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Editorial

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Hello and welcome back to the refreshed and rejuvenated Australian Counselling Research Journal.

After a short hiatus, we are excited to bring you the latest in counselling and mental health peer-reviewed research, which will offer new perspectives on how practitioners can approach, view and understand the world around us. Each article has been submitted by researchers across Australia and shows the diverse range of clinical expertise within the counselling profession.

In this inaugural edition of the relaunched Journal, we open with an empathetic and empirical investigation into the nature of intuition in a professional clinical context. Anna Boyce, a qualified counsellor of many years, has dived into the ethical framework of using intuition, defined as a "felt sense of knowing", and how it can be used to better connect with and respond to client needs. Ms Boyce's autoethnographic account of the experience of intuition in a clinical counselling and supervision practice points out limitations but also the many opportunities in this area of practice and research, and is an excellent integration of her observations and research skills.

Next, Sally Fish, Eleanor Clausen, Y. H. Yau, and Ian R. Whittle offer a perspective on how counsellors can effectively and meaningfully collaborate with other health professionals; in this instance, by evaluating and treating patients in an interdisciplinary spinal care clinic. Their inquiry focuses on how the role of the counsellor can be extended within a clinical care pathway and research project across the areas of neuropathic pain and mood disorders. The authors demonstrate how counsellors can and should be used to great effect across allied and clinical care, within a broader holistic approach to patient mental and physical health. This research is especially useful for practitioners working in collaboration with other medical workers in private or public healthcare.

And finally, Lijuan Chen's article on extending Schema Therapy takes a perceptive approach to treating clients with East Asian cultural and Confucian philosophical backgrounds. The paper examines how core concepts in Confucianism can contribute to maladaptive behaviours, adding to emotive distress – but offers considerate and empathetic guidance based in Taoist principles of thought to great effect. This research is an example of using culturally responsive psychotherapy, and is particularly practical for any counsellors and clinicians working in multicultural settings.

We thank all the contributors for their submissions to Volume 18, Issue 1 of the Journal, and invite researchers, students and academics to submit abstracts for consideration in future editions to the ACRJ Editorial Committee via our inbox (editor@theaca.net.au).

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The Ethics of Intuition in a Counselling Practice

Anna Boyce

Keywords: *Intuition; Collaborative Constructionism; Ethics; Curiosity; Autoethnography*

Abstract

Awareness of intuition in the practice of counselling and broader health care is generally acknowledged and often identified by therapists as a "gut feel". However, the awareness and intentionality as to how intuition might be ethically used by a therapist in their practice is less clear. This paper presents an autoethnographic account of the experience of intuition in a clinical counselling and supervision practice. The motivation for the study stemmed from the author's experience of intuition, and the desire to find an ethical and safe way to use intuition in a professional counselling practice. Data was collected from 35 reflective journals written over nine months of clinical counselling and supervision practice. Findings from the analysis and synthesis process led to the development of a reflective tool, underpinned by "Collaborative Constructionist principles" (Anderson, 1995), that offers therapists an approach for the ethical use of intuition in a counselling practice.

Introduction

Intuition has been a topic of interest in the counselling and psychology literature for over 50 years (Charles, 2004), yet there have been few studies that focus specifically on the use of intuition in counselling and psychotherapy (Bastick, 1982; Charles, 2004). This is significant for a literature review, beginning with the discovery that intuition has not been easily defined with any commonality across counselling and psychology literature. Sprenkle (2005), proposes findings of 44 differing definitions of intuition, suggesting world views, epistemological, philosophical, and theoretical ideas influence perspectives on intuition. This evidence is used to explore multiple perspectives in the following research.

The differing views on the research of intuition are discussed further on in this paper and bring relevance to the dominance of scientific perspectives in mainstream literature. Marks-Tarlow (2014a), Charles (2004), Bryant & Luft (2023), and Jeffery (2012), point out that intuition as a cognitive-led process holds dominance over more inward, right-brain, or somatic approaches to intuition in the psychology research space. Others – Boucouvalas (1997), Marks-Tarlow (2014a), and Welling (2004) – suggest the experience of using intuition in practice is "unique" to each therapist. This brings further discussion to the use of this type of subjective data, and the possible research limitations that might occur.

The exploration of the few recent, more subjective studies by Souser (2022), Marks-Tarlow (2014a), and Bryant & Luft (2023), give some broader perspectives for analysis, including how the awareness of intuition might be developed using reflective, mindful processes. This connects with the reflective data presented in this paper and the social constructionist lens of the study. With a lack of studies available on the use of intuition in the counselling context, a reflective tool for counsellors to navigate the use of intuition in practice is presented and put forward to address this gap.

Some initial reflections

The use of intuition has always been a natural way for me to engage with people when working with them. I define intuition as a "felt sense of knowing" that naturally arises when I connect with others in a collaborative and intentional way. This felt sense seems to have contributed not only to my own development as a therapist, but also to the healing, growth, and change that I have witnessed in people within the various caring roles I have held over the years. In particular I was curious regarding the meaning I attribute to intuition, and how it presents itself in my counselling and supervision practice. Furthermore, I was interested in how intuition could be utilised in a way that is safe, ethical, and helpful for clients and the influence my early background in holistic therapies might have had; drawing on therapeutic frameworks that value whole of body and somatic approaches in therapy. This paper describes my research process, the development of my relationship with intuition, and offers an ethical framework for the use of my intuition in professional practice.

The Masters of Counselling studies I undertook at Queensland University of Technology (QUT) privileges a Constructionist philosophical perspective (Munroe, et. al. 2008). Drawing on these theoretical ideas invited me to consider alternative perspectives and question the influences and distance I may have created between my ideas about being a professional counsellor and my intuitive way of being. In the past I had privileged dominant, scientific ideas and knowledges of expected client care, over my own intuition. The Masters program offered me the opportunity to connect more intentionally with my values, ethics, and key principles of practice; and the potential for this to function as a bridge between my intuition and my professional practice, became possible.

I set out with curiosity and openness to explore how intuition manifests in my current counselling and supervision practice. I had the opportunity to work one evening a week for

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nine months in a generalist counselling clinic, offering counselling and supervision using a Social Constructionist approach with a *reflecting teams* process, originally developed by Tom Andersen (1987). I had questions about how this inquiry might influence my practice framework, which was becoming more firmly anchored in a Collaborative Constructionist approach since starting my studies. This approach positions the therapist in a "not knowing stance" in which the client is the expert about their own life. This invites curiosity and collaboration between client and therapist and the co-creation of meaning (Anderson, 1995). I wondered what possibilities this offered for integrating intuition, and as this paper reveals, how this approach has helped me make sense of, and use intuition ethically, in clinical practice.

Researching my own intuition

In researching the topic of intuition, I found that autoethnography offered a research methodology that aligned my preferred theoretical lens of social constructionism, with an ethical and inclusive approach to research. More specifically, autoethnography holds a reflexive process, with the researcher positioned at the centre of the study, and "living" the research; being both the subject and the researcher (Coffey, 2002 as cited in Lapadat, 2017, p. 589). This research approach invited my sense of curiosity and created some nervousness about how my stories of intuition might be heard, reflected, or rejected, across the social, cultural and political counselling practice landscape. However, I could also see the opportunity to develop more awareness and dive deeper into the different perspectives that the use of intuition might hold in practice. My motivation for the research was fuelled by the quest to explore how my intuition shows up in a clinical practice, and what process or tools might help me, and other counsellors find an ethical place for intuition within a counselling practice framework.

The literature review provides a range of definitions, and key ideas relevant to my research question. This data was used in a synthesis process, with data collected from 35 reflective journals written over a nine -month period. The vignette that follows is an example reflection on my use of intuition when part of a *reflecting team* (Andersen, 1987). This reflecting team model of counselling gave me the opportunity to collaboratively reflect on my intuition experiences and gain other perspectives with the clinic team during the research project.

Further insights on my reflective process are discussed, including an example of the results of the research project included in Table 1. The paper concludes with a discussion of the implications of an intuition process for counselling practice, exploring possibilities for its future use, and expressing hope that this research might spark an interest among other counsellors to reflect on the potential of intuition in their own practice.

Intuition and my way of being

Intuition has always been a natural part of my life, and part of my way of being when working with people. My early experiences of having premonitions about the future, and "seeing things" as a young child orientated me towards wanting to work with intuitive and somatic practices. Studying drama and movement therapy based on Jungian ideas as a young practitioner in Europe introduced me to working with symbols and non-verbal communication. This opened a creative way for me to use intuition in my practice at that time. This experience planted a seed, and on my return to Australia I was drawn toward studying and working in the area of alternative natural therapy approaches. This alternative *energetic* approach to the energy systems of the body-mind (Krebs & O'Neil McGowan, 2014) supported my ideas about energy and intuition and also aligned with my holistic philosophical views.

Intuitive knowledge is given particular value within the community and the clients I was working with at the time. It was shocking when I stepped outside this alternative cultural environment and entered a more mainstream science-based health environment. I found it much more challenging to be as open about my beliefs about "energy", and the use of my intuition. I felt on the "outer" and found myself trying to find a different language in an attempt to connect with people about my ideas in a scientific system that held this dominant discourse. On reflection, I began to hide my ideas, adopting what was more acceptable in a mainstream health environment, and using my intuition more secretly. For the last 20 years, I have been on a journey to somehow bridge the divide between intuitive, creative, mystical ways of being, with the logical, objective, scientific, evidence-based stance that I experience as the more dominant system in our psychology and counselling field today. My resonance with Collaborative Constructionist approaches in counselling and supervision practice was sparked early in my recent studies. This approach has given me the ethical framework to consider exploring the topic of intuition, how it shows up in my practice, and how my practice framework might influence the use of my intuition.

Collaborative Constructionism

The Collaborative Constructionist practice approach holds a subjective view, with the understanding that meaning is co-created in collaboration with others (Anderson, 1995). and forms the basis of my counselling and supervision practice framework. This has allowed an openness, and inclusiveness to explore the many different perspectives of intuition and the bias I might have including or not including my more vulnerable, secret, perspectives and experiences of intuition in the research project. With support from my clinical team and by leaning into a Constructionist approach, I was able to anchor a practice framework that would help me safely explore and stay open to the many multiple perspectives that might be possible in my research.

I found the Collaborative Constructionist practice framework with the key practice principles drawn from Wayne McCashen's *Strengths Approach* (2017) useful. The application of these principles assisted me in taking a de-centered and influential position when working with clients. This position sees the client as the expert in and about their own life (D'Arcy & Holmes, 2020; White, 2005), with the therapist privileging the client's knowledge, and trusting that through collaborative conversation new knowledge will grow (Anderson,1995). In considering the research project, I was curious how this positioning along with reflection on my thoughts and feelings might support an ethical approach I could take to safely use intuition in my clinical practice. This ethical positioning in my approach to the research aligns clearly with the methodology of autoethnography.

Autoethnographic research

Autoethnography as a research method ignited a process of critical reflection and analysis of my experiences through the use of reflection and journal writing. This process provided an arena to explore and understand my experiences of intuition within a counselling context. Writing regular reflective journals on my clinic experiences allowed me to collect data from 35 journals over a nine-month period. The autoethnographic approach challenges traditional ideas about research, privileging stories rather than theories, and expressing an inclusive, ethical, social and political approach to research that introduces new and perhaps different ways of thinking (Ellis, et. al. 2010). This approach aligns with my constructionist practice framework and gave me hope. I envisioned that it might allow me to hold

the stories of my experiences of intuition with an openness to their interpretation and the ideas they might create in the light of differing contexts.

My methodology focused on my embodied experience and felt sense of intuition. Tami Spry's description of "autoethnographic performance" helps to describe the lived experience of this process, with the researcher's living body as a salient part of the research process (Spry, 2021). The reflexive process of journaling about my intuition, and the reflective and reflexive experiences with supervisors, peers, clients and reflecting teams, provided the data to critically analyse the themes that emerged over nine months. These themes were compared and then contrasted against the existing literature on psychotherapists and counsellors experience of intuition and how it might show up in their practice. Drawing on Kolb's inductive learning cycle method (1984) was useful in positioning literature to generalise ideas, but also as a focus for critical reflection and collaboration with others in relation to the meaning of my experiences.

Literature review

I was not sure what I would find in the literature, but I expected there might be a bias toward valuing more of the objective ideas generated from intuition in relation to decision making processes that support intervention practice approaches. This made me question if literature valuing rational, scientific, evidence base ideas would loom large in my search. I also considered how, in taking a social constructionist stance, this literature could be critically analysed in relation to the limitations and assumptions regarding multiple perspectives, context, and the social/political discourses. I was curious about what threads might link across epistemologies via the various schools of thought and integrated practice approaches, and how different perspectives might influence the way intuition shows up in practice. The first step however, was to try and figure out the meaning of intuition.

Definitions of intuition

There is a surprising lack of clarity around the meaning of intuition in the counselling and psychotherapy field (Charles, 2004; Marks-Tarlow, 2014a,). Shirley & Langan-Fox, note that researchers and scholars are unable to agree on the meaning of intuition (1996). Agor (1989), believes this is due to the very different disciplines they follow and perspectives they hold. This seems to indicate rational objective ways of thinking about the world from a structuralist perspective, and subjective, socially constructed ways of thinking and being in the world (Charles, 2004; Marks-Tarlow, 2014a). From a neurobiological perspective, Marks Tarlow states her integrative neurobiological approach with, "intuition is the means by which therapists perceive and respond to relational patterns" (2014, p. xvii). Rosenblatt & Thickstun (1994), present a psychoanalytic perspective, with the idea about brain function in the belief; *"that intuition reflects the operation of an unconscious pattern-- matching activity, wherein a currently perceived pattern is matched to a stored pattern"* (p. 700). Fox agrees with this (2013). On the other hand, Bastick, views intuition as more than a cognitive process, with the idea that *"it is an awareness arising from an emotional state of the individual"* (1982, as cited in Garcia, & Ford, 2001).

With over 40 differing definitions of intuition in psychological literature (Sprenkle, 2005), it would be reasonable to expect the rational, structuralist ideas to hold dominance, due to the discourses that privileges scientific thinking (Charles, 2004). This does, however, make me curious about possible alternative perspectives and unique experiences of the counsellor's intuition, and what the literature might hold about these experiences.

Dominant perspectives of intuition

As I dug a bit deeper there seemed to be some dominant ideas about intuition in counselling and psychotherapy that have stemmed from the early psychotherapists; namely Carl Jung and Carl Rogers, who refer to the use of intuition as " clinical intuition", and place importance on it in the decision-making process (Jung, 1971; Rogers, 1985). It could be argued the ensuing studies on this have been lacking because of the association of "intuition" with magic, and the paranormal, deeming it "unscientific" (Charles, 2004; Marks-Tarlow, 2014a; Muñoz-Cobos & Postigo-Zegarra, 2022), and not trusted by science (Keith, 1987; Shirley & Langan-Fox, 1996). Cohen (2017) seems to suggest discrimination exists in the field of research *"against the inclusion of intuitive modes of practice"* (p.2). Peña would add that the dominance of scientism has marginalised and discredited the use of intuition (Peña, 2019; Goldberg, 1983). This confirmed my thoughts, and I wondered if the gap I was finding in literature in this area was an indication marginalisation continues to occur, with scientific ideas being privileged, and holding dominance.

Rachel Charles has written one of the few books on intuition in psychotherapy and offers her definition of a "rational process" as an outer knowing derived from direct experience and observation. She recognises this is generally more privileged in the world of psychology, over inward ways of knowing (2004). From this I begin to see how cultural values and worldviews might be central in shaping the meaning and value of intuition, and why definitions might be different for different counsellors. I began to recognise how my world view is interconnected with my way of being, in which intuition is naturally generated from an inward way of knowing.

My definition in relation to the literature

In short, my definition of intuition could be defined as a deep, felt sense of knowing. I have experienced this sense of knowing gaining clarity, particularly when practicing meditation and mindfulness. There is some commonality in the literature with the internal process of slowing down thoughts that promotes intuition (Hunt, 1996; Marks-Tarlow, 2014a; Shirley & Langan-Fox, 1996). Other ideas consider mindfulness as a process of attunement (Bryant & Luft, 2023; Sousa, 2022), or as Charles might describe as "connecting at a subliminal level" (2004, p. 71). My reflection on my practice of mindfulness connects me with my whole being; mind, body, and spirit, along with the land, people, and environment around me. It seems that when I slow down my thoughts, I can become more aware and naturally attune to this broader perception.

I am struck by a semblance of connection with Australian Aboriginal ways of knowing, being, and doing, and the interconnection this has with all life: plants, animals, the land, the skies, and water (Cameron, 2010; Martin, & Mirraboopa, 2003). Purdie, & Dudgeon, et.al., (2010), strengthen this idea by suggesting that *Ngarlu*, which is located in the stomach, and the centre of wellbeing, is stronger than gut feeling or intuition (p.246). Robert Lawlor (1991) adds to this with the statement that the intuition of Aboriginal people has the ability to sense and participate in the subjective life and subtle energies of the entire natural world (p.111). This suggests a complex and deep understanding of the experience and knowledge of intuition as a natural part of Aboriginal culture. It seems that the influence of this extensive knowledgeable perspective on intuition – that had a striking resonance for me – was not reflected in the psychology and counselling literature that I was able to find.

The experience of intuition

It appears from the literature that the experience of using intuition in practice is unique to each therapist (Boucouvalas, 1997; Marks-Tarlow, 2014a; Welling, 2004), and is guided by processes from a therapist's theoretical orientation (Bryant & Luft, 2023). However, there is less in the literature about how a therapist's epistemology – reflecting the worldview of the therapist – might play a role in intuitive experiences or processes (Marks-Tarlow, 2014a). This might highlight the restrictions therapists might feel, as found in some studies, due to a lack of value in the professional environment or training, regarding the use of intuition in practice (Charles, 2004; Jeffrey & Stone Fish, 2011; Sousa, 2022).

A majority of the literature appears to support the idea of the quick fast-acting intuitive responses that can take place when working with clients. These ideas can also be described as a top-down approach, reflecting a cognitive led, left-brain, decision-making approach to intuition, found in the more dominant, accepted theories of clinical practice (Bryant, & Luft, 2023; Charles, 2004; Jeffery, 2012; Muñoz-Cobos, & Postigo-Zegarra, 2022, Marks-Tarlow 2014a). The right brain, intuitive body-mind connected process is a slower and deeper, mindful approach (Bryant, & Luft, 2023; Jeffery, 2012; Marks Tarlow, 2014a; Shirley & Langan-Fox, 1996), representative of a bottom-up approach, that is more of an embodied, inward, right- brain, somatic, approach to intuition (Cervini, 2020; Marks-Tarlow, 2014b; Peña, 2019). Even though these writers are using these terms, their interpretations are slightly different depending on their theoretical practice approach.

Sousa (2020) found the experience of intuition had numerous ways of occurring during her study: via bodily sensations, images, thoughts, energetic sense, and auditory thoughts. Similar experiences were found in the literature across a number of studies including those by Charles (2004), Hart (1997), Jeffrey & Stone Fish (2011), and Shirley & Langan-Fox (1996). These studies seem to take a more subjective view of the experiences of intuition, and I am curious to explore this view further, looking to research for ideas on how intuition might actually work in practice.

Guidelines for use of intuition

Various attempts to provide a theory or guideline for using intuition in practice have been researched in a variety of ways but also clearly influenced by the various schools of thought (Bryant & Luft, 2021; White, 2011). Vaughan is cited by a number of researchers, and her guidance refers to learning to relax and becoming aware of physical sensations in the body without trying to change them as a process to develop intuition (1979). Rea's guidelines for refining clinical intuition has a similar approach, with a leaning into deep observation, holding a presence and empathy with the client (2001). It is clear from the research that counsellors often use intuition, but in light of limited research on its use in counselling practice, there seems to be reluctance to discuss intuition in clinical settings (Jeffrey & Stone Fish, 2011; Sousa, 2022).

More recent qualitative studies (Cohen, 2016), hermeneutic studies (Cervini, 2020; Phelon, 2001; Pysklywec, 2008), and grounded theory approaches (Muñoz-Cobos, & Postigo-Zegarra, 2022; Sousa, 2022) in research, have progressed literature toward ideas that support therapists in discovering their own sense of the experience of intuition. Marks-Tarlow' supports this with her offering; "Although clinical intuition originates at a nonconscious level that cannot directly be taught, conditions for tapping into intuition can be fostered" (2014, p. xxxiii). Exploring these ideas had me thinking about the value counsellors might place on the *reflective and reflexive* practice, as suggested by Jeffery (2012), and foster this awareness that can tap into intuition, as Marks-Tarlow (2014 suggests.

My sense of intuition

My intuition sometimes manifests in a visual way that I see as an energy field in, and around people's physical bodies. This connects with a perspective regarding the idea of "field theory", that we are all connected energetically, and can be perceived in a sensory way (Loewenthal, 2022). I notice how my sense of this energy field connects to my intentionality and values when creating a sacred space with clients. My belief is that setting clear intentions internally, externally, and in the energy field of the space between therapist and client when initiating a session, sets up an environment of collaboration, openness, respect and trust.

When I connect with people in this way, it is like an energetic, intuitive, conversation takes place, in which images become visible to me, along with an intuitive sense of knowing. At this stage of my research, I was beginning to gain an understanding of how my *way of being*, my *way of doing* with intentionality, and my *practice principles* that reflect my values were helping to guide my intuitive process. However, questions still loomed in my mind – how does this happen? What meaning does it have, and from whose perspective is it useful?

The energetic collaborative conversation I was beginning to experience with clients was reflected in my literature research. The following reflection captures my learning about my ways of being and sense of knowing during a clinic session experienced during the research project.

Vignette

A new client arrived, for whom I was to be on the reflecting team, and I had gone to the front reception to retrieve some forms from the printer. When I returned the client and counsellor were in the counselling room ready to start. The room has a one-way viewing mirror in which the reflecting team observes from an adjacent room. I felt a little concerned that I hadn't met the client, but my supervisor reassured me that the client had been told I was on the reflecting team and was okay with that.

As I settled into being present for the session. The client mentioned she was interested in any " intuitions", which surprised me, and I noticed that it was nice to hear a client asking for this, and I wondered about tuning in more closely to her energy. Even though she was open to intuitive input, I felt that more permission was needed, particularly since I had missed the introductions before the session started. I was reminded of past times when I would energetically ask people for permission to enter into their energy field. I would ground and center myself in my heart, and then ask permission with words in my mind. Asking for permission to enter a place that belongs to another is an act of respect and has always been important to me. I think about how important this is in Aboriginal culture, and reflect on how asking for permission, and paying my respects to the ancestors when I am walking on Country has always been important to me.

So, how did I ask permission of the client in the clinic whom I had not physically met? I intentionally focused with a mindfulness practice, becoming aware of my whole body and energy, or what Tara Brach calls living *presence / aliveness* (Brach, 2023). This state of body/mind usually initiates a deeper breath and connects me to my physical heart, feelings of compassion, and creates a state of presence and stillness in which I can feel and see the energy field around myself and around others I am with. It was at this point I formed the words in my mind and asked the client for her permission to look into her energy field during the session. There was a clear "yes" response back that I

heard in my head, and at the same time I noticed her energy field brighten with a yellow glow that momentarily expanded, moving towards me, as I sat in the reflecting team room looking through the window. I recognise how important permission is, the ethical importance this has for me, and how this influences my access to intuition.

The client was talking about a lack of confidence that has been with her all of her life, and how just being more herself is helping her to feel more confident. This is what she wants to create more of, but it is a struggle to make this change and then stay with this change when other people and environments prefer the less confident person. As she spoke, I had a sense of "confidence" and "lack of confidence" being at different ends of the spectrum and she was in the middle. As I focused on her energy, I sensed a big fluffy warm purple blanket that she could snuggle under. It was a protective, nourishing, nurturing blanket that was creating the space for her to have a rest, perhaps just be herself, and have time out from all this hard work about " confidence". During the reflecting team discussion, I shared this vision of the blanket, offering it tentatively, so that she could make use of it or not. The client and counsellor continued the session in which the intuitive idea was not directly discussed, and the session ended with the client expressing that she had gained some different ways of thinking about her situation, which was a helpful outcome for her.

During our team debrief, the counsellor mentioned that when he and the client were in the reflecting team room, observing the reflecting team discussion, the client was deeply moved by the "purple blanket" intuitive offering.

De-construction and new perspectives

After the session I reflected on the role "confidence" had been playing in my research journey with intuition. Was there a parallel process with the client's "confidence"? Was it my connection with "confidence" that initiated the intuition? Was it a co-collaboration on some level with the client? These questions invited me to reflect on my intention, and what values I might draw on to gain more clarity.

I reflected on other experiences, when I had intuitions, but didn't share them in the reflecting team or offer them collaboratively with clients, and I noticed myself challenging the "logic" of the intuition. I realised privileging this perspective could pose a risk of eliminating them as an untruth, or distortion. I recognised the echoes of past experiences, with my intuition not fitting with mainstream beliefs in the professional allied health environment, and how these discourses have in the past shut down other perspectives that might have held real meaning for myself and those around me at the time.

This was a pivotal moment that helped me recognise alternative perspectives to the story – co-created with my peers, supervisors, and clients – that helped me shift into a more confident self. The use of journaling also helped me catch these moments, and enabled more awareness, reflection and critical thinking to occur during the research process. The collaborative conversations with the clinic team made alternative perspectives more possible to see, and the reflecting team process created a safe space for me to tune into intuitions, explore, and discover internal and external processes for using intuition in my counselling practice.

My research was unsuccessful in finding literature relating specifically to Collaborative Constructionist counselling approaches and the direct use of intuition. The review of literature privileged more modernist ideas in the use of intuition, with an objective, rational, scientific, dominance. This was a slight setback, as I was interested in how other Collaborative Constructionist counsellors might use intuition within their practice. I did, however, find a few Collaborative Constructionist ideas loosely related to the concept of intuition. A Collaborative Constructionist *practice principle* that Alice Morgan refers to in Narrative practice, views the client as the " expert" on their life (2000). This could be also reflected in Marks-Tarlow's suggestion that the practice of "checking in" with clients about a therapist's intuitions, which supports a safe and ethical way of using intuition in counselling practice (2014a). This discovery helped me to begin to see the ethical resonance that was possible between my *way of being* with the constructionist values and practice principles, and the *way of doing* internal and external reflective practice as a process for using intuition.

Table 1. Intuition Process

Intuition Process: Based on a Collaborative Constructionist Approach			
Way of Being – Who I am	**Way of Doing – Intentionality**	**Way of Being – Values / Principles**	**Self-reflective Questions for Counsellors / Supervisors**
Internal Intuitive Process			
Spiritual presence.	Mindfulness Heart/compassion practice Self-care/awareness	Compassion: self/client Empathy. Kindness	What is my ontology, beliefs, values? How is this reflected in my relationship with myself and others?
Sacred space.	Pay respects Permissions Grounding	Respect	What is my relationship with the space I am using for counselling and supervision?

Internal rituals.	Inviting the client into the space Set up of my internal shelf for emotions /triggers Inviting my mentors and supervisors as witness to my practice	Partnership & collaboration Openness Curiosity Power with not power over Respect Reflective practice Social justice Accountability	How does the client present to me when I think about them before a session? Where will I put my emotional responses/stories? What will I do about them if they arise and are a distraction during sessions? Who might I mentally invite to sit on my shoulder to support me in my practice?
Internal reflective practice at the start of the counselling session	Internal reflective check: Emotions of self, triggers / reactions Initial intuitive responses to client, and practice processes	Focus on values: reflective practice Curiosity Honesty Respect Transparency	As I listen to the client's story, how do my values engage with their story? Do I need to put my own emotions/triggers/stories/ bias aside? What am I sensing, and how might this influence the client's hopes for the session?
Sense of Knowing: Intuitive Sense and Reflective Process			
Internal reflection in response to intuitive sense.	Internal reflective check Self-check of: meaning/ feeling/constructs Therapeutic relationship Intuition becomes interpreted as an idea/image	Social justice Ethics Empathy Compassion Curiosity	How do I know what I know? How did I sense this? What does intuition mean to me personally? What does it mean for my understanding of the client's situation? How might this impact the therapeutic/ professional relationship? What social constructs might surround this idea? Are there cultural or ethical considerations? Is my decision to offer the intuitive idea to the client: - A rational cognitive thought process? - An intuitive, gut – feel decision? - Or both? How might the intuitive idea impact the counselling / supervision process?
Cognitive/intuitive/ reflective process.	Internal decision about offering intuitive idea/image to client Reflection on process	Self-agency Focus on values Focus on language as the primary medium of change Collaboration & partnership Curiosity	

Intuition: External Process			
External reflection & collaboration.	Reflection with client on intuitive offering 'Offering tentatively'	Focus on language as the primary medium of change Partnership & Collaboration Curiosity Empathy	What language and approach will I use to introduce the intuitive offering? How helpful /not helpful was the intuitive offering for the client?
External reflective /reflexive process.	Reflecting team process Debriefing Client feedback Supervision Journaling	Partnership & collaboration Social justice Compassion: self/client.	What part of this process would be most helpful to explore in my supervision?

Summary

My journey with this autoethnographic research project, and the result of an intuition process, has been based on a Collaborative Constructionist approach to practice. The process has opened me to curiously question how I make sense of my way of being in the world, and the values and principles I bring as a counsellor into practice. More broadly, I discovered through the research project a lack of discussion and resources in therapist's academic training, and supervision, about the use of intuition. I hope that in the future, there will be more openness and curiosity to bring the topic of intuition into the light for discussion and development in counselling and supervision practice.

This autoethnographic study has highlighted an important perspective; that all therapists are unique in their use of intuition, and that this is informed by their own ways of being, ways of knowing, and approach to practice. Given this, the intuition process offered in this paper will not necessarily fit with everyone. However, the *self-reflective questions for counsellors* suggested in the intuition process (Table 1.), could offer a starting point for counsellors interested in exploring their own process for the use of intuition in their practice. This might foster the development of the self-awareness and reflective practice processes suggested by the literature, that supports therapist trust and confidence in their use of intuition (Bryant, & Luft, 2023; Charles, 2004; Jeffery, 2012; Jeffrey & Stone Fish, 2011; Marks-Tarlow 2014a; Peña, 2019; Pysklywec, 2018; Sousa, 2022). As Marks-Tarlow suggests, the implications of engaging in critical reflective processes, brings ethical awareness to the experience and use of intuition in a therapist's counselling practice (2014a). This clearly aligns with the Collaborative Constructionist approach, and its inherent reflexive practice for critical and ethical reflection on practice and process. This approach would seem to support more open and inclusive discussion on intuition in the professional development of counsellors and psychotherapists.

The intuition process in Table 1., has been the product of the research, and will be regularly used to help me curiously question and reflect on how I make sense of my way of being in the world, and the values and principles I bring as a counsellor to the use of intuition in the process and practice of counselling and supervision. Further research on the topic of intuition could explore how clients might use intuition in the therapeutic process, and what these stories might make possible in the collaborative counselling journey.

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Extending the role of a counsellor: Experience from an Australian clinical and research interdisciplinary spinal centre*

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Keywords: *Extended role, Counselling, Chronic low back pain, Clinical Care Pathway, Clinical Counselling Research*

Summary: We describe the development of and experience with an extended role for a counsellor at an independent interdisciplinary Australian Spinal Centre. A bespoke professional, clinical and research educational program was designed, and the counsellor then applied these skills to patients with chronic low back pain (CLBP) in a Clinical Care Pathway (CPW) and a prospective clinical research project. Between November 2021 and February 2025, the counsellor assessed 160 patients in the preoperative component of the CPW and followed up 18 with moderate or severe levels of mood disorder (mean 3.5 sessions each). In the research study evaluating neuropathic pain, the Counsellor recruited and assessed 96 patients between August 2022 and December 2024. The clinical role of a Counsellor can be successfully extended in the appropriate clinical and research environment. This model has major cost-benefit implications for service delivery and research.

Introduction

Within Australia there are several ways to achieve the necessary qualifications to become a Counsellor and a diverse range of employment opportunities once qualified (Australian Institute of Professional Counsellors, 2025). Professional clinical and academic career progression can be undertaken with a range of post-graduate studies or diploma courses. Such additional studies widen career choice and expertise but may be both costly and difficult to undertake depending on individual circumstances. In this study we describe a bespoke career development program for a counsellor employed at an independent interdisciplinary spinal centre that manages patients with chronic low back pain (CLBP). The centre has senior clinical and allied health staff, as well as senior clinical research personnel, with backgrounds in medical education, clinical research and clinical service delivery. Previously we have described an extended role for medical general practitioners in the management of patients with CLBP (Whittle et al, 2023). Using the same principles (Gervas et al, 2007), we designed a course that extended the role of the counsellor at the centre.

The background to this study was generated by several factors. Firstly, there was an increasing number of patients with chronic low back pain (meaning pain persisting for more than 12 weeks) seen at our centre. Most of these patients have signs and symptoms attributable to various musculoskeletal degenerative conditions and the aetiology is termed “mechanical” LBP (Foster et al, 2018). Management of this cohort is challenging since the biopsychosocial factors contributing to the condition may cause long term disruption and restriction of social interactions, leisure and work activities (Anselmo et al, 2024; Kamper et el, 2015). This may lead to secondary disturbances in mood and behaviour (Demyttenaere et al, 2007; Stubbs et al, 2016).

Secondly, recent studies have shown that in selected patients a novel way of treating their mechanical CLBP is by surgically implanting a device that electrically stimulates the L2 medial branch dorsal rami nerves in the lumbar spine. This neurostimulation causes contraction of a lumbar paraspinal muscle called multifidus and is termed “restorative neurostimulation” (Chakravarthy et al, 2022). Clinical trials have reported significant

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reductions in both CLBP and disability that can last up to five years following this therapy (Gilligan et al, 2024; Schwab et al, 2025). To improve outcomes in these patients, we have developed an interdisciplinary Clinical Care Pathway (CPW) that incorporates the biopsychosocial approach to managing CLBP (Huang et al, 2025). This CPW offers scheduled, streamlined management of the patient from their initial introduction to the therapy until at least 24 months after insertion of the device. The CPW was not only designed to optimise patient care but also to provide a model by which collection of sequential outcome data could be attained to enable "real world" clinical outcomes to be compared to data from successful prospective clinical trials (Whittle et al, 2024; Huang et al, 2025). Additionally, it also provided an ideal infrastructure in which prospective academic clinical studies in this cohort could be performed.

In the CPW we chose to assess and support the mental wellbeing of these patients using a counsellor. Given significant mood disorders are reported in only about 14 per cent of patients with CLBP undergoing restorative neurostimulation (Thomson et al, 2021), most patients do not need to see a clinical psychologist but still require mental health screening. We therefore embedded a counsellor into both the pre-operative (screening) part of the CPW and the two-year postoperative follow up period. Prior to this project the counsellor, who was appointed in June 2020, saw patients referred to the centre with a range of musculoskeletal spinal disorders on an ad hoc basis. The counsellor's background qualification was a Diploma in Counselling (2020) from the Australian Institute of Professional Counsellors (AIPC). Once established in their clinical role, their position and client profile also provided the opportunity to seamlessly perform research studies on the patients with CLBP in the CPW.

Here we report; (i) how specialised training prepared the counsellor for the role in the CPW; (ii) the counsellor's experience in the assessment and management of patients in the preoperative and post-operative CPW; (iii) how we were able to seamlessly add in a prospective clinical research role for the counsellor within the CPW setting; and (iv) the counsellor's contribution to recruitment and assessment of patients in the research project; and (v) lessons learnt and implications of the model.

Methods

Setting

This study was undertaken at an independent Australian capital city interdisciplinary spinal centre that has a large clinical service and dedicated research facility.

Training of the counsellor for the extended role in the CPW

A series of in-house tutorial sessions were delivered by senior members of the clinical, allied health and research staff at the spinal centre. Topics covered included the scientific basis of CLBP and aspects of its assessment and management. Observing clinical sessions of patients being assessed and treated for CLBP were also organised. Relevant aspects of Good Clinical Practice (GCP) in human clinical research were taught. Practical training on recruiting and assessing patients on several well validated and widely used questionnaires was either consolidated or taught.

Design of the Clinical Care Pathway (CPW)

A CPW for patients having restorative neurostimulation using the ReActiv8 device (Mainstay Medical, San Diego, CA) for mechanical CLBP was designed using the four basic principles outlined for a CPW (Kinsman et al, 2010) and Laval et al 2017). The CPW was developed after a dedicated interdisciplinary workshop that included the counsellor in August 2021. Details of and experience with the first two years of this CPW have recently been published (Huang et al 2025). In brief, and relevant to this paper, the counsellor has a pre-operative screening and assessment role for all prospective patients and a postoperative role for selected patients, as expanded upon below.

Role of the counsellor pre-operation

The counsellor's first role in the CPW was to screen and assess the wellbeing of potential patients for this therapy in a pre-operative assessment session. This involved a structured interview, that is based on the 5A model for Assessment and Intervention in Integrated Healthcare (Glasgow et al, 2006) with a duration of 45 mins for the initial consultation. Using the 5A model, the counsellor can incorporate assessments of mental status using the Depression Anxiety Stress Scale 21 (DASS21) (Henry et al, 2005) and the neuropathic pain component of the patients CLBP using the PainDETECT questionnaire (Freynhagen et al, 2006) and also determine what if any further care is required for the patient. All this information was relayed to the senior spinal surgical consultant and used to facilitate decision making about:

- (i) the patient's suitability for the restorative neurostimulation, since this therapy is primarily aimed at patients with mechanical CLBP, which is nociceptive in origin rather than neuropathic
- (ii) whether clinical psychological intervention was deemed necessary
- (iii) whether the patient would benefit from longitudinal counselling later in the CPW

In addition, and as part of a research project designed to explore differences in the incidence of neuropathic pain documented using two different internationally recognised and recommended questionnaires (PainDETECT and the Short-Leeds Assessment of Neuropathic Symptoms and Signs (S-LANSS (Bennett et al, 2005)) the counsellor also guided the patients in completing the latter questionnaire during the consultation. Secondary aims of this project were to evaluate the inter-relationships between neuropathic pain and (i) demographic features (gender and age); (ii) mental status scores from the DASS21; (iii) prior spinal lumbar surgery; (iv) patient compensation claims; and (v) evaluate which questionnaire the patients felt was best representative of their pain and easier to fill in.

Role of the counsellor at the postoperative CPW clinic

The post-operative part of the CPW is designed for the care of patients with ReActiv8 neurostimulation devices only and is delivered at a "one-stop" clinic. At this clinic all the patients see the therapy manager (who adjusts the stimulus parameters on the implantable programmable device), a medical doctor who assesses pain, medication and general medical condition, and an exercise physiologist who assesses the patient's movement functions at the same visit. The counsellor reviews only those patients identified either (i) before surgery or (ii) after surgery as needing or potentially benefiting from post-operative counselling.

Therapies such as Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT), Solution Focused Therapy, breathing and relaxation exercises were introduced and used in 60-minute sessions. It is important to note that the counsellor was aware of their duty of care and limitations in scope of practice. The fact that the Spinal Centre is an interdisciplinary centre with collaborative clinical disciplines involved in the

planning and execution of patient centric care, uses a central shared electronic medical records system, a common clinical consulting area (with separate rooms) as well as face to face meetings and teleconferences, facilitated communication using cross-referral and consultation with other clinicians, including clinical psychologists.

Ethics

The research studies covered in this report were approved by the Low Risk Adelaide University Human Research Ethics Committee (HREC). They were HREC Approval numbers H-2022-110, Assessing Neuropathic Pain components using PainDETECT and S-LANSS; and H-2023-307, A single Centre audit of outcome following ReActiv8 therapy for chronic low back pain.

Results

Training of the counsellor

From June to November 2021, the counsellor underwent an intensive period of education, learning and practical experience concerning CLBP and aspects of its assessment and management. The educational sessions covered basic spinal anatomy; CLBP; pain mechanisms and its management (with emphasis on the biopsychosocial model), and commonly used medications for CLBP. The counsellor also attended clinical sessions that covered (i) General Practice and specialist spinal surgical consultations with patients suffering from CLBP; (ii) Exercise Physiology and Physiotherapy consultations with CLBP patients, particularly those being assessed for and managed with restorative neurostimulation devices; and (iii) how the implanted programmable neurostimulation devices, designed to alleviate CLBP, are programmed by therapy managers. These sessions provided insight into each discipline's particular role in the CPW and allowed the counsellor to become acquainted with her interdisciplinary colleagues providing the "one-stop" restorative neurostimulation clinic. Attendance was also organised for operating theatre visits that included observing open spinal surgery (discectomy and lumbar decompressions), insertion of neurostimulator devices to control chronic pain and image guided spinal interventional therapies designed to alleviate CLBP (radiofrequency denervation and epidural steroid injections).

From February to August 2022, training on the theoretical, practical and clinical use of the DASS21, PainDETECT and S-LANSS questionnaires, as well as recording and storing human clinical research data was provided by a senior clinical researcher (the counsellor had previous knowledge of the DASS21). Calculating questionnaire scores and their interpretation were taught directly and using web-based tools. Instruction in Good Clinical Practice (GCP) was provided and an Online Course successfully completed (10 Aug 2022) and certificate awarded (Investigator and Site Personnel GCP (ICH GCP) Training, Genesis Research Scheme

The counsellor's experience during the pre-operative stage

Since the inception of the Restorative Neurostimulation CPW in November 2021 until February 2025, the counsellor has assessed 160 new patients (86 female, 74 male; mean age 58 yrs: median 59 yrs, range 23-89); see Table 1.

Year	New Patients	Review Appointments	Total Appointments
2021 (Nov-Dec)	4	2	6
2022	63	15	78
2023	54	28	82
2024	37	30	67
2025 (Jan-Feb)	2	2	4
Totals	**160**	**77**	**237**

Table 1: The workload of the Counsellor in the pre-operative (New Patients) and postoperative (Review Appointments) components of the Restorative Neurostimulation Clinical Care Pathway from November 2021 until February 2025.

From August 2022 until the end of December 2024, 96 of these patients had their DASS21 scores recorded. Between 70-79 per cent of these patients scored within the either the normal or mild ranges for depression, anxiety and stress; 16-24 per cent scored in the moderate range, whilst 5 per cent scored in the severe category. Nobody scored in the extremely severe category for any mood disorder (see Table 2).

Grade	Depression Score on DASS	Depression Incidence / %	Anxiety Score on DASS	Anxiety Incidence / %	Stress Score on DASS	Stress Incidence / %
Normal	0-9	57 (59%: CI 49-69%)	0-7	66 (69%; CI 58-78%)	0-14	61 (64%; CI 53-73%)
Mild	10-13	11 (11%; CI 6-20%)	8-9	10 (10%; CI 5-18%)	15-18	7 (7%; CI 3-14%)
Moderate	14-20	23 (24%; CI 16-34%)	10-14	15 (16%; 9-24%)	19-25	23 (24%; CI 16-34%)
Severe	21-27	5 (5%; CI 1-12%)	15-19	5 (5%; CI 1-12%)	26-33	5 (5%; CI 1-12%)
Extremely Severe	28+	0	20+	0	33+	0

Table 2: Grade and incidence of depression, anxiety and stress in 96 patients with CLBP assessed by the counsellor using the DASS21 self-report questionnaire. The Confidence Intervals (CI) are reported at the 95 per cent level.

The Counsellor's role in the post-operative stage

Eighteen patients implanted with the ReActiv8 neurostimulation device (11%; 95% CI 7-17%) underwent post-operative counselling within the CPW (median 3.5 sessions each) and 3 were referred back to their psychologists. Counselling techniques introduced and used included CBT, DBT, Solution Focused Therapy, breathing techniques and relaxation exercises.

The counsellor's role in prospective clinical research

By incorporating the DASS21, PainDETECT and S-LANSS questionnaires in their initial assessment of patients in the CPW, the counsellor was able, between August 2022 and December 2024, to seamlessly recruit 97 patients for a prospective clinical trial. One patient completed the assessments but declined to sign the necessary written consent form for inclusion of their data in the research study. Thirteen of the 96 (14%; 95% CI 7-22%) had neuropathic pain on the PainDETECT questionnaire and 12 (13%; 95% CI 7-21%) on the S-LANSS questionnaire.

The counsellor met regularly with the director of research to monitor the project's progress, audit the research data, assist in annual reports to the HREC and an amendment to the HREC to increase the study sample size after an interim analysis of data. Preliminary data was presented at the Annual Scientific Meeting of the Spine Society of Australia (SSA) in Sydney April 2024 as a Top 10 poster. The extended role was presented at the subsequent SSA meeting in Perth April 2025 as an oral podium presentation. PainDETECT data for the patients in the restorative neurostimulation CPW was included in two articles recently published in the journal *Neuromodulation* (Huang et al, 2025; Whittle et al, 2024).

Discussion

In this study we have described an extended clinical role for a counsellor undertaken at an independent spinal centre that has its own dedicated research facility. The concept of "extended roles" has been used widely in general medical practice (Gervas et al, 2007; Whittle et al, 2023). The purpose of such clinicians is for them to be able, for a portion of their time, to offer a consultant-like role whilst still practising in primary care (Gervas et al, 2007). This improves patient access to necessary opinions, reduces patient costs, increases clinician self-esteem and job satisfaction and also increases patient satisfaction with their management. This study reports our experience with extending the role of an early career counsellor, who without added university undergraduate experience, was highly motivated and eager to accept the challenges of the extended role.

The project has been very successful in various domains. Firstly, it has provided a sympathetic and appropriately trained staff member who can perform an important clinical role in the initial assessment of CLBP patients interested in restorative neurostimulation. Secondly, it has provided supportive, continuing care for those patients with moderate mental health issues in the restorative neurostimulation CPW. Thirdly, it has provided data that assists understanding of the interplay between impaired mental health and the incidence and severity of neuropathic pain. Fourthly, it has provided a platform on which a dedicated research project was successfully completed; and finally, it provided the infrastructure and support through which the counsellor obtained extended experience in structured clinical care delivery and novel insights into participation and execution of clinical research.

The success of the project was due to the interplay of:

- A highly motivated, inquisitive counsellor who wished to develop their clinical skills through Continued Professional Development (CPD)
- The presence of thoughtful and proactive educators at the centre who are eager to explore extending responsibilities and providing professional development opportunities for medical and allied health staff
- The availability of dedicated senior clinical researchers seeking opportunities for allied health care personnel to acquire insight into and partake in the conduct of clinically relevant research whilst performing their routine clinical practice
- The clinical need at our centre for a Counsellor suitably trained to assess and triage the increasing number of CLBP patients
- The setting of a spinal centre with an interdisciplinary patient focussed approach to management of CLBP and multiple pathways of inter practitioner communication

The counsellor's personal reflections on their extended role were also very positive. They enjoyed the range of patients seen and the social issues uncovered that could be adding to the patient's mood disequilibrium. This was particularly relevant with respect to the significance of a patient's DASS21 scores, since this tool provides only a snapshot of how multiple issues in patients lives are perceived and reconciled. They also noted that many clients/patients are often reluctant and a little sceptical when asked to participate in a counselling session (particularly those aged in the late 50's to 70's). It often took the initial five minutes of the consultation to reassure them that they have not been pre-diagnosed with a mental health condition because they have CLBP. Once the counsellor's role was explained the patient would relax and progress through the session. This "destigmatisation" of the need to see a counsellor meant that frequently the patient would leave the session reassured and thankful for the service provided. This qualitative observation is supported by the high levels of satisfaction recorded in an independent assessment of patient satisfaction with the CPW (Huang et al, 2025).

The concept and execution of this project was similar to that devised for extending the role of general practitioners (GP) in spinal medicine and surgery at the centre (Whittle et al, 2023). In both situations there was a pressing clinical service need for this extended role, and the persons undertaking the extended roles were supported by the ready availability of other medical and research staff members – either at the clinic or in very close proximity in other consulting rooms. Discussion about specific patients and research findings was also undertaken to encourage reflective practice and inquisitiveness about the limits of tools used in clinical research projects. The counsellor actively partook in audit of her practice and the preparation and writing of two published manuscripts and one oral presentation at a national scientific meeting that emanated either in part or fully from their research endeavours (Huang al, 2025: Whittle et al, 2024).

In terms of putative financial costs for the clinical and research service, there were considerable benefits despite the time required by the senior staff in organising, preparing and conducting the additional training. Appointing a clinical psychologist to perform the initial mental health screening assessments in the CPW would have been an expensive undertaking for the Centre, costly for patients and done with the knowledge that such practitioners are in short supply. Also, because of the relatively low frequency of severe mental health disorders in the restorative neurostimulation focussed CLBP population, job satisfaction for a clinical psychologist may have been low with such a role. In comparison, the counsellor felt challenged by the role and took major satisfaction from the addition of the research aspect and their "ownership" of that data.

From the research team perspective, the enthusiasm of the counsellor for the project gave it considerable momentum as well as adding both an important dimension to the research data for this cohort and an additional source of expertise for

studies. The lost time that would have been invested, and the other challenges of obtaining an externally funded research grant, which statistically has a poor chance of success, were also obviated by using the counsellor as a research associate. Testimony to the validity of the counsellor's research finding were the neuropathic pain incidence of 12-15 per cent in our cohort, which is very similar to previous reports in this field (Forster et al, 2000). The incidence of mood disorders on the DASS21 was also similar to previous findings (Thomson et al, 2021). The distribution of the DASS21 data also showed that this CLBP cohort has a decrease of between 15-20 per cent in the number of people with no or mild levels of depression, anxiety and stress and an approximately four-fold increase in "moderate" levels of depression, anxiety or stress compared to a control population (Crawford and Hendy, 2003). These figures lie between previous high and low estimates of the increase in depression, anxiety, and stress associated with CLBP (Demyttenaere et al, 2007; Stubbs et al, 2016; Zvolensky et al, 2025).

Although our Centre was well staffed and structured to successfully develop this extended role for a counsellor, it is possible similar approaches could be taken at other centres to realise the full spectrum of a counsellor's skills.

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Culturally Adapting Schema Therapy for Confucian Heritage Clients: A Practice-Based Integration of Confucian and Taoist Principles

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Abstract

This paper explores a culturally adapted approach to Schema Therapy by integrating Confucian values and Taoist principles to enhance therapeutic responsiveness for clients from East Asian cultural backgrounds. It examines how core Confucian concepts such as filial piety, emotional restraint, and relational obligation can shape maladaptive schema formation, often contributing to psychological distress. In contrast, selected Taoist principles, including "benefiting without harm" and "returning to innocence," are used to support healing and facilitate the development of the Healthy Adult Mode. Drawing on practice-based insights and a detailed case study, the paper demonstrates how therapeutic strategies can honor Confucian-heritage values while promoting individual emotional wellbeing. The integration model presented contributes to the growing field of culturally responsive psychotherapy and offers practical insights for counsellors and clinicians working with Confucian-heritage clients in multicultural settings.

Keywords: *Schema Therapy; Confucianism; Taoist Cognitive Therapy; Cultural Adaptation; Cross-Cultural Psychotherapy; Emotional Needs; Eastern Philosophy*

1. Introduction

Schema Therapy (ST), originally developed by Jeffrey Young and his colleagues (2003), is an integrative psychotherapy model combining elements of cognitive-behavioural, attachment, and psychodynamic approaches to address chronic psychological difficulties (Arntz, 2021). Extensive empirical evidence supports its efficacy, particularly for personality disorders and treatment-resistant conditions (Arendt et al., 2024; Arntz & Jacob, 2017). However, ST's foundational emphasis on autonomy, emotional expressiveness, and boundary-setting reflects Western individualist paradigms (Hotan, 2019; Brockman et al., 2023), which may conflict with the value systems of clients from Confucian-heritage backgrounds.

In Confucian-heritage societies—including China, Malaysia, Korea, and East Asian diaspora communities—psychosocial development is deeply rooted in moral-relational frameworks. Core Confucian principles such as filial piety (*xiào* 孝), emotional restraint (*nèiliǎn* 内敛), and social harmony (*hé* 和) govern identity formation, interpersonal duty, and self-worth (Yuen, 2019; Elsevier, 2025). While these values promote familial and social cohesion, they may also perpetuate rigid expectations, emotional suppression, and conditional self-worth, fostering the development of maladaptive schemas including Defectiveness/Shame, Self-Sacrifice, Unrelenting Standards, and Subjugation (Cui et al., 2022).

Taoist philosophy offers a complementary framework for addressing psychological distress in Confucian-heritage contexts. Principles such as *wú wéi* (effortless action), *zìrán* (naturalness), and *wú niàn* (non-fixation) provide culturally congruent strategies for regulating emotional distress and cultivating psychological flexibility. Emerging modalities like Taoist Cognitive Therapy (TCT) leverage these tenets to mitigate internal conflict and restore equilibrium (Ding et al., 2020; Zhang & Young, 1998; Zhang et al., 2002), offering promise for clients grappling with perfectionism or shame-based schemas.

Despite growing interest in cross-cultural adaptations of ST, scant literature examines its application in Confucian-heritage clinical settings. Standard protocols often neglect the nuances of intergenerational obligations, stigma around emotional distress disclosure, and cultural prioritisation of harmony (Devenish & Sullivan, 2024; Wong, 2021). This study addresses this gap by:

1. Analyzing how Confucian cultural norms shape the formation and maintenance of specific maladaptive schemas;
2. Proposing a culturally integrated ST model synthesizing Confucian values and Taoist Philosophy to enhance the cultural responsiveness of Schema Therapy.

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Drawing on schema theory, cultural psychology, Taoist Cognitive Therapy, and a detailed clinical case study, this paper advances a conceptual and practical framework for working effectively with Confucian-heritage clients in multicultural practice.

2. Overview of Schema Therapy in Confucian-Heritage Contexts

Schema Therapy (ST) is a comprehensive psychotherapeutic approach targeting Early Maladaptive Schemas (EMSs), defined as enduring psychological patterns rooted in unmet core emotional needs during childhood (Arntz, 2021; Brockman et al., 2023). These schemas are perpetuated through maladaptive coping styles (surrender, avoidance, overcompensation) and schema modes (e.g., Vulnerable Child, Punitive Parent, Guilt-Inducing Parent) across the lifespan (Arntz, 2021; Brockman et al., 2023).

The International Society of Schema Therapy (ISST) has refined Young's original core emotional needs into a more nuanced, developmentally sensitive framework (ISST, 2023). This revision underscores the interplay between attachment security, autonomy development, and cultural-contextual factors.

Key updates include:

- Connection needs: Explicit inclusion of unconditional acceptance, critical for addressing Defectiveness/Shame schemas.
- Safety needs: Integration of fairness and predictability, aligning with trauma-informed initiatives (Arntz et al., 2021).
- Autonomy is bifurcated: Bifurcated into *Autonomy Support* (competence affirmation to counter Failure schemas) and *Autonomy Granting* (respect for individuality to challenge Subjugation schemas; Lockwood, 2022).
- Healthy role modeling: Addresses intergenerational schema transmission, particularly salient in Confucian-heritage families where hierarchical authority is seldom questioned (Markus & Kitayama, 2010; Yin, 2021).

This expansion aligns with neuroscientific evidence on secure base scripting and growth mindset (Louis et al., 2024; Roediger et al., 2018), while offering clearer clinical targets for unmet core emotional needs across cultures.

Cultural Nuances in Confucian-Heritage Contexts

Although ST's core needs are universal, their interpretation diverges markedly in Confucian-heritage societies, where emotional needs are often secondary to:

1. **Familial loyalty** (e.g., filial piety as a moral imperative; Cheung et al., 2022; Liu et al., 2019).
2. **Role-based obligations** (e.g., gendered expectations in caregiving).
3. **Social harmony** (e.g., avoidance of conflict to preserve *miànzi* 面子, 'face').

Within these contexts, the inability to meet rigid familial or societal expectations can precipitate the development of schemas such as:

- **Unrelenting Standards (Perfectionism)**: Often driven by societal and familial pressures to achieve excellence.
- **Defectiveness/Shame:** Emanating from chronic criticism, social comparison, or fears of losing face.
- **Self-Sacrifice:** Arising from culturally sanctioned obligations to prioritise others' needs above one's own.
- **Subjugation:** Reflecting a habitual suppression of personal autonomy to maintain social harmony.

Additionally, family structures within Confucian-heritage societies—particularly those characterised by authoritarian or hierarchical dynamics—frequently reinforce the Punitive and Guilt-Inducing Parent modes, wherein affection is conditional upon achievement or compliance. Emotional restraint is valorised as a marker of maturity, reinforcing both Emotional Inhibition and Subjugation schemas. Socially, the construct of *miànzi* (face) functions as a powerful psychological regulator, perpetuating internalised shame and heightening sensitivity to social evaluation (Liu et al., 2019; Wu et al., 2023; Yeh & Bedford, 2003).

In response, Schema Therapy must be adapted to address these culturally embedded dynamics. Therapists working with Confucian-heritage clients should develop an awareness of the cultural meanings ascribed to specific schemas, validate clients' lived experiences, and tailor interventions—such as reparenting and imagery rescripting—to honor cultural values while fostering emotional authenticity and psychological flexibility.

3. Confucian Cultural Values and Their Psychological Implications

3.1 Intergenerational Transmission of Schemas

Confucian values are often transmitted through parenting styles that emphasise discipline, obedience, and hierarchical respect. A salient example is "tiger parenting," characterised by strict discipline, high expectations, and conditional reinforcement aimed at fostering achievement (Chua, 2011; Zhang & Wang, 2024). Research indicates that such parenting styles are associated with the development of schemas including Punitiveness and Unrelenting Standards (Arntz, 2021; Kim et al., 2011; Zhang & Wang, 2024).

In Confucian-structured households, affection is frequently intertwined with performance, reinforcing the Guilt-Inducing Parent Mode which significantly contributes to a collective culture of shame (Cheng & Rossner, 2023; Kim, 2016; Jacob et al., 2014). Authoritarian parenting—more prevalent in Confucian heritage society—has been linked to the development of Self-Sacrifice and Subjugation schemas, particularly among daughters (Gunty & Buri, 2008; Zhang & Wang, 2024). Children raised within these dynamics learn to suppress their individual needs in favor of preserving family honor and relational harmony, internalising beliefs that self-expression is disruptive or selfish.

Clinical observations support these findings. In a sample of ten clients across a wide age range, all demonstrated schemas related to Defectiveness/Shame, Self-Sacrifice, Perfectionism, and Guilt-Inducing Parent modes. Many clients described their emigration as an act of self-liberation from restrictive familial roles, underscoring how entrenched cultural schemas can drive significant life choices.

3.2 Cultural Dissonance: ST Principles and Confucian Values

Schema therapy's emphasis on autonomy, emotional articulation, and assertiveness (Arntz et al., 2021; Arntz, 2021) often contrasts sharply with Confucian ideals of harmony and deference. This dissonance may lead clients to experience therapeutic techniques as uncomfortable or culturally inappropriate.

For instance, clients may resist imagery rescripting exercises that involve confronting critical parental figures or may avoid assertiveness training due to concerns about filial disrespect. Such resistance often manifests as guilt when clients engage in therapeutic activities that question or challenge familial authority. Therapists must navigate these dynamics with cultural humility, reframing assertiveness as relational honesty and using metaphors to facilitate emotional exploration indirectly.

Moreover, the pervasive cultural emphasis on *miànzi* (face) intensifies clients' fears of vulnerability and perceived weakness, sustaining the Defectiveness/Shame schema. Therapists should anticipate shame-induced withdrawal, provide consistent validation, and create safe relational experiences that gently challenge internalised norms.

3.3 Formation and Perpetuation of Maladaptive Schemas in Confucian Contexts

Confucian cultural values and relational structures contribute to the formation and perpetuation of several core maladaptive schemas:

- Unrelenting Standards (Perfectionism): This schema is often driven by familial pride and fear of bringing shame. In Confucian culture, the concept of *miànzi* (face) ties family honor to individual performance (Jun et al., 2022). Academic success is frequently framed as a moral obligation, rather than a personal goal (Chen, 2023). Clients with this schema may equate self-worth with flawless performance, leading to burnout and a pervasive fear of failure (Lavrijsen et al., 2023). The schema is maintained by all-or-nothing thinking patterns, such as: "If I'm not perfect, I'm a disgrace" (Smith et al., 2017).
- Defectiveness/Shame: This schema emerges from chronic emotional invalidation, critical parenting (Arntz, 2021; Calvete et al., 2013), and internalised social surveillance. Shame-based socialisation practices (e.g. "Do not embarrass the family") teach children to monitor their behavior for signs of social judgment (Bedford, 2004; Wu et al., 2023). Emotional needs are often dismissed as selfish, reinforcing beliefs of inherent unworthiness (Arntz, 2021; Bach et al., 2017; Kaufman & Jauk, 2020). Clients frequently report chronic self-criticism and hypervigilance to criticism (Chung, 2017; Gilbert et al., 2004; Zaccari et al., 2024). Emotional inhibition exacerbates this schema, as expressing vulnerability is perceived as a source of shame (Abdelrazek et al., 2024; Butler et al., 2007).
- Self-Compromising (Self-Sacrifice/Subjugation): This schema reflects the prioritisation of collective harmony and familial duty over individual needs. Confucian collectivism emphasises group harmony above personal desires (Markus & Kitayama, 1991; Yang, 2024). Gender roles further amplify this schema, particularly for women who are expected to subordinate personal aspirations to familial obligations (Chen, 2023). Clients with this schema often neglect self-care, resulting in resentment, emotional exhaustion, and a sense of invisibility (Chiao, 2017; Clinton, 2023). Moral framing, such as "Good people put others first," perpetuates these patterns (Spencer-Rodgers et al., 2009; Wang & Miller, 2020).

In addition to these schemas, the Punitive and Guilt-Inducing Parent modes are frequently observed in Confucian-heritage clients. These modes are reinforced by high parental expectations, performance-based affection, and the moral imperative of filial piety (*xiào* 孝). Parents may use guilt-inducing tactics (e.g., "We sacrificed everything for you") to enforce compliance, linking love to achievement (Fung & Lau, 2012; Jun, 2022; Wu et al., 2023). As a result, clients internalise a punitive inner critic that generates guilt for pursuing autonomous goals, such as prioritising personal needs over familial obligations (Kim, 2016; Wang & Miller, 2020). Clinical research indicates that these schemas and modes contribute to chronic anxiety and prolonged adolescence in Confucian societies, as adults fear parental disapproval and struggle to individuate (Chung, 2017; Zhang & Wang, 2024).

These schemas and modes often coexist, forming deeply entrenched personality structures. Schema therapists working with Confucian-heritage clients must therefore foster cultural sensitivity, navigating the complex interplay between cultural norms and schema dynamics to implement effective, culturally attuned interventions.

4. Clinical Implications and Cultural Duality in Therapeutic Practice

Effectively applying Schema Therapy with clients from Confucian-heritage backgrounds requires more than a theoretical understanding of schemas. It demands a culturally responsive clinical approach that acknowledges the moral, relational, and emotional frameworks internalised through upbringing. While traditional Schema Therapy emphasises autonomy, emotional expression, and the challenging of internalised parental voices, such interventions may inadvertently clash with Confucian values of filial piety, social harmony, and moral modesty. Therefore, therapists must adapt their strategies to respect these cultural imperatives while facilitating psychological growth.

This adaptation can be informed by the dynamic interplay between Confucianism and Taoism in Chinese cultural psychology. Confucianism serves as the dominant and explicit moral framework, emphasising relational obligations and societal achievement, while Taoism offers a complementary, often implicit, philosophy that promotes acceptance, balance, and effortless action (Chang et al., 2020; Ding et al., 2020; Zhang & Young, 1998; Zhu & Young, 2013). Many individuals from Confucian-heritage cultures draw on both traditions across the lifespan—Confucianism during periods of active striving and Taoism during times of adversity, such as failure, illness, or existential uncertainty (Chang et al., 2020; Zhang et al., 2002). This duality functions as a cultural coping mechanism; Confucianism guides ambition, while Taoism offers solace and acceptance (Chang et al., 2020; Ding et al., 2020).

Clinically, this dual framework suggests that therapists should validate Confucian values—such as filial piety and moral responsibility—during goal-oriented phases of therapy while drawing upon Taoist principles—such as *wu wei* (effortless action) and *ziran* (naturalness)—to address distress arising from unmet expectations. For instance, a Confucian-driven Critic mode (e.g., "You must excel to honor your family") can be gently balanced by a Taoist-informed Healthy Adult mode (e.g., "Growth unfolds naturally when rigid striving is released"). This integrative approach aligns with the Taoist emphasis on harmony and effortlessness, enabling schema restructuring without directly challenging deeply held cultural ideals.

This duality also complements the expanded core emotional needs framework proposed by the International Society of Schema Therapy (ISST, 2023). While Confucian values emphasise connection and role fulfillment, Taoist principles promote autonomy and self-acceptance. Culturally attuned therapists can thus validate Confucian-derived schemas while introducing Taoist-informed perspectives to meet unmet emotional needs in a culturally coherent manner.

4.1 Building the Therapeutic Alliance

Establishing a strong therapeutic alliance is particularly critical for clients from Confucian-heritage backgrounds, who may approach therapy with ambivalence, shame, or fear of emotional exposure (Badanta, 2022; Lui, 2019). Therapists must adopt a stance that is both authoritative and benevolent—akin to the "wise elder" archetype within Confucian relational models. This stance combines warmth, guidance, and structure, positioning the therapist not as an adversary to cultural values, but as a mentor who facilitates emotional growth within those values (Ding, 2024; Lee, 2018).

Within Taoist Cognitive Therapy (TCT), the therapist's role further embodies principles of balance and non-fixation, fostering a relational style that emphasises acceptance, flexibility, and alignment with natural rhythms (Chang et al., 2016, 2020). By modeling *wu wei* (effortless action), therapists create a therapeutic environment that encourages clients to align their personal growth with organic processes, rather than imposing rigid or confrontational interventions (Ding et al., 2020; Young & Zhu, 2008). This approach complements Confucian values by framing the therapist as a non-intrusive, guiding presence who facilitates emotional authenticity while maintaining relational harmony.

To reduce cultural dissonance, therapists should use language and metaphors that align with Confucian worldviews (Wong, 2021; Hwang, 2009). For instance, instead of framing assertiveness as defiance, it can be described as cultivating "inner integrity" or "honest communication for mutual respect" (忠诚沟通). Similarly, autonomy work can be linked to Confucian ideals of moral self-cultivation (修身) and the pursuit of "effortless action"(无为), emphasizing personal growth as a path to contributing more meaningfully to family and society (Ding et al., 2020; Analects 4.18; Zhu et al., 2012).

4.2 Working with Modes and Maladaptive Coping

Many clients from Confucian-heritage backgrounds present with Critic or Guilt-Inducing Parent Modes, which echo the disciplinary tones of moral obligation and perfectionistic expectations ingrained by caregivers (Nadene, 2023; White, 2022). These modes are often internalised not just as parental voices, but as extensions of moral conscience. Directly confronting or challenging these modes may trigger resistance or self-criticism. Instead, clinicians can use Imagery Rescripting or Mode Dialogues that validate the original intention of these voices (e.g., protection, promotion of achievement) while gently renegotiating their intensity and scope (White, 2022).

For example, in working with a harsh inner critic rooted in filial expectations, the therapist might guide the client to reimagine the "parent mode" evolving into a more compassionate mentor who acknowledges the client's humanity and intrinsic worth. This approach reframes cultural values not as pathological, but as potential sources of resilience, while addressing their psychological costs.

4.3 Supporting Vulnerable and Inhibited Parts

Confucian values often discourage open emotional expression, fostering the suppression of vulnerable or authentic needs (Cui et al., 2022). Clients may present with schemas of Emotional Inhibition, Subjugation, or Defectiveness/Shame that have become so normalised that they remain invisible to the client's conscious awareness. Therapists must explicitly validate and normalise emotional expression, using metaphorical or somatic techniques to bypass shame and facilitate access to vulnerable parts (Cui et al., 2022; Young, Klosko, & Weishaar, 2003).

Culturally attuned reparenting strategies should avoid framing parental values as inherently dysfunctional. Instead, therapists can employ dual imagery—visualising both the inner child and an idealised, compassionate parent acting in harmony. This approach preserves cultural ideals of harmony and relational duty while simultaneously addressing unmet emotional needs. In clinical practice, this approach has demonstrated positive outcomes.

4.4 Addressing the Migration Narrative: Cultural Duality in Transition

For immigrant clients, migration represents not only a geographical shift but also a profound psychological turning point. The rupture from the cultural context—whether voluntary or imposed—can serve as a catalyst for reexamining maladaptive schemas rooted in Confucian familial expectations (e.g., filial piety, perfectionism). Many clients conceptualise migration as an act of emancipation, framing it as an opportunity to "escape the weight of family duty" or "finally breathe freely" (Mao et al., 2022; Martin et al., 2024).

Schema Therapy provides a structured framework to explore these narratives:

- Reclaiming Autonomy: Migration often reflects a quest to meet autonomy needs. Therapists should validate these needs while acknowledging the client's loyalty to their cultural heritage.
- Dual Cultural Identity: Clients may oscillate between Confucian-driven schemas (e.g., "I am selfish for prioritising myself") and Taoist-informed perspectives (e.g., "My worth is not defined by productivity"). Therapists can facilitate the integration of these identities into a coherent sense of self.
- Symbolic Reparenting: Imagery rescripting can reframe migration as an act of self-protection (e.g., "The part of you that left was seeking safety, not betraying your family").

These interventions enable clients to reconcile cultural loyalty with the pursuit of psychological well-being, fostering a nuanced, culturally attuned healing process.

Clinical Example:

The following cases illustrate how Schema Therapy navigates the tension between Confucian obligations and migrant self-actualization.

Case 1: Male client, 49 years old

A 49-year-old male client who immigrated from mainland China a decade ago presented with profound guilt over his decision to leave, framed through a Confucian lens as "abandoning familial duties." Despite acknowledging the emotional burden that necessitated his departure ("I had no choice"), he struggled with self-perceived moral failure. The therapist integrated Taoist tenets (e.g., *wu wei*, effortless action) and Confucianism's emphasis on self-cultivation to reframe his migration as a natural response to systemic imbalance—validating his autonomy needs while honoring his cultural values. This approach softened his punitive self-narrative and fostered self-compassion without demanding rejection of filial piety.

Case 2: Female client, 50 years old

A 50-year-old female client reported immigrating seven years ago primarily to meet her mother's expectations of academic

and social achievement ("I came to prove my worth"). Though she preferred to remain in China, her mother framed emigration as a performance of familial honor. Therapy uncovered a Guilt-Inducing Parent Mode ("You must excel to validate our family") and a Subjugated Child Mode ("My desires don't matter"; "I should listen to my mum".). The therapist employed limited reparenting to reconcile her unmet needs for autonomy with Confucian loyalty, while Taoist principles (e.g., *ziran*, naturalness) helped her disentangle self-worth from external validation.

5. Case Studies and Clinical Applications

Patterns Across Cases

A review of ten clinical cases involving clients from China, Malaysia, and Korea (ages 16–49) revealed consistent activation of maladaptive schemas shaped by Confucian family dynamics. All clients exhibited schemas of Defectiveness/Shame, Self-Sacrifice, and Unrelenting Standards, alongside persistent Critic and Guilt-Inducing Parent modes. These patterns emerged within familial environments characterised by authoritarian parenting, high achievement expectations, and the cultural primacy of filial piety (*xiào* 孝) and face (*miànzi*面子). Notably, each client conceptualised migration as an act of psychological liberation—an attempt to escape oppressive familial obligations and reclaim autonomy. This recurring narrative underscores how cultural and intergenerational dynamics shape schema formation and highlights the importance of culturally sensitive interventions.

Case Study: A 29-year-old Chinese woman with complex trauma

The client, a 29-year-old Chinese woman, presented with symptoms consistent with complex trauma, including chronic insomnia, frequent panic attacks, pervasive self-blame, emotional suppression, and difficulties establishing interpersonal boundaries. Her developmental history was marked by significant emotional neglect, verbal, physical, and sexual abuse, and chronic criticism from both parents and extended family members. Despite this history of maltreatment, the client maintained a deeply internalised belief that her parents loved her and that their abusive behaviors were justified by her perceived inadequacy. Shame pervaded her self-narrative, as reflected in statements such as, "They treated me like that because I was bad," and "I feel ashamed and guilty for upsetting my entire family." These expressions revealed entrenched Defectiveness/Shame and Guilt-Inducing Parent schemas, as well as a rigidly internalised punitive inner critic.

Embedded within this schema constellation was a culturally reinforced sense of filial piety (*xiào*, 孝), compelling the client to prioritise her parents' well-being over her own. As an adult, she devoted substantial emotional and financial resources to supporting her parents, despite enduring severe Self-Sacrifice, Emotional Inhibition, and Unrelenting Standards schemas. She reported persistent difficulty in setting boundaries across multiple relational contexts and described herself as "never good enough," despite objectively high levels of achievement.

Cultural-Schema Formulation:

- Defectiveness/Shame Schema: Reflected in self-statements such as "They treated me badly because I'm not worthy and I deserved it," this schema was reinforced by the Confucian ethic of filial piety, which conflates obedience with moral worth.
- Self-Sacrifice Schema: Manifested in her prioritization of her parents' well-being at significant personal wellbeing cost.
- Critic and Guilt-Inducing Parent Mode: Internalised punitive self-criticism linked to unfulfilled parental expectations (e.g., "I'm selfish for having or prioritising my own needs").

Culturally Adapted Interventions:

Therapeutic Alliance: The therapist adopted a "wise mentor" stance, consistent with Confucian relational hierarchies, to validate the client's loyalty while gently challenging maladaptive schemas. Early sessions focused on establishing a safe and attuned therapeutic alliance, acknowledging that reflections on her parents' emotional failures initially evoked intense feelings of shame, as such acknowledgement were perceived as acts of disloyal or violations of filial piety. Rather than directly confronting maladaptive schemas, therapy began by fostering safety and trust.

Taoist Cognitive Therapy (TCT) Integration: Guilt was reframed through the Taoist principle of effortless action (*wu wei* 无为), prompting reflection on whether true love necessitates endless self-sacrifice—a question aligned with the Confucian tenet of "Respect, but do not obey blindly" (Analects 4.18; Chang et al., 2020; Ding et al., 2024).

Metaphorical Storytelling: The therapist used metaphorical storytelling as an indirect intervention, drawing upon the client's well-established nurturing relationship with her pet dog as a therapeutic analogy. This narrative technique served three key functions: (1) providing a culturally congruent vehicle to externalise her unmet needs for unconditional love and safety, (2) normalizing core emotional needs (affection, validation, autonomy) through non-threatening displacement, and (3) creating psychological distance from familial loyalty conflicts. The pet caregiving metaphor particularly resonated with Confucian ideals of benevolent care (*rén* 仁) while circumventing shame triggers associated with direct need expression (Ding et al., 2024; Ding et al., 2020). This approach successfully facilitated access to Vulnerable Child and Healthy Adult modes while preserving the client's sense of filial integrity.

Imagery Rescripting: The client revisited traumatic childhood scenes through imagery rescripting, not to condemn her parents, but to cultivate intergenerational empathy by recognising their own unmet needs and limitations. The therapist validated the client's filial piety while gently challenging the shame schema through Taoist-informed effortless action (*wu wei* 无为) and following nature (*ziran*, 自然). Over time, the client developed a more balanced perspective—one that acknowledged both her parents' hardships and her own developmental needs.

Limited Reparenting: Modeled self-compassion as "moral self-cultivation" (*xiu shen*, 修身), aligning autonomy with Confucian values (Ding et al., 2024).

Limited reparenting was instrumental in this process, as it offered a corrective emotional experience where needs for nurturance, autonomy, and affirmation could be directly met within the therapeutic space. Boundary-setting skills were gradually introduced as acts of integrity and mutual respect, reframed not as rebellion but as part of a healthy, adult relational dynamic. This case underscores the importance of cultural adaptation in schema work, particularly when working with clients shaped by Confucian ideologies. By embedding schema interventions within a culturally coherent framework, therapists can promote healing without rupturing the client's core identity or values.

Developing the Healthy Adult Mode: A Taoist–Confucian Synthesis

The Healthy Adult Mode was cultivated by anchoring eight core Taoist principles, each carefully framed to complement—in place of contradiction—the client's Confucian

value system. Drawing on the culturally adapted schema therapy framework and the clinical study on the application of Taoist Cognitive Therapy (Young et al., 2008; Zhu & Young, 2013; Ding et al., 2020), these principles were intentionally embedded into the therapeutic process to foster a culturally coherent and emotionally balanced sense of self. Zhu and Young (2013) outlined eight core Taoist principles relevant to schema healing. These include:

- Benefiting without harm (利而不害)—acting in ways that benefit both self and others.
- Do your best without competing (为而不争)—Striving for excellence without engaging in unhealthy comparison.
- Know harmony and embracing humility (知和居下)—maintaining balance while occupying a modest position.
- Moderating personal desires and limit selfishness (少私寡欲)—reducing self-centeredness and over-fixation/excessive ambition.
- Knowing when to stop and being content (知足)—Recognising sufficiency and releasing perfectionistic striving.
- Hold to softness to overcome hardness (守柔)—cultivating flexibility and gentleness as strengths.
- Return to childlike innocence (复归婴儿)—accessing vulnerability and authentic emotional expression.
- Following the way of nature (道法自然)—living in accordance with natural rhythms and one's true nature.

Each principle contributed to the reshaping of maladaptive schemas. For instance, ***Benefiting Without Harm*** helped the client reconcile self-care with familial responsibilities, reframing boundary-setting as an ethical and sustainable act rather than a betrayal of family duty. ***Doing One's Best Without Competing*** softened the grip of the Unrelenting Standards schema, allowing room for achievement grounded in self-acceptance. ***Moderating Desires*** preserved filial piety while enabling the client to negotiate between parental expectations and personal needs. ***Knowing Contentment*** countered perfectionistic striving by fostering an appreciation for "enough," reducing the drive for unattainable standards.

Metaphorical grounding enhanced emotional resonance: for example, ***Holding to Softness*** was likened to the client's nurturing care for her dog, illustrating how strength can manifest through gentleness. ***Returning to Innocence*** allowed the Vulnerable Child mode to emerge without shame, while ***Following the Way of Nature*** affirmed autonomy as an organic extension of family harmony, rather than a threat to it. ***Knowing Harmony and Maintaining Humility*** facilitated interpersonal balance, enabling the client to assert her needs respectfully while maintaining family cohesion.

Through this integrated approach, the client's Healthy Adult mode emerged not as a rejection of cultural tradition, but as a synthesis—one that embraced filial piety while fostering self-compassion, balancing discipline with emotional flexibility, and honoring both cultural identity and individual psychological needs.

To illustrate how Confucian and Taoist principles can be integrated into schema therapy, Table 1 contrasts Confucian values and Taoist principles with culturally adapted therapeutic strategies, demonstrating their integration into Schema Therapy to meet the unmet core emotional needs (Lockwood, 2022). This framework highlights potential synergies between cultural values and clinical interventions; however, it is not exhaustive. In practice, addressing a single emotional need may require flexibly combining multiple principles from both traditions to ensure culturally responsive care.

Table 1: Culturally Adapting Schema Therapy: Integrating Confucian Values and Taoist Principles to Address Unmet Core Emotional Needs

Confucian Value	Taoist Principle	Culturally Adapted Therapeutic Strategy	Core Emotional Needs Addressed
Filial piety (孝)	*Wu wei* (无为) - effortless action ：Doing one's best without force; *Li Er Bu Hai* (利而不害) - benefit without harm	Reframe autonomy as moral self-cultivation, allowing growth without violating family loyalty. Focus on relational boundaries and ethical self-protection.	Need for respect in developing autonomy (Autonomy Granting); Need for connection (Unconditional love, nurturance)
Face (面子)		Balance shame with self-compassion; honor social roles while expressing vulnerability. Reframe self-assertion as 'benefiting all' (including oneself); challenge overcompliance as harmful long-term.	Need for support and guidance in expressing needs; Need for affirmation of capability (Competence development); Need for a parent/caregiver who is experienced as confident and competent
Emotional restraint (内敛)	*Shou Rou* (守柔) - Holding softness	Model gentle assertiveness; foster safe expression of feelings.	Need for support and encouragement of play, emotional openness and spontaneity; Needs of safety and consistency.
Social harmony (和)	*Dao Fa Zi Ran* (道法自然)-Following nature	Support authenticity within collectivist norms; allow emotional needs to unfold naturally.	Need for compassionate, firm guidance (Realistic limit-setting); Need for connection Role Model Presence

High moral standards (礼 / 义)	*Zhi Zu* (知足)-Knowing contentment	Counter perfectionism by redefining success; promote satisfaction and balance.	Need for affirmation of capability (Competence); Need for support and encouragement of play/spontaneity
Suppression of personal needs (克己)	*Shao Si Gua Yu* (少私寡欲)-Moderate desires	Reframe self-care as ethical moderation; challenge overcompliance without rejecting duty.	Need for support in developing a sense of intrinsic worth; Need for compassionate limit-setting
Rigid self-discipline (自律)	*Wei Er Bu Zheng* (为而不争) -Benefit without harm	Reducing perfectionistic rivalry. Help clients differentiate self-improvement from compulsive striving; redefine success as alignment with inner values (not external benchmarks).	Need for compassionate, firm guidance (Realistic limit-setting); Need for respect in developing autonomy Need for affirmation of competence
Obedience and role conformity (顺从)	*Fu Gui Ying Er* (复归婴儿)- Return to innocence	Allow the Vulnerable Child to be seen without shame; nurture spontaneity, playfulness and emotional openness.	Need for support and encouragement of play/spontaneity; playfulness; Need for support in developing a sense of intrinsic worth Role model presence

6. Discussion

This paper underscores the complex interplay between Confucian cultural values and the development of Early Maladaptive Schemas (EMSs) among individuals of East Asian descent, particularly within Chinese communities. The clinical case and thematic analysis highlight how schemas such as Defectiveness/Shame, Self-Sacrifice, Unrelenting Standards, and Guilt-Inducing Parent mode are not merely intrapsychic phenomena but are reinforced and maintained within culturally sanctioned relational norms. While Schema Therapy (ST) provides a robust and integrative framework for addressing chronic emotional difficulties, its foundational emphasis on autonomy, emotional expression, and the confrontation of internalised parental modes reflects Western individualistic paradigms (Martin et al., 2024; Mao et al., 2022). These values may conflict with the moral-relational frameworks of Confucian-heritage clients, underscoring the need for thoughtful cultural adaptation.

6.1 Cultural Fit and Gaps in Empirical Validation

Despite growing interest in culturally adapted psychotherapy, empirical research on the efficacy of ST in Asian populations remains sparse. Few randomised controlled trials (RCTs) have evaluated ST's applicability in East Asian settings, limiting its generalisability beyond Western clinical populations (Mao et al., 2022; Zhang et al., 2023). Existing studies suggest promising results, but the lack of large-scale, culturally specific validation studies poses a significant challenge for widespread adoption. This gap is particularly critical for clinicians working with immigrants and culturally hybrid clients who must navigate the tension between Confucianism cultural values and the individualistic assumptions embedded in ST interventions.

Furthermore, the normative moral frameworks embedded in Confucianism may mask maladaptive schemas, making clients less likely to identify their patterns as problematic. For example, what Western psychology may interpret as pathological perfectionism or excessive guilt may, within a Confucian lens, be seen as moral diligence or familial devotion. This cultural framing can obscure the severity of symptoms, delay help-seeking behaviors, and foster therapeutic resistance when clients perceive schema interventions as disloyal to family or tradition.

6.2 Integrating Hybrid or Complementary Models

To enhance the cultural fit of Schema Therapy (ST) for clients from Confucian-influenced societies, the integration of Taoist-informed models alongside ST offers a promising avenue for therapeutic adaptation. While direct empirical studies on combined Taoist-Schema Therapy models remain scarce, existing research on Taoist Cognitive Therapy (TCT) provides substantive theoretical and clinical foundations for potential synergies with schema-based treatment paradigms.

Taoism philosophy has profoundly influenced Chinese culture for centuries, emphasising principles of harmony, balance, effortless action (*wu wei*, 无为), and acceptance of natural processes. These Taoist concepts provide a vital counterbalance to the achievement-oriented, self-critical schemas commonly reinforced in Confucian cultural contexts. Taoist principles—such as yielding, accepting impermanence, and embracing non-fixation (*wú niàn*, 无念)—may provide clients with culturally resonant strategies for emotional regulation, particularly in addressing schemas related to Perfectionism, Defectiveness/Shame, and Self-Sacrifice (Zhu & Young, 2013; Ding et al., 2020).

For example, integrating Taoist concepts of acceptance and effortless action into Schema Therapy could help clients reduce emotional inhibition and soften self-criticism. The Taoist notion of *wu wei*—"effortless action"—aligns with therapeutic goals of reducing overexertion and perfectionistic striving, fostering a mindset of balance, self-compassion, and natural growth. Specifically, Taoist Cognitive Therapy (TCT; Zhang & Young, 1998) presents a theoretically coherent adjunct to Schema Therapy through its systematic incorporation of Taoist philosophy with cognitive-behavioral techniques. TCT's emphasis on cognitive non-fixation and authentic self-alignment provides a specific therapeutic framework to reframe rigid thoughts, promoting cognitive flexibility, and fostering alignment with one's true nature. This integrated approach could provide a culturally congruent therapeutic framework, which may be particularly efficacious for clients grappling with the tension between filial

duty and personal autonomy (Zhang & Young, 1998; Ding et al., 2020; Ding et al., 2024).

Expanding this integration further, mindfulness-based approaches, drawing from Taoist principles of awareness and acceptance, can synergistically complement imagery rescripting and limited reparenting techniques in Schema Therapy. Such an integrative approach may reduce resistance to schema interventions, as Taoist principles encourage embracing all aspects of the self—including imperfections and vulnerabilities—without judgment or shame.

In practice, this hybrid model could be implemented through:

- Incorporating Taoist concepts (e.g. balance, harmony, effortless action) into schema dialogues to address internal conflicts between self-critical modes and compassionate self-states.
- Combining Taoist mindfulness and acceptance practices with mode work in Schema Therapy helps clients gently observe and accept their emotional states without judgment, thus reducing tendencies toward self-punishing behavior or emotional suppression.
- Using indirect narrative techniques such as storytelling, metaphors, or guided imagery rescripting that align with Taoist techniques, allowing clients to explore their schemas without the need for direct confrontation, which may feel culturally threatening or disrespectful.

While Schema Therapy offers an effective framework for addressing entrenched maladaptive patterns, the integration of Taoism's acceptance-based philosophies can help bridge the cultural gap and enhance the therapeutic process for clients Confucian-influenced backgrounds. Such integration could be particularly beneficial in helping clients navigate the tension between filial duties, social obligations, and their own psychological needs for autonomy, self-expression, and emotional safety.

Other culturally congruent modalities, such as mindfulness-based interventions, Compassion-Focused Therapy (CFT), Morita Therapy or filial narrative reconstruction, may also serve as adjunctive tools to reduce resistance and enhance schema healing without undermining cultural identity (Craig et al., 2020; Gilbert, P. 2009).

Future research is essential to empirically examine these hybrid approaches. Randomised controlled trials and longitudinal studies are needed to evaluate the clinical efficacy and cultural relevance of integrating Taoist principles into Schema Therapy for East Asian populations.

6.3 Therapist Role and Culturally Competent Delivery

Clinicians working with Confucian-heritage clients must cultivate a nuanced and culturally informed therapeutic stance. This includes not only adjusting interventions but also embodying relational qualities that resonate with clients' moral and cultural frameworks. Therapists are often perceived not merely as reparenting figures, but as moral guides—akin to the *junzi* (君子, noble person) archetype in Confucianism—who model integrity, balance, and compassionate authority.

Therapeutic interventions such as imagery rescripting, limited reparenting, and mode work must be conducted with attunement to the client's internal conflict between individual needs and social obligations. This requires therapists to hold space for both loyalty and liberation, for shame and self-compassion, for critique and care—thus enabling a dialectical integration that respects cultural values while promoting psychological healing.

6.4 Future Directions

Future research should prioritise:

- Conducting randomised controlled trials and longitudinal studies to assess the efficacy of Schema Therapy among diverse East Asian populations.
- Undertaking qualitative studies exploring client narratives around cultural identity, family dynamics, and schema themes.
- Developing training frameworks to cultivate cultural competence among therapists working with Confucian-heritage populations.
- Creating culturally adapted assessment tools, such as modified schema inventories that capture culturally normative but potentially maladaptive beliefs.
- Systematically studying hybrid Taoist-Schema Therapy models through rigorous empirical designs.

Strengthening both the empirical evidence base and clinical applications of culturally responsive Schema Therapy is essential for equipping clinicians to meet the complex needs of a diverse and increasingly multicultural client population.

7. Conclusion

The interplay between Confucian cultural values and the development of Early Maladaptive Schemas (EMSs) is a complex and critical area of study in cross-cultural psychology and psychotherapy. This paper has explored the intricate relationship between Confucian cultural values and the development of Early Maladaptive Schemas (EMSs), underscoring how core principles—such as filial piety, emotional restraint, and shame-based social regulation—contribute to the formation and perpetuation of schemas, particularly those related to Guilt-Inducing Parent, Perfectionism, Defectiveness/Shame, and Self-Sacrifice. These schemas are not isolated intrapsychic phenomena; rather, they are inextricably linked to moral, familial, and societal expectations that shape the self-concept and emotional functioning of individuals from Confucian-heritage cultures. For clients from Chinese or East Asian backgrounds, the internal struggle between personal autonomy and familial duty often results in the internalisation of patterns that impair emotional regulation, self-worth, and interpersonal relationships.

While Schema Therapy has demonstrated efficacy in treating various psychological conditions in Western contexts, this paper has emphasised the critical importance of culturally adapted interventions when working with Confucian-heritage clients. The traditional Schema Therapy model—rooted in values of autonomy, emotional expressiveness, and direct confrontation of internalised parental voices—may not fully resonate with clients whose schemas are deeply embedded in relational obligations and respect for family hierarchy. Culturally sensitive adaptations are thus essential. These adaptations include reframing reparenting techniques to reflect Confucian relational structures, employing indirect therapeutic methods such as metaphorical storytelling or dual-awareness imagery to maintain cultural respect while fostering emotional insight, and integrating Taoist-informed principles—such as *wu wei* (effortless action) and *ziran* (naturalness)—to promote acceptance, balance, and self-compassion.

Furthermore, the integration of Schema Therapy with Taoist Cognitive Therapy holds promise as a hybrid model for clients navigating the tensions between Confucian moral imperatives and individual psychological needs. While early research has examined the clinical application of Taoist Cognitive Therapy among Chinese immigrant populations in the United States (Zhang et al., 2002) and clinical samples in Mainland

China (Ding et al., 2020), further empirical validation, including randomised controlled trials (RCTs) and longitudinal studies, is essential to empirically assess the efficacy and cultural fit of such integrated approaches. The development of culturally specific assessment tools—such as a Confucian Schema Inventory—would also enhance the precision of schema measurement and facilitate targeted interventions that reflect the unique cultural configurations of schemas within Confucian contexts. Research should also explore the integration of Schema Therapy with other culturally relevant therapies and interventions, refining hybrid models that enhance cultural fit without compromising therapeutic integrity.

In conclusion, the development of culturally competent Schema Therapy practices offers significant potential to support the psychological healing and empowerment of clients affected by the internalised demands of Confucian values. By respecting cultural contexts while adapting therapeutic methods, clinicians can help clients reclaim autonomy, cultivate emotional well-being, and develop a healthier, more integrated sense of self within the context of their cultural heritage (Martin et al., 2024).

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