supervision Guidelines for Mental Health Services* in Queensland is the mandate that . . .

> "On-going supervision for all clinicians involved in the delivery of mental health services is critical to ensure quality assurance in mental health practice, regardless of experience and level of appointment." (Queensland Health, 2009. p6).

More significant than compliance with a "need" imposed from sources outside of Self, is the "want" that emanates from one's internal professional motivation, resulting in participating in supervision not because I must, but because I want to. In consultation with a supervisor, the supervisee creates opportunity to reflect on all elements of practice: to look back on therapeutic engagements with clients and critique what was done, what was said, somatic transferences and counter-transferences, and the counsellor/client therapeutic alliance. One reviews what worked and what did not work, and discerns what might be done differently, next time. One also explores the impact that work is having on well-being and the cyclical flow of well-being impacting work. This is the space where the practitioner seeks and accepts support and where there is engagement in mentoring and learning activities that will be beneficial for both personal and professional development.

Figure 2 – The supervisory cycle.

The purpose, goals, and objectives of supervision can be summarised in the following five statements...

- Monitor and promote welfare of clients seen by supervisee;
- Where supervisee is also a supervisor, monitor and promote welfare of clients seen by supervisee's supervisees;
- Monitor supervisee's holistic well-being and self-care;
- Promote development of supervisee's professional identity and competence;
- Fulfil requirement for supervisee's professional accreditation;
- Fulfil membership and registration requirement of recognised professional body.

Thus, it can be determined that the focus of professional supervision is the need to promote learning, to foster the therapeutic alliance continually, and to continually develop professional practice in all areas.

ROLE OF THE SUPERVISOR

The supervisor's primary role is to do all that is within their power of control to ensure that the supervisee's clients are receiving appropriate therapeutic counselling. When the supervision is 'supervision of supervision', the supervisor has a dual role – that is, to do all in their power of control to ensure that the supervisee's practitioner clients are receiving best practice supervision such as to enable them (the practitioners), in turn, to do all in their power to ensure that their clinical clients are receiving appropriate counselling and therapeutic support and intervention.

The supervisor also has an ethical responsibility to ensure that the supervisee is aware of the importance of their own physical, emotional, and psychological health: and supports the supervisee in sustaining a healthy holistic state of well-being. An additional element of responsibility that accompanies the supervisory role is being alert for any symptoms of burn out, transference, countertransference, dependency, co-dependency, or hidden agendas in the supervisee and/or in the supervisee's practice.

Where signs or symptoms of these reactions are detected, they need to be discussed with the supervisee and if it is felt that there is potential risk to either the supervisee or the supervisee's clients, the supervisor's role is to direct the supervisee to seek relevant support. Furthermore, depending on the severity of the condition, the supervisee needs to be directed to cease practice until presenting issues are resolved. Should it be that the supervisor discerns that the supervisee's clients are at risk of harm – physically, emotionally, or psychologically – the supervisor has no option but to report to the relevant professional association: and in extreme circumstances, to report directly to the office of the Health Ombudsman: Health Care Complaints Commission (HCCC).

DUTIES AND RESPONSIBILITIES OF THE SUPERVISOR

Summarising recommendations suggested in the literature, (Pelling, Barletta, and Armstrong Eds, 2009; Pelling, Armstrong, and Moir-Bussy Eds, 2017), the following list of supervisory duties and responsibilities is offered for reflection . . .

- Challenge supervisee to validate approaches and techniques in professional practice;
- Intervene where client welfare is deemed to be at risk – that is, welfare of supervisee, welfare of supervisee's clients, and – where applicable – welfare of clients engaged with supervisee's supervisees;
- Provide information relating to alternative approaches for the supervisee to consider;

- Monitor basic micro-skills and advanced skills, including transference and counter-transferences and dependency and co-dependency issues;
- Encourage supervisee's on-going professional education;
- Ensure supervisee is aware of scope of practice and ethical guidelines and commits to maintaining professional standards across all areas of practice;
- Challenge and support supervisee in professional growth;
- Monitor supervisee's holistic well-being;
- Provide consultation when necessary;
- Discuss administrative procedures;
- For supervisees who are in private practice, also discuss business practice issues as may be relevant.

Reflecting the ethos expressed by the Victorian Department of Health (2012), it is suggested that for the supervisory process to be successful, it is important that both supervisor and supervisee are involved in planning processes and the setting of the agenda items, and that each party has a clear understanding of how their own position and positions of other stakeholders across the industry contribute to the wholistic success of the supervisory alliance. It is also imperative that the supervisor and supervisee hold mutual respect for each other, that the contributions of each party is valued, and that there are regular opportunities to meet and to discuss practice behaviours and matters of concern, and to discern ways to address emerging issues, to improve effectiveness in the field of operation, and to enhance client well-being.

ROLE OF THE SUPERVISEE

Each participant in the supervisory relationship has a role to play. For the supervisee, that role is to engage in processes of reflective practice through exploration and critical reflection; and in that reflection, to be open to learning that is focused on knowledge, theories, values, and perspectives that can be applied to enhance the quality and outcomes of practice. It is also the role of the supervisee to explore how personal reactions and emotional well-being are impacting on the counsellor/client relationship and all aspects of practice.

Pivotal to the role of the supervisee is the review of client outcomes, therapeutic and administrative practices, organisational policies and procedures, and ethical and practice standards of the industry. Within this broader industry arena, a significant aspect of the role of supervisee, is to reflect on the broader professional context of the field of practice within which there is engagement, to be aware of the organisational context of practice, and to clarify one's own role and responsibilities within the specific context of engagement.

DUTIES AND RESPONSIBILITIES OF SUPERVISEE

For the supervisory process to be effective, both supervisor and supervise need to be engaged and committed. The Supervisee's engagement begins with establishing a daily routine of reflective practice which begins with making regular opportunity to take time to think about work and the practice of client support (Morrell, 2013). This involves focussing on the basic needs of safety, belonging, and dignity, and discerning how autonomic regulating behaviours are working to enhance or relationship with both Self and Client.

In a similar vein as defining duties and responsibilities of the supervisory role, the following list of supervisee duties and responsibilities is offered for reflection. Data sourced through personal discussion with clinicians and extracted for Pelling, Barletta, and Armstrong Eds (2009) and Pelling, Armstrong, and Moir-Bussy Eds (2017) . . .

- Uphold ethical guidelines and professional standards;
- Discuss client cases with the aid of written case notes and video/audio devices as may be appropriate in relation to specific contexts;
- Validate diagnoses and professional judgements made;
- Validate approaches and techniques used to address presenting issues;
- Consult supervisor or designated contact person in cases of emergency;
- Maintain a commitment to professional growth, on-going education, and the profession;
- Complete homework tasks as may be either negotiated or directed;
- Implement supervisor directives in subsequent sessions;
- Be open to change and incorporate alternative methods of practice.

QUALITIES AND SKILLS OF AN EFFECTIVE SUPERVISOR

Referencing the emergence of 'counselling supervision' as a professional specialty, Dye and Borders (1990) highlight the notion that professional supervisors require specific training in processes of supervision and in industry related topics. They also highlight the notion that effective counsellors are not necessarily effective supervisors. According to Armstrong (2020) . . .

Professional supervisors are generally experienced, well-rounded professionals who have experience in leadership roles, policymaking, motivating others, administration, working at the coal-face, and some form of knowledge that is parallel to any speciality areas in which their supervisees work (p.33).

Effectiveness is directly linked with outcome. Thus, when measuring supervisor effectiveness, it would seem to be reasonable to step beyond the supervision session and the supervisee in a two-phase process and focus on the client and client well-being. How helpful is the supervision session for the supervisee? How helpful are the supervisee's support and intervention strategies for the client?

Research findings across allied health professions suggest that effective supervisors negotiate with the supervisee a contract that clarifies roles and responsibilities. They also negotiate session agendas that reflect supervisee need and adapt the style and content of sessions to the needs and learning style of the supervisee. They value the supervisory alliance and from a platform grounded in legal and ethical considerations, they acknowledge the dignity or each participant and build positive relationships with supervisees. They create and sustain an atmosphere of trust, safety, belonging, resect and integrity (Armstrong, 2020; Leosch, 1995; Snowdon et al, 2020)

Within supervision sessions effective supervisors use basic counselling skills such as listening, reflecting, mirroring, empathy, compassion, and encouragement. They facilitate the process of supervision so that supervisees are enabled to define their own goals, to reach their own decisions, and to become self-directed. They judge without being judgmental and offer

clear guidance and direction when needed. They also encourage professional development and provide/suggest resources for the supervisee to consider.

Effective supervisors are available for consultation between sessions – within reason. They support their supervisees through personal issues that may impact best practice, and they promote reflective practice by providing a safe space for reflection as a means to transform practice and to promote professional growth. They demonstrate practice skills and expertise by relating practice to theory and disclosing professional knowledge that is relevant to the supervisee's presenting concerns. They ask open questions, give frank and honest feedback, and where applicable, discuss business practices and business management strategies. They discuss industry focused ethics and legislation and support innovative practice by encouraging supervisees to bring new ideas into their practice and service delivery.

CONTEXT OF SUPERVISION SESSIONS

Professional supervision offers the opportunity for a practising clinician and a professional supervisor to critically reflect on the supervisee's practice, focusing on interactions across the supervisee's client base, within the supervisee's workplace, and across the broader industry arena. As previously stated, supervision has an educative, relational, and developmental function. It is a space for mentorship and support.

Supervision sessions can be individual face-to-face supervision with supervisor and supervisee, group supervision led by a registered supervisor, or peer supervision within a collegial context of mutual support. It can also be distance mode using phone, face time, Zoom or Skype. Mixed mode of face-to-face and electronic may also be an option when busy schedules in both private and professional aspects of life are the order of the day.

Undertaken at a prescheduled time and on an "as-needed" basis, there is a minimum requirement for clinicians to participate in professional supervision in order to maintain registration with a professional body or to work within government or agency arenas – for example, Queensland Department of Health regulates one (1) hour per week of supervision for practitioners of under two (2) years' experience in the field, one (1) hour per fortnight for practitioners with two – five (2-5) years field experience, and one (1) hour per month for practitioners with more than five (5) years field experience.

The recommendation of Australian Counselling Association (ACA) for participation in supervision is one (1) hour professional supervision per 20 hours client contact; with the requirement for renewal of registration being 10 hours participation in professional supervision per year. For supervisors to maintain registration to ACA College of Counselling Supervisor, there is requirement if 10 hours supervision of supervision in addition to the 10 hours professional supervision. Each allied health professional association has it's own specified requirements.

TYPES OF SUPERVISION

Supervision can take many shapes and forms, some of which are defined as follows.

Professional supervision: Professional supervision is an interactive dialogue between at least two people, one of whom is a trained supervisor. This dialogue shapes a process of review, reflection, critique, support, and education that incorporates evaluation of client and workplace relationships, associated administrative practices, personal and professional support, education, and business practices as may be appropriate and relevant.

Clinical supervision: The focus of clinical supervision is evaluation of client outcomes with a view to enhancing professional practice skills, raising levels of competence and confidence, and ensuring quality of service to clients.

Cultural supervision: Culturally relevant supervisory arrangements explicitly recognise the influence of the social and cultural contexts. They acknowledge diversity of knowledge and plurality of meanings, and they use collaborative approaches to strengthen practice from cultural perspectives.

Group supervision: Group supervision takes place between an appointed supervisor and a group of clinicians or a multi-disciplinary group. Participants can benefit from the collaborative contributions of group members as well as the guidance of the supervisor.

Peer supervision: Peer supervision applies to collaborative learning within a supervisory forum that consists of a pair or a group of professional colleagues of equal standing.

Formal supervision: Supervision that occurs in scheduled sessions and provides dedicated time for reflection and analysis in a setting that is removed from day-to-day practice is defined as being "formal".

Informal supervision: Reflection and learning focused discussions that capitalise on a heightened awareness and experiential engagement with an event is termed "informal". It occurs in preparation for, during, or immediately following a practice situation such as might be associated with emergency support following a critical incident event. A typical example could be represented by cyclone, flood, drought, and bushfire responses.

Line supervision: Focus of line supervision is on day-to-day operational matters and the supervisor is the line manager – that is, the person to whom the practitioner is accountable or the person to whom the practitioner reports within the organisational structure of the employing body.

Internal supervision: Internal supervision takes place between a practitioner asnd a supervisor within a work place.

External supervision: External supervision takes place between a practitioner and a supervisor who is not an employee of the same organization/agency as the supervisee.

SUPERVISION MODELS

Models of professional supervision can be aligned under three (3) umbrellas, reflecting the three (3) differential functions as cited above, educational, relational, and developmental.

There are **Psychotherapy based models** where theoretical orientation informs the observation and selection of clinical data and where focus is on the meaning and relevance of the selected data. Approaches underpinning Psychotherapy based models include (a) Psychodynamic which draws on clinical data and (b) Feminist which affirms that the personal is also political and is oriented towards gender fairness, flexibility, interaction, and life-span integration. The (c) Cognitive-Behavioural approach focuses on cognition and behaviour and the (d) Person-Centered approach is grounded in Rogerian

theory and focussed through a perspective of collaboration (Frawley-O'Dea and Sarnat, 2000; Haynes, Corey, and Moulton, 2003; Lambers, 2007; Liese and Beck, 1997).

Developmental models are defined by stage progression as the supervisee moves from beginning practitioner to highly skilled and highly experienced practitioner. Ronnestad and Skovholt (2003) proffer the notion of a six (6) phase approach – suggesting that the use of 'phase' dispels connotation of hierarchy and sequential ordering and focuses the gradual and continuous nature of learning and development. Falender and Shafranske (2004) reference a three (3) levelled stepped approach where the supervisee is guided through learning experiences focussed on the development of skills, abilities, and knowledge and where summative assessment of performance is ongoing and progressive. The focus on 'competency' is further discussed by Falender (2014) when she highlights how competency-based supervision enhances accountability.

Models of supervision that are focused through discrimination (Bernard, 1979), systems (Holloway, 1995), reflective learning (Ward and House, 1998), and schema- (Haynes, Corey and Moulton, 2003) are referred to as **Integrative models** (Haynes, Corey, and Moulton, 2003). According to Stoltenberg and McNeill (2010), integrative models focus on counsellor development as movement over time, experience, and training: movement that Forster (2011) refers to as a 'parallel process' being born out of the ability of the supervisee to bring to supervision aspects of the client they do not know that they know, with the supervisor being drawn into reciprocating behaviour as co-explorer of what is happening for both supervisee and the supervisee's client. Forster also states that 'Integrative' is not a licence for a 'personal potpourri'. Rather, it is grounded in a deeply held and constantly reviewed sense of what is in the best interests of each client.

One of the most commonly used frameworks of supervision integration is Proctor's Model. Derived from the work of Bridgid Proctor (Proctor, 2010): The model describes three aspects of the tasks and responsibilities of supervisor and supervisee: Normative (management), Formative (learning) and Restorative (support). The 'Normative' aspect is about maintaining standards of practice and care, the 'formative' highlights the educational function, and the 'restorative' focuses on provision of a supportive setting with space for clinicians to vent their feelings in a listening environment.

Broadly speaking, supervision models fall into three categories of operation and participation – individual, group, and peer – each of which has its own benefits and challenges as well as being empirically defined by supervisees and supervisors in the field.

Characteristics of **individual** models include...

- Agenda is tailored to individual need of supervisee;
- Allow for "actual" case studies to be discussed and examined without concerns of breach in confidentiality;
- Enable supervisee to explore practice weaknesses without feeling defensive or exposed;
- Ad hoc sessions are useful for providing more immediate support and learning from difficult situations that arise;
- A trusting and supportive supervisory relationship can develop more quickly;
- Allow for more in-depth reflection and discussion in relation to both personal and professional matters;
- No sense of inferiority in the presence of other practitioners who may be more experienced or more vocal;
- Supervisor and supervisee need to be appropriately matched;
- Resource and time intensive;
- Need experienced and trained supervisors to be able to provide reliable ad hoc as well as scheduled sessions.

Characteristics of **group** models include...

- Opportunities to learn from others and appreciate alternate points of view;
- Encourage, support, and validation of experiences;
- May be an efficient use of time and resources – for example, in a workplace situation, issues that are relevant to most staff, such as policies and procedures, can be discussed in group rather than one-to-one;
- May help develop skills which are transferable to other practice situations – for example, working in teams and facilitating groups;
- Fear of being judged;
- Risk of quieter or less experienced practitioners being overshadowed or intimidated by the louder or more experienced or pushy participants;
- Interactions between members have potential to detract from learning – for example, disagreement and competition;
- A cohesive group may make it difficult for individual or newer members to express different views or challenge the group norms. This can limit new ideas, constructive debate, and sound decision making;
- Difficult to meet individual needs of all participants as discussions remain generalised and do not meet particiupant's specific needs in a satisfactory way;
- As issues of confidentiality need to be carefully monitored, there is little opportunity for individual participants to discuss "real", current, and presenting issues that arise in clinical practice;
- Clear expectations need to be set;
- Clear ground rules need to be established;
- Time needs to be carefully monitored;
- Facilitating supervisor needs to have sound knowledge of core supervisory skills, experience and understanding of group dynamics, and the ability to adapt knowledge, skills, experience, and understanding to a group supervisory context – particularly "this" group in "this" context: whatever "this" may represent.

Characteristics of **peer** models include...

- Participants tend to feel less threatened and more comfortable in using skills and resources of trusted colleagues to support reflection on practice;
- Peers will usually be familiar with the situation being discussed;
- As a sole method, less appropriate for the less experienced practitioner;
- There is risk of sessions becoming chat and complain forums;
- Sessions may become too informal, lacking the process and challenge to enable growth;
- Limited opportunity for accountability and education when peers are inexperienced;
- In the absence of a group leader there is greater need for a clear structure and specific outcome objectives;
- There is opportunity to be highly productive when participants are experienced;
- Require greater commitment from the group.

CONTENT OF SUPERVISION

The nature of supervision will change over time, depending on the growth in experience and qualifications of the supervisee – for example, as discussed by Knight (2017), inexperienced supervisees would be expected to initially require the supervisor to assume more of a teaching role, helping them improve their practice and meet agency mandates. Turner-Daly and Jack (2017) suggest that, as practitioners become more experienced, one might find that there is less need for case management and more need for in-depth reflection and professional development.

When using the RISE UP model of professional supervision developed by Armstrong (2020/2018/2003), focussed discussion will incorporate aspects of evaluation (anything to do with people – for example, clients, colleagues, work-place relationships, interaction with any person encountered within the scope of supervisee's practice), education (modalities, interventions, professional documents, theory), administration (anything to do with paper – for example, ethics documents, scope of practice documents, policies, procedures, recording/ reporting documentation), and personal and professional support (wholistic well-being): where I am at the core of my Being, is the Me I take into the therapeutic space. For supervisees in private practice, aspects of business building and business management will also be discussed.

This holistic model of professional supervision is in contrast to pure clinical supervision, where the focus is on reflection, critique, and review of the evaluation component as it relates to clinical work. As referenced by Queensland Health (2009)...

> Clinical supervision can be seen as a process that promotes personal and professional development within a supportive relationship, formed in order to promote high clinical standards and develop expertise by supporting staff and helping them to prevent problems in busy practice settings (p8).

GOOD SUPERVISION

Echoing the words of Morrell (2013), the essence of making the most of supervision is encapsulated within the intrinsic belief that I deserve good supervision. Good supervision is not the same as performance appraisal, crisis management, line management, complaining, counselling, debriefing, coaching, debating, or chatting. However, sometimes it will contain elements of each of these.

Good supervision is not about control. It is about empowerment – empowerment of the supervisee which leads to empowerment of the client. It will help practitioners to reflect on their own therapeutic practice, to provide the absolute best professional service to clients, and to manage the complex situations and conflicting work pressures that arise from time to time. Good supervision will help the practitioner to recognise ethical dilemmas and clarify professional boundaries, to focus on possibility, and to challenge Self to recognise strengths, own vulnerabilities, and find what Pearson (1991) describes as, 'the hero within'. From this space, the practitioner will grow in competence and confidence, develop professionally, and constantly improve the quality of practice and delivery of service.

Good supervision will also help the supervisee to feel energised, motivated, and in control; to be ever mindful of paying attention to their holistic wellbeing – psychological, emotional, physical, spiritual; and to clarify hopes, dreams, and expectations. The ultimate gift to the professional Self is ensuring that one's own supervision is good supervision and that one makes the most of every supervision session: embracing the opportunity to seek and find what James (1890) describes in terms of the conscious identity of the empirical Self: that place where I meets Me and I like what I see.

Bio

Dr Judith Boyland is a clinical counsellor, professional supervisor, supervisor of supervision, behaviour consultant, and life coach and is principal practitioner of "judy boyland counselling", located in Redland Bay, Queensland. Prior to establishing her own counselling practice, Judith worked in the field of education and for some 40 years enjoyed teaching and learning experiences across all sectors – early childhood, primary, secondary, and tertiary – where she held roles of teacher, behaviour consultant, counsellor, and school principal.

Her Masters studies were in the field of organisational culture and leadership and her Doctoral studies were in the field of social science focused through the discipline of counselling.

Judith is currently Vice President on the Board of Australian Counselling Association where she holds the role of Chair of Ethics and Complaints Tribunal.

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Counselling and Counting, Listening and Literacy: One Counsellor's Account

Yvette Carter

Gaps in numeracy and literacy skills in Indigenous Australians has long been a topic of concern and debate. In Far North Queensland one Counsellor is combining both counselling skills and psychological and emotional support with academic processes to achieve longlasting, positive outcomes. These outcomes are changing lives for individuals, families and the communities in which they live.

Introduction

In Far North Queensland a numeracy and literacy program, combined with several elements of counselling and the counselling process, has changed lives. On the west coast of Queensland, a dedicated Counsellor has blended the components of counselling with numeracy and literacy sessions to support the program's participants and ultimately their communities. This unique format is making a difference for many residents of two remote Indigenous communities.

To READ is to EMPOWER, to empower is to WRITE, to write is to INFLUENCE, to influence is to CHANGE, to change is to LIVE (Vandergrift, 2008). Sue McGinty (2002) cites research of Garlick (1999) who identified the major elements for building community capacity, particularly in Indigenous communities: Knowledge building, leadership, network building, valuing community and supporting information. These same elements combine to achieve a state of well-being in the community. They incorporate the intergenerational transmission of Indigenous knowledge, the skills and knowledge of alphabetic literacy practices and social capital. Community capacity, in this context, also requires the integration of both Western and Indigenous cultural influences, to enable a genuine coming together of 'two ways' or 'both ways' approach to a community's development of its capacity to pursue its goals and aspirations.

The literacy and numeracy program we share here, aimed to improve the numeracy and literacy development of adult learners who were experiencing learning difficulties or delays, hence, not achieving their academic potential. It was designed by the University of New England. Acknowledging thatpParticipating adult learners may have varying levels of learning obstacles due to knowledge gaps, lack of practice, anxiety, low confidence, or associated behaviour problems, the lessons emphasised the development of conceptual understanding by explicitly teaching strategies that highlighted the key concepts underpinning the academic skills being taught. Specifically, this program aimed to provide intensive involvement focused on basic knowledge and understandings that equip students with the skills necessary to engage more successfully while improving their basic mathematics, and/or reading, vocabulary, and comprehension skills (https://simerr.une.edu.au/quicksmart/program-description/).

My work in numeracy and literacy

About five years ago I was successful in obtaining a job providing numeracy and literacy sessions to adults in two Indigenous communities in Far North Queensland. I had worked in both these communities for several years prior to this appointment so was very comfortable moving about community and spending time with many of the residents from both areas. Rooms for the delivery of this service were renovated and furnished while posters promoting this service were strategically positioned in prominent venues throughout these communities. I was ready for business.

Adult learning is facilitated through effective two-way communication between the teacher and the learner which emphasises clarifying, summarising, listening, and reflecting (Byrnes, & Fielding-Barnsley, 1993). In addition, when examining the components of effective counselling several elements must be present. The ability to effectively communicate is a counsellor's fundamental role. The role of the counsellor is to enable the client to explore many aspects of their life and feelings, by talking openly and freely. The counsellor may encourage the client to examine parts of their lives that they may have found difficult or impossible to face before, http://www.skillsyouneed.com/general/counselling.html#ixzz4F6HxWep0

A counsellor's job throughout a counselling session is to provide support to a client (Canning, 2004). Having been employed in the community for several years prior to this

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appointment, I was fully aware of many of the challenges the residents faced on a daily basis. Due to this, a casual, safe and comfortable approach was adopted, and every session commenced with a cup of tea and a casual chat. Over time, this became the norm when commencing the numeracy and literacy sessions. It was during this chat that relationships of trust and hope began to grow.

As part of the support offered it was acknowledged that for an individual to be open to the learning process, he/she must first have a clear mind so as to assist the client to see things more clearly, possibly from a different viewpoint. This can enable the client to focus on feelings, experiences or behaviours, with a goal to facilitating positive change. http://www.skillsyouneed.com/general/counselling.html#ixzz4F6HxWep0

With this concept in mind, the opening 'chats' were always accompanied with a cup of tea which then began to move into unscheduled counselling sessions. Regardless of age, gender, religion or social status, each of the numeracy and literacy sessions quickly became a combination of counselling and learning. Many of the issues addressed would overlap into cultural beliefs, community, family and personal expectations, family loyalties and commitments. This was always underpinned with a desire to improve oneself and, in the process, improve the lives of their children and grandchildren.

AIPC Code of Ethics notes that establishing the helping relationship in order to maintain the integrity and empowerment of the client without offering advice is paramount in any therapeutic and/or academic relationship. http://www.aipc.net.au/articles/ethics-and-counselling/ . Below are two case studies offering testimony to this statement and highlighting the how counselling and numeracy and literacy lessons scombined successfully.

Case Study I

'Peter' is an Indigenous 29-year-old male who first presented saying he 'wanted to read better'. His mood sometimes fluctuated and over time I began to understand and work with him better. With his initial statement in mind, we set about achieving this goal. During our sessions together he would sometimes talk about his home life and about his alcohol and drug usage and how this affected his relationship with his partner and his children. It was around this time he talked about how his children were afraid of him and about the times he beat his partner. We discussed these issues in depth many times during our sessions. As our 'literacy and numeracy' sessions became more and more frequent, I believe 'Peter' became increasingly at ease. As this occurred, our sessions became longer in duration and included conversations about his dreams, his fears, his hopes and about his passions. At the same time we slowly built on engagement and empowerment to enable change to successfully take place. It is reasonable to affirm that the counsellor's main focus in the communication process is the client's expression, and if needed, encourage that expression (PACFA – Ethical Standards/Ethical Responsibilities, 2017).

When these conversations were 'rounding off', we would then seamlessly move into our numeracy and literacy session. Over time, and together, we addressed many emotional issues such as feelings of worthlessness, inadequacies, and self-actualisation. From this, and an improved and ever-increasing numeracy and literacy level, 'Peter's' self-esteem slowly started to rise. It was at this point he started to 'want' to set goals for himself. Some of these goals included applying for jobs in the local area. 'Peter' laughingly stated he would be happy if he was 'able to read and fill out the application form by myself', so to actually obtain employment would be a 'dream come true'.

It was around this time 'Peter' and I discussed how he had reduced his alcohol and drug intake and the frequency of domestic violence was also decreasing. "Counsellors promote client autonomy and encourage clients to make responsible decisions on their own behalf" (PACFA – Ethical Standards/Ethical Responsibilities, 2017). Peter was feeling positive about himself and was spending more time with his children. *"Effective counselling reduces confusion, allowing the client to make effective decisions leading to positive changes in their attitude and/or behaviour"* http://www.skillsyouneed.com/general/counselling.html#ixzz4F6J7Yrfi

In due course 'Peter' submitted his job application and together we waited. In the interim he continued to attend the numeracy and literacy sessions and would often share positive stories regarding the connection he was enjoying with his partner, his children, and the community in which he lived. *"Counsellors consider the social context of their clients and their connections to others"* (PACFA – Ethical Standards/Ethical Responsibilities, 2017). http://www.pacfa.org.au/practitionerresources/ethical-standards/ .

He told these stories with pride in his voice – and in his eyes. After a six week wait, 'Peter' was interviewed and shortly after, was informed he had been successful in obtaining this position. As a result of 'Peter's' commitment to his health, his emotional, social, and psychological wellbeing, his family and his education, he is now drug free, his home is now free of domestic violence, he is employed and reads to his children. I continue to support 'Peter's' journey of empowerment.

Case Study 2

I would now like to share another account of empowerment and capacity building through the process of counselling and its potential to change and enhance lives. Yet another testimony demonstrating the true value in combining both formal education and counselling.

'Gary' presented stating he wanted to improve his reading and writing skills. After a cup of tea and a casual chat he then went on to tell me he was 'not very good at that reading stuff'. I offered him a smile and told him he was 'safe'. He smiled and said 'God bless you, see you tomorrow'. The next day we commenced our journey.

It was obvious early in the first session 'Gary' was not able to identify letters of the alphabet. Due to this he became teary and asked if we could stop the session. It was here the lesson stopped and the counselling and support began. An hour later 'Gary' left vowing to return the next day. And so he did, and the next day and the next day and the next day and the day after that. And the day after that. The weeks passed and 'Gary's' self-esteem and self-assuredness grew. Then he suddenly, and without warning, stopped attending. In community, I had learned this was not unusual, so I decided to do the only thing I could do, I looked forward to the day I saw him again.

Several months later I was attending a community event where I spoke with 'Gary's' mother. She commented to me about how 'Gary's' literacy skills had improved since having sessions with me. I then enquired about his whereabouts as I had not seen him for some time. His mum informed me he was in jail. She then began to cry. I immediately began to comfort her, and it was at

this point she told me she was not crying because her son was in prison. She told me she was emotional because 'Gary' had written her a letter saying he could now read and write because he 'had done literacy with Yvette'.

This was an amazing story for me. I appreciate whilst hearing a story of someone entering prison one would not normally expect to evoke the response 'that is amazing', but rather, identifying the real beauty here lies in the telling of 'Gary's' story which started many months ago. It tells of the underlying, and again, the life changing qualities of counselling and emotional support. It tells of the strength of learning in an academic capacity and also of the empowering 'worth' of the journey of the self.

I believe Carl Rogers best summed it up when he said 'In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth? http://www.brainyquote.com/quotes/quotes/c/carlrogers202206.html).

Bio

Yvette Carter began her counselling career in the early 1980's. During this time she has worked throughout Australia and internationally as a Counsellor. For the past 17 years, Yvette has worked in Indigenous communities in Far North Queensland. In this time she has developed long lasting, authentic relationships with the men, women, and children form these communities. In 2014 Yvette found herself delivering a numeracy and literacy program to adult learners from these same communities. As the program progressed, it was evident the amalgamation of Yvette's counselling skills and support, coupled with academic delivery was the key to programs success.

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